

Patient Mobility in the European Union

Learning from experience

Edited by

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This book has been elaborated under the *Europe for Patients* project and is published under the auspices of the European Observatory on Health Systems and Policies

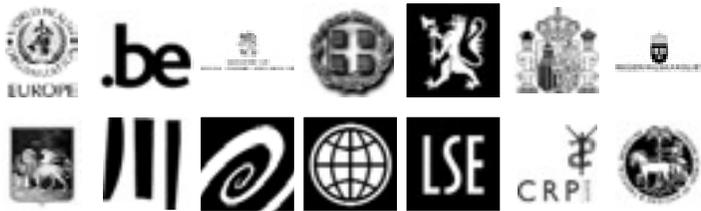


The Europe for Patients (e4p) project, launched in February 2004, studies the benefits and challenges of patient mobility in Europe with the objective to provide the evidence needed to maximize the benefits that can be achieved with enhanced patient mobility in Europe. The objective is to enable policy makers at EU and national level to take concerted and coordinated action to allow Europe's citizens/patients to benefit from enhanced mobility in Europe through actions at different levels (regional, national, European) employing legal, organizational and regulatory approaches, building on earlier work developed for the Ghent conference of December 2001 under the Belgian Presidency.

The project brings together a multidisciplinary team drawing on legal, health policy, health services research and health management perspectives, covering the European Union, including the new Member States. The team, led by IESE Business School (Spain), is formed by the London School of Hygiene & Tropical Medicine (United Kingdom), the London School of Economics and Political Science (United Kingdom), the Observatoire Social Européen (Belgium), the Faculty of Law of Ghent University (Belgium), the Centre for Cross-Border Studies (Ireland), the Institute of Public Health (Slovenia), Praxis (Estonia), the European Observatory on Health Systems and Policies, the Veneto Region (Italy) and the Association Internationale de Mutualité (AIM).

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In memory of Ruta Kruuda (1967–2005)

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Foreword



It gives me great pleasure to introduce and commend this publication of case studies on patient mobility, one of the first set of results to come from the Sixth Framework Programme's policy-oriented research strand in the area of health.

Indeed, the Europe for Patients project (e4p) is one of the first to be supported under the "Scientific support to policies" (SSP) activity of the Sixth Framework Programme. This SSP project initiative aims to provide scientific underpinning and the evidence base needed by European Union (EU) policy-makers to take concerted and coordinated action to allow Europe's citizens/patients to benefit from enhanced mobility in Europe.

These first results of the Europe for Patients project represent a continuation of a series of research publications developed under the EU Framework Programmes, including the BIOMED 2 project "Impact of the Single European Market on Member States", that substantially contributed to the health policy process at European level. The patient mobility issue was brought to the fore through findings that identified four main areas that required attention. These were: waiting lists and free capacities; centres of excellence/reference centres; closer cooperation in border regions; and health care for persons undergoing long-term stays. The project also builds on earlier work by the high-level reflection process on patient mobility and health care developments in the European Union and its follow-up by the European Commission.

This account of practical experience comes at an interesting moment in the policy debate over health care and the role of the European Union, particularly

in the light of the Lisbon Agenda and the discussion on the social implications of the EU internal market. It brings together the rich cross-border experiences in different areas, and these practical accounts will help to better shape policies in the area of patient mobility, and health systems and health care services in general. Thus, Europe for Patients is proving to be a value-added resource for policy-makers, demonstrating the importance of a coherent policy-oriented research effort at European level in the field of public health and health systems.

Looking to the future, the Commission recently presented a proposal for a specific part under the Seventh Framework Programme to include more extensive research on optimizing the delivery of health care to European citizens. It will focus on practical and implementation aspects, such as translating clinical outcome into clinical practice, quality, efficiency and solidarity of health systems, health promotion and disease prevention, evidence-based medicines and better and appropriate use of new health therapies and technologies. All this will contribute towards strengthening policy research at EU level.

The Europe for Patients project results and their policy relevance highlight the strong link between research and policy, being both responsive and coherent. We believe this book will provide policy players throughout the EU with better insight and evidence for enhancing policy decisions – ultimately for the benefit of all European citizens. It should also demonstrate that first class research leads to high-quality policies.

The patient mobility issue is, I believe, an issue that will remain on Europe's agenda for some years to come, and will increase in importance. EU research funding is ideally placed to serve the needs of policy-makers in this domain and we look forward to further results and policy contributions from the SSP activity and under the new direction provided for in the Seventh Framework Programme.

Octavi Quintana i Trias

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Foreword



As we seek joint approaches to shared problems concerning the mobility of patients across the European Union, I am always keen to ground our European discussions in reality. These case studies provide an invaluable account of real experience of both the benefits and challenges arising from patient mobility in Europe. They show cases where Member States are keen to collaborate in capacity sharing and in the creation of centres of reference, for example. So if the conditions are right, there does seem to be scope for more cooperation at European level to bring benefits to all patients throughout the Union, whether they exercise their rights to move between countries or not.

This work has emerged at just the right time. The recently established EU High Level Group on Health Services and Medical Care is preparing concrete proposals for considerations by ministers. The work of the High Level Group has been dynamic, with active contributions from all Member States and solid progress on key issues including the facilitation of cooperation in cross-border care, centres of reference, and the establishment of a European network for health technology assessment.

The Europe for Patients research team, led by IESE Business School, has made a valuable contribution to the patient mobility debate, as have other projects under the Commission's research programme. In the present case the research group has been working closely with the High Level Group and with the Commission. I believe that these practical accounts will be of great value in this process, and I look forward to further results from the project in the future.

Robert Madelin

Director General for Health and Consumer Protection, European Commission

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Chapter 1

Patient mobility: the context and issues

Magdalene Rosenmüller, Martin McKee, Rita Baeten, Irene A. Glinos

Introduction

A decade ago, there was little discussion of the issue of patient mobility at a European level. The Treaty of Amsterdam made clear that health systems were a matter for national governments. It was recognized that freedom of movement of people within Europe required that those people who travelled could obtain health care should an emergency arise and this had been taken care of by Council Regulation (EEC) No. 1408/71, which had established the E111 system. It was also recognized that there may sometimes be benefits to health systems from collaboration across borders, for example to avoid the need to duplicate specialized facilities. This could be addressed either under the E112 system or through one of the many bilateral agreements that existed. Furthermore, the number of people who moved across borders was still relatively few, and most of those who did were unlikely to need health care.

This situation has changed, in many ways. The extent of mobility within Europe has increased markedly. Many people from northern Europe have decided to spend their retirement years in the warmer climates in the south. The growth of budget airlines means that many people whose parents might never have travelled beyond the nearest large city may take several short breaks each year in a different part of Europe. These same airlines allow a growing number of people to commute weekly between a home in one part of Europe and work in another. This new European generation, accustomed to crossing frontiers with ease and able to purchase goods and services from any part of the European Union, is less likely to accept constraints on where it can obtain health care. As a consequence, a succession of individuals has challenged the

status quo and, in many cases, the European Court of Justice has upheld their arguments. At the same time, Europe's politicians have avoided legislation that would provide a clear framework for the new reality, in part because of apprehension about the risks of opening Pandora's box, but also because it was not clear what should be done given the complexity of health care. But what is this reality? The individuals whose cases have been heard by the European Court of Justice represent only a very small and often atypical selection of European patients. So far they have come from a small number of Member States and elsewhere there seems to have been little interest in pursuing a legal remedy to any problems that may exist. Is it the case that problems elsewhere have been resolved by other means or are there serious problems that have yet to be resolved? This book is an attempt to inform the debate that is already taking place between Europe's policy-makers, looking at a series of case studies that illustrate the different aspects of patient mobility within the European Union and how Europe's health systems have responded to them. Most of the case studies presented in this book have been analysed within a project funded by the European Union's Sixth Framework Programme – Europe for Patients (e4p).

How much mobility of patients is actually taking place? If it is only a marginal phenomenon, why should we bother about it? A survey undertaken by the German Techniker Krankenkasse (2001) found that its members were very mobile, with 80% going to another country as least once a year. However, of those, only 2–5% needed health care and this was mainly for ambulatory services whose costs represented less than 0.5% of the fund's overall expenditure. So why should we care? There are several reasons for doing so. First, there is a substantial amount of so far largely anecdotal evidence suggesting that cross-border care sometimes falls outside the mechanisms designed to ensure that the care provided is of high quality and responsive to the needs of the patient, especially where that patient does not speak the language of the country in which he or she is being treated or does not understand the health system. Second, given the continuing imbalance between supply and demand in Europe's health systems, it may be that there is scope for greater mobility that would benefit both patients and health care providers within Europe.

The emergence of patient mobility on the policy agenda

Patient mobility has only slowly emerged on the European health policy agenda. Although there are some earlier judgments of the European Court of Justice that relate to this issue, it is generally held that the seminal ones were those in 1998 concerning *Kohll* and *Decker*, which unleashed a flurry of political and academic discussion about the precise implications of these rulings that established an important principle while offering very little detail of what they

meant in practice (Busse et al., 2002). In December 2001, a conference held in Ghent organized by the Belgian presidency of the European Union focused the attention of many more health policy-makers on the impact of European law on health care (McKee et al., 2002; Mossialos and McKee, 2002). The debate continued under the Spanish presidency of the European Union, in particular at a conference held in Malaga in February 2002, leading to the Council of Ministers calling, in June 2002, for the creation of a high-level process of reflection on patient mobility and health care developments in the European Union. In December 2002 this led to a report under the auspices of three commissioners (health, social and internal market) that made a series of 19 recommendations in five main areas.

- 1 European cooperation should enable better use of resources, covering issues such as the rights and duties of patients; activities to facilitate the sharing of potential spare capacity; fostering cooperation in border regions; creation of European centres of reference; and shared evaluation of medical technology.
- 2 Better information should be provided for patients, professionals and providers, with a strategic framework for information initiatives covering issues such as health policies, health systems, health surveillance, technological solutions, quality assurance, privacy, records management, freedom of information and data protection.
- 3 Care should be accessible and of good quality, covering issues such as improving knowledge about access and quality issues and analysing the impact of European activities on access and quality.
- 4 National objectives should be reconciled with European obligations, covering issues such as improving legal certainty and developing a permanent mechanism to support European cooperation in the field of health care and to monitor the impact of the EU on health systems.
- 5 The European Union's cohesion and structural funds should be examined to find ways to facilitate the inclusion of investment in health, health infrastructure development and skills development as priority areas for funding under Community financial instruments.

The Commission responded to these recommendations in a communication in the spring of 2004 (European Commission, 2004) defining the following areas of work: rights and duties of patients; sharing spare capacity and transnational care; health professionals; European centres of reference; health technology assessment; health systems information strategy; motivation for and scope of cross-border care; data protection; e-health; improving integration of health objectives into all European policies and activities; establishing a

mechanism to support cooperation on health services and medical care; developing a shared European vision for health systems; and responding to enlargement through investment in health and health infrastructure. Additionally it recommended the creation of a High Level Group on Health Services and Medical Care, which would subsequently develop working groups on issues such as cross-border health care; health professionals; centres of reference; health technology assessment; information and e-health; health impact assessments; patient safety and e-health. The first recommendations emerged in December 2004.

The Europe for Patients research project

When we conceived the research project “Europe for Patients”, we saw enhanced patient mobility as a potential opportunity, beginning from the premise that, in an increasingly integrated Europe, it could bring benefits for patients, providers and health systems. Benefits for patients were seen in terms of better access to health care and centres of excellence. Benefits for health policy-makers and providers were seen in the possibilities of sharing capacities across borders. This would allow the concentration of European excellence, mutual learning and exchange of best practices, and would facilitate the quest for common solutions to common problems. Our main research questions were whether this hypothesis was correct and, if so, what was required for the potential advantages to be realized.

This project falls within the scientific support to policies (SSP) component of the Sixth Framework Programme, designed to support policy development at EU level. The research team is drawn from academic and policy organizations across the European Union. The research is proceeding in two ways. One looks across Europe, for example to understand the legal framework within which patient mobility is taking place, the contracting arrangements that have been employed, and the systems in place to ensure quality of care and information for patients. A second looks in depth at what is happening on the ground, by means of a series of detailed case studies on cross-border care. These include arrangements spanning new and old Member States (Slovenia/Austria, Estonia/Finland); the response to the needs of long-term residents (Spain), the situation wherein purchasers in one country contract with providers in another (United Kingdom, the Netherlands, Belgium), mass tourism (Veneto region), sharing capacity, and the use of centres of excellence (Malta), cross-border hospital cooperation (France), cross-border contracting (Germany), and the particular situation on the island of Ireland in which arrangements between the Republic of Ireland and Northern Ireland have been entered into primarily for another purpose, the promotion of peace and reconciliation between the

two populations. This book, which is one of a series that is arising from the e4p project, focuses on the case studies.

The case studies

The case studies contained in this book provide a wealth of material on the current nature of patient mobility across national frontiers within the EU. While they do not claim to be comprehensive, they do paint a very broad picture of contemporary developments. Each case study describes the extent of the patient mobility between the featured countries, the scale and nature of mobility, the reasons why mobility exists, the factors that either facilitate or hinder it, and the potential impact on the health care systems concerned. The authors have analysed each situation, indicated opportunities and challenges, and made recommendations for policy-makers.

Before highlighting what we can learn from these case studies, we would like to stress the *limits to what we have been able to discover*. There were two main problems in obtaining and analysing data. The first is the critical lack of valid data. Accurate statistics on patients moving across borders is almost nonexistent. This became clear in almost all the case studies. Often the receipt of health care by foreign patients is not recorded or the information (such as that on E111 forms) is lost or details are missing, such as the country of origin and the volume or type of care provided. Even where forms are completed they are rarely analysed. In many European health systems the administrative processes simply do not take account of the existence of foreign patients. Spain serves as one example: responsibility for health care is decentralized to the autonomous regions while responsibility for European social security coordination, including health, remains with the INSS, the social security institute, at national level. Elsewhere, where relevant data exist, some key stakeholders, particularly private providers, are unwilling to share data and some public authorities have adopted restrictive interpretations of data protection laws that render the information they collect inaccessible and thus essentially useless for informing policy. As a consequence, some of the case studies have involved the undertaking of ad hoc surveys although these are not a sustainable long-term source of information. There have been some expectations that the introduction of the European Health Insurance Card (EHIC) might improve the situation. Yet the card is no more than a means of certifying entitlement to care and it is difficult to see how, without substantial investment in information infrastructure and systems, it will address any of the problems that we have faced in quantifying the scale and nature of patient mobility within Europe. Furthermore, while the lack of appropriate data was an irritation for those conducting the research reported in this book, it raises questions beyond the scope of pure scientific

research – how can policy-makers hope to take into account patient mobility in their planning, budgeting and monitoring if they do not have access to relevant data?

The second major problem is the lack of information about the commercial sector. Private for-profit providers were the least willing to cooperate with interviews. Public sector policy-makers are often either completely unaware or inadequately informed about the practices of commercial providers. This is especially problematic as this sector is often not subject to effective quality controls, with Europe's citizens potentially at risk from opportunistic behaviour at a time when they are most vulnerable, requiring health care in a system they do not understand. We gathered considerable anecdotal evidence of tourists being taken to private clinics by taxi drivers where they were required to pay out of their own pockets as the E111 scheme was not recognized, and of general practitioners associated with large campsites who referred tourists to commercial providers. We also found that many private health insurers would sell policies while avoiding any responsibility for the quality of care that patients received abroad.

The nature and extent of patient mobility

Before moving on, it will be useful to first ask – who is the “European patient”? One can distinguish *five categories of mobile patients*.

The first category includes those citizens who, while on holiday, need to use health care services in the country they are visiting. In these cases there are arrangements throughout the European Economic Area (EEA) to facilitate the process, based on the E111 form, conferring the right to treatment during a temporary visit. These are considered in detail in the case studies looking at tourists in the Veneto region of Italy. However, this group is also considered briefly in the case studies from Malta, Estonia, Germany and Slovenia.

The second category includes those citizens who retire to a different country and wish to use the health care system of the country where they are currently living. These are considered in detail in the case study looking at long-term residents in Spain.

The third category consists of people sharing close cultural or linguistic links with the region where care is provided. In regions where a natural community is divided by a national frontier, people look for treatment close to home – which happens to be on the other side of the border. This is often the case where a town that has developed over centuries is divided by a river that forms a country border. This patient group also includes migrants returning to their country of

origin to receive care. When access to cross-border care is relaxed, for instance within the framework of cooperative agreements, these patients are likely to be the first ones to take advantage of the new possibilities. This is described in the case studies from Germany, Belgium, Estonia, France, Ireland, Slovenia and Spain.

The fourth category includes those patients who cross a border to receive health care or to buy health goods. This is often because of perceived advantages related to quality, accessibility or price, specifically out-of-pocket payments borne by patients. Examples include patients going abroad to avoid long waiting lists in their home country and patients seeking treatments that are cheaper, typically moving from old to new Member States. The case studies looking at this kind of patient mobility are those from Belgium, Slovenia and Estonia.

The fifth, and numerically the least significant category concerns those patients who are sent abroad by their own health system to overcome capacity restrictions at home. It concerns mainly smaller countries or regions with a low population density where the domestic health system cannot reasonably provide a comprehensive range of health care services for its population. Health care provided in this category is, in general, actively managed by public authorities, seeking to ensure continuity of care, coverage of extra expenses and appropriate selection of providers abroad. Some patients cross borders within the framework of cooperative agreements in order to share facilities, especially in relation to capital-intensive or highly-specialized services. The Maltese case study provides an example. To some extent English patients receiving care abroad and patients from Zeeuws-Vlaanderen being treated in Belgian hospitals can also be included under this heading, as can the contracting described in the German case study.

By bringing together this wide range of experiences, we hope that this book will contribute evidence that can inform the policy debate on patient mobility in Europe.

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Chapter 2

Cross-border care in the south: Slovenia, Austria and Italy

Tit Albreht, Rade Pribaković Brinovec, Jurij Štalc

Introduction

There are two issues to consider in looking at patient movement between Slovenia (a new Member State of the European Union) and its neighbours Austria and Italy (old Member States). The first is the new situation that has arisen as a result of Slovenia's accession; the second is some patient movement that pre-dated the act of accession. There is, however, only a small amount of information about the situation until now, with one of the few examples being a paper (Albreht, unpublished paper, 2002) that, for the first time, provided specific data on patient mobility between Slovenia and Italy and Austria.

Anecdotally, the movement of patients that took place across Slovenia's borders was driven by two factors: movement to Slovenia's health care system reflected its lower prices; and movement from Slovenia was eased by the existence of bilateral agreements. However, the scale of movement was very modest. Slovenia's accession to the European Union introduces a new situation, and a greater and more spontaneous flow of patients across Slovenia's borders might be expected.

The context

As shown in Figure 2.1, Slovenia borders two European Union Member States (namely, Italy and Austria) and lies at a crossroads of two major transportation routes, one leading from the European south-west to the east and north-east, the other one leading from Europe's north-west to its south-east. Parts of the territory that is now Slovenia have, in the past, been part of both Italy and



Figure. 2.1 *Map of Slovenia*

Source: UN Cartographic Section

Austria but traditional links have survived the turmoil of the 20th century and national frontiers have never been a serious obstacle to cross-border cooperation. Indeed, the degree of cooperation is facilitated by the many special arrangements made for those people who are former citizens of the neighbouring countries to enjoy social benefits from both systems. In the past, such cooperation was, however, more intense in sectors other than health care, providing a stimulus for actions that would address health-related risks for citizens of the one country when staying in another country.

Several factors have played a role in promoting cross-border cooperation, including transit traffic, tourism and cross-border economic cooperation. The high volume of transit traffic is a result of Slovenia's geographical position, while tourism and cross-border economic exchange developed gradually after the Second World War. Most of the tourism in Slovenia (some of which is for health-related reasons) originates from Italy and Austria, with much less from Slovenia to its neighbours. In the 1960s and 1970s a deteriorating economic situation in the then Yugoslavia drove many Slovenes to seek employment in the neighbouring regions of Italy and Austria where more opportunities existed. Then, and throughout the 1980s, Slovene health care developed a reputation in Italy as a place where one could obtain non-urgent treatment at low cost (for example dental care, gynaecological treatments and orthopaedic surgery). An additional factor was the use by Italian women of gynaecological departments

in Slovene general hospitals and the Clinical Centre in Ljubljana to obtain abortions in the period before these were legalized in Italy. These links acted as drivers of intense cooperation between health professionals in both countries at many levels and in many areas, a situation that has continued to the present. On the other hand, Austrians have traditionally visited spa resorts to receive some treatments and rehabilitation services. Their stays have been reimbursed by the Austrian social insurance system.

The political transition in Slovenia brought privatization of some elements of health care provision, opening up new opportunities for cross-border movement. This particularly affected adult dentistry. Italian and Austrian patients were attracted by the proximity of providers, which were just across their borders, and their low prices. The concentration of dentists in border areas is not as marked as in some other regions of Europe (for instance Sopron, in Hungary, which borders Austria), but it is still quite apparent (Institute of Public Health, 2005).

As the Slovene economy is growing, the flow of ideas, capital and workforce is becoming more of a two-way stream. In these circumstances, it is likely that many new links and forms of cooperation will be established, involving some new stakeholders, with initiatives stimulated by entrepreneurial entities responding to demand rather than political imperatives.

In Slovenia, the political transition coincided with independence from Yugoslavia. One element of these processes was the creation of a new health care system, whose origins actually preceded independence by about a year and a half. The reform that took place in 1992 re-established a Bismarckian model of social health insurance funding, with privatization of some elements of the delivery of health care. It created a framework within which a more service-oriented health care market could gradually be developed and where more stress would be put on consumer choice. The reform was medically driven and physician-centred, with a major, if implicit, goal being strengthening the power of the medical profession. However, contrary to the original aim, Slovenia only partially privatized its publicly-owned (that is, by the central government and municipalities) providers because of concerns from the government about the potentially destabilizing effects during the delicate political period of the 1990s. Only some services were partially privatized, accounting for half of all dentists and about 20% of all general practitioners by 2003 (Institute of Public Health, 2005). The public sector remained dominant in the hospital sector; almost all hospital facilities are still publicly owned.

From the perspective of a potential patient from Italy and Austria, the most important features of the reformed Slovene health care system are:

- lower prices for some hospital procedures (such as cosmetic surgery) and dental treatments performed for direct payment (which would be privately paid for in the patient's country of origin);
- development of small, flexible private practices, with incentives to attract foreign patients;
- medical treatments in spas, either as a supplement to tourism (Italians) or as part of the basic benefit package (Austria and Germany).

Both of the neighbouring countries included in this research – Italy and Austria – are currently expanding the share of out-of-pocket expenditure within the overall health budget. This common phenomenon is both interesting and curious, as the two countries have different health care systems. However, this, together with some other factors listed later, is certainly one of the most important drivers of patient mobility from Italy and Austria to Slovenia. Private health care now accounts for a remarkable 30% share of overall health expenditure in the neighbouring regions of Italy and Austria (Donatini et al., 2001; Hofmarcher and Rack, 2001). In these circumstances, greater patient movement becomes understandable. The situation in Italy's north-east is also characterized by rising market shares of private insurers that offer more diversified packages to those insured with them.

The perspectives of the different actors

Even before full membership of the European Union, there was already some possibility of patients moving across Slovenia's borders and some providers have found ways to establish direct cooperation with their neighbours on the other side of national frontiers. The subsequent sections draw on the research undertaken within the Europe for Patients project.

The patients' perspective

Patients have enjoyed the rights enshrined in bilateral agreements that Slovenia inherited from former Yugoslavia. These agreements existed with all the neighbouring countries, thus offering coverage that was, in its effect, practically identical to that provided by the E111 system. The most important agreement between the former Yugoslavia and Italy was the Udine Agreement, forming part of a wider package of agreements signed in 1956 (Government of the Federal People's Republic of Yugoslavia, 1956). Given Slovenia's long border with Italy, this was one of the more important agreements inherited by the newly independent Slovenia (Government of Slovenia, 1992). The agreement facilitates cross-border travel for citizens who live in the former seven

municipalities of Slovenia, with collaborative arrangements in relation to social rights and benefits. Slovenia and Italy subsequently concluded a new and broader convention on social affairs (Government of Slovenia, 1999). This provides a framework for regulation of social security arrangements for workers of both states when temporarily in another country for work, and for those living in the bordering areas and their families. Similar agreements have been made with Austria.

The providers' perspective

In our interviews with Slovene and Italian health care providers, it was clear that neither had any particular incentive specifically to seek foreign patients at present. Salaried physicians and other health professionals in Slovene hospitals cannot accept additional pay for the services they would deliver outside their normal working time. Thus, attracting more patients in an otherwise publicly financed and regulated system is counterproductive. Slovene providers had also experienced some negative experiences in the past. The General Hospital in Maribor had offered to provide the Austrian social insurance fund in the region of Styria with some plastic surgery procedures but the offer was later rejected when the Austrians decided that their patients could be treated in Austria.

Italian providers take different views depending on their legal status and their position in the system. The region of Friuli-Venezia-Giulia (FVG) has greater autonomy than most other Italian regions. Its autonomous status enables it to set its own prices for health services (for example different weights for diagnosis-related groups (DRGs) compared with the national averages). Local health authorities in Italy own many hospitals and they can decide, on behalf of the regional government, whether they will enter into agreements with other hospitals, regions and countries, taking account of the regional government's strategy.

The scale of movement

Cross-border care between Slovenia and its neighbours, Austria and Italy, has never contributed an important share to the public health care system of any of the three countries involved. However, it has disproportionately affected certain medical and dental specialties and facilities, leading researchers to examine the mobility of patients, professionals and providers (Albrecht, unpublished paper, 2002).

This chapter provides a detailed analysis of in- and outpatient hospital care, specialist outpatient care and dental care, using the most recent data. However,

it should be noted that, in seeking information, there was a degree of reluctance to collaborate by spas and private providers, whether they formed part of the public health care system or not.

The Austrian Federal Ministry for Health and Women provided data on Slovene inpatients treated in Austrian public hospitals. The University Hospital of Udine (Policlinico Universitario di Udine), City Hospital of Udine (Azienda Ospedaliera S. Maria della Misericordia) and Allied Hospitals of Trieste (Ospedali Riuniti di Trieste) provided data on Slovene in- and outpatients treated in these hospitals.

Hospitals provided detailed quantitative data on patients who had been treated between 2000 and 2003. Qualitative and semi-quantitative approaches were used to assess dental care. Only partial and largely descriptive information could be obtained about medical rehabilitation in spas and specialist outpatient care in private settings.

Austrian and Italian patients in the Slovene health care system

Outpatients in hospitals – are Italians different from Austrians?

Austrian patients accounted for 1140 outpatient attendances in Slovenia per year between 2000 and 2002. There was an unexpectedly high proportion of men between 30 and 60 years (57% of all attendances), with men more frequent visitors than women (36%). Almost 80% of all attendances were at the hospitals in Maribor and Murska Sobota, close to the Austrian border. Injuries and poisonings were the main reason for attendance, accounting for 33% of male patients but only 20% of female patients. Similar gender differences were observed with cardiovascular diseases. About 85% of the costs were covered through bilateral social security agreements; the remaining 15% were covered from out-of-pocket payments.

Italian patients contributed 1679 outpatient attendances per year between 2000 and 2002. In contrast to attendances in Austria, in Italy women (55%) were in a higher proportion than men. Surprisingly, 60% of all attendances occurred at the Clinical Centre in Ljubljana, while only 30% of all attendances were at the border hospitals of Izola and Šempeter-Nova Gorica. As with Austrians, injuries and poisonings were the main reason for visits, followed by cardiovascular, eye and metabolic diseases. Only 30% of the costs were covered through bilateral social security agreements; the rest was from out-of-pocket payments.

Inpatients – transit causes injuries

Data on hospital discharges of Austrian and Italian inpatients confirmed our initial assumption that foreign patients would account for only a small fraction of all discharges in the country (171 cases yearly for Austrians and 155 cases yearly for Italians). Slovenia's hospitals typically treat about 330 000 inpatient cases per year (Institute of Public Health, 2005). Thus there is less than one Italian or Austrian patient per 1000 inpatient cases. The characteristics of inpatients were similar to those of outpatients. The leading causes for admissions were injuries and poisonings, followed by cardiovascular and urogenital diseases. A similar pattern of cost recovery was seen (76% coverage by social insurance among Austrians versus 35% coverage by social insurance among Italians).

Dental care for foreigners – a challenge for researchers

In our study we contacted 730 private dentists and achieved a 40% response. The number of patients in the years 2000–2002 was a little more than 18 000, with 11 000 patients from Austria and 7 000 from Italy. If these figures are scaled up to allow for non-responders, the figures for Slovenia would be 45 000, 27 500 and 17 500 respectively. The geographical distribution within Slovenia is highly skewed (Table 2.1). In Maribor and the Kranj region, bordering Austria, the reported annual cases per provider (cpp) were 44 and 39 respectively, with the majority being Austrian patients. Italian patients were more likely to be treated in the regions of Koper (30 cpp) and Nova Gorica (27 cpp), both bordering Italy.

The vast majority of dentists (75%) treated five cases from abroad per year or less and 70% of all cases were treated by only 15 dentists (Figure 2.2).

Spas and specialist outpatient care in private settings – an unexplored field

Our survey of rehabilitation in Slovene spas used the same approach as with inpatient and outpatient hospital care. During the study it became clear that medical and/or rehabilitation departments in spas were not incorporated in national health statistics systems, unlike hospitals and outpatient practices. The study was taking place at a time when modern information systems were just beginning to be introduced in spas. The Slovenian Tourist Board has, however, performed a survey among tourists in Slovene spas (Slovenian Tourist Board, 2004): 9% of foreign tourists visiting spas came for medical rehabilitation and another 33% to take part in preventative health or wellness programmes.

Table 2.1 Cases per provider: average number of cases per provider of dental care per year

Regional centre	Austria	Italy	Sum
Ljubljana	1.25	2.00	3.24
Maribor	43.78	0.27	44.06
Celje	5.94	9.35	15.30
Kranj	39.16	5.54	44.70
Nova Gorica	0.00	27.24	27.24
Koper	1.81	29.84	31.65
Novo mesto	13.42	0.00	13.42
Murska Sobota	1.47	0.00	1.47
Slovenia – Total	13.08	8.15	21.24

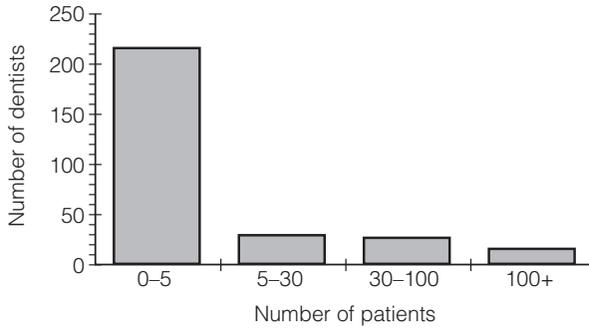


Figure 2.2 Distribution of dentists according to the number of patients per year

It was assumed that there would be considerable potential for cross-border care in certain medical specialties, such as plastic surgery, ophthalmology and diagnostic services, leading us to focus on this field. However it was not possible to obtain accurate data, although qualitative reports suggested that, in border areas, foreign patients might account for as much as a third of yearly attendances with some providers.

Slovene patients in Austrian public hospitals

Between 2001 and 2003 Slovene patients accounted for a negligible share ($\approx 0.01\%$) of discharges from Austrian public hospitals. There were 332 cases on average between 2001 and 2003, most of whom were hospitalized in Styria (58%) and Carinthia (19%). 63% were men, with a mean age of 40 years. The most common diagnoses were injuries and poisonings (29%), cardiovascular diseases (11%), neoplasms (11%), digestive system diseases (11%) and others (Pfeffer, 2005).

Slovene patients in Friuli-Venezia-Giulia

Outpatients

Two hospitals in Udine provided data on Slovene outpatients. There were 73 attendances on average in the years 2001–2003. Patients presented with various medical problems and were evenly distributed among the different departments in the hospitals. They were reimbursed mostly on the basis of bilateral agreements between the two countries.

Inpatients

Use of hospital care by Slovene patients in Friuli-Venezia-Giulia was extremely modest in the years 2000–2003, with 56 inpatients treated on average per year. As expected, injuries were the most common cause for admission although they represented less than 25% of all cases. The vast majority of costs incurred (€3500 per case) were covered on the basis of bilateral agreements. Less than two patients per year were reported as paying out of pocket.

The movements and the players: patients, professionals and providers

Slovenia and its old EU neighbours, Austria and Italy, have experienced very modest cross-border care prior to accession. Although small in number, patient mobility represents the major part of health care movement. Health professionals, especially nurses, have moved from Slovenia looking for better working conditions and salaries. On the other hand there has been intense cooperation between health care professionals in neighbouring regions for many years, although providers were constrained by national regulations and opportunities for active for-profit cross-border cooperation were very scarce.

The Health Insurance Institute of Slovenia (HIIS), the leading purchaser of health services in the country, has been interpreting strictly the regulations on access to health care for Slovene patients in countries that have signed bilateral agreements on social security in ways that limit their use. As described earlier, agreements between Slovenia and Austria and Italy gave beneficiaries certain rights not included in other agreements. However the HIIS has sought to use health care abroad to tackle certain national concerns. For example, it has approved some requests for elective treatment in other countries, but only for certain methods of treatment not available in Slovenia. Reflecting a concern about long waiting lists, the HIIS offered patients on the national waiting list for cardiac surgery the opportunity to receive treatment abroad. Less than 10% of patients decided to take up the offer.

Interviews with providers also indicated that the Italian national health system and Austrian health insurance funds applied strict regulations to patient mobility between the three countries.

The survey of patient movement between the years 2000 and 2003 suggests that hospitalizations were for emergency cases, with only rare exceptions. However outpatient care in Slovenia was different, with various reasons for attendance. This pattern suggests that foreign patients were using the Slovene health care system for elective care paid either out of pocket or through social insurance. When we looked at the distribution of attendances by ICD-10 codes there were some interesting differences between patients from Austria and Italy. For example, ophthalmology services were used by Italian women coming to Slovenia. Dentistry in Slovenia was attractive to foreign patients, mainly because it offered lower prices and a satisfactory quality of services. Spas have a long-standing reputation for rehabilitation services and wellness programmes.

Some years ago, hospitals in Šempeter (Slovenia) and Gorizia (Italy) embarked on a joint investment in a magnetic resonance imaging (MRI) device. This enabled both hospitals to have access to an important diagnostic tool. After lengthy administrative problems, the hospital in Gorizia decided to invest alone in the MRI. However, they offered Slovene radiologists from Šempeter the use of the MRI, so serving the needs of patients from the Slovene side of the border.

Facilitating and hindering factors

Health systems in the three countries give little space for elective cross-border care within the frameworks of statutory health systems. On the other hand, a rising share of out-of-pocket expenditure in Italy and Austria is driving people to look for cheaper health care in Slovenia. At present, there is little to facilitate Slovene patients who would like to go for treatment abroad, although pressure may arise from long waiting lists for hip replacement, cataract surgery, heart surgery and some other conditions (for instance, radiotherapy). There is, however, so far no sign of an increased outflow of patients from Slovenia and even those who are offered the possibility of travel are refusing these opportunities, preferring to wait at home. There is some anecdotal evidence that, in recent years, an increased number of Slovene women are going for abortions at Italian hospitals. If this is true it would be a reversal of the pattern in the 1970s when Italian women were coming for abortions in Slovenia. The reasons for this are unclear as there have been no formal changes in the right to abortion in Slovenia.

In contrast, some patients from Austria and Italy still come to Slovenia, motivated by good value for money. We have already mentioned certain areas of interest.

Slovene facilities along the borders with neighbouring countries have been attracting foreign patients, with information about their services seemingly being transmitted by word of mouth. An important barrier to greater mobility is a lack of adequate, validated information for patients/consumers on their rights and opportunities regarding cross-border care and within their own country.

Emerging issues

Given the changing circumstances following European Union accession, there are several types of mobility that are likely to develop:

- more direct contracting and purchasing by the national authorities (e.g. national health insurance in Slovenia, Sozialversicherung in Austria, regional governments in Italy);
- more provider–provider arrangements for exchange of patients and common use of facilities;
- “second opinion” and similar types of diversified and increased demand for health care.

Developments in patient mobility are likely to depend on the following:

- future trends in liberalization of the health care market(s) in the European Union;
- share of private insurance and out-of-pocket payments in each country;
- institutional and legal provisions for patient exchange and mobility.

The role that the EU will take in relation to liberalization of the delivery of health services will certainly influence national decision-makers and, more importantly, patients across the European Union. Easier access to second opinions as well as to publicly sponsored and reimbursed health care services may lead patients to opt for providers they consider to be better, more efficient and more adapted to their needs.

From the policy point of view a number of issues need to be addressed:

- facilitation of free choice of provider and of second opinions, especially where providers are geographically close by but separated by a border;
- macro system issues – financing and reimbursement of services in each country, sustainability of free movement of patients, limitations imposed (in view of the European Court of Justice (ECJ) judgments);
- micro system issues – regional coordination of patient flows irrespective of national borders, sharing of capacities.

Provider choice and access to second opinions were strongly advocated in a focus group study in Slovenia (within the European Patient of the Future project (Albrecht et al., 2003)). This suggested the scope for future growth in Slovene patients seeking care in other countries.

It is possible to identify some areas for action based on the findings of this case study. These include:

- the need for multilateral agreements on patient exchanges for emergency and non-emergency cases (as with agreements in one country to permit regional cooperation);
- adoption of a harmonized approach to reimbursement by public financing agencies in different countries;
- creation of common waiting lists;
- sharing of capacity under a uniform financing strategy;
- development of Internet-based information that could be trusted and reliable.

Conclusions

Patient mobility between Slovenia and Italy and Austria is a reality that reflects the geographical situation, historical experience and the sociopolitical developments. The new environment, facilitated by Slovenia's accession to the European Union, offers an even more favourable setting for cross-border cooperation in the field of health care.

At present, the number of patients from Italy and Austria treated in the Slovenian health care system is very modest. Still, we can see that there continues to be a group of patients from both these countries who actively seek care in Slovenia for various conditions.

Our research has shown that injury was the most common reason for the majority of patients on both sides of each border to seek hospital care. Thus it would be hard to speculate about the potential for further development in this sector. Outpatient care seems to offer much greater potential. It was, however, much more difficult to study for several reasons. The most important were reluctance to reveal data on procedures and costing of the services delivered and the inadequate information systems. In many cases the information systems failed to identify foreign patients as a separate entity or providers were unable to separate medical and other health care services from tourist programmes (as in the case of spas).

Finally, we should note that we faced some problems in carrying out this research. In particular, there was a certain inability or unwillingness of providers in Slovenia to provide us with insights into the delivery of care to Austrian and Italian patients. That was especially true of spas and of privately practising dentists.

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Chapter 3

Cross-border care in the north: Estonia, Finland and Latvia

Maris Jesse, Ruta Kruuda[†]

Introduction

With its natural harbours and interconnected waterways, Estonia has for centuries been an important link in the trade routes between Europe and Russia. However, it experienced 50 years of relative isolation from the rest of Europe behind the Iron Curtain until recent geopolitical changes opened up possibilities for re-establishing Estonia's historical relations with the west. The transition represented an opportunity for the Estonian health system to scale up its quality of care by adopting modern medicines and technologies, not previously accessible, even though they had long been available in much of western Europe. As Estonia regained independence and with the opening of its borders, a wide variety of opportunities became available through professional cooperation. Yet so far, little is known about the extent to which Estonian patients have been able to use these opportunities to obtain health services abroad. Nor is there much knowledge about how Estonian health care providers have been able to cope with the skyrocketing number of multilingual and multicultural foreign visitors who have required health services in Estonia. The close links to Scandinavian countries and the scale of price differentials favour tourism to Estonia and could be an incentive for health tourism. On the other hand, the legacy of the Soviet Union and subsequent very low level of investment in the health sector during the period of transition mean that Estonia may not be seen as a high-quality health care destination, either for foreign visitors or the resident population.

The objective of this case study was to understand better the existing trends in patient mobility from and to Estonia and the impact that this mobility has on

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the Estonian health system and its providers. We were also interested to find out about Estonian providers' plans for treating foreign patients, to identify existing cross-border collaborations and to assess the willingness of the Estonian population to seek treatment abroad.

To answer these questions, surveys were undertaken among Estonian health care providers and among policy-makers in Estonia and Finland, foreign visitors and Estonian residents. Additional information was obtained from, among others, the Estonian Statistical Office, the Estonian Health Insurance Fund (EHIF), STAKES (National Research and Development Centre for Welfare and Health in Finland), tourist agencies and professional associations, with data being obtained from Estonian and Finnish hospital discharge statistics.

Context: the geography, connectedness and health system

Estonia, with its 1.3 million people, is the northernmost of the three republics on the east coast of the Baltic Sea. Even though Estonia has a land border with Latvia in the south and the Russian Federation in the east, Estonia has historically closer cultural ties to its northern neighbour across the Baltic Sea, Finland, in part because of the similarity of the Estonian and Finnish languages. Helsinki, only 85 km distant, can easily be reached by ferry, as can several destinations in Sweden, Estonia's neighbour across the Baltic Sea to the west. In contrast, the Latvian capital, Riga, is 307 km distant from Tallinn and 395 km from the Russian city of St Petersburg.

According to the Estonian tourist board, the voyage from Finland is the most frequent means of access to Estonia, bringing about 70% of all visitors. During the summer there are 37 boats or ferries between Helsinki and Tallinn every day. By speed boat the journey takes only 1.5 hours, costing between €20 and €50 to "hop over" from Helsinki. The hourly helicopter crosses the sea in only 18 minutes, at an approximate cost of €100.

After Estonia regained independence in 1991, with the opening of borders to tourism,¹ foreign visitor arrivals rocketed from a mere 175 000 visitors in 1985 to 1.3 million visitors in 1993. In 2003, Estonia was host to 3.4 million foreign tourists: 53% were Finnish and 12% Latvian, with other sizeable groups from the Russian Federation, Sweden and Lithuania. With entry into the European Union in May 2004, tourism to Estonia has increased by about 20% in comparison to 2003.² Increasing numbers of people are currently

¹ During the period of Soviet occupation tourism was very restricted. Visitors had to stay in the capital's very few Intourist hotels with a total of 214 beds in 1965. Some day trips were allowed under the supervision of a government official.

² Estonian Tourist Board, 2004, www.eas.ee

coming from Germany, Norway and the United Kingdom, in part fuelled by the emergence of budget airlines.

The Estonian health care system

Estonian health care is financed mainly from public sources (76% of total health expenditure in 2003), with a social health insurance system covering 67% of total health care expenditure. The health insurance system comprises a single national scheme and is almost universal, covering up to 94% of the population. It is administered by the Estonian Health Insurance Fund, with no opt-out allowed. The entitlements are regulated in the Health Insurance Act and are quite broad, covering primary and specialist care, some dental care, long-term care, pharmaceuticals and sickness cash benefits. In general, the system is based on the principles of territoriality³ and in-kind benefits.⁴

Health care providers are private companies (mostly primary care and outpatient specialist care) or public bodies operating under private company law as foundations or joint-stock companies (hospitals). Providers are funded on a case-by-case or fee-for-service method. The health insurance fund has no obligation to contract with a provider and can exercise selective contracting, which is common with outpatient specialist care and dentistry for children. Total expenditure on health care was 5.4% of GDP in 2002, Estonia being one of the lowest spenders on health care in the EU both as a percentage of GDP and in absolute terms. While in 2002 average total spending on health care per person in the 15 “old” EU Member States was \$2364 (purchasing power parity-adjusted), the Estonian figure was \$625, with only Latvia and Lithuania having lower levels (WHO Regional Office for Europe, 2004).

In these circumstances, there are financial incentives for Estonian health care providers to seek additional revenues by attracting foreign patients for elective treatment.

Estonians treated abroad

Patients’ rights and experiences

When determining the rights of Estonian patients to seek treatment abroad, two factors were taken into account: Estonia’s small population size on the one hand and availability of public resources on the other. The small population base makes cooperation with foreign providers necessary for rare diseases or

³ Only providers situated on Estonian territory can be contracted.

⁴ Providers are directly reimbursed by the health insurance fund for the health services provided.

treatments. The limited public funds available in the health care system have forced legislators to place restrictions on patient mobility.

Within the framework of EU regulations, non-urgent treatment received abroad will be reimbursed only if the insured Estonian resident has obtained prior authorization from the EHIF. Conditions for granting authorization have been established by the Health Insurance Act as follows: the care sought is not available in Estonia; the service is medically justified; and it is of proven medical efficacy, with a probability of success of at least 50% (Republic of Estonia, 2002).

Waiting times have become a problem in Estonia, especially in some specialties. The reasons vary and include administrative, human and financial constraints. Waiting time targets have been set by the Supervisory Board of the EHIF. However, a long waiting time is not usually accepted as a justification for prior authorization for treatment abroad, as the wait is often associated with a specific provider while other providers can offer faster treatment.

The number of people receiving treatment abroad under this prior authorization procedure has been quite low over the years. Since 1998, between 12 and 20 patients have been treated abroad each year, from between 14 and 31 who apply. Initially, almost all applications were granted authorization, but, in reality, the process was driven by health service providers, who selected the cases for treatment abroad, rather than by patients themselves. Over time, the number of applications has increased, as has the number of rejections, mainly because the treatment has been available in Estonia or has been of an experimental nature or not evidence based (Peetsalu, 2004). Thus, patients are now taking the initiative to seek alternative treatment options, even when treatment is available in Estonia.

The countries and providers receiving Estonian patients have mostly been selected by Estonian providers on a case-by-case basis, based on existing professional contacts. As can be expected, owing to geographical and linguistic proximity as well as close contacts between health care professionals in the countries, Finland has received the highest share of Estonian patients (34% of the total), followed by Germany, the Russian Federation and Sweden, with shares of approximately 15% each. In a few cases, the EHIF has assumed a more active role, comparing prices from different providers in several countries before agreeing a destination with the patient, while taking account of price (for example, where a patient with an ophthalmic malignancy went to Prague rather than to a United Kingdom provider) (Praxis, 2004).

The general rule of territoriality does not apply to health services that are reimbursed with cash benefits in Estonia. Since 2003, adult dental care has been in the category of reimbursed benefits: the patient pays for the service directly to the provider and later receives reimbursement from the fund, up to a predefined ceiling. For its part the fund is obliged to reimburse these services irrespective of the location of service provision, a regulation which is, interestingly, directly influenced by the *Kohll* and *Decker* rulings of the European Court of Justice.

Allowing patients free selection of their dental care provider should, in theory, have led to more competition between providers and to increased patient mobility in border regions where prices of Estonian health services are higher than in neighbouring countries (such as the Russian Federation and Latvia). There is some evidence that in urban border areas people are obtaining care in another country but there is no information on the scale of this activity and it seems that those involved may not be claiming reimbursement. The EHIF has received only two invoices for dental care, from the Russian Federation and Latvia, in 2003 and 2004 (Praxis, 2005). This could indicate a lack of information among the insured about their rights. As an aside, the number of foreign patients seeking dental care in Estonia is increasing steadily.

Changes in mobility after EU accession on 1 May 2004

Although the number of Estonian patients treated abroad is relatively small, there is increasing interest in obtaining information about patient rights while travelling or working within the EU. Estonians were very active in applying for the new European Health Insurance Card (EHIC), which was introduced on 1 August 2004, just a few months after EU enlargement. Between 1 August and 31 December 2004, the Estonian Health Insurance Fund issued a total of 55 798 EHICs and 47 107 EHIC replacement certificates. Thus, 8% of the population are EHIC holders. The application process is simple and convenient. The insured can apply online through a citizen portal (<https://www.eesti.ee>), via an Internet bank, or via the fund's customer service using mail or e-mail, using the digital signature facility. Based on experience with existing bilateral agreements with Lithuania, Latvia, Finland and Sweden and other tourist information, it is estimated that 0.1% of Estonians will need medical treatment when travelling abroad. The average cost of emergency care in Finland was €1112 per case in 2003. The cost of emergency care for Estonians abroad has increased from €51 374 in 1998 to €79 000 in 2001. In 2004 the actual expenditure related to the implementation of Council Regulation (EEC) No. 1408/71 was €118 624 (EHIF, 2004). In 2005, the fund envisages that expenditure on care that Estonian citizens receive within the EU will amount to €703 000, ten times the amount of four years earlier (EHIF, 2005).

Experience and satisfaction with health care services abroad

The little existing information on mobility of Estonian patients has made it very difficult to assess the size of the phenomenon or how it is perceived by the population. A population survey was conducted within the framework of the e4p project, concurrently with the EHIF annual health care satisfaction survey in September 2004. The objective was to get an idea of the population's experience and satisfaction with health services abroad over the last three years, and in particular how foreign health services compare with those provided in Estonia. The results should shed light on the future potential that people will seek medical care abroad, the destinations they favour and why and how they might obtain information on health services provided in foreign countries. In total 980 respondents were interviewed.

The study confirmed that the Estonian experience with health services abroad is very limited – only 2% of those aged 17 to 74 have experienced health services in a foreign country over the past three years and an additional 2% have a family member who has done so. Most of those with experience abroad were young and educated, such as entrepreneurs or managers, and in most cases they either paid for the services themselves, or their company did (in a third of cases). Only in a quarter of cases did a private insurance company pay. Surprisingly, no problems with language, access to information, speed of assistance or payment for services were reported by respondents. Fewer than 50% of respondents considered the treatment provided better than in Estonia, 21% found the quality of care similar and 17% were dissatisfied with the care provided (Praxis/Faktum, 2004).

Reasons for, and perceptions of, seeking treatment abroad

EHIF annual health care satisfaction surveys conducted among the Estonian population showed that nearly 90% of those who had used health services in Estonia were very or mostly satisfied with the care received. However, there was a discordance between their personal experiences and their views about the system in general, with only 52% and 59% of the population considering access to care and quality of health care, respectively, as generally good⁵ (EHIF/Faktum, 2004).

⁵ Results need to be interpreted with some caution, as the survey coincided with difficult negotiations between the insurance fund and the physician association, while the media coverage emphasized long waiting lists and questioned the quality and sustainability of the system.

This low level of confidence in the Estonian health system is also reflected in people's attitudes towards seeking care abroad, as 63% prefer to be treated in Estonia. They see care as being provided close to home, with lower out-of-pocket expenditures and better access to care and health professionals they can trust and who speak their native language (Praxis/Faktum, 2004).

The study indicated that interest in seeking health care abroad is likely to increase in the future. Should services abroad be fully reimbursed, at Estonian rates of co-payment, 25% of the population would prefer treatment abroad. These were mostly the young, the educated, and the healthy. Even in the town of Tartu, which has the only university medical faculty in Estonia, 40% would prefer medical treatment abroad. Those people who were less satisfied with the Estonian health system were more likely to want to move.

The three main reasons for seeking treatment abroad were for treatment that was not available in Estonia, to attend facilities abroad that were perceived to be better equipped than those in Estonia, and to obtain a second opinion from an independent institution or doctor (Figure 3.1). Waiting lists, which are a factor in other countries, are less important in Estonia as they are not very long.

The findings from this survey paint a gloomy picture of popular perception of hospital equipment and quality and they also show that people are aware of differences in other countries. This should act as an incentive for national hospitals to strive for excellence and to work for greater local acceptance.

Even when people go abroad for care, they usually prefer the treatment to be carried out close to their home country. Finland and Sweden are the most popular destinations, Finland for its location and good connections and Sweden for both the high quality of its health services and its good connections to Estonia. With respect to other EU countries, the high quality of health services was the factor most often cited.

When considering why people decide whether they would be willing to move, a lack of particular services in Estonia is a significant factor, but even more so is coverage of the costs by the health insurance fund. Thus, if current restrictions on public reimbursement of health services obtained abroad were to be lightened or lifted, the number of patients considering treatment in Sweden or Finland could increase significantly, with loss of income to the Estonian health system. On the other hand, such contestability could, in principle, also provide additional motivation to Estonian providers to increase quality, efficiency and responsiveness.

The way people would like to get information about health services abroad is largely from their personal doctor, either a family practitioner or specialist, or from the health insurance fund.

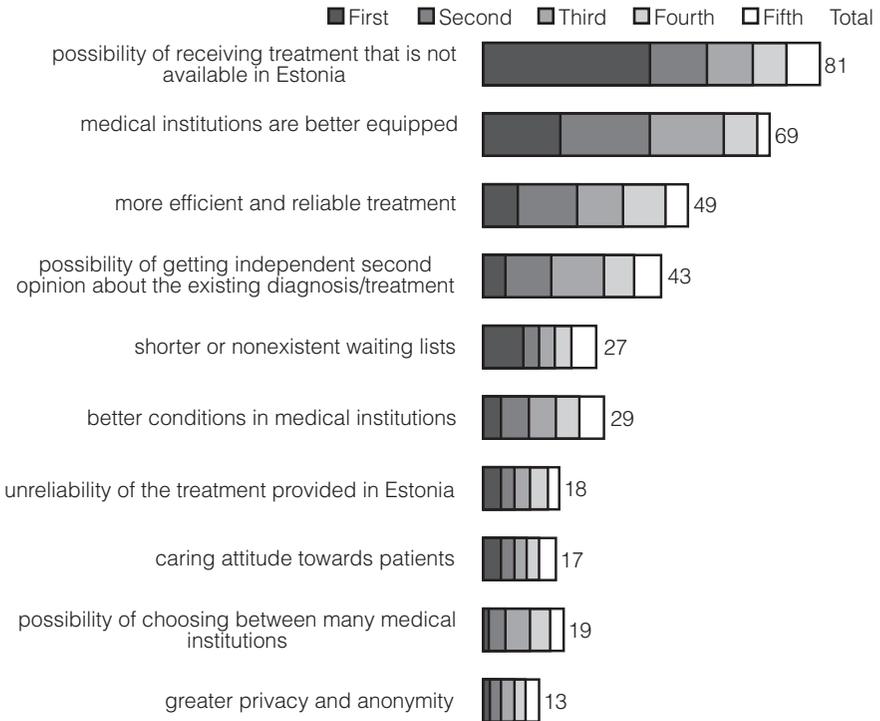


Figure 3.1 Reasons for seeking medical help abroad, in order of reason being selected, % of all respondents, n=980

Foreign patients in Estonia

There are few data on the extent to which foreigners receive treatment in Estonia, let alone information on their satisfaction with the care they receive or their motivation for seeking care in Estonia. Lower prices of health services in Estonia compared to neighbouring Scandinavian countries could, in principle, motivate patients to move and it is known that Finns do come to Estonia where they are willing to pay out of pocket for services such as dental care, cosmetic surgery and treatment at spas.

To get a better understanding of these issues, hospital data were examined and a survey was carried out among selected Estonian spas to assess the experiences of foreign visitors with the Estonian health system.

Health spa tourism

Spa tourism in Estonia is on the rise and is particularly popular with foreign tourists. The spa tradition goes back to 1865 when therapeutic mud was discovered on the west coast of Estonia. Several health resorts, which were highly popular with the Russian aristocracy and Baltic Germans, were

established in Haapsalu, Pärnu, the Island of Saaremaa and Narva Jõesuu in northern Estonia. Today two in three visitors to Estonia's spas are foreign tourists, accounting for 32% of all overnight stays by foreign tourists, with an average stay of four nights. The number of foreign tourists visiting spas has grown from 12 000 in 1994 to 200 000 in 2004.⁶ During the same period, most of the spas have expanded their services to combine pure health treatments with relaxation and wellness-oriented services.

A visitor survey, within the framework of the e4p project, was carried out in six spas in four different towns along the sea coast. There were 384 respondents, who were mostly Finnish and Swedish. Their average age was over 60 years. The visitors reported their main reason for coming was to have a holiday that included some general health improvement. Thus, the spa treatment was not perceived as seeking health care. The level of satisfaction with services offered by spas was generally good. We then asked if they had additional contact with the health system, and about the extent of and attitude towards seeking elective or planned treatment from dentists, ophthalmologists, gynaecologists and other specialists renting space in the spas.

It emerged that there is some use of services where out-of-pocket costs are lower than in their home countries, but the extent to which these services are used is very limited. While staying in the spa, 4% of respondents had required emergency care, 4.8% sought dental care, 1.3% an eye check, and 6% some other elective services. When asked, few had explicitly come to Estonia for elective treatment. The main obstacle to doing so was a lack of information (about 40%) and the language barrier (31%). 17% of respondents had doubts about the quality of the Estonian health care system.

Experience of Estonian health care providers with foreigners

Estonia inherited an oversized hospital infrastructure from the Soviet Union. It had a total of 120 hospitals and far too many beds for the population, reflecting the building of facilities primarily for military purposes. The hospital reforms during the 1990s reduced capacity, renovated existing infrastructure, and created incentives for greater efficiency linked to increased decision rights by hospital managers. At the same time, licensing procedures were reinforced and the purchasing power of the EHIF strengthened, particularly through the introduction of diagnosis-related groups (DRGs) for hospital reimbursement (Jesse, 2004).

⁶ Estonian Tourist Board, www.eas.ee, 2005.

The persisting overcapacity, coupled with the autonomy possessed by hospital managers and the scope to compete on price could, in theory, motivate plans to attract foreign patients. We were interested to learn about the existing experiences of Estonian providers in attracting foreign patients and if and how the foreign patients fitted into the strategic development plans of Estonian hospitals. To address this issue the relevant data was examined and providers were interviewed. The focus was on larger hospitals providing emergency and elective care, as well as smaller providers who had been known previously to consider attracting foreign patients.

Data from 2004 reveal that the overall numbers of foreign patients treated in Estonia were relatively modest. For example, 157 patients were treated in Pärnu Hospital in south-western Estonia, with 755 in the Regional Hospital in Tallinn. Most were emergency cases, mainly from Finland and other Nordic countries. The EHIF received 734 invoices for reimbursement of care provided to foreign patients under Council Regulation (EEC) No. 1408/71 (including outpatient and inpatient care) from the hospitals in 2004 (EHIF, 2004).

Public providers seem to have no plans actively to seek elective patients from abroad, as reported by hospital managers who were interviewed. Their strategies seemed more reactive, stating that if a contract for hip replacements was offered, they would of course consider it, but they were not actively seeking it. Some cross-border cooperation initiatives in the areas of radiology and telemedicine were, however, under way.

A few private providers in orthopaedic and vascular surgery had actively been seeking patients and contracts for patients from abroad, especially from neighbouring Scandinavian countries. All those interviewed admitted having experienced difficulties and resistance while trying to enter foreign markets, despite themselves having worked as specialists abroad. A certain lack of trust was noted among foreign colleagues. As a result, these providers have changed their strategies for attracting foreign patients, from trying to market themselves directly to patients to adopting a strategy to build up relations with networks of private providers and “middlemen” in those countries.

The most well-developed plan involving cross-border care is not related to tourist flows, but can be found in the twin towns of Valga and Valka on the Estonian-Latvian border. These adjacent towns are seeking ways to optimize facilities and health care staff across the border that divides them (Box 3.1).

The highest levels of patient mobility take place in price-sensitive areas such as dentistry and cosmetic surgery. Unfortunately these were also the specialties where information on foreign patients was the most difficult to obtain, largely because data are not collected based on country of origin, but also because

Box 3.1 *Rationality over nationality, cross-border collaboration on the Estonian-Latvian border: the case of twin towns Valga-Valka*

There is significant ongoing cross-border collaboration between Estonia, Finland, Norway, Lithuania and Latvia, mostly in the areas of e-health, radiology, and surgery. One notable example of cross-border collaboration occurs in the southern region on the Estonian/Latvian border at Valga-Valka. This offers a good example of both favourable elements and obstacles for cross-border collaboration.

The Estonian-Latvian twin towns Valga-Valka, on the borders of the two countries, are on the way to developing true cooperation in cross-border health care delivery. The area of Valga is 16.5 km² and that of Valka 14.2 km². Populations are 15 330 and 7100 respectively. Both towns are surrounded by counties with populations of about 30 000.

Historically, until the 19th century, the area now divided by an international border was just a small town, populated by Germans, Latvians, Estonians and Russians. The building of the railway in 1889 led to a doubling of the town's population over 20 years, and by the beginning of the 20th century Estonians represented the biggest nationality in the town. With the declaration of independence in 1918, both Latvia and Estonia claimed Valga as their own territory. The dispute was finally settled by international arbitration involving a British special envoy who established the border between the two countries. The larger part of Valga, including the railway station, remained in Estonian territory. Unlike similar twin towns, Valga-Valka has no natural division such as a river.

During the Soviet occupation, both towns developed their own social infrastructure, including two hospitals separated by a distance of about two kilometres.

these providers were somewhat resistant about sharing information. In interviews, the managers of dental clinics in Tallinn and Pärnu estimated that the share of foreign dental patients treated in Estonian clinics is relatively modest, varying in their clinics from 5% to 30% of the total number of patients. The same prices are charged to foreign and local patients. Patients pay out of pocket and, in rare cases, use private insurance. Reportedly, the price of dental care in other Scandinavian and EU countries is 50–200% higher, with the greatest difference for prosthetics, orthodontic appliances and advanced dental surgical procedures. Although most foreign patients come from Scandinavian countries (mostly from Finland and Sweden), increasing numbers of patients seeking dental care come from Norway and the Russian Federation.

After regaining independence, both countries faced the same challenges of transition and reorganization of their health care systems, with a need for increasing efficiency of hospital-based care delivery. The problem was exacerbated in an area such as this, which has experienced depopulation and internal migration to the capitals. In the mid-1990s, new premises for the Estonian Valga hospital were built, but about one fifth of the hospital space remains unused. At the same time, the facilities in Latvian Valka remain outdated and in urgent need of renovation.

In the last few years, the development of cooperation in hospital services has been on the agendas of regional cooperation committees in both countries. The main reason for this is the financial impossibility of maintaining two parallel on-call medical teams for this relatively small area, as well as the need to increase the efficiency of capital investments. Obstetrics was identified as the most suitable area for cooperation; the Estonian Valga hospital already employs a part-time bilingual Latvian specialist in gynaecology. Another area being discussed was a joint ambulance service: the Estonian side would provide emergency care for the whole area during the evenings and nights. The hospital expressed an interest in employing medical doctors and nurses from the Latvian side and, with 30% higher salaries on the Estonian side, there are ample financial incentives for the medical staff to agree to this cooperation.

Yet some administrative hurdles remain to be overcome before the joint delivery of services can be implemented. Unresolved issues by the beginning of 2005 included questions such as where birth certificates should be issued and what the country of birth should be for Latvian babies born on Estonian territory. Other issues include reimbursement mechanisms and the application of co-payment rates, both of which differ between Latvia and Estonia, a problem which still needs to be resolved (Tapfer, 2004).

Although local newspapers on both sides of the border have reported on the developments, the public's views on this process are not yet clear. The general response appears to be one of "wait and see". This is probably because the process is not yet seen as concrete, with no firm proposals having been made.

Attitudes of policy-makers

As this chapter shows, patient mobility is relatively modest between Estonia and Finland. EU enlargement, European Court of Justice decisions and EU service directives have brought the issue onto the agenda of policy-makers at national level. Attitudes towards these developments, as revealed by interviews with Estonian and Finnish decision-makers, were cautious and mixed.

From the policy-makers' perspective, patient mobility is considered positive in many ways: it opens up new opportunities for patients, allows the best available resources to be combined in centres of excellence at European level, helps to clarify what is meant by a European standard of quality of care and provides insights into pricing policies elsewhere in Europe. As one of the respondents stated: "People should get appropriate, high-quality treatment with fewer bureaucratic obstacles." Some of the Estonian policy-makers found discussions on patient mobility to be an opportunity to focus on the financial sustainability of the current health care system and on the need to direct more resources into health care.

However, policy-makers are concerned about the financial sustainability of the national health system lest more patients seek health care services in other countries. Almost all stressed the need to know more about this phenomenon and to learn more about people's preferences, attitudes and experiences of using health services abroad.

Overall it could be said that the approach taken by policy-makers was more one of "let's not rock the boat and just wait and see" than actively pursuing enhanced mobility. Cross-border collaboration was strongly encouraged and supported: "We support sensible cooperation like health technology assessment, e-health and to keep it on the realistic level where real added value at the European level can be achieved."

Conclusions

Patient mobility as a topic is not yet an important item on the Estonian health policy agenda, but there is clearly a growing awareness on different levels of the health system, where it is seen as both an opportunity and a threat. Clearly, both features are present in patient mobility, and it is up to governments of EU Member States to find a balance that would truly serve the interests of patients without jeopardizing the quality of health services and financial sustainability of the health system.

For smaller countries, such as Estonia, it is inevitable that there will be some degree of cross-border cooperation if it is to assure services to its population. However, for poorer countries, there are other issues to be taken into account when balancing the risks and benefits of enhanced patient mobility. Reduced confidence in one's own health system may create significant outbound mobility to seek health services, if these are fully reimbursed by the public sector, as indicated by the survey of the Estonian public. This may, however, create a vicious cycle that poses risks to the underfunded local health system.

On the other hand, contestability in an otherwise somewhat monopolistic market for specialized care may create extra pressure for local health service providers to enhance their quality, efficiency, and responsiveness to patients' medical and nonmedical expectations.

Providers consider patient mobility an opportunity, but are not developing strategies to explore the opportunities actively. Although the incentives provided by the autonomous status of public hospitals, payment mechanisms and price differences could all favour inbound patient mobility, few providers are actually pursuing these opportunities. Even private providers see the future of cross-border health service provision more as involving increased choice for patients within a network of providers from many countries, rather than as entering into a competitive international health service market.

Considering the special nature of health services, their sensitivity, and the many information asymmetries involved between different parties, it is difficult to disagree with the attitude taken by the providers. What patients need most are assurances that whenever and wherever they need health services within the European Union, high-quality health services will be available and there will be minimal administrative barriers to obtaining them. This can largely be delivered by providing people and providers information on service entitlements and how to use these services when need arises. As a beginning, the Estonian Health Insurance Fund has published on its web site the language proficiencies of Estonian family practitioners as a means of facilitating access to the health system for foreigners residing in Estonia.

Access to and availability of information are not only necessary for the European citizen to exercise their basic rights while travelling within Europe, but are also essential for evidence-based policy-making at national and European level. The present study showed that data are difficult to obtain or are completely absent. Current trends suggest that patient mobility will increase in the future, making it important to establish mechanisms to monitor developments. Member States' experiences of collecting appropriate information could be helpful for others. For example, in Finland there are several ways to identify foreigners in Finnish health registers. Medical birth and abortion registers and hospital discharge registers will in future allow recording of data on country of birth, language, nationality, and migration to Finland, with specific decision rules on how to identify foreign residents. However, there is no information currently available to identify immigrants, asylum seekers or refugees, or to indicate whether the patient is a visitor, health service seeker or is referred from another hospital that has a contract with the Finnish provider (Gissler, 2004).

In conclusion, although enhanced patient mobility can easily be seen more as a threat to existing health systems in Europe than an opportunity for patients, the opportunities can be increased if the process is managed sensibly. Encouragement of coordinated collaboration and concerted action among purchasers, providers and centres of excellence in Member States could contribute to assuring access to high-quality health care services for European citizens which need not depend on where the need for care arises.

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Chapter 4

Cross-border care in Ireland

Jim Jamison, Helena Legido-Quigley, Martin McKee

Introduction

Northern Ireland has now experienced over ten years of relative peace, following nearly three decades of violence and disorder. The multiparty agreement of 1998 (usually known as the “Good Friday Agreement”) paved the way both for the establishment of a new devolved power-sharing administration and for structures to enable formal cooperation between Northern Ireland and the Republic of Ireland in six policy fields, including health.

Although the devolved arrangements have been subject to a series of interruptions, the Irish and British Governments, and the EU, have continued to give considerable moral and financial encouragement to cross-border initiatives in the health and other fields. A study conducted in 2001 (Jamison et al., 2001) found a great deal of enthusiasm for cross-border cooperation in health services, both in the vicinity of the border and at all-Ireland level.

We set out to establish how much cooperation that involved the movement of patients or professionals had actually taken place. We also documented the extent of cross-border cooperation in “non-patient” activity such as professional accreditation, exchanges, training and conferences.

We examined how attitudes and policy had changed over the period and investigated the reasons for the lack of further progress in patient mobility since the earlier study.

Context

Political context

In 1921 the island of Ireland was partitioned, with Northern Ireland, consisting of the six north-eastern counties (current population over 1.7 million), remaining within the United Kingdom, and the remaining twenty-six forming an independent state, the Republic of Ireland⁷ (population over 3.9 million). Figure 4.1 shows the political geography of the island.

Health systems

Northern Ireland

Health and personal social services in Northern Ireland are available largely free of charge on the same basis as in the National Health Service in Great Britain.⁸ This includes primary care, hospital services and most care in the community.

Overall policy, regional planning and resource allocation functions are exercised by the Department of Health, Social Services and Public Safety (DHSSPS) in Belfast. At this point, a brief explanation of the system of government of Northern Ireland may be useful. Health and Social Services is one of several sectors that have been devolved by the United Kingdom Government to a regional government in Northern Ireland. The department is a ministry within this government, normally headed by a minister who is a member of the locally elected assembly and of the Northern Ireland Executive (cabinet). The Northern Ireland Executive operates on a series of rules designed to ensure participation of the two religious communities in Northern Ireland. At the time of writing, however, it has not been possible to achieve agreement between the main parties so the assembly and executive have been suspended and the department is headed by a minister from the United Kingdom Government.

There are four health and social services (HSS) boards, whose members are appointed by the DHSSPS, and which are responsible for commissioning health and social care from 19 HSS trusts, organizations that are part of the National Health Service and which provide acute and community care.

Republic of Ireland

The Republic of Ireland has a mixed public/private health care system. Those in the lowest income groups have access to the full range of services free of

⁷ Established as a republic in 1937; the official name is Ireland.

⁸ England, Scotland and Wales.

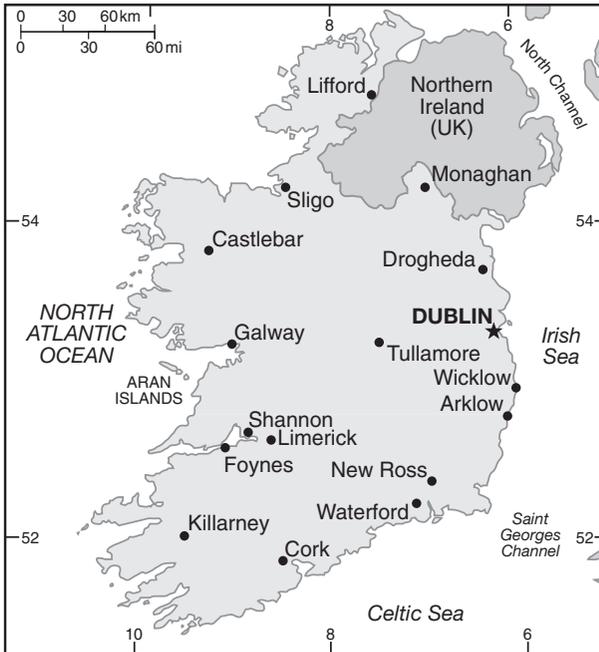


Figure 4.1 Map of Ireland

Source: CIA World Fact Book

charge. The remainder pay directly for primary care services and have entitlement to a bed in a public ward of a hospital, subject to a per diem charge. Almost 50% of the population are privately insured to cover co-payments in public hospitals and services provided in private hospitals.

The Department of Health and Children in Dublin is responsible for policy and overall service planning. The services are managed by a recently created national body, the Health Services Executive (HSE). The republic's 53 acute general hospitals are publicly owned and are managed locally through 10 local hospital networks responsible to a National Hospitals Office. However, hospitals contain wards catering for both public and private patients. Community services are managed locally by local health managers responsible to the Primary, Community and Continuing Care Directorate.

Financing of the health system is mainly from public sources (about 80%); around 13% is financed through co-payments for services. The main share of public funding is raised by general taxation and a specific health contribution of 1.25% of gross income for all of the population except those on a low income.

There are 2500 private and semi-private beds in private hospitals and, of 12 300 acute beds in the public sector, 2500 are designated for use by private patients.

Comparisons

Despite the differences in structure and funding mechanisms, the systems in the two parts of Ireland suffer from similar problems in the form of lengthy waiting lists for admission to hospital; patients frequently having to wait on trolleys in accident and emergency departments before a bed can be found for them on a ward; staff shortages; and constant media scrutiny.

Each jurisdiction has a policy favouring concentration of hospital services, although, particularly in the Republic of Ireland, progress has been slower than anticipated largely owing to public and political resistance.

Levels of provision

Provision of services in the two jurisdictions is similar (see Table 4.1), although Northern Ireland has more medical specialists and greater investment in community care.

Historical context

Following the 1985 Anglo-Irish Agreement, which provided for a consultative role for the Irish Government in the affairs of Northern Ireland, cross-border cooperation was put on a formal basis, with regular bilateral ministerial/departmental meetings, within the framework of a north-south Ministerial Council (NSMC), to discuss the potential for joint working.

The first formal commitment to work towards specific objectives in relation to cross-border cooperation was in the Good Friday Agreement, which as well as including provision for the establishment of a north-south “implementation body” in the field of health (the Food Safety Promotion Board), recognized health as one of six fields for cooperation to be overseen by the NSMC. Five specific areas for cooperation were identified: accident and emergency services, major emergency planning, cancer research, health promotion and procurement of high technology equipment.

Scope of study

Types of cross-border cooperation

As elsewhere in the EU, patient mobility across the Irish border can be the result of an emergency, where the condition concerned arises during a visit to the other jurisdiction, or on a planned basis, with prior authorization by the authority normally responsible for the individual’s care. There is also a long-established practice of residents of the Republic of Ireland accessing free care

Table 4.1 *Provision of health and social services (2004 unless stated)*

	Northern Ireland	Republic of Ireland
Acute beds/1000 population	2.6	3.0
All discharges/1000 population	198.1	150.5
Day cases/1000 population	91.3	114.8
Accident and emergency attendances/1000 population	396.9	306.7
Outpatient attendances/1000 population	881.1	571.8 (2003)
Medical specialists/1000 population	0.60	0.38
Total medical and dental staff/1000 population	1.82	1.73
Nursing etc.	10.02	8.49
Scientific, professionals ancillary to medicine, etc.	3.27	3.17
All hospital and community health services staff providing direct patient care	15.11	16.99
Management and support staff	10.69	7.43
Total HCHS staff/1000 population	25.80	24.41
General practitioners/1000 population	0.63	0.72 (est.)

Sources: Department of Health and Children (DoHC) and Department of Health, Social Services and Public Safety

in Northern Ireland through the use of an “accommodation address”. By its very nature such traffic is very difficult to quantify, but may be substantial. Patients paying privately for care also cross the border in both directions for elective surgery, for example hip replacements. The focus of our study was mainly on planned, pre-authorized treatment.

In relation to hospital services, the potential for flows across the Irish border exists at two levels. Over short distances, people living in the vicinity of the border can access services fairly readily in the other jurisdiction; over greater distances, those living throughout the area of one jurisdiction may travel for specialist care in the other jurisdiction.

Other forms of north-south cooperation in health care include:

- training and professional development;
- joint service development;
- research and policy development.

Data on numbers of patients

Data on cross-border movement of patients provided by the two departments and the Economic and Social Research Institute in Dublin enabled us to establish the extent of patient mobility and how it had changed between 1996 and 1999.

Table 4.2 and Table 4.3 show the numbers of patients (inpatients and day cases) from the Republic of Ireland treated in Northern Ireland, and vice versa,

Table 4.2 *Patient flows into Northern Ireland*

	Total inpatients and day cases treated in Northern Ireland	Patients from the Republic of Ireland treated in Northern Ireland	Patients from the Republic of Ireland as percentage of total
1996/97	436 164	1 330	0.30
1997/98	450 417	1 438	0.32
1998/99	473 600	1 328	0.28
N.B. Data below exclude regular day/night attenders			
2000/01	429 985	1 708	0.40
2001/02	435 072	1 636	0.38
2002/03	445 263	1 722	0.39

Source: Department of Health, Social Services and Public Safety

Table 4.3 *Patient flows into the Republic of Ireland*

	Total inpatients and day cases treated in the Republic of Ireland	Patients from Northern Ireland treated in the Republic of Ireland	Patients from Northern Ireland as percentage of total
1997	679 214	915	0.13
1998	696 723	920	0.13
1999	758 149	995	0.13
2000	798 620	974	0.12
2001	857 270	1 069	0.12
2002	891 312	902	0.11

Source: Economic and Social Research Institute

over two three-year periods before and after the original study. It can readily be seen that there has been some increase in patients from the Republic of Ireland treated in Northern Ireland, but no increase in the other direction. The numbers overall remain very small.

As can be seen from Table 4.4, most of the cross-border discharges were from hospitals in the former Eastern Health Board area (which includes Dublin), or those close to the border (the North-Eastern and North-Western Boards in the Republic and Altnagelvin (in Londonderry), Daisy Hill (in Newry) and Erne (in Enniskillen) in Northern Ireland).

Current and past cooperation

As noted above, cross-border cooperation involving patients generally falls into two categories: those in the vicinity of the border between Northern Ireland and the Republic of Ireland (see Figure 4.2 below) and those on an all-Ireland basis.

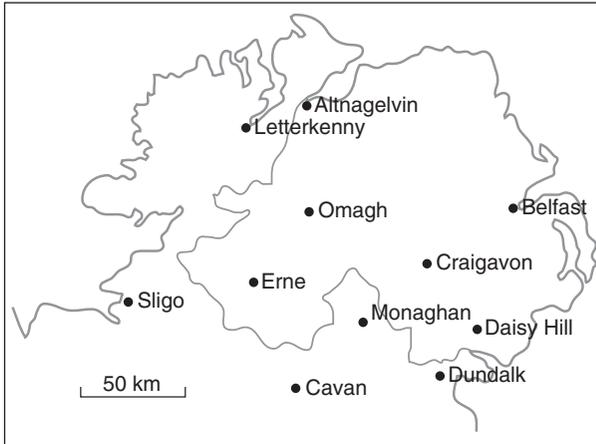


Figure 4.2 Location of hospitals serving border areas in Ireland

Table 4.4 Health board of treatment of Northern Ireland patients discharged from hospitals in the Republic of Ireland, 2001 to 2003

	2001	2002	2003
Eastern	319	285	310
Midland	24	14	13
Mid-Western	31	18	12
North-Eastern	254	269	261
North-Western	305	283	267
South-Eastern	37	37	27
Southern	48	41	43
Western	76	84	68
Total	1 094	1 031	1 001

Source: Department of Health and Children

The border area

The Cooperation and Working Together Agreement (CAWT)

The CAWT initiative began in 1992 with an agreement between two pairs of health boards adjacent to the border in the Republic and Northern Ireland. Its stated objectives are:

- to improve the health and social well-being of their resident population;
- to identify opportunities for cooperation in the planning and provision of services;

- to assist border areas in overcoming the special development problems arising from their relative isolation; and
- to involve other public sector bodies to fulfil common primary objectives.

Support for CAWT has been provided largely by the EU. From 1996 to 2000, over £5 million (€7.3 million) was provided under the EU Special Support Programme for Peace and Reconciliation (Peace I). More recently funding has come from the EU Peace II⁹ and Interreg programmes.

An agreement has recently been made for a pilot scheme for general practice out-of-hours services whereby patients will use the nearest out-of-hours service, regardless of what side of the border a patient lives on. The two Departments of Health have also commissioned CAWT to develop three cross-border projects in emergency planning and pre-hospital emergency care.

CAWT supports a wide range of other projects. These are funded largely by the EU Interreg programme, although a 25% contribution comes from the two governments (in the proportions of 3/5 United Kingdom to 2/5 Republic of Ireland). The process of selecting the successful projects was delegated to CAWT itself.

Altnagelvin/Letterkenny hospitals

For some years concerted efforts have been made to foster cooperation between Altnagelvin Area Hospital in Londonderry,¹⁰ Northern Ireland, and the neighbouring Letterkenny General Hospital in the Republic. A formal agreement between the North Western Health Board, the managers of Letterkenny General Hospital, and Altnagelvin Health and Social Services Trust contained a number of conditions governing any cooperation between the two hospitals, including:

- no proposal would undermine the services currently being provided in either hospital;
- cooperation should be confined to services that a particular hospital could not see itself providing in 5 to 10 years.

These conditions were thought to be necessary because of concerns on the part of politicians and professional staff, in particular that Letterkenny General Hospital could otherwise lose out to its dominant neighbour.

Although a joint feasibility study in 1999/2000 identified a large number of areas for joint working, only a few have been carried forward.

⁹ Programme for Peace and Reconciliation.

¹⁰ Usually referred to as Derry.

Oral and maxillofacial surgery. The existing Altnagelvin service is to be extended to the north-west of the Republic of Ireland, thus increasing the total population served to approximately 600 000 and justifying the maintenance of a team of four consultant surgeons.

Neonatal intensive care. This service is provided under contract from Altnagelvin to premature/sick babies from Letterkenny.

Others. Patients from Donegal can avail themselves of bone scan services in Altnagelvin.

Monaghan/Craigavon

Hernia surgery. This pilot initiative involved patients who had been waiting more than 18 months for operations at Craigavon Hospital (near Portadown, in Northern Ireland) being treated at Monaghan Hospital in the Republic of Ireland.

Mobile cardiac catheterization. A mobile catheterization service has been piloted at Craigavon Hospital for patients from both jurisdictions to reduce the need for patients to travel long distances to centres in Belfast or Dublin.

Daisy Hill Hospital

Haemodialysis is provided under contract in Daisy Hill Hospital, Newry (Northern Ireland), to a small number of patients from the Dundalk area in the Republic of Ireland who would otherwise have to travel to Dublin (a distance of about 90 km) twice or three times a week. Daisy Hill Hospital also provides maternity services on a private basis to patients from the Dundalk area.

Other examples of cooperation

These have included:

- the provision of emergency assistance by health professionals from the Republic of Ireland, with a recent example following the bombing at Omagh in 1998;
- emergency treatment for casualties of road traffic accidents and emergency obstetric treatment provided by the nearest hospital, irrespective of jurisdiction;
- ear, nose and throat services from Tyrone County Hospital to patients from Donegal, Cavan and Monaghan.

All-Ireland level

Following the introduction of a limited amount of competition in the National Health Service in Northern Ireland under the United Kingdom Government's

reforms after 1993, a number of one-off contracting arrangements were negotiated. For example, in the mid-1990s the Royal Group of Hospitals in Belfast entered into an arrangement with the Southern Health Board in the Republic of Ireland (covering the area around Cork) to provide hip replacements in order to reduce the numbers waiting for surgery. For a variety of reasons, including distance and apprehensions about security, such initiatives were only partly successful and none developed into a continuing arrangement.

Waiting list initiatives

There are still intermittent initiatives in which health boards in Northern Ireland contract with hospitals in the Republic of Ireland, usually employing one-off funds made available by the DHSSPS to reduce waiting lists. Recent examples include the purchase by one HSS board of coronary artery bypass grafts and neurology investigations from a private hospital in Dublin.

National Treatment Purchase Fund (NTPF)

The NTPF was established in the Republic of Ireland in April 2002 with the objective of reducing waiting lists for admission to public hospitals by arranging and purchasing treatment, mainly in hospitals in the Republic of Ireland. However, about 1000 patients have been treated in a private hospital near Derry in Northern Ireland and approximately 600 have received treatment in England.

Other examples of cooperation

These have included:

- ophthalmic services to patients from the North Eastern Board by the Mater Hospital in Belfast;
- training and professional development, including joint training programmes for paediatric surgery and neurosurgery, and distance learning nursing courses;
- the Institute of Public Health in Ireland, established in 1999;
- a tripartite relationship with the United States National Cancer Institute;
- cooperation in health promotion campaigns;
- infectious disease planning.

Assessment from different perspectives

Health officials

In 2000 and again in 2004, an extensive series of in-depth interviews was carried out with senior health officials from purchaser and provider bodies in the two

jurisdictions. In the first study our respondents saw considerable advantage to be gained from cross-border cooperation. Views frequently expressed were:

- collaboration would address the relative disadvantage of border areas;
- the border region is a “natural” geographic area;
- there are benefits from planning health care on an all-Ireland basis;
- threats to health do not respect political or other boundaries;
- cross-border collaboration will bring a faster response in an emergency;
- patient benefits will accrue from pooling expertise and exchanging good practice;
- cooperation will enable the development of “critical mass” and economies of scale in areas such as education, workforce planning and health technology assessment.

In this study, our respondents were still positive about the potential for cooperation. Those involved in CAWT were particularly enthusiastic, but along with others were more realistic about the practical difficulties and less optimistic about the immediate prospects, particularly for initiatives involving patient mobility. There was a greater degree of appreciation of the problems inherent in arranging cooperation in the vicinity of the border, where hospitals are often perceived to be under constant threat of closure and where cooperation may be viewed as having an implicit goal of future rationalization.

Those health officials who had been involved with past cooperation initiatives generally had positive views about their value.

Patients and the public

Due to constraints arising from data protection legislation it was not possible to approach directly patients who had been treated “across the border”. As we noted above, the number of patients who have been directly involved in cooperation initiatives is quite small. We were, however, told that the response from those who had been involved was positive.

No research has been undertaken into public attitudes to cooperation.¹¹ It is notable that the issue has not become a matter of public controversy across the “religious divide” as have suggestions for cross-border working in other fields. However, given the extent of negative public reaction to any proposals for rationalization of hospital services *within* one jurisdiction, it is perhaps

¹¹ A proposal to CAWT for research in this field was turned down.

reasonable to assume that resistance to any perceived loss of services across the border would be at least as stringent.

Factors facilitating cooperation

Without exception those interviewed were keen to develop links with their counterparts in the other jurisdiction. There are a number of other encouraging factors.

Social and cultural

Although there have been two separate legal jurisdictions in Ireland, each with its own administration, since the partition of the island in 1921, in many aspects of life the island is far from forming two distinct entities. Many cultural and most sporting bodies are organized on an all-Ireland basis, there is a common language and to a large extent a shared culture, there are common health, social and economic problems and there is a great deal of day-to-day social movement across the border. Since the Republic of Ireland and the United Kingdom both acceded to the EEC (now the EU) in 1973, barriers to trade and movement of people have diminished greatly.

Political

Since the 1985 Anglo-Irish Agreement and to a greater extent since the 1998 Good Friday Agreement, cross-border cooperation in health care in Ireland has been the subject of a great deal of consideration and encouragement.

Health policy

Similarities in the structure, organization and provision of health and social care in the two jurisdictions are conducive to cooperation.

Economic considerations

On the face of it, cooperation initiatives have the potential to enhance the services provided to populations either in the vicinity of the border, or more widely, by increasing “critical mass” to justify service concentration. Evidence that this will produce benefits from economies of scale in the acute sector is, however, not strong, and is counterbalanced by good evidence that utilization of a service declines as the distance from it increases. Evidence supporting a positive relationship between volume and outcome is mixed. However, where the viability of small hospitals is threatened, rationalization may secure the

future of a smaller number of hospitals, improve effectiveness, reduce costs and not necessarily adversely affect access.

Factors hindering cooperation

There are a number of reasons why very little actual cross-border patient movement has occurred.

Funding and reimbursement arrangements

In both jurisdictions health care is financed largely through general taxation. Hospitals and other facilities are funded through annual allocations which are based on the previous year's budget with adjustments for inflation, etc.¹² From time to time additional funds are made available for initiatives such as reducing waiting lists, but by and large there is very little opportunity to shift funds from one provider to another, even within the same jurisdiction. This is because, as well as having responsibility for the health and well-being of their populations, health authorities are responsible for maintaining the viability of the hospitals on which their patients depend and, in practice, this consideration tends to dominate. It could be said with some justification that concerns about provider viability, to the extent that they inhibit competition, are potentially inimical to the interests of patients.

Proximity to facilities

As in other countries, patients in Ireland prefer to receive hospital treatment as close as possible to where they live. This applies both to emergency care (for reasons of perceived safety) and to elective treatment (for convenience, both for the patient him/herself and for visiting relatives). This means that unless there are good reasons (for example to obtain a needed operation more quickly), any suggestion that patients should have to travel for their hospital treatment is unlikely to be well received.

Hospital rationalization

In many areas, particularly rural ones, local hospitals attract support because they are regarded as an important source of local employment, both directly and indirectly. Residents see a hospital as enhancing the status of their town.

Obligations to reduce health service costs (including capital), the standards that a hospital must meet to be authorized to train junior doctors (set out by

¹² In the Republic of Ireland there is a partial case-mix reimbursement scheme.

the Medical Royal Colleges, which supervise medical training in both jurisdictions), the European Working Time Directive, and expectations of hospital doctors themselves mean that there is constant pressure for smaller hospitals to be merged or “rationalized”. Accordingly, in each jurisdiction hospitals close to the border are often considered too small to be viable.

It is important to realize that hospital planning in rural areas is often rightly seen as a “zero-sum game”, with rationalization almost always resulting in a diminution of services on one site to provide for investment on another. There is often keen, not to say bitter, rivalry between hospitals and communities even in the same jurisdiction. It seems unlikely that controversy surrounding such decisions would be any less if there was a threat of services being reduced or subject to unwelcome change as part of a plan that could see improvements in the other jurisdiction.

Clinical and public resistance

Conservative attitudes on the part of clinicians and the general public mean that, for each proposal for patients to be treated in the other jurisdiction, questions are raised about continuity and quality of care, safety, legal liability and political/professional accountability, often linked to the travel involved. There is also a concern on the part of health service managers that if they are seen to be challenging medical opinion or the wishes of the local community or local politicians, their careers may suffer.

Other factors

These include:

- the pace of other forms of organizational change, a preoccupation of staff in both jurisdictions;
- legislative differences regarding eligibility for services and licensing of products;
- transaction costs and currency fluctuations;
- difficulties in referring patients to tertiary services across the border;
- differences in:
 - clinical/professional standards, protocols, guidelines and audit procedures;
 - pay scales, conditions of employment and job descriptions;
 - medical defence insurance arrangements;
 - professional training and accreditation;

- the public/private mix and in insurance coverage;
- grades of staff (consultant/junior doctor ratio).

Many of these should be regarded as technical barriers, capable of resolution given the right incentives and sufficient will on the part of managers and clinicians.

Conclusions: issues and recommendations

Over the last ten years politicians, senior civil servants, health service managers, health professionals and others have made speeches, attended conferences, sought election, attended meetings, written and read papers and reports and funded initiatives all aimed at facilitating and encouraging cooperation across the Irish border. Despite that, patient and professional mobility has been much less than expected. This experience raises a number of important issues.

Rationale for cooperation

As we noted above, cross-border cooperation in health services was an area chosen for particular mention in the 1998 Good Friday Agreement on the future of Northern Ireland and much encouragement has been given to initiatives in this field. However, when statements by government ministers and other senior policy-makers are examined it is difficult to find any clear, well-thought-out rationale for such cooperation. In the “Assessment from different perspectives” section above, we set out the advantages adduced by our interviewees, and many of these points appear to have merit. However, they were expressed at a very general level and we have not been able to find any detailed appraisal that could be used to justify public investment in a cooperation strategy or in individual initiatives. For example, although there is a general presumption that the population of border areas suffer from unmet need for hospital services, comparative analyses of mortality and utilization data conducted for the earlier study failed to confirm this.

It would appear that greater clarity is needed about the objectives of improving cooperation and the obstacles to be overcome in achieving that improvement. This would include clear statements about existing problems and how they can be ameliorated through closer cross-border working. One objective might be to overcome disadvantage in terms of particular documented levels of unmet need in border areas. Others might be to plan more effectively for “natural” cross-border catchment areas or to learn about the effectiveness of different responses to common problems. On the other hand, expenditure on cooperation might be justifiable in “reconciliation” terms, although in that case the funding concerned should come from a budget other than that for health services.

Competition and funding

One of the most useful examples of cooperation has involved contracting (by the health boards in Northern Ireland and the NTPF in the Republic of Ireland) for elective surgery to reduce waiting lists within each jurisdiction. In Northern Ireland such initiatives are invariably of short duration because of concerns on the part of the boards that they should be investing resources to maintain the services in their own jurisdiction rather than “exporting” them.

Northern Ireland and the Republic of Ireland are both small places and for some specialties there is only one provider. The funding system in each jurisdiction, which means that resources are essentially “locked in” to one provider no matter how poor the service, carries no incentive to good performance. Even if a provider defaults on its contract it suffers no financial penalty. Health authorities cannot withdraw funding from a provider to invest elsewhere without effectively paying twice for the same service.

It is clear that if it is to be acceptable, cross-border cooperation has to be reciprocal rather than seen as a “one-way street”. That requires *both* jurisdictions to have funding flexibility and the capacity to facilitate it.

If the two governments are keen to exploit the putative advantages of cooperation, one option would be to open up competition by creating a fund (or in the Republic of Ireland increasing the resources available to the NTPF) to facilitate contracting for elective surgery, either within or across jurisdictions.

Joint planning

Perhaps the greatest potential for cooperation is in secondary care, where there are persistent and growing problems in both jurisdictions in maintaining the viability of small hospitals. Each Department of Health has a policy favouring raising standards through the concentration of resources. Small hospitals have difficulty in attracting medical staff because of the amount of risk they are exposed to. To the extent that the catchment population of hospitals is unnecessarily restricted by the border, people there are clearly disadvantaged by receiving a substandard service. Also, in some cases Northern Ireland health boards have lost confidence in the capability of hospitals in the Republic of Ireland to deliver on a contract because of the perception that they are constantly under threat.

Ideally, hospital rationalization and planning exercises in both jurisdictions should take account of the possibility of attracting patients from across the border. In the past this has been done only to a limited extent. There would appear to be scope for research that would examine, in an objective way, the “theoretical” potential for establishing services (at both specialty and hospital

level) that would serve populations in both jurisdictions. Such a study would consider population numbers and locations, travel distances and the population size required to support various specialties. It would take into account the experience of such exercises in other parts of Europe and would be able to draw on the findings of the Europe for Patients study.

We recommend that consideration should be given to including a cross-border element in all appropriate service reviews in each jurisdiction.

Population health or preservation of facilities

Any examination of the dynamics of hospital cooperation needs to consider the relationships and incentives involved. A range of factors from the drive for economic growth in a small town to the desire on the part of clinicians for a bigger empire militate in favour of aggrandizement. Such tendencies should not be seen as irredeemably negative: as in the bulk of human activity, growth through competition is often conducive to improved cost-effectiveness, higher standards, and greater satisfaction on the part of provider and consumer alike. However, if it is to be effective there need to be incentives for better performance. In the Irish systems such incentives are lacking, and in fact cooperation may be damaging to the interests of existing institutions.

Although Letterkenny and Altnagelvin hospitals have developed a useful model of cooperation, as we noted above the agreement between the two hospitals contains a number of important restrictions designed to protect the parochial interests of one or other hospital. Such restrictions intended to protect existing services clearly have the potential to impede cooperation which could lead to improvements in patient care and benefits for the overall health of the population.

Mainstreaming cooperation

It is notable that the bulk of resources devoted to cooperation in health services across the Irish border have been provided by the European Union, through the two Peace and Reconciliation Programmes and Interreg. Apart from their required 25% contribution to the current Interreg projects, the two governments have made virtually no specific financial provision for such cooperation. Nor, despite their avowed enthusiasm, have the health boards in the north or south (except in terms of people's time). There is virtually no evidence of "mainstreaming" in process, thinking or management.

Consideration should also be given to mainstreaming cooperation in departmental and board strategies, service plans and performance management processes.

CAWT

Although many of the current CAWT projects no doubt provide valuable enhancements to health services and/or capacity in the vicinity of the border, disappointingly none involves the movement of patients for treatment. A recent population profile undertaken by CAWT did not, unfortunately, examine population need for services in the border area.

The current projects funded by Interreg through CAWT were themselves selected in a closed process by CAWT itself. There was virtually no opportunity for those not already associated with the organization to bid for funding and no peer review of proposals. This appears to open up the possibility of “insiders” capturing resources for initiatives they are enthusiastic about. At the very least the practice introduces questions about impartiality and accountability for public funds.

Consideration should be given to introducing a greater degree of openness and transparency in the selection of projects to be funded using EU and Health Department resources.

Research

The enthusiasm about the future potential for cross-border cooperation needs to be backed up by careful studies of:

- population distribution;
- morbidity and other population characteristics;
- unmet need in rural areas;
- distance from facilities on either side of the border;
- the determinants of utilization in border areas;
- the potential for economies of scale;
- baseline levels of provision in the two jurisdictions, any spare capacity and the scope for expansion;
- the political/service impact of losing services, given that it will often be a “zero sum” game;
- patient and public attitudes to cooperation;
- economic research on the benefits of cooperation.

Consideration should also be given to awarding priority for cross-border research funding to projects comparing the effectiveness of the two systems.

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Chapter 5

Meeting the needs of long-term residents in Spain

Magdalene Rosenmöller, Maria Lluch

Spain: a country of passage and retreat

Spain has always been a country of passage, with widespread movement in and out of the country. In ancient times, Phoenicians, Greeks and Romans all landed on Spain's Mediterranean shores. In the medieval era, Arabs entered the Iberian Peninsula from North Africa, while the Visigoths and Vandals came from the north via the Pyrenees. From the time of Columbus onwards, there was a large exodus of Spaniards to the New World, in search of a new life. The 20th century saw a reversal of the flow, with large numbers of people from South America trying to improve their living conditions by coming (back) to Spain. During the Franco era, Spain remained somewhat closed to the outside world, but large numbers of people passed through while escaping war-torn Europe, and in the immediate post-war period, some Germans came in search of the protection that the Franco regime offered. Between the late 1950s and early 1970s Spain gradually started to open up. Economic exchanges increased and tourism quickly became an important source of income, with visitors attracted by the sun, beaches and low cost of living. Very soon it became a preferred destination for retired people, particularly from northern European countries. Many of those enthusiastic, active, just-retired arrivals of the 1970s and 1980s are now old and frail and in significant need of care. With its entry into the European Union in 1986, Spain began to participate in the EU's systems for social security coordination, including Council Regulation (EEC) No. 1408/71.

Mobility was further facilitated by the entering into force of the Schengen Agreement in 1995, 10 years after its official signature, which Portugal and

Spain had joined as latecomers. The Erasmus programme, started in 1987, has seen more than a million young European students taking up courses outside their home country, with Spain being one of the preferred destinations. More recently, the emergence of numerous cheap airlines has enhanced Spain's allure as a tourist destination.

Patient movement

European patients needing access to Spanish health services can be subdivided into three main groups: short-term visitors (tourists and students); long-term residents (people retiring to Spain) and people living on or near borders with France (Pyrenees and ski resorts) and Portugal. The present case study focuses on long-term residents, while additional insight was gained by looking at tourists, and in particular at the so-called floating population.

Short-term visitors (tourists, students and business people) are increasing in number, thanks to Spain's continuing attractiveness, coupled with a general increase in tourist travel in Europe as a consequence of economic development and lower fares. Tourists come mainly from economically well-off northern European countries (Table 5.1). Health care needs are often of a minor nature, and are taken care of in the many public hospitals along the coast. The regional health authorities most involved make special efforts throughout the year to cater for this extra demand. A number of long-term residents have stayed while retaining their tourist status – the so-called floating population. Their needs go beyond emergencies and include care for chronic conditions, screening, health promotion and disease prevention. They are often less well cared for, as their presence is in many cases not acknowledged by the system, an issue we will look at in more detail later.

The number of long-term residents (those who spend more than three months a year in Spain) has continuously increased. In 2004 the chair of the INE¹³ announced that the Spanish population had reached a historic height. The “legalization” of many illegal migrants has made the issue especially visible: in three years the Spanish population jumped from 41 million to 44 million. Now, almost 7% of the population are migrants from outside the EU, compared to which the number of people from other EU Member States seems insignificant (Table 5.2). The figure does not include the thousands more illegal immigrants who live and work in the country but who are not registered with the local authorities (Euroresidents.com, 2004), suggesting that the true percentage of Spanish residents born abroad is more likely to be around 8% of the overall population.

¹³ Instituto Nacional de Estadística (National Statistics Institute), www.ine.es

Table 5.1 Trends in tourism to Spain from Europe by country of origin

	1997	1998	1999	2000	2001	2002	2003
United Kingdom	10 148 193	11 371 946	12 181 455	13 238 973	14 011 225	14 697 387	16 021 262
Germany	9 995 459	10 780 820	11 586 318	11 171 050	10 783 029	10 211 494	9 814 186
France	4 877 258	5 234 899	5 732 640	5 680 578	6 712 905	8 143 463	7 690 151
Scandinavia	2 224 285	2 490 532	2 704 744	2 891 427	3 037 975	2 980 210	2 872 874
Italy	1 716 093	1 796 512	2 087 697	2 097 666	2 412 126	2 532 055	2 380 681
Netherlands	1 608 558	1 677 882	2 043 774	1 968 010	2 148 486	2 415 193	2 374 738
Belgium	1 523 167	1 744 846	1 809 811	1 679 874	1 716 924	1 774 970	1 775 697
Switzerland	1 141 770	1 251 337	1 203 440	1 198 479	1 233 503	1 223 203	1 049 904
Portugal	956 606	1 174 674	1 286 524	1 489 856	1 632 488	1 761 550	1 693 048
Austria	473 651	537 025	558 514	462 028	421 013	461 000	436 986
Russia	299 784	286 657	212 544	237 459	298 863	270 039	217 234
Others Europe	1 775 091	1 775 091	1 775 091	1 775 091	2 739 350	3 244 292	3 391 748
TOTAL	36 739 915	40 122 221	43 182 552	43 890 491	47 147 887	49 714 856	49 718 509

Source: IET – Instituto de Estudios Turísticos, Spain

Of course, overall figures conceal large geographical variations. In certain areas, long-term residents from other EU Member States represent a significant proportion of the population, with most of them being pensioners: research by King (2000) indicates that 50% of the United Kingdom nationals are over 50 years old, with the corresponding figure 29% for Germans and 24% for the French. However, all available figures are only approximations. While there is a decennial population census linked to review of the municipal registries, there is no reliable evaluation of the numbers of residents from elsewhere in the EU. Many are unrecorded and, as there has been no legal obligation for European citizens to register with their consulate since 1995, the actual number of residents from abroad is believed to be much higher.

There are three groups of long-term residents in Spain: “active” people (with social security coverage), retired people (officially registered), and the “false tourists” (people living more than three months in Spain but without regularization of their situation).

Employed/working residents

Citizens of other EU countries who are resident in Spain and who participate in the labour force are typically white collar workers with above average educational levels, although this may change following enlargement if, as has been the case in some other countries, a significant number of skilled workers come from the new Member States. Anyone working for a Spanish company and paying taxes has access to the Spanish health system, and many also have

Table 5.2 *Percentage of residents of Spain born abroad*

	EU citizens	Total foreign residents
Before 1961	0.07%	–
1970	0.04%	–
1980	0.10%	–
1990	0.19%	–
1996		1.22%
2001	0.47%	2.44%
2004		6.82%

Source: INE – Instituto Nacional de Estadística, 2004

private health insurance. A particular issue arises with the so-called “posted workers”, who are employed by an EU company and relocated to Spain for a number of years. Often these people are covered only by the tourist E111, and this may only cover themselves, with family members excluded from coverage.

Retired residents/pensioners

According to the 2001 population census (INE, 2001), retired foreigners are mainly from wealthier EU countries (i.e. United Kingdom, Germany, France and Scandinavia). When their situation is formalized, they are completely “invisible” to the system and are treated as any other Spanish citizen. This makes it impossible to determine their specific needs, their use of the system and the costs of the services provided to them, and thus it is not possible to ascertain whether the monetary transfers from the social insurance funds in their home country correspond to their level of consumption.

The “floating population”

The “floating population” or “false tourists” are residents who stay in Spain for more than three months of the year, but without regularizing their situation. They travel back and forth between their home country and Spain. Because of the informality of their condition, their numbers are difficult to assess, and obviously the official population census and other statistical sources do not capture them. This can be illustrated by the case of Valencia, where there is a significant difference between the number of official residents and those registered with the municipality. In 2003, in the Valencia region, where many older British and German citizens live, 73 000 residents held official residence cards (and thus were registered with the police), 158 000 were registered in the municipalities (*padrón*), and a significant proportion were not registered at all.

Many European homeowners do not register with the authorities because they use their Spanish home as their second residence, spending only part of their

time in Spain. They often do not consider registering with the local authorities. As tourists, they cover any necessary health care with the E111, or more recently with the newly introduced European Health Insurance Card (EHIC). Some also have travel and/or private health insurance in addition. This often leads to confusion as to whether they should be accessing the public or private system.

As expected, there is a strong seasonal pattern to health system use among tourists, with a peak in numbers of treatments provided to foreign patients between May and October, corresponding to the main tourist season. However, in one of the two main public hospitals in Majorca, there are still quite a large number of cases covered by the E111 scheme in winter, and while this may include some short stay tourists from northern Europe, it is highly likely that this also includes “floating” long-term residents who spend the entire winter there. This highlights the need for more detailed primary research on those using E111 forms.

The preparation of this case study continually faced the problem of obtaining adequate data, particularly for the “floating population”. However, the problem with data also has implications for policy; if research is constrained then surely so must be policy-making and planning, which leads us to wonder if, and how, these groups of patients have been taken into account in the planning of the health and other sectors.

Health system context, information and financial flows

The general context

As elsewhere in Europe, the system established by Council Regulation (EEC) No. 1408/71 (and its subsequent amendments) is fully operational in Spain: tourists come with an E111 form or the new European Health Insurance Card. While this should have simplified matters, in practice there is often confusion as some people still have the old E111 forms, others have transitional documents, and some have the new health insurance card itself. The situation is further complicated by the incompatibility of information technology systems, with nearly all of Spain’s 17 autonomous regions having their own health card, with poor interoperability between the different systems. The Spanish sector has come a long way in transforming the original family-based entitlement to one of individual entitlement. However, there is an ongoing process to create a unique identification number that can be used nationwide. The health card is fairly well developed in the autonomous regions. National bodies have tried to assume a coordination role, but without complete success, as some regions perceive this as an unwelcome intrusion,

perhaps a metaphor for the European model. It is expected that the new EHIC will lead to considerable improvements, in particular facilitating data collection that can provide a basis for invoicing, particularly with regard to patients from other parts of Europe. Further improvements that will streamline the very complex information and financial flows between the different levels (regional/national) and institutions (providers, funders, ministry, INSS¹⁴) will, however, also be needed.

The Spanish national health system

The Spanish health system is a national, tax-based universal system. While the responsibility for the planning and delivery of health care was devolved to the 17 regions, the social security system was – for reasons of national equity – retained at national level. The INSS is responsible for a common social security fund, manages occupational injury and other mutual funds, and is the competent agency for coordination of social security with other European countries, through the system established by Council Regulation (EEC) No. 1408/71. Thus the responsibility for European social security coordination is with the national social security organization, which receives transfers from other countries, while the delivery of care is decentralized, a dual system which hampers coordination and information gathering, as we will see in more detail below.

The principle of *universality* is established through the *Ley General de Sanidad* (1986), the general health law, stipulating that access to health care is a right for Spanish citizens. Under the system set out in Council Regulation (EEC) No. 1408/71 and various bilateral agreements, European citizens have the right to emergency care (E111), or the same health rights as Spanish citizens when they transfer their rights as pensioners (E121). However, professionals working in health care institutions are so used to universal access to care that all patients turning up at a public hospital in Spain will receive treatment, regardless of whether they can provide proof of entitlement (E111 etc.). In general, at primary care level the identification of foreign patients is more rigorously carried out than in the case of an emergency attendance at hospital. In some autonomous regions, such as Catalonia, care given to EU patients is well recorded, not only in terms of numbers, but also with regard to services provided and costs incurred. In 2002 these costs were estimated to be €3.7 million, mainly attributable to French patients, followed by German and British ones.¹⁵

¹⁴ Instituto Nacional de Seguridad Social (National Institute for Social Security), www.seg-social.es

¹⁵ 2002 Data facilitated by CatSalut, the Catalan public funding agency.

Various bilateral agreements with different European countries exist at national level, reportedly the only way to assure timely payments from some Member States. An example is the agreement concluded with the United Kingdom, in which the total number of United Kingdom tourist days in Spain is entered into a formula to obtain the estimated number of individuals who will seek treatment under the E111 scheme. Remarkably, no studies seem to have been carried out on actual volume of care provided to assess whether, at the end of the year, the estimated lump sum agreed upon corresponds to the costs incurred by the Spanish system for treatment to United Kingdom citizens.

There is anecdotal evidence that the ease with which care can be accessed may be attracting foreigners to Spain. While the Mediterranean climate and diet are sufficiently good “health reasons” for coming to Spain, it is suggested that there is also travel to obtain care from countries with long waiting lists. No precise data exist, but there are many accounts of hip replacements being carried out under the E111 system – quite a broad interpretation of emergency care. “Our doctors are just not used to refusing anyone here”, stated one official who requested anonymity. The lack of means to control access to care certainly provides an opportunity for this type of interpretation.

Some tourists use travel insurance, particularly when travelling in groups. Some hospitals in the public network have started to invoice the travel insurers in these cases and one Catalan hospital reported increasing its income from this source from zero to €1.3 million in one year,¹⁶ a welcome change from unrecovered costs under the E111 system. This led to a wake-up call for the travel insurance industry, which has started to require its clients to take their E111 form with them on holiday, even though full coverage of health costs is still stipulated in their policies.

Spain also has an effective private health care system, which is especially well developed in the coastal regions: private providers work with Spanish and European private health insurance schemes or for direct, out-of-pocket payment. In some places, such as Marbella or Palma de Majorca, there is a large network of taxi drivers and hotel clerks who direct tourists to private clinics and doctors that do not accept the E111. In Marbella, even the information on health facilities displayed in the tourist office in the central square only includes private clinics and other private care institutions. Private providers count on tourists’ willingness to pay the – for the circumstances – often relatively small amounts. Once they have been taken to a private clinic, tourists tend to stay there to avoid the hassle of transferring to a public hospital, where they are told to expect long waiting times. They will readily produce a credit card – the first thing they are asked for on arrival.

¹⁶ Interview with the financing director of a Catalan hospital.

Decentralization is the other main characteristic of the Spanish system, and is an important factor to be taken into account. As noted above, Spain's 17 autonomous regions, "comunidades autónomas", have responsibility for health care. The process of devolution began in Catalonia (1981) and Andalusia (1984), and concluded only in 2001, when responsibility was assumed by the remaining 10 regions, including Madrid, Extremadura and the Balearic Islands, which until then were managed by the national body Insalud. Each autonomous region now has its own health network, health legislation and health plan. Most regions have vertically integrated public systems, with no separation of financier, purchaser or provider, while in Catalonia half of all hospitals are privately owned, contracting with the public funding system. Thus, it is not possible to speak of a unified Spanish health system, but instead 17 regional health services, while the national Ministry of Health assumes a coordinating role through the so-called interterritorial council (*Consejo Interterritorial del Sistema Nacional de Salud*, CISNS). The legal framework defines the roles of different tiers, with management and planning being the exclusive task of the regional tier. The system has – with some adjustments – worked well over its 25 years of existence but there is some controversy as to how coordination can be improved. The work of the CISNS is not always easy (Castellón and Cabasés, 2005). In 2002, regional health care funding was integrated into a new regional financial agreement, which allocates the state budget to the regions according to a complex formula based on the historical budget, population size, age structure, geographical isolation, etc. While a minimum level of health expenditure is established within the framework of national health legislation, each region will, in the future, have flexibility in allocating resources to health care, as with some other sectors of devolved competence (education, infrastructure, etc.). Some taxes are collected at regional level and some regions have established specific taxes (for example an oil tax in Madrid, the so-called "*centimo sanitario*", the health cent), as a means of increasing health care funds.

With the abolition of an earmarked health budget allocation, a *cohesion fund* was introduced to take account of cross-regional and cross-border flows as a complementary funding mechanism for "receiving regions", in particular Madrid and Catalonia. The fund is managed by the national Ministry of Health. Cross-regional compensations are limited to a series of selected high-cost DRGs, and the distribution of the balance of the international transfers received from other EU members. In 2002, 82% of the total of €55 million was distributed in respect of Spanish patients cared for in the regions of Madrid, Catalonia and Valencia, with the remaining 18% for patients from other (mainly EU) countries going mainly to Catalonia, Andalusia, Balearic

Islands, Galicia and Murcia.¹⁷ While it is easy to see which region European patients have been treated in, identifying the origin of Spanish citizens treated abroad and the origin of European citizens treated in each autonomous region remains a problem. This explains the decision to adopt a simplified process to distribute the available funds. The allocation of the funds is based on a calculation in which the cost of transfers in respect of Spaniards treated abroad is subtracted from the total, including an INSS handling fee, and the remainder is distributed to the autonomous regions in proportion to the amount for which they invoiced. Initial ideas to include the E121 in the scheme were rejected as the money in question is already included in the national budget; they are treated as “Spaniards” with a Spanish health card and are thus impossible to differentiate from national citizens. The cohesion fund is not considered to cover the costs that autonomous regions incur from treating EU patients, who are often not even known to the regional authorities (Sanchez Franco, 2004a). A thorough evaluation of the mechanism has not yet been undertaken.

Information and financial flows in the public system

The integrated health systems in most regions are based on public providers¹⁸. Staff in hospitals and primary care centres, including doctors and nurses, are mostly civil servants working within a financial system that does not allow for invoicing. As noted above, often no explicit check of a patient’s health card or entitlement to care is carried out; thus not much is known about the costs incurred by foreign patients. There are no effective mechanisms for registering such patients when they first present; nor are there any incentives to develop them. Some regions, such as Valencia and Catalonia, have functioning cost control mechanisms, but many have no idea of the costs incurred by tourists (Sanchez Franco, 2004b). Even when patients carry proof of coverage (forms E111, E112), and when this is registered on admission, administrative staff have little incentive to link it to information on the care provided or its cost. The provincial INSS office collects whatever it receives from different care providers, which is then sent to the national INSS office where it is processed for cost recovery from the corresponding EU countries. Even though some individual efforts are made to improve compliance, provincial INSS staff see this as an additional burden and not part of their normal job. No control mechanism exists, and nothing happens when a hospital fails to report activity or do so incompletely. The complex design of financial flows means that

¹⁷ Recursos Económicos del Sistema Nacional de Salud Datos y Cifras, 2002; Ministerio de Sanidad y Consumo, Instituto de Información Sanitaria, Madrid, 2004.

¹⁸ For the purpose of this study, the main focus has been on the public system.

reimbursements never reach the hospital so the hospital has little incentive to administer the E111 system properly. Logically, when processing invoices, hospitals are more interested in those which will represent a direct income for the hospital. No one seems to feel responsible for this process, and the boxes full of unprocessed E111 forms that we saw in a corner of one hospital may still be there – a potentially significant loss of income to the Spanish health system.

Practical arrangements for reimbursement (including pricing schemes and payment terms) are decided at the EU Administrative Commission on Social Security for Migrant Workers, formed by officials from social affairs ministries of Member States. Payments are often subject to lengthy delays. Bilateral agreements have proved an effective way to improve payment and the lump-sum agreement between the United Kingdom and Spain includes a 90% advance payment.

In the E111 scheme, a foreign citizen obtains treatment with an E111 form. The hospital or primary care centre sends the form, with information on the treatment provided, to the provincial branch of the INSS where the forms are collated and forwarded to the national INSS office, with a copy to the national Ministry of Health. At the INSS they are processed and sent to the respective foreign funding institutions. Reimbursement is then returned to the national treasury, from where it is transferred to the national budget. Some is distributed through the aforementioned cohesion fund, even before the money is actually recovered from other European countries. Most of the money transferred from other EU Member States stays at national level, as part of the general regional budget allocation, a source of much political discussion. However, whichever mechanism applies, none of that money will actually reach the hospital or primary health care centre directly, even though this is where the costs originated.

The procedures involving the E121 are somewhat different. A foreign citizen decides to retire to Spain. With the E121 she/he asks her/his home social security scheme to transfer her/his rights to the Spanish social security fund. As a consequence, a sum of money, agreed upon in the Social Commission on Migrant Workers, is transferred to the Spanish INSS to cover costs of health care. The retired person will be given a Spanish health card just like any other Spanish citizen, and will be registered in the population registry. There is no explicit transfer of the E121 funds received to the region in which the elderly EU citizens choose to live, but as they will feature in the population registry they will be taken into account in future allocations of the state budget to the regions.

The provincial INSS office records the entitlement of the retired person, but there is no clear feedback loop, and at times the office remains uninformed

about the death of a person while the foreign institutions continue to pay. However, many retired persons do not transfer their rights (E121), instead relying on the E111, thus forming part of the previously described floating population. As a result, they have access to emergency care but are excluded from prevention and health protection programmes.

As we have seen, the system is poorly defined, and from a financial point of view does not really work properly. Hospitals and health care centres have no incentive to record or process information on care provided and costs incurred, as they do not receive any reimbursement. A better solution might be for the money to follow the European patient more closely.

The lack of information is a huge problem, and where data do exist they are incomplete. INSS has some information, which it shares only very hesitantly with other institutions in the systems. Even in the Ministry of Health there are suggestions that this could improve. And it lacks basic information, such as the type of care provided and its actual cost. There is no means of comparing the cost incurred by the health care system and the reimbursement received. These flaws mean that many services remain unrecorded and unpaid for, creating a potentially large loss to Spanish public finances. The contradiction between the central social security system (INSS), as the national EU coordinating point, and the public health systems at regional level fails to take properly into account foreign patients and their related financial arrangements.

Concrete cases – favourable and hindering factors

In the following section, we will use concrete cases¹⁹ to illustrate the reality of long-term residents in Spain. First, we will look at the story of Peter and Brenda from Birmingham, England, who in their mid-fifties decided to take early retirement and move to southern Spain, to spend their retirement in a village in the hills close to Marbella where they spent their savings on a small property. What made them decide was the wonderful area, the warm climate, the healthy Mediterranean diet, the lifestyle, and the comparatively lower cost of living. Even though they never really learned the Spanish language, they felt very comfortable and had a large circle of compatriot friends in very similar situations. During the hottest period of the summer they returned to Britain for a few months.

¹⁹ Names are invented for the sake of illustration. The information is based on interviews carried out with expatriate associations in Marbella and Palma de Majorca in summer 2004 and a study by Age Concern (Spradbery et al., 2003). Additional information was found in information provided by the AOK Office in Palma de Majorca, newspaper articles, and Internet searches.

They had transferred their rights to health care to Spain – using the E121 system – back in the early 1990s. It was then not easy to do this and it took them some time to find out what administrative steps they should take. Much later they heard from some newcomers that the NHS had created a special Internet page for this purpose, and they also found out that there was now a series of specialized law firms in Marbella dedicated exclusively to facilitating these administrative processes for people retiring to the Costa del Sol. All of this would have been nice to know when they had first arrived in Spain. However, at the time there was still very little information on how different health services worked. They had no idea until a few years ago that Brenda had a minor health problem. It was then that they realized that their Spanish health card (*Tarjeta Sanitaria*, TS) conferred on them the same rights as on Spanish citizens, with all costs being assumed by the Andalusian Health Service. The British consulate in Malaga provided them with further useful information. They were then surprised to find that access to hospital was quite easy and that the care received was of good quality. The hospital worked closely with a volunteer translator association whose members were very helpful during all their contact with the doctors.

Our second example is the German couple Werner and Ingrid from Regensburg. They bought their small house at around the same time as Peter and Brenda in the northern hills of Majorca, but only spent the six months of winter there. They did not transfer their rights, and would access health care whenever they needed to with the tourist card, the E111. They were afraid of losing their rights back home, and thought that if ever they had something really serious they would prefer to be treated in a hospital in Germany. When Werner first got ill he went for a checkup with one of the many German doctors working in Palma de Majorca, but found that he had to pay for the care himself. The office of the Allgemeine Ortskrankenkassen (AOK), the German health insurance company, was very helpful in informing them of their rights, even though they were affiliated with a different German health insurance fund. Very recently, Ingrid was diagnosed with diabetes and worried about how more regular visits to the general practitioner could be covered with the E111. Their neighbours were affiliated with the BKK Taunus, which had started to draw up direct contracts with some of the German doctors installed on the island. This avoided all the bother of the E forms, and other administrative problems. Ingrid wondered why their health insurance fund did not make similar arrangements with German doctors or even with the Spanish public hospitals. Why would the public hospital not hire a German – or other – doctor in the light of the high demand from German-speaking patients? She had heard that Spanish public hospitals were staffed by civil

servants and had difficulties with more flexible employment procedures – but should that be a reason for not adapting their services to the needs of their patients?

Let us return to Peter and Brenda. A few years later Brenda's general practitioner diagnosed a kidney problem that required surgery. Brenda did not know what to do. She knew that the Andalusian hospitals were of good quality, but she preferred to be treated in a hospital back in the United Kingdom. She found out that this was not possible unless she could obtain a E112 form from the Spanish authorities, signifying their agreement to meet the costs of treatment in the Birmingham hospital. Brenda thought this was the world turned on its head. She had contributed taxes to the British system all her life, and now she could not even receive treatment there, where her children and friends lived, and where everything was so familiar to her, including the language. She turned to the British charity Age Concern and learned that she was far from being the only person with this problem (Spradbery et al., 2003). She was finally treated in the Costa del Sol Hospital in Malaga and things went very well, with great help from the translation service.

Peter and Brenda had had a great time in Spain, but things had slowly been turning sour in recent years. Neither felt they had the strength they once had. Then came something they had always feared, that one of them would pass away before the other. When Peter died after a second heart attack, Brenda did not know how to go on. Their house was very isolated – exactly what they had wanted when they first came to Spain. Brenda had never learned to drive, as Peter always drove. In her frail state she needed daily help, but this was difficult to organize and very expensive. Earlier their United Kingdom pension had placed them in a good financial position, given the relatively low local cost of living, but now everything seemed so expensive and her pension could barely cover her basic needs. Eroding purchasing power among foreign pensioners has also been a major issue for the German population in Majorca (Busch, 2002).

She felt lonely and thought it would be good to get a place in one of the old people's homes in Marbella. However, she discovered that the waiting lists were long, and that priority seemed to be given to those Spanish citizens who had the least resources, with only a very limited number of places reserved for long-term residents from abroad such as her. In addition, the staff would not be able to speak English. Home care in the public system seemed to be only in the early stages of development and dependent on the social security system. She did not know how to access it. This was something that back home was quite well organized and she felt it might be a good idea to go back to the United Kingdom. But in the meantime many of her friends there had

died and her son's house was too small. Also, she did not know what steps to take to transfer her rights back to the United Kingdom and she was afraid to have to start this administrative battle again at her age.

Challenges and some tentative responses

As we have seen with the examples of our two couples, people's mobility is influenced by some basic contextual factors, such as Spain's great beaches, warm climate, healthy diet and lower cost of living, even though this latter advantage is eroding as Spanish prices converge with those in northern Europe. The universality of the health sector, good access and high quality services are other favourable factors. The basic structure for European coordination works well: the different entitlements (E111, E121, etc.), mutual recognition of doctors, etc. However, it seems that although the system provides good services, the administrative design does not really take foreign patients into account. The issues that arise can be subdivided into those directly related to patients and those inherent to the system's design. The adverse factors for patients seem to increase with age and degree of illness. A summary is shown in Table 5.3.

We will now examine in detail some of these challenges.

Language/social context

Hospitals are starting to be aware of the need to assist non-Spanish speakers and are beginning to include language skills as a criterion when hiring new staff. Catalan hospitals are starting to employ "catalysers" to assist in language and social problems. They are similar to the translator associations in Andalusia, and play a key role in the patient–professional relationship, also taking care of patients' other needs such as informing them about rights and duties, contact with relatives, etc. This is surely a function which could be more consistently assumed by the public sector.

Lack of long-term and home care

It has historically been the family that has taken care of elderly people. Consequently, long-term and home care have developed in a particular way in Spain and are not always recognized as an activity to be covered by the public system. Because of capacity constraints, foreign elderly residents (despite their rights) are usually not high on the priority list. Cultural habits are different in the north of Europe, where services for the elderly are much better developed and are usually covered by the public funding system. In Spain some improvements are taking place, and an increase in the number of nursing homes is occurring (Rodríguez, 2004), although this is considered to be social

Table 5.3 *Favouring and hindering factors***PATIENTS**

	Favouring factors	Hindering factors
General context	– geography, climate, diet	– isolation when older and ill
Economic context	– higher purchasing power of northern European pensions	– increasing economic and price development in Spain
Language	– voluntary associations in hospitals – German doctors in Palma – younger Spanish professionals with better foreign language knowledge	– no knowledge of language – lack of pensioners' integration – lack of language knowledge of Spanish doctors and health professionals
Social context	– young retired not so much in need – voluntary association (Age Concern)	– need for social support when getting older/ill; some “catalysers” in Catalan hospitals, but usually no public services
Access to the system, coverage	– universality, easy access to the Spanish system, good quality of care – residents on the E111	– new urban developments; geographical spread; waiting times – when on E111 no continuous care for chronic illnesses/ prevention and health protection actions
Long-term care	– some self help groups (Age Concern) – German citizens can use their long-term care insurance in Spain	– more in need when older and ill – high expectations compared to home country – services little developed, depending on social services rather than on health system in Spain
Availability of information	– not much official information on the Spanish system – NHS web page, AOK office in Palma – embassies, expatriate associations	– wrong information: network of hotel clerks and taxi drivers to draw E111 patients to private providers – tourist offices – only information on private system – lack of one reliable European source of information

(cont.)

Table 5.3 *Favouring and hindering factors (cont.)***SYSTEM – PROVIDER – FUNDER**

	Favouring factors	Hindering factors
Provider: recording	<ul style="list-style-type: none"> – doctors' culture: treat everyone, independent of rights 	<ul style="list-style-type: none"> – no practice of registration and invoicing – possibilities of abuse, hip replacement on E111
Generous system	<ul style="list-style-type: none"> – residents on the E111 (floating population) – no co-payment for drugs for retired people 	<ul style="list-style-type: none"> – possibilities of abuse: cover of annual supply with E111, shopping list for family members
Provider attitude	<ul style="list-style-type: none"> – some hospitals have special services such as translators, etc. – only the private system has realized the business opportunities of the foreign patients, outside the E111 system 	<ul style="list-style-type: none"> – foreign patients are seen as disruptive – as payment is not received directly they are at times considered free riders – the business case is usually not realized inside the public/E111 system
Information flows	<ul style="list-style-type: none"> – will be facilitated by the EU health insurance card 	<ul style="list-style-type: none"> – no owner of the process – information gets lost – duality of information and financing flows. Lack of transparency
Financial flows		<ul style="list-style-type: none"> – providers do not directly receive reimbursement, thus have little incentive to process the invoices. Payments not linked to information flow. – INSS records rights, don't feel responsible for processing the reimbursement information
Data availability	<ul style="list-style-type: none"> – scattered data, usually based on individual efforts 	<ul style="list-style-type: none"> – decentralization of health care and incompatibility with the central social security system (INSS) – no coherent overall system and data collection design – no ownership of the process
Desynchronized systems	<ul style="list-style-type: none"> – decentralization with decision-taking closer to the patient 	<ul style="list-style-type: none"> – little communication between the different institutions at national and regional level, no common strategy and vision regarding foreign patients (and sometimes even Spanish patients)
Unclear rights of patients	<ul style="list-style-type: none"> – double coverage gives more security 	<ul style="list-style-type: none"> – unclear if travel insurance or E111 will cover the care provided – fraud: travel insurers include health care coverage but request E111

and not health care. Planning of care facilities should take into account the needs of the expatriate population, not only in terms of numbers but also other needs such as language. We have already seen private providers stepping in. For instance, Dutch-owned private nursing homes are being built, some under contract with Dutch health insurance companies. In the future they could also be partly integrated into the Spanish public funding scheme.

Information for patients

Patients are not usually well informed on how the system works. This is due to the segregation of expatriate communities, language barriers, and ignorance of the problem. Some German residents believe that if they live for too long in Spain they will lose their rights in Germany and thus they are afraid to get the necessary information and prefer to stay ignorant. This has prompted the German Embassy in Madrid to launch a major information campaign involving several NGOs and national associations in German communities all along the coasts. The British NHS has created a special web page, and the German AOK sickness fund has installed an information office in Palma de Majorca. Yet besides these isolated initiatives, an effective public information function is missing or is not readily available to foreign patients in Spain, either at national or at regional level.

Lack of data and information systems

Parallel functions and completely disconnected financial and information flows create much imbalance in the system, with no institution feeling it has ownership of the system. The incomplete recording of the E111 transactions and the costs created by foreign use of the Spanish system lead to potentially large losses for Spain owing to unrecovered payments. The lack of reliable information means that policy and planning functions at different levels cannot work properly.

Double coverage/rights to care

Many tourists purchase travel insurance that includes health care coverage, but they are requested to produce their E111, which is a direct response of travel insurance companies to their experience in some Catalan and other hospitals where tourists were asked for their travel insurance as the best way to get direct reimbursement. This is confusing, and a clarification of the regulations may be necessary.

We have identified some very interesting developments that begin to address some of the issues identified. They are surely worthy of further study. One is the initiation of *direct contracts* between German health insurance companies

and private health care providers in Spain, such as that between the BKK Taunus and German doctors in Majorca (*Ärzte Zeitung*, 2004). This could be beneficial to the public system – allowing part-time employment of foreign doctors with their language and cultural knowledge as a means of providing a higher quality service to foreign patients. This will create a powerful incentive for hospitals to record details of costs of services provided, so reducing the money lost owing to bad record keeping. A European framework could be helpful here, to ensure that the respective policy-making function is involved.

The new European Health Insurance Card may eventually provide additional benefits, as it could carry additional information or even work as a smart card. Once systems become properly interoperable, the card could be an important element in facilitating the processing of information. It will allow easier recording of data such as nationality, rights, costs incurred, etc., thus providing an improved means to ensure reimbursement, and create better insights to inform policies. It may even open the way to direct reimbursement from foreign funding organizations to Spanish providers.

It is clear that there is much room for improvement. In this very decentralized system, communication between the institutions at different levels needs to be improved. At European level, transparent frameworks for tariffs and price setting would be helpful, based on realistic cost information. A legal framework for bilateral/direct contracting is needed. Residents lack knowledge on their rights and access to the system. Here a better public information function would be beneficial, perhaps coordinated at European level. The exchange of best practices should be fostered, to pass on knowledge about how to deal with the different challenges identified.

In order to provide better care and avoid unnecessary cost recovery problems, the Spanish health system could take better account of foreign patients in system design and planning. This could include the creation of additional capacity for long-term care and nursing homes. Although considered social care, it would still respond to health care needs of the elderly. Professionals could be better prepared to deal with foreign patients, and not just in terms of language and cultural differences. Training sessions should ensure that professionals know about the rights and financial coverage of their patients, enabling them to provide a better service and to make sure the health system is gaining from the service provided.

The topic needs to move up the political agenda in Spain – there is a lot of interest at different levels and in different institutions, but it seems that everyone fears that a new status quo could be a disadvantage. Thus no one really claims ownership of the process, citing as a reason a lack of a clear legal basis for doing anything.

There is an urgent need for action in Spain; it remains to be seen in the near future how the problems will be addressed.

Conclusion

In no other European country is the reality of patient mobility in Europe so clearly demonstrated as it is with long-term residents in Spain. The main lessons to be learned are that system design and policy planning are not always taking European patients into account. While care provided in Spain is of high quality to Spanish and foreign patients alike, there are some obvious problems in the administrative processes. It is hard to understand how there can be people in need of care, with explicit financial coverage on one side and providers (public and private) on the other who are ready to cover this need, and for the system to still not work properly. Why is no one interested in taking up this business case? The reasons lie in the rigid and opaque national system, which contrasts with those regions where innovative care designs are undertaken, and in the fact that all systems regarding mobility of patients are seen only as a consequence of Council Regulation (EEC) No. 1408/71 at European institutions and at the Ministry of Labour and Social Affairs. The absence of any links to and coordination with the parallel social security system (INSS) is hindering the process because Council Regulation (EEC) No. 1408/71 concerns social security and not health care. The Spanish health system must study how better to take foreigners into account and to create better administrative processes at all levels.

A supporting function at EU level could be advantageous: a requirement to establish systems for collection of data on patient mobility, legal and organizational frameworks for pricing and contracting, support for national and regional planning functions of institutional and human resources, and an information function (such as a web portal with information for patients on their rights, access to the system, provider quality, etc.). Other initiatives might include EU-wide accreditation schemes. These offer means for citizens of other parts of Europe, living in Spain, to receive ever better services and for the Spanish health system to fully benefit from the financial flows to which it is entitled.

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Chapter 6

Health care for tourists in the Veneto region

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The Veneto region: a tourist destination

The Veneto region has always enjoyed an important strategic geographical location, at the crossroads of Europe. In the medieval period the “Serenissima” Republic of Venice was dominated by seafaring, trade and the related fight against the import of communicable diseases from far away countries, as the interesting history of its lazarettos records (Vanzan Marchini, 2004). More recently, it has become famous as a tourist destination, thanks to three main attractions: Venice itself, as a city of art and culture; the Mediterranean beaches of the Adriatic Sea; and the lake region (Lake Garda), with its backdrop of the Dolomite mountains. Because of its long history as a centre of trade, the region has always had a very open attitude to other cultures, customs and people. As a result, trade and tourism are not only of economic importance but also a way of life. This is reflected in the region’s engagement in European affairs, and in the many contacts it maintains with both old and new Member States and candidate countries.

Thus, the Veneto region, in its capacity as a popular tourist destination, makes for a very interesting case study of patient mobility in Europe. The significant flow of tourists brings with it a series of health care challenges that regional health care services must deal with, in some cases by organizing specific services to respond to the high demand from tourists. Today, there is a wide range of services available to visitors to the region who suffer medical emergencies.

The Veneto region decided to join the Europe for Patients²⁰ research project in order to contribute its insights drawn from its experience of mass tourism,

²⁰ Europe for Patients, FP6 research project on patient mobility, www.europe4patients.org

and at the same time to learn from the experience of others. The present study was undertaken to describe, quantify, and analyse health service needs related to mass tourism, and the response this elicits from the health care system in the Veneto region. The situations of three local health authorities (LHAs) were examined in detail, each representing a very different setting: the seaside tourism of “Veneto Orientale” or Eastern Veneto (LHA 10); the cultural and, in parts, seaside area of “Venezia” (LHA 12); and the lake and mountain area in “Bussolengo-Lake Garda” (LHA 22). The study is based on data available at local and regional levels, complemented by qualitative research.

Veneto region: territory and population

The Veneto region, situated in north-eastern Italy, shares a large mountainous border with Austria and has 120 km of coastline to the south (see Figure 6.1). The region, with a population of 4.6 million inhabitants, is subdivided into seven provinces covering an area of 18 390.7 km².

The demographic pattern of the region is characterized by a continuous ageing of the population, with those aged 65 and over accounting for 16% of the population in 2004, which is well above the national average. Immigration is also above the national average: foreign residents in the Veneto region total 153 074,²¹ about half of whom are from European countries, mainly Germany, France and Poland, with another 40% from south-east Europe (Albania, Romania and the former Yugoslavia).

The Veneto regional health care system

Italy’s national health care system is tax-based and provides universal coverage, with health services organized regionally and free of charge at the point of use. The system has three levels: national (general objectives and legal framework for organizing, financing and monitoring the national health care system), regional (some legislative and administrative functions, planning and ensuring the delivery of a benefits package) and local (health care provision through a network of population-based health management organizations and public and private accredited hospitals). The Veneto Regional Government – like other regional governments – has both legislative and administrative functions.

The organizational structure

The regional tier is responsible for the provision of health and social services to its resident population through the so-called “local level”, a network of

²¹ ISTAT. 14 Censimento Generale della Popolazione e delle Abitazioni. [2001 Census]



Figure 6.1 *Italy and the Veneto region*

Source: Adapted from www.egm.it

population-based health care organizations, LHAs, and public and private accredited hospitals. Four different categories exist:

- local health authorities: geographically based organizations responsible for assessing needs and providing comprehensive care to a defined population;
- public hospital trusts: reference hospitals with an inter-regional or national catchment area, which enjoy financial and technical autonomy and provide highly specialized tertiary care;
- national institutes for scientific research (IRCS): research-oriented hospitals operating at local level and distributed throughout Italy. They are under the authority of the national Ministry of Health, which appoints their general managers and provides the funding, not only for research, but also for inpatient and outpatient care, and for specific services such as intensive care and transplants;
- private providers: these deliver ambulatory, hospital treatment and/or diagnosis services under the national health care funding scheme with a special accreditation provided by the regional health departments.

The Veneto health care system comprises 21 local health authorities; two hospital trusts; 89 general hospitals; and 250 residential homes for the elderly. This makes a total of 19 429 public hospital beds (85%), the other 15% being made up by private beds.²² Health expenditure represents about 5% of the regional GDP, with a per capita spending of €1149.5.

²² 2002 data.

The foundation of the system is the LHA, which has a dual role of both purchaser and provider of health care. The authority manages contracts with general practitioners, hospitals and other health care and social service facilities, and is also in charge of health promotion and prevention activities. A general director, who is appointed by the regional government, manages the local health authorities, as well as the hospital trusts. Each LHA is divided into health districts, which are geographical units responsible for coordinating and providing primary care, non-hospital-based specialist medicine, and residential and semi-residential care to their assigned population. LHAs receive a global budget based on a combination of historical levels of spending and a weighted capitation mechanism, with additional compensation for cross-boundary flows. Hospital inpatient care is funded by a mixture of fees for services and diagnosis-related groups (DRGs), complemented by various mechanisms for outpatient and other specific elements of health care, such as intensive care, transplants, and chronic disease management.

The impact of tourism on the Veneto region

Italy heads Europe in the list of countries with the highest number of tourists, followed by Spain and France.²³ Of approximately 84 million arrivals, citizens from the 15 EU countries before May 2004 account for 25%, corresponding to 28% of the 95 million tourist days of stay. The main tourist origin is Germany, followed by the United Kingdom and France.

Veneto heads Italian regions in terms of overall tourist numbers, with 14.3% of total arrivals (11.6 million) and 16% of total days of stay (54.5 million). Tourists stay an average of 4.7 days in the region, which is above the national average. Foreign tourists outnumber domestic visitors (30.5 million days of stay equal to 56% of the total 6.9 million arrivals, equal to 59% of the total).

The Veneto region offers a variety of tourist attractions in five different geographical areas: the seaside, cities of art, lakes, mountains and spas. With its renowned beauty and variety of tourist attractions, the region enjoys a strong competitive position alongside other European tourist destinations (Schmidt, 2002). Veneto's seaside, with half of all days of stay (24.8 million), is the most important tourist district, followed by the cities of art and culture – Venice (12.5 million), the lakes (8.4 million), the mountains (6.2 million) and finally the spas (3.5 million).²⁴ Specific aspects of tourism are described below.

²³ Eurostat data, 2002.

Tourist flows in three tourist districts of the Veneto region

Seaside tourism is marked by large and seasonal fluctuations in numbers, with consequences for the facilities and services established to respond to this demand. In 2004, more than 24 million days of stay were spent on the Veneto coastline, with 94% of this tourism concentrated in the Province of Venice. The coastline of the Province of Venice, which includes LHA 10 (9 057 591 days of stay by foreign tourists), LHA 12 (4 956 923) and LHA 14 (490 045) is top of the list in Italy in terms of the number of days of stay and arrivals by both European and non-European tourists.

The *Veneto Orientale* (LHA 10), in particular, with 20 local municipalities and covering an area of 1068 km², has a resident population of 202 865 inhabitants, and it is characterized by a long coastline that includes four beach areas: Bibione, Caorle, Eraclea and Jesolo Lido. This area, with a resident population of 60 000 inhabitants, is the destination for massive numbers of seaside tourists, resulting in a temporary boost of the local resident population, growing to more than 205 000 in the summer.

Tourism targeting the *cities of art and culture* is substantial, with several cities of historical interest in the area. Venice is the leading destination, with 2.5 million arrivals, but tourists usually opt for shorter stays here than in other destinations. LHA 12, known as LHA Venezia, includes, in addition to Venice, a further three municipalities and has a resident population of 303 944 inhabitants. The territory is made up of the historic centre of Venice, a densely populated inland area together with the islands of the lagoon, and a coastline (Venice Lido and the municipality of Cavallino-Treporti) which is a seaside tourist resort. Venice's historic city centre is the most important tourist destination for this region.

Tourism to the *lakes*, particularly Lake Garda in the Province of Verona, known as *Bussolengo* (LHA 22), also has a seasonal pattern, though less pronounced. LHA 22 Bussolengo-Lake Garda covers an area of 1237.80 km², including 37 municipalities, with a population of 257 815 inhabitants.

There are significant differences between these three areas, owing to their different attractions, but they all have a large number of foreign tourists, mostly from the 25 EU Member States. The tourist rate (tourist days of stay per 100 inhabitants) provides a measure of how the tourist population relates to the resident population. Over the whole year the Veneto region has a tourist rate of 12.2, although rates are very much higher in some areas such as Veneto Orientale (74.3), Venezia (38.2) and Bussolengo-Lake Garda (32.9).

²⁴ Istat. *Annuario statistico 2004* (<http://catalogo.istat.it/asi2004/contenuti.html>, accessed 15 January 2005).

Veneto Orientale is the area with the largest number of days of stay (13 232 239), while Venezia has the greatest number of arrivals (3 350 201) (shorter periods of stay), of which 81% are foreigners. A similar picture can be seen in the other areas (LHA 10 and 22) concerned (Figure 6.2).

We can see that foreigners greatly outnumber Italian arrivals, and that most tourists come from countries of the 25 EU Member States. However, there are certain significant differences in the concentrations of foreign visitors in each of the areas in the current study. The Venezia area, which incorporates historical Venice, is the most “international” destination, with the highest tourist arrival numbers, especially from Germany and England, but also from outside the EU. In Veneto Orientale, Germans and Austrians are the most common, while in the Bussolengo-Lake Garda area, there are more German and Dutch tourists. The coastal Veneto Orientale (Eastern Veneto) seems to hold a particular attraction for people from the new Member States, particularly Hungary, the Czech Republic and Poland. They make up 13.5% of arrivals and stays by foreign tourists in LHA 10 while in the other areas they represent no more than 2% of arrivals and foreign stays.

For a better understanding of the statistics it is useful to bear in mind some additional groups visiting the coastal Eastern Veneto area: seaside day trippers (bound for the Jesolo beaches, estimated as bringing at least 25% more visitors in the summer); and people staying in second homes or located outside normal hotels, who make up an extra 7.3 million. Neither are included in the official statistics.

The Venezia area has a shorter average length of stay (3 days) compared to the coastal Veneto Orientale area (7 days) and Bussolengo-Lake Garda (5 days), which reflects the differences between cultural and seaside tourism (Schmidt, 2002). In the municipality of Cavallino-Treporti, where tourists are largely beach-loving campers, the average stay amounts to 9.4 days whilst for the historic city centre of Venice the average stay is 2.2 days.²⁵

The average length of stay is an important factor, in that longer stays may result in a different typology of health services that are required. Longer stays might not only involve emergencies, but also require services for chronic conditions (Aviles, 2002).

²⁵ Data from the Veneto region, 2003.

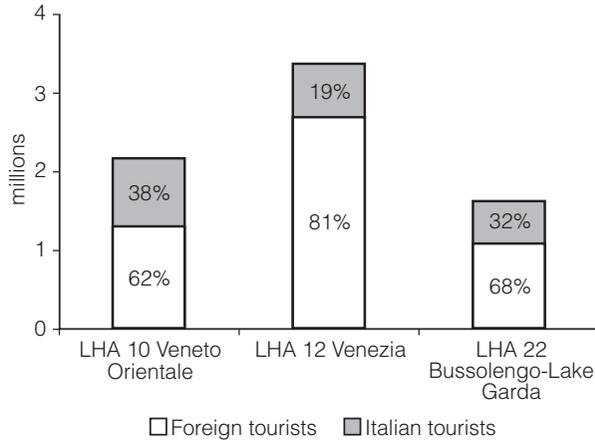


Figure 6.2 Italian and foreign tourist arrivals in LHAs 10, 12 and 22 in 2003

Tourism's increasing demand for health care (Palm, 2000) is a challenge that the Veneto local health authority strives to meet year after year. To this end, a series of specific measures have been put in place.

Increased supply

The coastal Veneto Orientale area has extended existing schemes and initiated a series of new services, aimed at coping with the impact of the summer season. On the coast, services have been developed at Jesolo Hospital, responsible for covering the marina, and first-aid points open 24 hours a day were set up in Caorle and Bibione in order to support the emergency department. Additionally, dialysis services have been installed in Bibione, as there is no hospital there. In the main hospital in Jesolo, human and technical resources have been increased.

In the Venezia area, additional care and extra ambulatory services were set up over the summer period to guarantee emergency aid to tourists on the island of Venice Lido and the seaside. A central unit coordinating emergencies and organizing helicopter services for the whole coastal territory is based in Venice Lido. In the Bussolengo-Lake Garda region, services have been increased by the opening of eight specific tourist medicine clinics, including dialysis services.

To provide an adequate response to this concentrated demand, the supply of services has had to be adjusted and extra resources put in place. The coastal Veneto Orientale region has recruited 71 extra health workers and introduced economic incentives for extending the number of working hours carried out by health workers in the area (in 2003, 17 410 working hours were

contributed to the LHA by the nursing staff, costing €891 308). Strengthening of human resources was important in Jesolo Hospital and at the two 24-hour first-aid points. Additionally, a whole series of private providers – who do not form part of the public health system – exist in the area. Doctors working as private consultants offer health services to locals and tourists on a direct payment basis.

Tourist Medicine and Emergency Services Department

Foreign tourists requiring medical attention can turn to the services of “tourist medicine”, of hospital emergency services, and of the aforementioned first-aid points, the latter being available during the period May to September only in the coastal Veneto Orientale area.

A “tourist medicine” service has been activated in all three areas during the summer period. In 2003, eight tourist medicine centres were activated in Veneto Orientale, one in the Venezia area, and eight in the Bussolengo-Lake Garda region. Data on activity, although recorded in a somewhat different way in each area, show a similar picture. In the summer season of 2003, the Veneto Orientale coastal area provided 16 648 ambulatory consultations, 75% to Italians and 25% to foreign tourists. Therefore, despite the large number of foreign tourists in the area, with 92% from European countries, this service was predominantly used by Italian nationals. This illustrates the general lack of information provided to foreigners on the availability of services. The picture is similar in the other two areas, albeit with a somewhat lower number of ambulatory consultations.

The two first-aid points in Veneto Orientale operate from 1 May to 30 September. These are 24-hour emergency services staffed by a medical doctor, nurses, and an on-call ambulance team. In 2003, 9941 tourists used this service. The number of citizens of the current 25 EU countries accessing hospital emergency services in the years 2001–2003 is highest in the coastal area, amounting to 4908, compared to 2264 in Venezia and 907 in the Bussolengo-Lake Garda area, an indication of the different intensity of tourist flows in the three areas.

In 2003, the average number of people accessing emergency services, per 100 000 tourists from today’s 25 EU countries, varied from 57 in the coastal area to 34 in Venezia and 13 in Bussolengo-Lake Garda, again clearly showing the differences, on the one hand of more tourists (higher demand), but on the other hand better access to health care services (higher supply).

Hospital admissions

These differences are not as marked in cases of hospital admissions. In the

years 2001–2003, there was an average of 394 admissions (85% citizens of the “old” EU countries) in hospitals in the coastal area of LHA 10, 247 (86% citizens of the “old” EU countries) in Venezia, and 251 (95% citizens of the “old” EU countries) in the lake area of Bussolengo-Lake Garda. The average number of admissions per 100 000 tourists was equivalent to 4.7 in Veneto Orientale, 3.7 in Venezia and 3.9 in Bussolengo-Lake Garda, as shown in Figure 6.3.

The separation of the data into the 15 EU countries before May 2004 and the 10 new Member States shows similar numbers for the Veneto Orientale area. However, large differences between the “old” and “new” Member States were registered for admissions in the Venezia and Bussolengo-Lake Garda areas. Further analysis will highlight why such differences in hospital admissions exist.

Reasons for hospital admission, divided into 25 main diagnostic categories (MDCs), were studied. Among all hospital admissions, 75% are represented by six diagnostic categories: pathologies related to the skeletal-muscle system, digestion, neurology, cardiovascular systems, respiratory systems and pregnancy. As can be seen in Figure 6.4, for the year 2001–2003, hospital admissions in the three areas are reported according to those pathologies that accounted for the largest number of admissions, here given as a percentage of total tourist hospital admissions per year.

There are important differences between the areas. In Veneto Orientale the six categories represent 77.8% of total admissions, with the digestive system top of the list (20.2%), followed by the nervous system (19.5%) and the skeletal and muscular system (13.9%). Similarly, in Venezia, the six diagnostic categories represent 68.4% of all admissions, but with a very different distribution, most notably a twofold higher number of admissions related to pregnancy. Musculoskeletal disorders head the list, a result of the very high number recorded in Bussolengo-Lake Garda (28.1%), with women admitted for reasons related to pregnancy coming next. All six diagnostic categories make up 72.4% of admissions. Further investigation will be needed to identify the reasons underlying the differences emerging from the dataset.

It is important to consider the distribution of admissions over the course of the year. As can be seen in Figure 6.5 there is a seasonal peak coinciding with the main summer season, which is more pronounced in LHA 10. Seasonality is an important factor for the organization of health care services, which need to be flexible in their response to tourists’ needs.

Some special services have been set up: in Veneto Orientale haemodialysis services were provided for 246 tourists during the 2003 season, while in Bussolengo-Lake Garda, seven foreigners made use of these services.

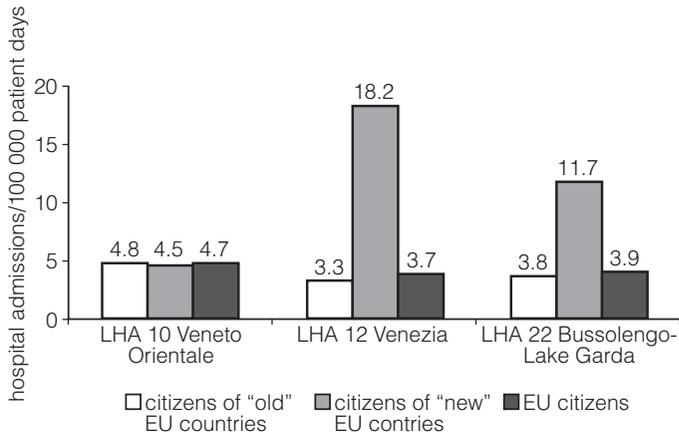


Figure 6.3 Average number of hospital admissions per 100 000 EU tourist days (2001–2003)

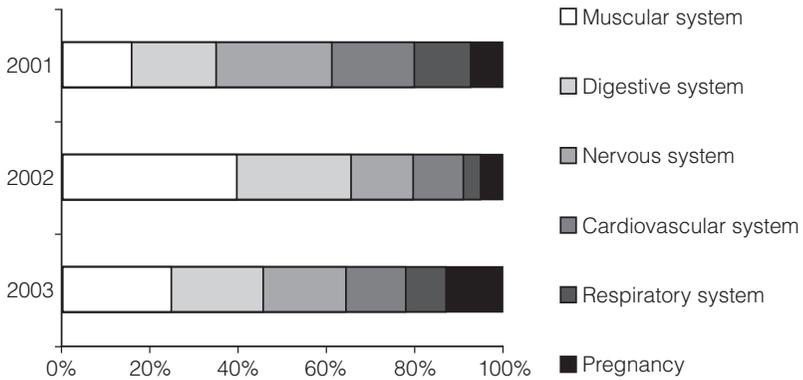


Figure 6.4 Six main pathologies of hospital admissions in the three LHAs during the years 2001–2003

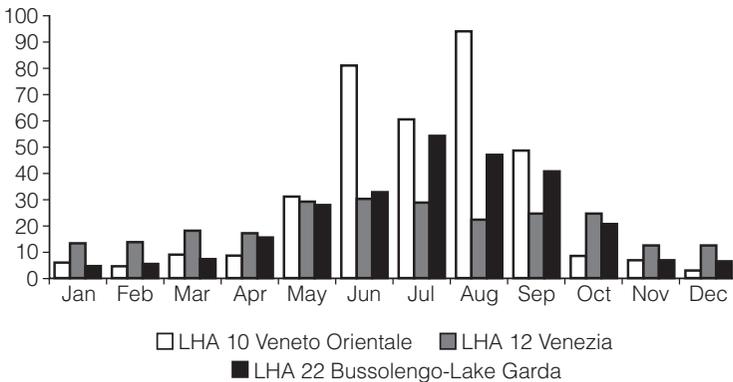


Figure 6.5 Average number of monthly admissions in LHAs 10, 12 and 22 during the years 2003, 2002, 2001 (EU citizens)

An assessment of the needs of the travelling patient

Quality, as perceived by foreign tourists accessing health care services in the three local health authorities, was assessed through a questionnaire. Responses were received from 751 people of different age groups – 63.6% in Veneto Orientale, 21.7% in Venezia, and 14.7% in Bussolengo-Lake Garda. The majority were collected at the tourist medicine centres and in emergency departments. 90.1% of the patients interviewed were from the EU: 46.9% were German, 13.2% Austrian, followed by the British, Dutch and French, with an additional 3.8% coming from the 10 new EU Member States.

The main reasons for foreign citizens accessing health services in the region included the sudden alteration of their state of health (in 70.6% of cases). 9.5% needed pharmaceutical drugs. Only 2.8% of cases underwent medical treatment or surgery and 1.1% underwent dialysis. 59% had proof of eligibility (24.6% with the European Health Insurance Card and 29.8% with the E111). 40% of patients said that they had previously received information about the Italian health care system: 35% from their health insurance providers, 22% from their national health care system, 13% from their general practitioners, and 6% from their travel agents. Other sources of information were friends and acquaintances with previous travel experience.

In general, those interviewed said they were satisfied with the treatment provided, and expressed a very positive view of the health care system and the personnel dealing with them. They considered directions to hospitals and health care facilities adequate and rooms in health centres welcoming and comfortable. They were pleased with the medical personnel, appreciating their kindness, politeness and professionalism. They considered they had received the necessary information for continuing their medical treatment. 46.2% considered the treatment received to be very good, with 30.9% finding it good. The general impression of the administrative organization of these services was good. A total of 78.4% would return or recommend the use of the health care services to others. While it needs to be understood why 25% do not consider the service good enough to merit a return visit, some suggestions for improvement of services do indicate some problems. They concern the need for better signposting and easier access to health care facilities. There was a particular request for a more widely available English translation, with the suggestion that the number of interpreters should be increased or that health care personnel with better knowledge of foreign languages should be employed.

Financial flows

In recent years the regional balance has been positive: reimbursements for emergency health care services (financial contributions for planned care were insignificant) were partially offset by funds paid for emergency services received by Veneto citizens abroad. Until now, Veneto's health authorities have had no incentive to treat EU patients for planned care, as the compensation mechanisms do not allow direct payment to the local health authorities. Each of the three areas examined have a heavy tourist presence and could increase financial revenues considerably by providing planned care to European citizens. The areas receive annual funding from the Veneto region (financing of the tourism function), recognizing their specific needs for additional expenditure to respond to the demands of the fluctuating population. Not all citizens from the "old" Member States or EFTA²⁶ citizens making use of health care services have the right of access to health care with the E111 form. When patients from groups with no coverage are treated, invoices are presented either directly to the patient or to his/her insurance company and, if they are unable to pay, to the Italian prefecture. An overview of the financial revenues can be seen in Table 6.1.

The average annual revenue requests submitted to the Ministry of Health through the telematic system for the coordination of European social security (TESS – Telematics for Social Security Programme) was €670 820 for Veneto Orientale, €398 109 for Venezia, and €482 154 for Bussolengo-Lake Garda. In Veneto Orientale, more than half of the transfer payments come from Germany, followed by Austria, together totalling 75.8%. In Venezia, the United Kingdom and Germany make up a total of 52.6% of the payments and in Bussolengo-Lake Garda, Germany and Spain make up 78%.

The examination of invoices for hospital admissions shows average costs per admission are markedly different: in Veneto Orientale they are €1300, Venezia €1949, and Bussolengo-Lake Garda €1413. One task for the future will be to understand the reasons for this difference.

In Veneto Orientale, 83% of the average annual revenue (€807 322) is invoiced via the TESS system; the remaining 17% is invoiced directly to the citizen or the insurance company.

In Veneto Orientale, 96% of hospital admissions are invoiced through the TESS system, but this is only 78% of overall treatment (hospital admissions and emergency services combined). When patients admitted to hospital lack an E111, there is time and an incentive for the local authority to request the

²⁶ European Free Trade Area.

Table 6.1 Average yearly financial revenues for care provided to foreign citizens (+/- E111) (2001–2003)

	LHA 10 Veneto Orientale	LHA 12 Venezia	LHA 22 Bussolengo-Lake Garda
“Old” EU countries with E111	643 787.60	388 299.86	473 287.67
“Old” EU countries without E111*	103 278.82	53 905.37	70 993.15
“New” EU countries	34 601.65	16 827.53	19 796.33
EFTA	25 655.50	8 844.23	6 008.93
Other European citizens*	46 991.53	55 318.58	51 155.05
Prefecture	141 402.70	49 580.05	76 320.76
TOTAL	995 717.80	572 775.62	697 561.89

* these data for LHA 22 are rough estimates

form from the relevant institution. This helps to avoid direct out-of-pocket payments by EU citizens, who will be reimbursed later. Revenues for treatments provided to citizens of the “old” 15 EU countries are related to the number of tourists. The average revenue per 100 000 tourists is very different from one area to another: in Veneto Orientale revenue amounts to €10 586 per 100 000 tourists, in Venezia €6903 and in Bussolengo-Lake Garda €8614. It seems likely that this reflects, at least in part, differences in the extent to which areas make specific provision for tourists.

Tourist medicine centres

In the coastal Veneto Orientale area (LHA 10), four outpatient clinics were established to operate during the months of May and September, increased to eight clinics for the period June to August. These facilities provide a total of 113 opening hours per day, with 22 doctors and 6 interpreters. It was quickly realized that the clinics at the beach location were not being used by foreign tourists in the way that was expected. It was decided to have one of the three clinics at Jesolo Hospital, right next to the emergency department. This allowed not only a proper triage of patients, but also created patient awareness of how to best use the services on offer and not to overload the hospital’s emergency services.

In Venezia (LHA 12) a special clinic for tourists was opened between mid-June and mid-September, with opening hours from 8:00 to 20:00. This was staffed by one doctor, increased to two doctors for July and August (open 20 hours per day). To activate this service, nine doctors and an administrator were required. Bussolengo-Lake Garda (LHA 22) has set up nine clinics, six of which are located in the Lake Garda area, and three in mountainous areas, guaranteeing 30 hours of opening each day. Annual additional expenses for

Veneto Orientale were €333 023, for Venezia €50 000, and for Bussolengo-Lake Garda €65 000.

Interpreting services

Since 1995, Veneto Orientale has operated an interpreting service during the main tourist season. External services were used at first, but in 2000 it was decided to hire interpreters with a working knowledge of English, German, French, Polish and Czech during the main tourist season. The interpreting service is a central element in the communication with the foreign tourist population. The increase from nine interpreters in 2002 to 17 in 2003 during the main tourist season made it possible to guarantee services in emergency departments, first-aid points, and in the main tourist clinics. A telephone-based interpreting service has also been set up to provide cover at nights.

Health care services on campsites

There are 114 campsites located in the three areas, with a total of 172 232 places. Thirty-eight of the sites can hold between 1000 and 4000 campers, nine of them more than 4000 campers, and two of the campsites can house over 10 000 people during the peak season. Some of the campsites have a medical centre (in Venezia there are four officially established medical centres, one of which has its own ambulance service; two in Bussolengo-Lake Garda and one in Veneto Orientale, making a total of seven medical centres²⁷). Most services are provided on a private funding basis, so the extent of services is difficult to quantify. Some of these might be reimbursed later by the home (EU) health insurance, thus ultimately entering into the public funding scheme, but this is difficult to estimate and not all out-of-pocket payments are submitted for reimbursement. The potential to establish some form of public-private collaboration is currently being studied.

Safe holidays – seasonal helicopter rescue for the Veneto region coastline

In 2004 an additional helicopter rescue service with a special focus on the tourist population was established as a further element within the complex system of emergency services available in the Veneto region. The helicopter health care rescue service guarantees coverage throughout the Veneto territories from four helicopter bases. During the summer season, with the aim of ensuring a prompt response to medical emergencies, a regional project called the “Safe

²⁷ More information on: <http://turismo.regione.veneto.it/it/ric/campeggi.htm> (last accessed 21.01.05)

Holidays Project” has been implemented along the Veneto coastline, incorporating a series of initiatives: the distribution of 150 semiautomatic defibrillators, seven medically equipped vehicles, three medically equipped motorbikes, 16 ambulances (including two water ambulances), and the establishment of a seasonal helicopter base station covering the coastline, equipped with sea rescue facilities. The helicopter, based at the Venice Lido, serves the entire 120 km of Adriatic coastline. In the space of 10 to 15 minutes the medical staff (doctor, nurse, air pilot) are able to reach the person in danger at the site of the emergency. The helicopter has all the equipment necessary for sea rescues. The cost of this service can amount to €72.30 per minute per flight during the day, and €103.29 per minute per flight at night-time. In 2004, during the first two months of service, the seasonal helicopter rescue service undertook 79 interventions with a total of 46 hours of flight.

Potential responses

Mass tourism to the Veneto region is an extremely important factor for the economic development of the region but it puts considerable strain on the health system. The large increase in demand, particularly in summer, creates significant capacity problems. Additionally, the demand is concentrated on minor emergencies, which can often be treated close to the scene of the incident. More needs to be done in terms of communication to tourists, as they seem to stick to the traditional view that all emergencies need to be treated in a hospital. Locating the ambulatory emergency unit just next to the hospital has proved a great help in “educating” patients in this area. Additional private services, particularly on campsites, need to be better integrated into the public service.

However, all in all, the Veneto region has shown how the challenge of fluctuating demand can be met, responding well to the need to provide quality services to European citizens on holiday in Veneto. The greater mobility of EU citizens is very visible in the field of tourism in particular, and needs to be taken into account. European Court of Justice decisions related to patient mobility provide a new opportunity for responding to the demand, while the introduction of the EHIC will surely facilitate administrative procedures. The decentralization of the Italian health system, and the greater responsibilities given to regional levels, for instance the Veneto region, provide opportunities but also challenges in terms of freedom of movement within the European Union.

Collaboration in the Europe for Patients project provided a great opportunity for evaluating the current activities and services provided for tourists and for reflecting on the challenges and opportunities offered by systems in other countries.

The Veneto region has the largest tourist flow of all Italian regions, and this is an important economic factor. Thus, to combine its high quality tourist appeal with high quality health care services for tourists – for acute and chronic conditions – is an important challenge. As this chapter shows, the Veneto region has taken important steps towards adapting its health care system to handle the enormous impact of mass tourism from northern and central Europe. This effort is being made in order to increase the appeal of the region to both foreign and national tourists, and to compete effectively with other major European tourist destinations.

The challenges faced are not insignificant: the sudden rise in demand, particularly in the summer, represents an important burden on the region. As we have seen, the demand differs depending on the type of tourism: cultural, seaside or activity. Heat and internal medicine emergencies characterize Venice, the cultural city, sunburn and small surgical emergencies the seaside, and injuries the Bussolengo-Lake Garda district. Each local health authority has responded to these different types of demands in a flexible way, with a service adapted for national and international tourists alike. Other challenges include the increased average age of the tourist population during the summer months, with the presence of chronic conditions such as dialysis, diabetes and chronic illness, and the increase in mainly older residents in winter, with problems similar to those described in the Spanish case study in this book.

Surveys carried out within the e4p project show quite high levels of satisfaction with the services provided, both for emergency and chronic care, even though it seems that more efforts need to be made in making the care more visible, by facilitating access to care and to language services. Local and regional policy-makers have taken the results of the survey very seriously.

Other problems exist on the administrative side. Budgetary transfers to the region are not sufficient to cover the necessary services. At a technical level, existing procedures have been reviewed and discussed at various levels. It seems that most problems are related to the reimbursement mechanism for E111 and E112 forms by foreign health insurance companies. Often E111 forms are not adequately completed, owing to misinformation on the part of tourists or insufficiently trained administrative staff in the different locations. In the context of this project we have taken a closer look at the compensation mechanisms regulating patient mobility among the 20 Italian regions and have compared them to European standards. It is also expected that, with the introduction of the EHIC, the administrative processes will be much improved, particularly in the light of a series of projects aimed at facilitating electronic data collection mechanisms in the region. Opportunities for improvement have been identified; for example direct contracting with

European health insurance companies will be examined to see if it can resolve some of the existing problems.

We have noted that closer and more effective collaboration between technical, administrative and medical staff, both at regional and local health authority level, is advantageous. The work has forced all those involved to focus on the forthcoming new challenge of Europe-wide patient mobility. Within the framework of the reorganization of the Department of Health and Social Services of the Veneto region following the recent regional elections (April 2005), we are now setting up a specific unit for European patient mobility, the first of its kind in Italy, with trained and dedicated personnel responsible for dealing and liaising with various European health insurance companies. The main objectives of this new department will be to:

- develop monitoring and surveillance systems to analyse phenomena associated with European patient flows in the Veneto region;
- develop and exploit ways of analysing health care practices in the Veneto region, and to see how to align them with best practices adopted by the 25 Member States;
- promote the right of citizens to be informed on their entitlement to best health care treatment on arrival in the Veneto region, and to be treated at “centres of excellence” for various medical and surgical pathologies;
- promote an integrated health care strategy through the development of intersectorial policy-making, by developing links between health care and other policies related to tourism development in the region;
- implement health services in campsites, drawing on a scheme of a private-public mix of resources and personnel.

A regional reorganization of health services has been taking place. A new type of service, specifically geared towards tourists, has been set up, functioning on the coast in summer and in ski resorts in winter. Better marketing will ensure that tourists will be more aware of the services offered by the public sector, including information on emergency phone numbers.

Conclusions

This study has shown that the organization of new services targeted at tourists needs to be flexible, and able to respond to both expected and unexpected tourist flows. In the future, services will need to be extended in order to respond more readily to the changing needs of EU tourists, different emergency settings and increasingly chronic conditions of the elderly population, such as

those with diabetes or needing dialysis. This will have a significant impact on the organization of the regional health care system in charge of providing essential services. The study undertaken here is seen as the start of an institutionalized, systematic and continuous monitoring process, with the important aim of providing the necessary information to policy-makers to enable them to plan and manage the system properly. Evidence will be gathered on the flow of tourism and its demands, on planned care, and on the application and use of the EHIC.

An issue to look at in the future is how countries can balance capacity variations, seasonal or otherwise, by one country providing services that another lacks. Idle capacity in winter, characteristic of the Veneto region, could be filled by developing “health tourism”. Another way of attracting patients off season is by establishing “centres of excellence”, something the Veneto region will be actively involved in. Long-term, closer cooperation with other EU partners will be established, as the best way of ensuring good, high-quality services for both national and European patients in the Veneto region.

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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
Total	13 823	12 061	25 884	

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*

	Dutch patients	Total numbers
1998	3 970	10 773
1999	4 915	11 262
2000	6 262	14 061
2001	7 539	16 019
2002	9 254	17 085
2003	12 526	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 hospitals²⁸*

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

²⁸ 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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Chapter 8

Sharing capacities – Malta and the United Kingdom

Natasha Azzopardi Muscat, Kenneth Grech, John M. Cachia, Deborah Xuereb

Introduction

While patient mobility has emerged as a key issue on the policy agenda within the European Union in recent years, stimulated by a series of rulings by the European Court of Justice, for Malta, patient mobility has been an integral feature of the health care system throughout the 20th century. By virtue of its size and location, Malta can claim to have a long and extensive experience both of treating patients who come to the island from other countries and of referring Maltese patients for treatment abroad.

During the first half of the 20th century, Malta experienced an influx of overseas patients, especially during the First World War when it earned the eponym “Nurse of the Mediterranean”. Since gaining independence from the United Kingdom in 1964, Malta has developed a strong tourist industry, with the United Kingdom being the major provider of tourists. In this period, the Maltese health care system had to learn to cater for overseas patients, this time as visiting tourists.

As medicine became more complex and travel became easier, it was inevitable, for a country with under 400 000 people, that certain interventions could not be offered locally and would be obtained from centres overseas. Reflecting the traditional links that had developed between Malta and the United Kingdom during almost 200 years of colonial rule, the United Kingdom proved to be the country of choice for referral of Maltese patients overseas.

As a new Member State of the European Union, Malta finds itself obliged to implement the EU *acquis* in the area of patient mobility. This has given rise to a number of changes in the way that health care benefits are offered to

EU/EEA citizens through the implementation of EU regulations on coordination of social security (benefits in kind). An entitlement unit has been recently established within the Ministry of Health to deal with these matters. Malta, however, must also address the issues that arise in relation to referral of patients overseas using the E112 mechanism. This presents new challenges for a small health care system in which patients treated overseas received their care within the framework of a tightly regulated mechanism in which the United Kingdom was the main overseas partner.

This case study seeks to document the experience that Malta has garnered over recent decades in the field of patient mobility. The analysis will focus on providing health care for tourists and referral of Maltese patients abroad and will serve to highlight areas of best practice. Finally it will present an assessment of the challenges that Malta is facing in view of the developments taking place in relation to patient mobility across the European Union with recommendations on the way forward.

Background and context

The Maltese archipelago is located in the centre of the Mediterranean Sea with a total land area of 316 km². The total resident population of the Maltese Islands is 399 867 of whom 198 099 (49.5%) are men and 201 768 (50.5%) are women. These figures correspond to a population density of 1265 people per km², the highest in the European Union (National Statistics Office, 2003a).

The Maltese population presently enjoys a relatively high health status. Life expectancy at birth in 2003 was 80.4 years for females and 76.4 years for males. At the age of 60 years (which is around the current age of retirement) life expectancy in 2003 was 22.9 years for women and 19.7 years for men. Infant mortality rates have been steadily improving and fell to 3.5 per 1000 live births in 2003.

Circulatory disease is the leading cause of death, accounting for 44% of deaths. The standardized mortality rate for ischaemic heart disease is relatively high at 149 (per 100 000 population). Cancers currently account for 24% of deaths (Ministry of Health, 2002).

Malta's accession to the European Union has dominated the political agenda over the past few years. Following a substantial reform in its legislative and administrative structures, the main challenges now facing Malta are achieving sustainable public finances and enhancing the island's competitiveness and economic growth whilst maintaining social cohesion and sustainable development.

Malta has a rich history of health care provision. The initial developments were influenced by the Order of the Knights of St John, which was primarily a “Hospitallers” order and which ruled the country between 1530 and 1798. Malta was a British colony between 1800 and 1964. The British heavily influenced the development of Malta’s public health system and contemporary health care services. This influence is still evident today in the way the health care system is funded and organized and in the training and culture of the health care professionals.

The Maltese health care system comprises a public health care system and a private health care system. The statutory system is publicly financed from taxation and exhibits the features of a fully integrated model of health care delivery, organized and managed at national level. It offers a highly comprehensive basket of services, free at the point of use to all the population. Private health care is funded by voluntary health insurance and out-of-pocket payments.

Government expenditure on health care continues to rise yearly, with estimated recurrent expenditure on health and elderly care for 2004 making up 12% of total government recurrent expenditure. The total health expenditure as a percentage of GDP for 2003 was 9.63%, slightly higher than the EU average. However, in terms of purchasing power parity (PPP) per capita, Malta spends less on health care than the EU average. As noted above, health care financing in Malta is split between public financing and private financing. During 2003, 65% of total health expenditure took place in the public sector (Table 8.1).

St Luke’s Hospital, Malta’s only main acute general and teaching hospital, is synonymous with the development of modern medicine and health care in Malta. Links between St Luke’s and prominent, mostly London-based teaching hospitals were developed, as Maltese doctors underwent specialist training in the top centres in the United Kingdom and returned to provide services locally. Although service development has been continuous, with the establishment of specialized units such as intensive therapy, neonatal intensive therapy, neurosurgery, cardiology and cardiac surgery, the need to send some Maltese patients overseas for treatment remains.

Maltese patients seeking treatment overseas

Outward patient mobility takes place from both the public and private health care systems although there are no figures for the extent of movement from the private sector. It is known that patients often make their own arrangements through private consultants in Malta to attend, mostly for outpatient consultations, the private medical sector in the United Kingdom. These are

Table 8.1 *Trends in health care expenditure*

Year	1999	2000	2001	2002	2003
Total health expenditure in PPP\$ per capita	1 262	1 521	1 173	1 709	
% GDP spent on health care	8.31	8.81	8.92	9.69	9.63
% Public health expenditure	50.8	53.5	65.7	69	65.4

Source: WHO Health for all database, 2005

often paid for out of pocket. People covered by international private insurance may also obtain treatment overseas. In the public sector, patient mobility has so far taken place in the context of a bilateral agreement with the United Kingdom with a highly regulated and organized system for patient referral. Reimbursement by the public system for treatment sought overseas by personal initiative and outside this scheme has so far not been granted.

Patient mobility in the public health system

Numbers and profile of patients undergoing treatment overseas

Given Malta's historical relationship with the United Kingdom, a bilateral health care agreement that has served both the United Kingdom and Malta very well has been in place for the last 30 years. This agreement provides for the referral of a quota of Maltese patients for treatment in the United Kingdom National Health Service. The number of Maltese patients requiring treatment overseas has always exceeded the agreed quota, with additional patients incurring an additional charge to the Maltese Government. Figure 8.1 shows the number of patients referred from the Maltese public health care system for treatment in the United Kingdom between 1990 and 2004. Over the past few years the number has stabilized and represents around 0.06% of the Maltese population. There are two specific points on the graphs showing a sharp decrease in patient numbers: 1995 and 1998. These points correspond to the date of introduction of a cardiac surgery programme and magnetic resonance imaging (MRI) for patients at St Luke's Hospital.

The profile of cases that are currently referred for treatment abroad consists mainly of bone marrow transplants, liver transplants, complex major spinal surgery, paediatric cardiac surgery, maxillofacial surgery, and specialist paediatric cases, particularly endocrinology, gastroenterology and neurology. These cases all exhibit the features of high cost and low patient volumes. To date there have been no strong clinical or economic arguments to develop these services in Malta. The investment cost is too high, the patients are too few and full-time professional staff employed to perform this type of service will quickly become deskilled.

In addition, several overseas specialists from centres of excellence in the United Kingdom visit Malta once or twice yearly to carry out consultations. These visits serve as a follow-up assessment of patients who have been operated on or received treatment in their hospital and also help to identify new cases that require treatment abroad.

This system can be viewed as an extension of local health service provision in the public sector, a tertiary care backup service with centres of excellence abroad. Malta has links with approximately 25 centres of excellence in the United Kingdom. For example, oncology patients are referred to the Royal Marsden Hospital, infants are sent to Great Ormond Street, neurology patients go to the National Hospital for Neurology and Neurosurgery at Queen Square, whilst patients with liver disease are transferred to King's College Hospital. The system has its roots in the fact that most of the local doctors receive their specialized training in the United Kingdom, where close professional ties with key consultants are created. These personal acquaintances then become care sharing opportunities.

The shared-care approach is a multidimensional type of arrangement where a relationship with a hospital and a particular consultant is present. It has a consultation dimension where cases and treatment options are discussed (second opinions), a visiting consultant dimension where foreign consultants go to Malta and carry out consultations there, and also identification of patients who need to go for treatment.

In addition, in certain areas, for example the treatment of scoliosis patients, a programme of visiting surgeons has been in place for a number of years. This movement of providers has several advantages since it allows the patient to be treated locally and also provides learning opportunities for the local staff.

Policies and procedures regulating the overseas treatment programme

Treatment Abroad Advisory Committee

The Treatment Abroad Advisory Committee (TAAC) is responsible for regulating patient mobility. This committee advises the Chief Medical Officer, giving recommendations as to which patients warrant referral to an overseas hospital for treatment. The TAAC is composed of senior clinicians with expertise in medicine, surgery and paediatrics, and is chaired by the Director of Institutional Health. The final decision regarding the type of services to be included in the package of care for which Maltese patients may be referred overseas lies with the ministry's Health Policy Board and the minister responsible for health.

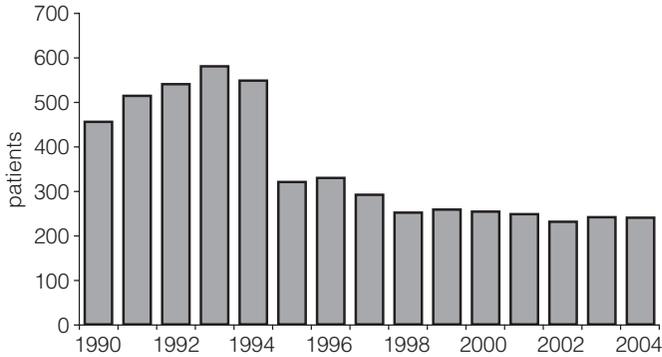


Figure 8.1 Number of patients treated in the United Kingdom 1990 to 2004

Source: Department of Institutional Health, 2005

The treatment abroad package

The TAAC has developed a list of established services and treatments for which Maltese patients may be referred overseas under the public programme. Once a decision is made that a particular condition/disease merits treatment abroad, the TAAC does not review each case referred in detail.

The TAAC discusses referrals for inclusion of new treatment options, assesses the pros and cons of treatment and then makes a recommendation as to whether or not to offer the service. The referring consultant is invited to the committee meeting in order to justify the referral for treatment overseas. In considering whether a new service or treatment should be added to the list, the TAAC examines whether:

- a proven, non-experimental treatment for the disease exists;
- the treatment is unavailable locally;
- there is evidence of potential benefit for the patient;
- the financial impact of sending patients abroad would not be prohibitive for the system.

The authorization process

When a consultant decides that a patient requires treatment that is not available locally, a request is drawn up using a form that contains all relevant details about the patient. A case summary, relevant X-rays and an airline Certificate of Fitness to Travel are also required. Following endorsement by the TAAC, the referring consultant contacts the overseas specialist who shall be responsible for the patient to discuss the case and ensure that the patient can be referred. If the patient has a condition that is recognized as requiring treatment abroad

under the public programme, authorization from the TAAC is conferred automatically, permitting urgent transfer where necessary.

Referral of patients

Once permission to refer arrives, the Treatment Abroad Section takes over to make the necessary arrangements for transportation, admission and accommodation for the patient and accompanying relatives. This section liaises with the Maltese Embassy in London to arrange outpatient appointments, reserve a bed, and book accommodation for the patient and accompanying relatives. The referral of patients to centres of excellence outside the country has necessitated the setting up of protocols which set out the different patient categories (such as intensive, highly dependent or cold cases) and the procedures to be followed in preparation for, and during transfer of, each category of patients. Malta has also had to invest in reliable portable equipment together with mechanisms for ensuring accommodation and remuneration for the accompanying hospital team members where this is necessary.

The patients' perspective

Interviews with patients and their relatives reveal some of the strengths and weaknesses of the system:

“The arrangements made from Malta by the Treatment Abroad Section were excellent.”

“Lodging is the biggest headache for the parents.”

“The expenses are huge. I go up every three months for treatment.”

“Since my husband earns more than LM80 (€185) a week I have to pay my ticket in full. Each time I go I have to pay two flights: mine and that of the person accompanying me.”

Pre-admission arrangements

Patients generally believe that the system of referral and preparation for transfer to a hospital outside Malta works efficiently. The Treatment Abroad Section deals with all the necessary practical arrangements, including admission arrangements, airline ticket booking, transfers to hospital and accommodation. This relieves the patient and his or her relatives of a large burden, especially since the time prior to admission is often a period of great anxiety.

Accommodation

Most Maltese patients referred to the United Kingdom for treatment are admitted to hospitals within or close to London. Patients receiving treatment

on an outpatient basis and relatives accompanying patients need a place to reside. The Treatment Abroad Section makes arrangements with the order of Franciscan Nuns in London to accommodate the patients and their family. The nuns run a small hostel so it is not uncommon for relatives to be turned down at the door owing to lack of space. This creates inconvenience and added anxiety, as alternative accommodation would then need to be sought by the relatives themselves. Although the nuns do their best to provide for the basic needs of their visitors, the hostel has several limitations such as shared bathroom facilities and the lack of a laundry service on site.

Travelling

Airline fares are provided on a means-tested basis. Accompanying persons do, however, have to pay their own fare. Patients are provided with a free taxi service to and from the hospital where they are receiving treatment.

Communication channels and language issues

Since almost all Maltese patients referred for treatment abroad go to hospitals in the United Kingdom and English is the second language for the Maltese, communication problems seldom arise whilst the patient is receiving treatment. The receiving hospitals often provide the patient and accompanying relatives with an information pack which provides essential information to assist patients during their stay in hospital, such as admission times, hospital maps, travelling facilities, etc. Some hospitals also provide these guides on the Internet. This has the added benefit of allowing the patient to start familiarizing him or herself with the new surroundings and systems while still at home in Malta.

For patients who have difficulty communicating in the English language, a community of priests in London offers their services as interpreters. These priests go to the hostel of the Franciscan nuns daily and offer to accompany patients and their relatives to the hospital.

Psychological support

Patients state that the main source of support comes from the nurses working in the hospitals. Patients were generally impressed with the excellent bedside manners shown by the health care professionals and do not find any difficulty with the culture of hospitals in the United Kingdom.

Some families may stay abroad for months, for example when a patient is receiving prolonged outpatient care and for bone marrow transplants. Often these patients and their relatives are homesick, bored and need psychological support.

Financial problems and support

One of the main issues for patients requiring treatment abroad is the financial burden associated with travelling to a foreign country, especially when the patient needs to go abroad several times each year. Often a close relative accompanies the patient when abroad for treatment, especially when the patient is a child. Relatives have to pay for their flights and their own stay. The Treatment Abroad Section often refers patients and their relatives to the “Community Chest Fund” which is the main charity organization in Malta. Patients can then apply for financial assistance to cover some of the expenses. Still, it appears that donations are far from adequate to cover the expenses involved.

“I’m not saying that they [family] should not pay a dime, but I feel that they do not have enough financial support. It is true that the government covers most of the expenses and I am aware that the budget is tight, but these are the things which the patients and relatives mention most.”
(Referring consultant)

The doctors’ perspective

As with the patients, the Maltese consultants interviewed also provided a variety of perspectives:

“We have been working with this hospital for years now, we know people there and they know us and they do help us, especially if it’s an urgent case.”

“I can’t say enough, really, how good the service is. It’s a shame that the general public don’t always realize what a 5-star service they have.”

“You make a diagnosis today for a condition that is eminently treatable here and they’ll come the next day and ask ‘Can we go abroad?’”

From the interviews conducted with referring consultants the picture that emerged is that the system is very efficient and the referring doctors rarely encounter problems with the referral itself. If problems arise following the patient’s treatment overseas, local doctors liaise with the overseas specialists, usually via e-mail. This seems to be the system most commonly adopted now for consultations and second opinions involving local and foreign specialists.

The main problems with the treatment abroad programme, identified by the local consultants are as follows:

- limited funding available for treatment abroad, which restricts inclusion of new services in the treatment abroad programme such as brain stimulators for Parkinson’s patients;

- receiving hospitals may lack readily available bed space and this prolongs waiting time for local patients;
- patients are sometimes prescribed medicines that are not available from the Maltese health service. Whilst referring consultants seek to provide the “receiving” doctor with a list of locally available drugs as guidance for prescription, it is not always possible for the doctor to stick to this list. If upon discharge the patient is prescribed medicines that are not available locally, a special urgent request for these drugs has to be made.

Another issue raised by the doctors is that the success of the programme often leads local patients to pressurize their doctor to send them abroad for treatment. This is possibly fuelled by the cultural belief that treatment provided overseas is of a higher standard than that available locally. This creates a problem in that the doctor has to seek ways to convince the patient that treatment abroad is unnecessary as the required service and expertise are readily available locally. The majority of cases are convinced, yet occasionally a few still seek treatment privately. Some of these actually send the bill to the Treatment Abroad Advisory Committee, which is not reimbursed.

Patient mobility within the private sector

Although there are no statistics, it is believed that only a small number of people residing in Malta actually seek treatment overseas within the private sector. This may be due to the emergence and subsequent sustained improvement of tertiary care services within the Maltese private sector during the last decade. Amongst those who do seek treatment the majority are adults. Treatment options range from orthopaedic surgery and oncology treatment to gynaecological checkups. The most popular countries where private treatment is sought are the United Kingdom and Italy, mainly owing to the number of specialist hospitals available and also familiarity with the languages.

Privately insured patients with international coverage plans can usually seek treatment in a hospital of their choice. However, insurance companies compile an international directory of hospitals, which helps patients identify hospitals with which the company has package deals. In such cases the prices for a range of treatment options would be pre-established, thus increasing the possibility that the client is reimbursed in full. If treatment is sought in a hospital with which the insurance company has no agreement, it is possible that the health insurance would not cover all the expenses.

Patients are responsible for choosing and contacting the hospital where they wish to receive treatment. Although it seems that the choice of providers is

endless, in reality it is quite restricted in terms of the surgery required, the consultant and the corresponding hospital. If a particular surgeon is desired, the patient must go to the hospital in which the doctor works.

The role of the insurance company is to check the client's insurance coverage. Insurance companies are not primarily responsible for the quality of the service that their customer receives when abroad. However, it is reported that the few patients who have commented about the quality of service they received all gave positive feedback.

Overall, the administrative process of settling insurance claims for health treatment abroad is rather straightforward. Once the client informs the insurance company of his or her decision to seek treatment abroad, details of the treatment sought, the consultant providing the treatment, the location of the care facility, and duration of treatment must be agreed. This information is then forwarded to liaison officers at overseas insurance offices, who confirm the estimated fee and give official permission. This provides the client with pre-authorization for treatment. An official letter is then mailed to the care facility, detailing the insurance coverage of the patient. Once treatment is received, all expenses are billed to the insurance company which verifies that the price charged was according to the pre-established package. If verified, the bill is settled. Delays arise when large differences result between estimates given by the hospital and the actual bill.

Health care provision for tourists

The tourist industry and access to health care

Tourism represents one of the main pillars (around 25%) of the Maltese economy: 40 000 workers earn their living directly or indirectly from the tourist industry, which generated an income of LM424 million (€990 million) in 2002. The vast majority of the 1.1 million tourists visiting Malta annually come from EU/EEA countries with almost half (450 000) coming from the United Kingdom. One quarter of tourists is aged 55 years or over (National Statistics Office, 2003a, 2003b).

As a result of its dependence on tourism, Malta has always sought to provide uncomplicated access to quality health care for temporary visitors. An open-door policy of immediately treating all emergency and/or urgent cases, with claims being settled at a later date, has been in place for decades in the public health service.

Demand for hospital care by temporary visitors

Demand for hospital care by temporary visitors exhibits a marked seasonal

variation. The winter months bring in large numbers of elderly patients with cardiorespiratory problems whilst in summer younger persons tend to present with accidents or heat-related conditions.

In 2003, 1229 foreign inpatients were treated in St Luke's Hospital, accounting for 2.7% of admissions. The number of outpatient and accident and emergency visits to St Luke's by foreigners in 2003 was over 4000. It is important to note that these figures do not include patient contacts in government-owned primary health care centres and in the private sector. The cost of treatment of foreign nationals accounts for around 2.4% of the total recurrent costs of the hospital.

Congruent with the mix of nationalities of tourists on the island, the majority of patients treated at St Luke's Hospital come from the United Kingdom, followed by Germans, Italians and French (Table 8.2).

Until 2002, the hospital did not have an effective administrative system to bill foreign patients and usually only billed for inpatient episodes. In 2002, a billing section was opened and all foreign patient episodes are processed for payment. Since EU accession, EU/EEA temporary visitors automatically benefit from free treatment that becomes medically necessary during their stay upon presentation of the E111 certificate. The details are then forwarded to the Entitlement Office within the Ministry of Health, Elderly and Community Care for further processing and onward transmission to the relevant Member State (Ministry of Health).

Impact of treating temporary visitors

Implications for the health system

Whilst there should not be any negative financial impact from treating EU/EEA nationals with an E111 certificate if costs can be recovered, the financial impact of caring for pensioners in possession of the E121 certificate has yet to be evaluated. This will be possible after there has been experience over several years. It is expected that certain pensioners, such as those who are dependent on renal dialysis can skew costs considerably, especially for a small country's health care budget.

Third country patients are usually billed following their treatment and discharge from hospital. The number of defaulters has risen over the years. Some of these costs have been written off whilst others have attracted lengthy legal and administrative procedures in the hope of recovering some of these expenses. As a result, changes in the procedure for collection of claims are due to be instituted, wherein guarantees for payment will be required prior to elective or non-urgent treatment.

Table 8.2 *Number of overseas patients undergoing treatment at St Luke's Hospital*

	United Kingdom	EU (excluding United Kingdom)	EEA	Non-EU/EEA	Total
2003					
Inpatients	624	160	11	434	1 229
Outpatients	1 355	805	43	1 919	4 122
2004					
Inpatients	593	201	7	371	1 172
Outpatients	1 665	1 065	46	2 190	4 966

Source: St Luke's Hospital Malta, 2005.

Implications for providers

Capacity constraints

Hospital capacity planning has always included the impact that tourists have upon the number and type of beds available in hospital. Despite such planning, given that there is only one acute general hospital in Malta, the capacity to accommodate all patients is sometimes exceeded, especially in critical care areas. Overcrowding of the acute hospital has become a necessary but expected evil to contend with during the winter months.

Managing expectations of foreign patients

Although health care standards in Malta compare well with those in other Member States, foreign patients' expectations still need to be managed carefully. Compared to Maltese patients, foreign patients have a greater propensity to make their feelings known and this gives rise to more praise or more criticism than local health care providers would normally expect. Anecdotal experience shows that they are more likely to institute formal complaints than Maltese patients.

Consent and data protection issues

Unconscious patients who are not accompanied by relatives present particular problems, including that of obtaining the necessary consent. Legal proceedings are instituted in these situations in order not to delay treatment. Owing to the existence of harmonized data protection legislation across the EU, the transfer of patient data across EU borders does not present particular problems.

Implications for patients

Psychological impact

Admission to hospital has a significant psychological and social impact upon temporary visitors, especially since most admissions are unplanned and involve elderly patients. These are often alien to the local culture, language, health care systems and policies. They may not have any friends to help them and may totally depend on the guidance given to them by health care professionals. Relatives, if present, also require psychological support.

“They would not be sure of the culture, the quality of medical care and have a lot of anxieties when they come in.” (Hospital nurse)

Language difficulties

Although all Maltese health care professionals are fluent in English and many are proficient in some other European languages, the language barrier still presents some challenges to overcome, especially for non-English speaking patients. Nurses seek to locate an interpreter to help them but the hospital has no official list of interpreters who can be contacted for assistance. Help is usually sought either at the relevant embassy in Malta or the hotel where the patient was staying. If an interpreter still cannot be located, nurses try to find an employee within the hospital having knowledge of that particular language who can help out.

Logistical issues

Patients and their relatives also require assistance with logistical and financial matters, often running out of funds if the stay is prolonged. The majority of foreign patients and their accompanying relatives require transport facilities to and from the hospital. Often local taxi services overcharge these visitors. Hospital staff often encounter difficulties when there is a need to make international phone calls from hospital to the insurance company or to contact the patient’s doctor abroad.

“Sometimes the elderly partner is stranded. Their funds would have finished and they just leave the hotel and show up on the ward. They expect to be fed and ask for a place to rest. We do try to help them and accommodate them here, but this is not a suitable place for relatives.” (Hospital nurse)

Although staff at the billing section within the hospital are specifically trained to deal with logistical requirements, tour operators and embassy staff are also called upon to assist with matters such as transportation, transfer of funds and insurance. The main objective is always to assist the patient to return home as quickly and as safely as possible.

Conclusions

Facilitating factors

This case study has demonstrated that patient mobility is greatly facilitated by the following factors:

- interinstitutional links;
- personal interprofessional links, especially between consultants;
- existence of an organized programme that caters for logistics and practical support;
- intervention by insurance prior to patient travel;
- common language;
- movement of providers in addition to movement of patients;
- agreed protocols for pre- and post-intervention care within the country of origin between the referring institution and the host institution.

Hindering factors

The following factors were identified as hindering patient mobility or creating difficulties for patients undergoing treatment in a different country:

- budgetary constraints within the referring health system;
- costs of travel and accommodation (subsistence) for both patients and accompanying relatives, especially for conditions requiring treatment over weeks or months;
- lack of information prior to departure or during stay in the host country;
- isolation and linguistic difficulties;
- difficulties in gaining access to certain institutions rapidly;
- reluctance of institutions to accept overseas patients because of capacity problems or delayed and complicated reimbursement proceedings;
- different medicine formularies and resulting lack of availability across borders.

Potential developments

Following accession to the European Union it is possible that the framework regulating outward patient mobility will change in Malta. It is anticipated that outward planned mobility will begin to take place through the framework of the regulations on coordination of social security with the E112 certificate.

It is not expected that patients will shift their preference to countries other than the United Kingdom because of the comfort of the language and also because of the established links and referral patterns between consultants. Therefore, within the framework of EU regulations, it is highly likely that Malta and the United Kingdom will retain some kind of bilateral agreement that will serve to reduce unnecessary bureaucratic transactions and will be more advantageous for patients and health care providers.

Malta is likely to find itself increasingly challenged to open up opportunities for treatment abroad within the context of the ECJ rulings. To date, overseas treatment has been restricted to those services that are not available locally but are deemed to form part of the package of care. The authorities are going to come under increasing pressure to define explicitly and transparently those services and interventions not available locally, that are eligible for funding by the public system.

The experience from the private sector in Malta seems to indicate that even where persons are covered for treatment abroad, they will usually prefer treatment in Malta unless the intervention is considered to be complex or innovative. Therefore, on the basis of the evidence to date, it would seem unlikely that patients will seek out hospital care for routine procedures overseas, incurring the additional travel and accommodation costs. In making this assessment, it has to be borne in mind that travel out of Malta usually requires air travel and is not cheap.

In terms of catering for incoming patients and provision of the E111 certificate to outgoing Maltese temporary visitors, the relevant changes have already been carried out. Malta will face additional costs in having to pay for urgent care delivered to Maltese temporary visitors in other Member States. There will also be the impact of delays in recouping costs of care delivered locally to temporary visitors. The financial impact could be significant when one considers the relatively large number of tourists making use of Maltese health care facilities. To date the private sector in Malta is not recognized as providing accredited facilities for the purpose of treating persons covered by an E111 certificate. There has already been some pressure to include the private sector in this scheme and this pressure is likely to increase, especially as the public sector increasingly faces capacity problems.

Finally, it should be appreciated that for a small tax-funded health care system the impact of finding additional cash to pay for patients to receive treatment overseas can be relatively substantial even if the numbers of patients moving are small.

Recommendations

The main lessons that can be drawn from this case study are as follows:

- patient mobility, when well managed can have positive effects for patients, providers and health care systems;
- patient mobility requires policies, procedures and effective backup systems to ensure that patients obtain safe, good quality care in a holistic manner;
- patients exhibit a preference to be treated in their home country where possible unless there is a perception that better care can be obtained overseas;
- patient mobility is expensive, requiring additional cash and hidden expenses. This raises equity issues both in terms of patients who are more able to afford it benefiting more and in terms of health systems that are more able to fund it providing more flexible systems for treatment outside the competent Member State.

Policy-makers at European level should examine the implications that arise before encouraging widespread patient mobility. The three pillars currently being pushed at European health policy level are quality, access and financial sustainability within the context of applying the open method of coordination to health care. Patient mobility can have an impact on all three pillars.

- 1 Ensuring that an effective framework to regulate patient mobility is in place at European level and can safeguard quality and safety.
- 2 Access to treatment in another Member State poses equity dilemmas both at national level and at European level. European policy-makers may wish to consider making available central funding to assist those Member States who need to refer complex cases to centres of reference across borders in meeting the costs associated with patient mobility.
- 3 The financial impact of patient mobility on health care systems will require regular monitoring with a view to taking corrective action if this is shown to impact negatively on national health care budgets.

In view of its unique geodemographic situation, Malta will continue to rely on patient mobility for complex and supra-specialist procedures in the foreseeable future. However, experience has shown that both patients and the health care system itself stand to benefit when it is a safe and cost-effective decision to introduce the service locally. In view of its dependence on tourism, Malta will continue to ensure that its health services are geared to meet the needs of patients from overseas. The experience gained in this sector may also prove invaluable if the country engages in health tourism in the years to come.

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Chapter 9

Cross-border contracting: the German experience

Thomas Nebling, Hans-Willi Schemken

German health insurance funds have developed extensive experience of cross-border contracting in a variety of settings. This experience provided valuable insights from which it is possible to draw lessons for patient mobility in Europe more generally.

Statutory health insurance in Germany

To understand the different types of cross-border contracting that will be described, in this section we will outline some basic facts about the statutory health insurance (SHI) system in Germany. The so-called “Bismarckian System”, subsequently adopted in various forms in a number of other countries (Austria, France, Luxembourg, Belgium and the Netherlands), consists of sickness funds, whose numbers have decreased from 20 000 in the late 19th century to about 300 now.²⁹ Although the German system is characterized by a plurality of sickness funds³⁰ the process of contracting health care providers is pooled. Historically, different types of sickness funds have been created: the Allgemeine Ortskrankenkassen (AOK), with membership based on place of residence, operating at regional level, the Innungskrankenkassen (IKK) (organized at regional and national level), the Betriebskrankenkassen (BKK) and the Ersatzkassen (EK) (respectively manual and non-manual occupationally-based scheme, organized at national level). Each of these types of funds is represented by an association, with the funds within the corresponding category

²⁹ The number of sickness funds is constantly changing.

³⁰ In comparison, France has only 17 sickness funds.

obliged to join the association. It is the sickness fund associations that are responsible for contracting with health care providers, with the contracts binding on all their constituent members, in a form of corporatism. Individual sickness funds thus have very few opportunities for negotiating individual contracts with individual health care providers.

The system is also subject to a supervisory regime to ensure its viability. For sickness funds operating at national level, the Federal Insurance Office is the responsible supervisor, irrespective of which association the sickness funds belong to. For all regional sickness funds (which includes all AOK sickness funds as well as some IKK and BKK sickness funds), the social ministry of the *Bundesland* (state) in which the sickness fund headquarters is located assumes a supervisory role. Social ministries might act less strictly than the Federal Insurance Office, leading to distortions in competition as sickness funds operating at national and regional levels are treated differently.

The European internal market, with its principles of free movement of people, goods, services and capital, has increasingly been seen to be in conflict with some of the basic principles of the German health system, as became apparent after the *Kohll* and *Decker*³¹ rulings of the European Court of Justice. German health policy-makers had at first believed that these rulings would not apply to the benefits-in-kind system in place in Germany but this was rejected in subsequent rulings.

German patients abroad

Despite their public position, which often seemed to ignore the issue of cross-border care, some sickness funds have sought to address this issue. As many of their insurees take holidays abroad and some fall ill while abroad, the sickness funds accept that there is a legitimate demand for medical treatment outside Germany. In order to obtain information on people's experiences of and expectations for cross-border treatment, the Techniker Krankenkasse (TK) undertook two surveys in 2001 and 2003 (Techniker Krankenkasse, 2001; 2003). One of the main conclusions to emerge from these surveys is the failure of the E111 system. It was reported that the E111 was often not accepted by health care providers abroad and in many cases cash payment was asked for. This was attributed to the delay incurred by the health care providers in recovering reimbursement. In some countries the E111 form had to be exchanged for a national document, which was often a complicated process. In addition, some people forgot to obtain an E111 form or, if they did, they left it at home. In exceptional cases, cash advances were reimbursed, usually

³¹ See European Court of Justice C-158/96 and C-120/95.

for not more than 80% of costs incurred and never for more than the equivalent cost in Germany.

The studies also found that three quarters of people interviewed travel to another European country at least once a year, and apart from drugs, the most frequent medical costs were for outpatient care. There was a clear demand for information on health care systems and providers in the countries to which they were travelling.

Health care reforms in 2004

Before 2004, the possibilities of contracting with providers abroad were limited for sickness funds in Germany. However, the AOK sickness funds used opportunities to establish arrangements with partners abroad (hospitals, health insurers) abroad – tested in pilot studies. In these contracts, the foreign payer pays the foreign health care providers and is then reimbursed by the German sickness fund. Such contracts were made possible on the basis of Council Regulation (EEC) No. 1408/71.³² These contracts only worked for people falling ill during a temporary stay abroad (E111) and were aimed at preventing patients from having to pay for treatment out of pocket. They could not be used for planned purchased care, for which the E112 was needed, or for which a cash advance had been made, that would not always be reimbursed.

The most recent German health care reforms, implemented in 2004, took account of the rulings of the European Court of Justice on cross-border care; changes to the Social Code Book (SCB) paragraph 140e now permit all sickness funds to enter into cross-border contracts with foreign health care providers within the EU. However, exclusively those services included in the German benefits catalogue can be covered. Only public health care providers in the other country qualify, and contracts must incorporate the requirements of German law (Schneider, 2004). The Federal Ministry of Health and Social Protection reports that overall expenditure on cross-border treatment is minimal. Its share of total health expenditure in 2004 was 0.3% (€455.8 million out of €140 billion or €9 out of €2764 per capita) (BMGS, 2005).

Different types of cross-border contracting

In the following sections we will look at different categories of contracts, as set out in Table 9.1.

³² Experts concluded that those arrangements were possible based on EEC Regulation No. 1408/71 (see also the example of case 1 below) Additionally they had more freedom of action, as they were not under supervision of the Federal Insurance Office.

Table 9.1 *Typology of cross-border contracts*

	Contracting indirectly	Contracting directly
People falling ill during a temporary stay in another country	Case 1 Hospital care Netherlands/Belgium	Case 2 Ski accidents Austria
Patients travelling to another country to receive medical treatment	Case 3 Cross-border care Netherlands	Case 4 Rehabilitation Czech Republic

Indirect contracting refers to contracts for cooperation, where a foreign sickness fund plays the role of middleman, while direct contracting relates to direct contracts with foreign health care providers. The other distinction to make is between falling ill during a temporary stay abroad (for instance, a holiday) and going abroad with the express purpose of receiving medical treatment.

In this chapter we will use four different examples to illustrate these categories:

- a project by the AOK Rheinland and the Techniker Krankenkasse, contracting with hospitals in the Netherlands and in Belgium, in cooperation with the insurers CZ (NL) and ZMG (B), (Case 1);
- a project by the Techniker Krankenkasse, seeking to improve medical care for ski injuries in Austria (Case 2);
- a project by the AOK Rheinland and CZ Actief in Gezondheid, seeking to improve accessibility to care in regions bordering the Netherlands and Germany by using the *GesundheitsCard international (GCi)* (Case 3);
- a project by the Hanseatische Krankenkasse, offering rehabilitation in the Czech Republic (Case 4).

Cases 1 and 3 are mainly based on Council Regulation (EEC) No. 1408/71 (E111 and E112), while Case 3 also incorporates elements of German social laws that allow sickness funds to permit their insured to obtain specified treatment abroad, with subsequent reimbursement. Cases 2 and 4 are mainly based on paragraph 140e of the German Social Code Book.

Case 1: Contracting with hospitals in the Netherlands and in Belgium

The sickness funds involved are the AOK Rheinland and the Techniker Krankenkasse (TK). With 2.6 million insured people, the AOK Rheinland is the largest sickness fund in the Rhineland, on Germany's western border with

Belgium and the Netherlands, and has a contribution rate of 13%. With 3.8 million members (who, with family members, number 5.8 million individuals), the TK is Germany's third largest sickness fund operating on a national level. Part of the Ersatzkassen, with more than 9 000 employees, it has 200 customer service offices across Germany, with a total turnover of €12 billion and a contribution rate of 12.8%.³³

The project began when it was realized that many people insured with the AOK and TK who went on holiday to Belgium and the Netherlands experienced problems using the E111 form (that is, the form was either not accepted or not even recognized) when they needed access to health care. The goal was to improve access to medical treatment in Dutch and Belgian health facilities without the patient facing bureaucratic hurdles or needing cash advances. An additional goal was to ensure that there would be German-speaking staff in the facilities, as tourists do not necessarily speak the Dutch or French languages well, particularly in relation to medical terminology. Dutch and Belgian hospitals had strong incentives for participating: they were interested in minimizing bureaucratic procedures and in being reimbursed faster. They also hoped to see higher levels of activity. We will now take a closer look at the arrangements.

As the project was implemented at the beginning of 2003 (and before the reforms in 2004), direct contracting with health facilities was not an option. Thus, the AOK chose the Dutch sickness fund CZ Actief in Gezondheid and the Belgian sickness fund Christelijke Mutualiteit (CM) as partners. The TK entered into the project in the first half of 2004 when it was clear that the reforms implemented in January 2004 would allow direct contracting (paragraph 140e of the SCB). Participating hospitals were suggested by the Dutch and Belgian sickness funds. Ten Dutch hospitals are involved: Antonius Ziekenhuis in Sneek, Gemini Ziekenhuis in Den Helder, Medisch Centrum in Alkmaar, Spaarne Ziekenhuis in Heemstede, Rijnland Ziekenhuis in Leiderdorp, Medisch Centrum Haaglanden in The Hague, Ziekenhuis Bronovo Nebo in The Hague, Oosterscheldeziekenhuis in Goes, Ziekenhuis Zeeuws-Vlaanderen in Terneuzen, and Ziekenhuis Walcheren in Vlissingen.

In Belgium the hospital AZ OLV Ter Linden in Knokke-Heist³⁴ is involved and the hospital AZ Damiaan-Campus-Oostende³⁵ is expected to enter the project soon.

³³ www.tk-online.de

³⁴ Note: AZ Konigin Fabiola in Blankenberge recently merged with AZ OLV Ter Linden in Knokke-Heist.

³⁵ Note: AZ Damiaan-Campus St. Josef – Oostende and AZ Damiaan – Campus H. Hart – Oostende also merged recently. Contracted hospitals can be searched under <http://europa.aok-tk.de>

All these facilities are located on the Northern Sea shore, an area very popular with tourists. The spread of participating hospitals allows for good access for tourists from any place of stay on the coast, as can be seen in Figure 9.1.

The 11 hospitals provide outpatient as well as inpatient care 24 hours a day. AOK and TK are stated as contractual partners at the main portal and the emergency unit of each hospital. Every institution employs German-speaking staff to facilitate communication with German patients. In addition to the services on site, both German sickness funds provide telephone call centres. For the AOK this is called Clarimedis, while the TK's facility is called TK-Auslandsassistance. These call centres seek to help insured people to find an appropriate hospital and assist in all other medical matters, as well as in questions relating to insurance law.

A person insured with the AOK/TK enters one of the contracted hospitals. The receptionist – who would usually ask for an E111 form or a credit card recognizes the AOK/TK insurance card produced by the patient. After requesting permission from the patient, (s)he enters the insurance number and date of birth into an online form on a secure AOK/TK website,³⁶ and learns in a few seconds that the card is legitimate and that claims are valid. Here (s)he can also find general information on this mechanism. Where questions cannot be resolved, the receptionist can access a hotline run by the sickness fund to provide support to patients and hospital staff.

The patient does not have to pay any money to the hospital. The hospital will recover payment for the services provided from the AOK or TK via the Dutch CZ Actief in Gezondheid or the Belgian Christelijke Mutualiteit. This arrangement avoids the formerly cumbersome procedures of Council Regulation (EEC) No. 1408/71. There is a slight difference in the Belgian situation as an additional Belgian authority acts as an intermediary between the Christelijke Mutualiteit and the authority in Germany.

For the hospitals, the only difference between German and domestic patients is the process of checking entitlement of the insurance claim via the Internet. The modalities of settlement remain the same as the Dutch and Belgian tariffs are used and the German patients are treated as if they were insured in the Dutch or Belgian statutory health insurance. From the German sickness funds' point of view, the settlement process is straightforward because their Dutch and Belgium counterparts undertake the checking of the settlement data, so that both AOK and TK are confident that the claim for reimbursement is valid.

³⁶ <https://europa.aok-tk.de>



Figure 9.1 Location of Dutch and Belgian hospitals

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

The basis for contractual relationships between all players and for the delivery of cross-border benefits is Council Regulation (EEC) No. 1408/71, supplemented by national laws. As a first step the AOK and the TK signed cooperation contracts with the CZ Actief in Gezondheid in the Netherlands and the Christelijke Mutualiteit in Belgium, as well as the selected hospitals in these countries. As a second step, those four sickness funds signed contracts with the selected hospitals. This means that each of the ten selected Dutch hospitals has a joint contract with the CZ Actief in Gezondheid, the AOK and the TK. On the other hand the Belgian hospitals have joint contracts with the Christelijke Mutualiteit, the AOK and the TK (Figure 9.2).

The joint contract includes details of the medical benefits to be provided, as well as additional services such as the provision of German-speaking staff, patient information, procedures for checking insurance status, and means of settling accounts.

So far 480 patients (420 AOK and 60 TK) have been treated under this scheme and in most cases it was to the complete satisfaction of all involved. In four TK cases, cash advances were requested, reflecting ignorance among

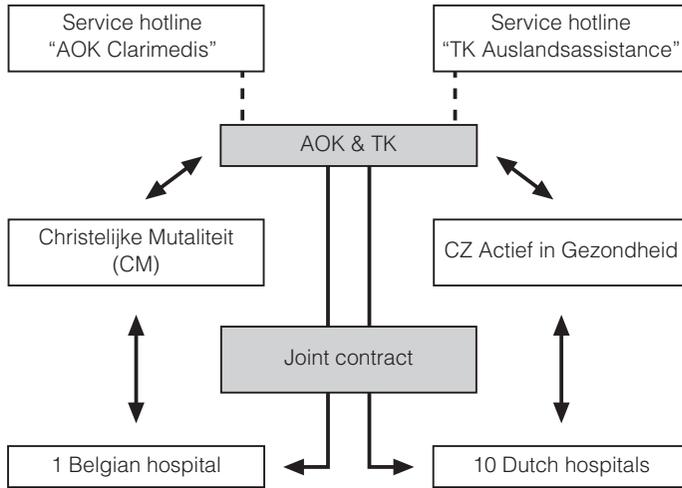


Figure 9.2 *Contracts between Germany, the Netherlands and Belgium*

hospital staff who were not familiar with the new cooperation procedures. Enhanced training should reduce the probability of this happening again.

Evaluation

Two years into the project, both sickness funds have drawn very positive conclusions. They were successful in improving access for their insured people to health facilities in both countries. Once basic procedures were put in place, it became easy to manage the cases, without an excessive administrative burden. It also seems to have delivered a better service to their clients. From the patient’s point of view, having a medical problem while on holiday is likely to be an even worse experience than when at home. The individual seeking care in a foreign country may have to struggle with a foreign language, finding their way through an unfamiliar health care system. The AOK and TK members thus derive real benefits from the enhanced support that they receive: they have access to a special hotline which provides the relevant information on the nearest hospital to their place of stay. The knowledge that a contract has been agreed in advance gives patients some reassurance about standards of quality. On arrival at the hospital, they are received in their native language. A further advantage is that there is no need for a cash advance, nor are there adverse consequences for those who forget their E111. Anecdotal evidence suggests that patients consider the services they receive in the contracted hospitals in the Netherlands or in Belgium as being similar to those at home. From the health care provider’s point of view, they formerly had two possibilities: accepting the E111 form, which means a long wait for

reimbursement from the interstate authorities, or asking the patients for cash, with the risk that they may not be able or willing to pay. The cooperation with the German sickness funds has thus improved the situation for the providers. The hospitals receive their reimbursement promptly from their usual national purchasers. The use of the corresponding domestic tariffs reduces confusion about the invoices. Checking the claim status via the Internet is easy and not time-consuming. Overall it is a very non-bureaucratic procedure.

So what is the benefit for the Dutch and Belgian sickness funds, that only act as middlemen? The managers from the Christelijke Mutualiteit recognize the opportunity for gaining better knowledge of Belgian hospital practice and services provided for foreigners. A trend can be observed whereby Belgian hospitals seek to increase income by treating increasing numbers of private patients; this is of real concern to the insurance companies. To curtail the rising proportion of private patients, the Christelijke Mutualiteit is keen to ensure that (public) foreign patients are treated on a basis of public regulation (Council Regulation (EEC) No. 1408/71), under their control. Both Belgian and Dutch partners see European integration as an opportunity; they are important drivers of this process and are very concerned that foreign patients should gain a good impression of their health care system.

Case 2: Improving medical care for skiing accidents in Austria

The increase in ski tourism brings with it an increased number of skiing injuries. In order to gain a better insight into the scale of the problem, in 2001 the TK carried out a special survey among its insurees who had received emergency care in Austrian health facilities. The survey concluded that in about 40% of the cases patients had made cash advances, as the E111 form was not accepted, in most cases by private providers (Techniker Krankenkasse, 2001). Even though, in general, patients can later claim for reimbursement of their costs, it is rare for them to recover 100% of the costs, and out-of-pocket payments can easily reach several hundred or even thousand euros, as stipulated in Council Regulation (EEC) No. 574/72 (Figure 9.3).

As Austrian tariffs are lower than German ones there shouldn't be any problems for costs below €1000. Yet experience shows that Austrian hospitals often charge more than their domestic tariffs, and this is particularly true for private health care providers. However, this overcharging was also observed in public health facilities, which explains the high personal contribution to costs. For costs above €1000, reimbursement is based on Austrian tariffs (Figure 9.3). Although in most cases the prices charged are higher than the actual tariffs, the

difference cannot be reimbursed by the TK and has to be assumed by the patient. Skiing injuries can easily require a hospital stay of several days, increasing the cost beyond €1000. The high out-of-pocket advances represent a real problem for patients in both scenarios. Some decide to take private travel insurance, but most expect the TK, as their sickness fund, to solve the problem. This is why the TK began to explore the possibility of cooperating with health facilities in Austria.

Initial attempts were unsuccessful. Private hospitals and clinics located close to the ski slopes in Tyrol are the main providers of emergency care in case of injuries. In order to gain a better understanding of this phenomenon in 2001, the TK began to analyse the provision of health care in Tyrol with the view to identifying suitable hospitals with which to establish contracts. Even though German social laws do not provide for cooperation with foreign health care providers, TK social law experts advised that contracts could be based on the legal cross-border agreements based on Council Regulation (EEC) No. 1408/71. However, the German Federal Insurance Office, the supervisory board for the nationally organized sickness funds in Germany, signalled that it would not permit such cross-border contracting. We can see here that for successful cross-border cooperation, not only is a supportive legal interpretation required, but there must also be political willingness. 2001 was still three years before the regulation amending paragraph 140e of the Social Code Book was introduced, which enabled German sickness funds to sign contracts directly with health care providers in other EU Member States. Thus, at that point in time, the TK had to stop the project, being unable to enter into the type of arrangement that the AOK later made with Dutch and Belgian hospitals, as we saw in the previous example.

On the basis of the new opportunities provided by the German social law (SCB 140e), a new approach was adopted. The TK is now able to sign contracts directly with Austrian hospitals. An essential legal condition is that the hospital is part of the national public health system, which is not the case for many of the private hospitals on the ski slopes. Negotiations have begun with the University Hospital of Innsbruck, the capital of Tyrol. This is a 100-bed hospital whose principal focus is on care for injuries. It has five outpatient clinics and six operating theatres and performs more than 5000 procedures and cares for 42 000 emergency cases each year. In part in reflection of its high activity, the hospital is viewed as offering very high-quality care for injured patients (Blauth and Goldhan, 2003). As a university hospital, it is part of the Austrian public health care system, making it eligible to be a contracting partner. The contract currently being negotiated is based on Austrian tariffs (according to Council Regulations (EEC) No. 1408/71 and (EEC) No. 574/72).

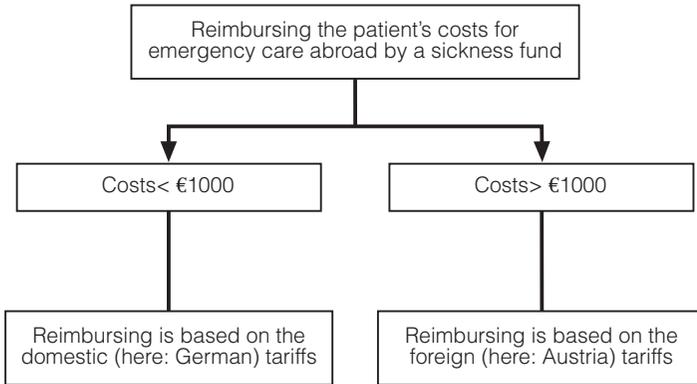


Figure 9.3 Reimbursement and EEC-Regulation No. 574/72

There are several advantages from the patient's point of view. The risk of incurring unexpected costs is reduced. Even if there is still some cost sharing by the patient, it can be quantified at the outset. One major advantage is that patients can be confident that someone else has assessed the quality of the facility, which they would find difficult in an emergency situation. Those accustomed to the German system expect hospitals to be free of charge at the point of use.³⁷ Tourists may not be well informed about the financial consequences of visiting a foreign health care provider, as people on holiday have many concerns other than health insurance on their mind. Furthermore, it is quite difficult to determine whether a health care provider is public or private. By directing the patient to Innsbruck University Hospital, the TK ensures that the patient receives treatment from an approved, high-quality provider, without the fear of paying high co-payments.

The high cost of treatment of skiing injuries has given rise to a situation in which individuals must pay a considerable share of the cost of treatment themselves. These high co-payments often lead to patient complaints and disputes between the insured person and the TK. These are seen as inconsistent with the image it wishes to portray as a modern client and service-oriented company. Reliance on the German social laws that do not allow complete reimbursement in certain cases such as these has created an image of sickness funds as "bureaucratic administration machines", provoking a view that the funds seek to avoid making payments by reference to the "small print". Against this background the amendment to paragraph 140e of the Social Code Book was the long-awaited opportunity to improve access to health care for the

³⁷ A co-payment of €10/day is charged for each day stayed in hospital in Germany, up to a maximum of 28 days per year.

insured. Direct contracts simplify reimbursement procedures, resulting in higher customer satisfaction and lower administration costs for the TK, as the processes become routine and disputes are avoided. Furthermore, the relationship with Innsbruck University Hospital offers the potential for future purchase of care.

At first sight there seem to be disadvantages for Innsbruck University Hospital. As the terms of reimbursement are based on Austrian tariffs, it will not be able to charge higher rates. Yet on the other hand the hospital does not face the risk of non-payment by patients. A second advantage is that the TK effectively advertises the hospital as a benefit for its members, which in turn increases its activity and thus its income. Furthermore, satisfied customers may wish to return for private treatment or the TK might consider purchasing additional care as a direct result of the successful initial collaboration.

Challenges to be overcome

While both the TK and the University Hospital of Innsbruck are willing to cooperate by direct contracting, the Austrian regulatory system poses some problems. As the facility is dependent on the Government of Tyrol,³⁸ the hospital's scope for action is limited. The authority responsible for economic and legal decisions, the *Krankenanstalten* (health services) department of the Tyrol Government, is interested in maintaining the benefits-in-kind assistance according to Council Regulation (EEC) No. 1408/71, where interstate authorities are responsible for reimbursing health care providers.³⁹ There are two reasons for this. Firstly, the government has invested time and effort in establishing procedures to comply with the regulation. Secondly, it fears uncontrolled patient movement from Germany to Austria, with adverse consequences for the Austrian health care system. Thus, the government is not willing to allow direct contracts between Innsbruck University Hospital and the TK fund. The fear of massive demand by German patients seems to be unfounded. Compared to the total annual number of patients treated by the hospital, the potential contribution from the TK is relatively small. At the time of writing negotiations are still in progress.

Case 3: Improving accessibility to the Netherlands in cross-border regions

Incrementally, the AOK-Rheinland has begun to cooperate with several key health sector players across the Dutch border. The long-term objective of this coopera-

³⁸ Austria is subdivided into nine *Bundesländer* (states) and Tyrol is one of them.

³⁹ See Self-portrait, www.tirol.gv.at/themen/gesundheit/krankenanstalten/start.shtml

tion is to break down barriers to cross-border health care and thus obtain economies of scale. To prepare the implementation of projects, the AOK met with representatives from the Euregios Maas-Rhein, Rhein-Waal and, from 2002, with Rhein-Maas-Nord. Together they made an inventory of all medical care available in the Dutch-German border region and assessed people's treatment needs from the perspective of any possible contribution by cross-border care. These activities have resulted in intensive cooperation between the AOK and the Dutch sickness fund CZ Actief in Gezondheid.⁴⁰ Since 1995 there has been a customer service office serving patients from both countries, in Vaals, near the Dutch border with Germany, where bilingual staff support Dutch and German insurees. A survey revealed that intensive exchanges across the border were long established. Both sickness funds have members who live on one side of the border and work on the other side: the so-called cross-border commuter, who is very common in this region where the language barriers are not significant.

This project seeks to provide medical care that is delivered in a timely manner close to home, with the additional objective of reducing waiting times and simplifying administrative procedures. In Germany, where waiting times are nearly nonexistent, proximity to home is the more important issue. Many German patients living in border regions have to drive long distances to see a specialist, while across the Dutch border it is just a few kilometres to the next one. On the other hand Dutch patients face waiting times of several weeks in some medical fields, for example ophthalmology, while in Germany there is enough capacity for treating Dutch patients. Cooperation between the AOK and the CZ Actief in Gezondheid thus tries to compensate for the respective disadvantages, by cooperating in health care provision.

Cross-border contracts include the following benefits: treatment by specialists, pharmaceuticals, medical devices (permission needed) and inpatient care. The project started in July 2000 and will run to the end of 2005. On both sides of the border general practitioners, specialists, hospitals and pharmacies are involved. In Germany, general practitioners, specialists and pharmacies participate through their corresponding associations. To simplify the procedures for applying for cross-border benefits and for settling reimbursements, a special health insurance card, the *GesundheitsCard international* was introduced.

People living in one of the three Euregios, Maas-Rhein, Rhein-Waal or Rhein-Maas-Nord, can apply for the *GCi* at the customer service office of the AOK (the first two Euregios) and the Dutch sickness fund (the last one)⁴¹, and they

⁴⁰ Both sickness funds have the highest market share in their corresponding region.

⁴¹ This project is not supported by the Interreg/Euregio project of the EU. It only applies to the same region.

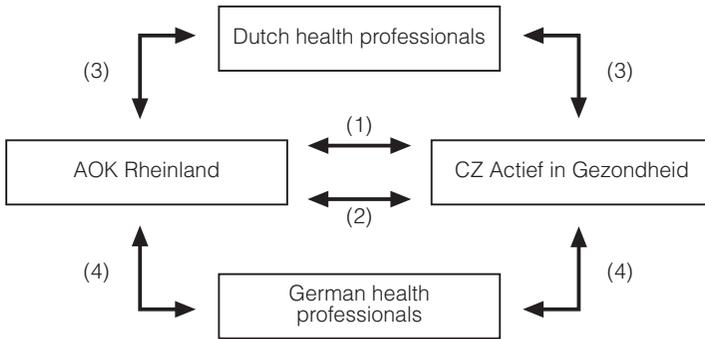
can expect to receive their card by post within a few days. The *GCI* provides the following benefits:

- universal treatment by specialists, including diagnostics (e.g. laboratory, X-ray performances, ultrasonic) and therapy;
- provision of drugs: to achieve a high level of transparency with Dutch and German supplies of pharmaceuticals, doctors are encouraged to prescribe the chemical name, as the product name may differ from one country to another;
- required inpatient care in relation to specialist treatment.

For other cross-border benefits, prior authorization must be requested. This includes procedures such as cardiac surgery or the use of large medical equipment as well as medical devices (for example prostheses, wheelchairs, physical therapy) and provision of oral and maxillofacial surgery and plastic surgery. In these cases each sickness fund makes decisions for their own insured on a case-by-case basis. Not covered by the *GCI* card, and therefore only accessible in the respective home country, are some aspects of dentistry, such as dental prostheses or orthodontic treatment.

Before the *GCI* project was implemented, German patients required an E112 form to obtain health care in the Netherlands as a non-cash benefit. Because of the short duration of the form's validity, people had to visit their sickness fund's customer service office at least quarterly and sometimes even more frequently. Even the referral obtained from their general practitioners had a very short period of validity. Thus, access to specialists on the Dutch side involved a lot of time and effort. Now everything is easier. Once it is obtained, the *GCI* card is valid for as long as the project is running (initially until the end of 2005). There is no longer any need for an E112 form. On the other hand, doctors are now able to make referrals that have a one-year validity. In summary, one phone call to the sickness fund and one visit to the general practitioner once a year are all that are necessary in order to see a specialist on the other side of the border.

As we have already seen in Case 1, using the E112 form also creates disadvantages for the health care providers on the Dutch side, as reimbursement from the interstate authorities takes a very long time. As we will see in the next section, contracts between the AOK and the CZ Actief in Gezondheid take the form of direct settlements, without involving the interstate authorities. Dutch health care providers send invoices to the Dutch sickness fund, which in turn reimburses them. Thus, treating a German patient is financially equivalent to treating a Dutch one. The insurance claim can easily be checked by showing the *GCI* card. The same is happening on the German side. German health care



(1) General agreement between the AOK Rheinland and the CZ Actief in Gezondheid on cross-border cooperation independent from the GCi-project (since the mid-1990s).

(2) Special agreement for implementing the GCi, including direct settlement between both sickness funds and paying the health professionals for treating each others' insured people, as well as determining the benefits package, measures of data protection, liability rules and support of errors in treatment.

(3) Agreements with the Dutch health care providers declaring that they treat German patients with the benefits mentioned above and receive their reimbursement from the Dutch sickness fund based on the domestic tariffs.

(4) Agreements with the German health care providers declaring that they treat Dutch patients with the benefits mentioned above and receive their reimbursement from the German sickness fund based on the domestic tariffs.

Figure 9.4 *Contracts in the GCi-project*

providers send their invoices to the AOK and are reimbursed by them. Doctors make claims through the regional association, as is the usual practice in Germany. Again, treating a Dutch patient in Germany is the same as treating a German one. Health care providers involved on both sides are quite happy, as there is no extra effort in treating foreign patients and reimbursements are quick. The *GCi* project consists of four contracts (Figure 9.4).

Evaluation

Before this project was implemented, there were fears that uncontrollable movements in the border region could occur. But such apprehension turned out to be unfounded. On the contrary, the *GCi* card proved to offer added value, making the advantages of European integration tangible for citizens living in the border region. This impression is confirmed by looking at the demand for the *GCi* card. Up to 3800 cards have been sent out to those insured with the AOK, with 18 500 for the insured people of the CZ Actief in Gezondheid. However, the number of treatments is not that important. People often apply for the *GCi* card to ensure access to cross-border treatment “just in case”, and have no concrete plans for treatment. Experience shows so

far that neither the German nor the Dutch health care system has been overstretched. Furthermore, by maintaining the benefits-in-kind principle, which is in use in both health care systems, and avoiding the reimbursement method, no “off-system” elements were introduced into the *GCI* project. The new procedures are improvements for patients and health care providers alike. For its achievements in providing timely and close-to-home care, the *GCI* project won the Janssen-Cilag future prize in 2002.

Case 4: Rehabilitation care in the Czech Republic

Following the aforementioned European survey, 63% of the European population expect advantages from European integration and more than 75% would like to see a free choice between domestic and foreign health care providers in a united Europe. After drugs, rehabilitation is the health service most often mentioned that people would like to receive abroad. In early 2005, the Hanseatische Krankenkasse (HEK) was the first sickness fund that used the possibilities of paragraph 140e of the Social Code Book to meet people’s demand for rehabilitation care in the Czech Republic.

The HEK is a rather small sickness fund insuring 330 000 people from all over Germany. Operating with 25 customer service offices, it counts on just over 600 employees. Its budget totals some 705 million euros. With a current contribution rate of 13.3%, the HEK is an average-sized sickness fund in Germany.

The starting point for the HEK managers began with the number of their insured seeking rehabilitation in the Czech Republic, in places such as Marienbad, a highly regarded location of spas and rehabilitation facilities. To identify appropriate partners, the HEK managers decided to cooperate with a third party, the Deutsches Medizinisches Zentrum (DMZ). The DMZ is a management organization specializing in the field of rehabilitation, and is located in Munich in southern Germany. It runs its own rehabilitation facilities near the Dead Sea in Israel and Jordan. Furthermore, the DMZ organizes health travel, for instance when German patients go to the Dead Sea, or Israeli patients go to German rehabilitation centres. However, the DMZ is also active in the field of cultural and religious exchange. Over the years DMZ has built good links with rehabilitation providers in different countries.⁴² The relationship between the project’s key players is illustrated in Figure 9.5.

Because of its long-standing experience, the DMZ already knew of some good quality health care providers offering rehabilitation treatment in the Czech

⁴² See Self-portrait, www.dmz-klinik.de

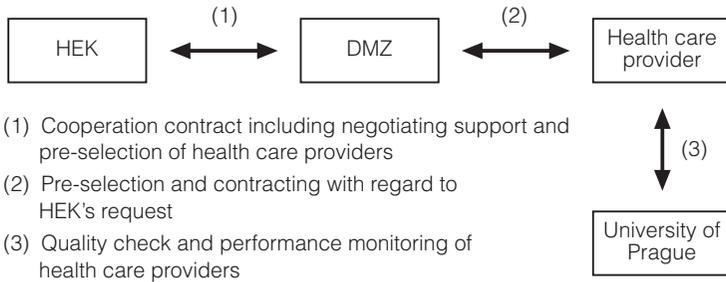


Figure 9.5 Relationships in the HEK case

Republic. Following HEK's request, the DMZ suggested several suppliers. In the end three facilities were chosen. Together they cover a series of conditions, treated on both an inpatient and outpatient care basis: kidney and urinary tract diseases, respiratory and metabolic disorders, gynaecological problems and diseases of the musculoskeletal system. To ensure that quality standards are adhered to, the University of Prague was contracted to evaluate the services' quality and to monitor the performance of the three facilities. The University of Prague is particularly suitable for this task because of its teaching and research experience in the field of balneology.

HEK had two main requirements of the Czech facilities: quality standards comparable with those established in Germany and the absence of any communication difficulties between the medical staff and the patients (Schubert, 2005). According to the DMZ, the selected health care providers do offer the expected quality of care. Many Czech health professionals in the field of rehabilitation have a long track record of receiving and treating German patients on a private basis. Their language skills, as well as those of other staff, are therefore not a problem.

With a good quality standard established, the Czech institutions have the advantage of being able to offer health services at a significantly lower price than in Germany. DMZ managers estimate that they achieve savings in a range of 30% to 40% compared with German providers, an advantage for both the sickness fund and the insured. Two different procedures for reimbursement of health care providers exist. For inpatient treatment, they are reimbursed by the DMZ, who in turn invoice HEK. For outpatient treatment, the health facilities are reimbursed directly by the HEK and in some cases by the DMZ. Patients benefit in particular from contracts for inpatient treatment, as they do not need to make cash advances. Besides, they benefit even with outpatient treatment, as price levels of hotels and restaurants are significantly lower than in Germany – an advantage for the accompanying persons.

The dual principal–agent relationship, with the DMZ as a third party, has several advantages for the HEK. Contracting with health care providers abroad is something that sickness funds have little, if any, experience of. As foreign health markets are quite unfamiliar, a huge effort would be needed to select adequate partners among the health care providers. Moreover, even after signing a contract, the risk remains that the chosen health care institutions would not maintain quality standards. Avoiding high transaction costs and keeping risk to a minimum are good arguments for involving a third party. Furthermore, by reimbursing the Czech health care providers, the DMZ also checks the invoice and supervises the administrative process, one fewer task for the HEK.

There are, however, some disadvantages. Involving another party may make the negotiations more complicated if the opinion of the third partner differs too much from the principal (here the sickness fund). The DMZ administration also generates costs. And DMZ may not cooperate with only one sickness fund. By offering other health insurers the same services, the competitive advantage of the HEK may depreciate, as other health insurers become competitors. However, in this new and somewhat experimental area of activity, the advantages seem to outweigh the disadvantages.

Will this project be successful?

Customer advisers in HEK offices receive a great many enquiries about spas and rehabilitation treatment in health facilities in the Czech Republic. Until now only a small number applied for such treatments and actually travelled to the Czech Republic. Assessing the success of this cross-border contracting remains difficult. Time will tell whether insured people take up this opportunity to a greater extent. The HEK, as with other sickness funds, will face some limits to the extent to which they can access Czech rehabilitation facilities. First, they are limited to referrals for the six specified conditions listed above. Second, the number of people with access to rehabilitation services via their sickness fund is limited. Most of those with entitlement are retired and it is not clear how many like the idea of travelling to a foreign country for rehabilitation, whatever its potential advantages.

Conclusions

We have seen how, in all four cases of cross-border contracting, the initiative came from a single sickness fund. This is novel in the context of the cooperative

⁴³ Very few exceptions exist where the single sickness funds are allowed to sign selected contracts on their own.

German social health insurance system. Contracting with health care providers within Germany is usually the responsibility of the sickness fund associations.⁴³ The forms of cross-border contracting adopted by German sickness funds have had different consequences for German health providers. Projects aiming to improve accessibility to health care providers during a temporary stay abroad (for instance, holidays) (see Cases 1 and 2) do not affect domestic health care providers. As patients visit foreign health care providers, in cases of unforeseen illness, they have no choice between a domestic or foreign supplier. In Case 3 where people travel abroad with the sole objective of visiting a foreign health care provider, the impact on German suppliers is rather small. Some will lose a few patients, but the numbers are not large. The Dutch specialists are located much closer to the patients' home than the German ones. On the other hand, German health care providers also receive patients from the Netherlands, so that from the health care system's point of view there is some compensation. A different picture can be observed in Case 4. Providers of rehabilitation are concentrated in certain regions with special climatic characteristics. Therefore, even within Germany, patients often have to travel longer distances to reach a spa, making the issue of geographical proximity irrelevant. Thus, Czech suppliers have become true competitors with the German health facilities. As patients are offered free choice of supplier, cross-border contracting may stimulate intensive competition among domestic and foreign health care providers, depending on how many will use the foreign health facilities. Even though there are some reservations about the likely uptake of this opportunity by German patients, German rehabilitation care suppliers already see themselves in tough competition with Czech suppliers (*ÄrzteZeitung*, 2005). Several other sickness funds have already taken up the opportunity to sign rehabilitation contracts with Czech facilities.

Case 2 showed that it is not enough to merely change domestic laws, to give sickness funds the opportunity to contract across borders. It is also necessary for foreign health care providers to be allowed to sign cross-border contracts. In the Austrian case, the local government of Tyrol had some concerns and did not allow the contract to be signed with the Innsbruck University Hospital.

Cross-border contracting may become a new factor in the competition between sickness funds in Germany. As sickness funds give their insured more choice and easier access to health care providers abroad, domestic providers will be faced with more intensive competition whether they want it or not. Cross-border contracting gives more security to patients who need care abroad. They do not need to look for good quality suppliers by themselves. An advantage of healthy competition is that sickness funds are forced to choose only those health facilities which can guarantee high-quality standards. Thus, patients are

ensured access to good quality health care providers. Furthermore, patients do not have to pay cash and there is no need to worry about liability rules, as sickness funds can include this in the contracts and also offer support in case of medical errors.

More competition between domestic and foreign health care providers could bring benefits for patients. To survive in a competitive market, each health care provider is forced to improve the quality of service to respond to patients' demands. Competition can also exert downward pressure on prices. German health care providers are unlikely to be able to match the price levels in the Czech Republic. They will therefore have to focus on other elements, such as quality and innovative services. The likelihood that this will happen depends on how extensive cross-border contracting becomes. It is an area that is only just beginning in Germany. Specific purchasing of care abroad is not comparable to the situation in the Netherlands, where sickness funds purchase benefits from foreign health care providers to a much larger degree (see Chapter 7). As we saw in this chapter, all four cases of cross-border contracting improve the situation for patients, providing better care, at lower cost and with more choice. It is likely that patients and the insured will increasingly make use of these opportunities. Cross-border contracting thus brings the advantages of European integration closer to the citizen, and this with key players at the grass-root level.

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Chapter 10

Hospital cooperation across French borders

Philippe Harant

Introduction

Border regions account for 15% of European Union territory and 10% of its population. With the disappearance of physical borders in Europe, these regions are now considered more and more as integrated areas where common activities can take place regardless of national differences, with populations often enjoying close historical and cultural links.

France, in the middle of Europe, with an extended border along very different countries, has a long history of cross-border cooperation in very diverse areas, such as in economic development (for example, reconversion of industrial and mining landscapes on the Belgian border), transport (a train station on the French-Swiss border), environment (water purification and waste treatment facilities on the Belgian and German borders), tourism (cross-border tourist zones and cycle paths, common web sites, guidebooks and maps), public procurement and health care. The diversity of the countries sharing France's border – Spain, Italy, Switzerland, Germany, Luxembourg and Belgium – makes the experience very interesting. Only the United Kingdom – most probably because the Channel acts as a natural border – has seen very little cooperation to date.

Health care is a distinct field, as according to the European Treaty it remains a matter of strict national competence. However, many factors make health an area of major interest as far as cross-border cooperation activities are concerned:

- health is an area in which cooperation can directly help to respond to the population's day-to-day needs;

- in the context of containment of health care costs, in most European countries, cooperation can help to optimize health care supply and so reduce costs;
- an adequate geographic distribution of health care resources as well as reasonable access times are critical in ensuring a high level of care. In that context, cross-border cooperation can alleviate a relative lack of resources;
- hospitals generally enjoy a certain degree of autonomy, allowing cooperation to be initiated at local level;
- decisions of the European Court of Justice, regarding patient mobility⁴⁴ have helped to legitimize patient mobility across national borders, although it remains restrictive in terms of hospital care.

Hospital cooperation has been an important area of cross-border working, as French hospitals enjoy a certain degree of autonomy, allowing them to take the lead in developing areas of cooperation. Direct contacts between providers and patients and very tangible results have also identified it as a preferred area for regional policy-makers to address. Many of the initiatives are started by local policy-makers and health sector executives in border settings, with the idea that some populations' needs are best met by cooperation across the borders. But this cross-border cooperation received only limited exposure and attracted little awareness by national authorities and hospital associations.

French hospitals are able to develop international cooperation on the basis of the Hospital Act of 1991, now part of the Public Health Code,⁴⁵ which specifies that hospitals can participate in international cooperation initiatives with public or private partners as long as they respect national and international commitments. The agreements are signed by the director of the hospital, after validation by the board of administrators.

In April 1997, the French authorities created the "Mission Opérationnelle Transfrontalière" (MOT) (cross-border operational task force), an interdepartmental public body led by the national delegation for territorial planning and regional development (DATAR), in association with a selected group of pilot sites. The objective of the MOT is to facilitate the implementation of key cross-border projects that have been initiated by the state or local government to link the territories of different countries. The MOT brings together local governments, economic and social players and institutions in an effort to link cross-border partners systematically. The aim is to build up and strengthen, where they exist, cross-border structures with players of two or

⁴⁴ ECJ 28 April 1998 Kholi & Decker (158-96 et 120-95); ECJ 12 July 2001 Smits & Peerboom (C-157/99); ECJ 13 May 2003 Müller Fauré (C-385/99).

⁴⁵ Art L-6134-1 Code de la santé publique.

three nationalities working on the same project.⁴⁶ The task force is chaired by politicians and members of parliament, who are able to raise issues at the national decision-making level.

The MOT has played a crucial role in supporting projects, providing legal expertise and conducting mapping exercises, so creating a favourable basis for cross-border activity and networking.

In the field of health, two mapping exercises have been conducted that have helped to provide an overview of the situation on the French borders. In 1999, a study conducted (and published by the MOT in 2001) shows interesting examples of hospital cooperation in France (Bassi and Denert, 2001). The survey has been updated, extended, and integrated into a Europe-wide study conducted by HOPE⁴⁷ on hospital cooperation in border regions (Harant, Hastert and Scheres, 2003). Very recently the MOT published an update on projects that provides a good overview of the state of French cross-border hospital cooperation (Denert, 2005).

Examples of cooperation

Four specific initiatives, representative of major or particularly innovative projects, illustrate the benefits of cross-border cooperation and the lessons to be learned. We then look at a set of tools France has developed recently to facilitate cooperation, and, finally, at trends and perspectives, before drawing some general conclusions.

The Thierache “free zone” of care

Thierache is a region located across the French-Belgian border, covering an area of about 2800 km² and with almost 150 000 inhabitants (100 000 on the French side and 46 000 on the Belgian side). Health care institutions are scattered, with what little infrastructure and poor equipment there is inadequately linked by poor transportation systems, a state of affairs that has earned the region the description of “hospital desert”. On the other hand, the region is a “melting pot frontier”, with few geographical obstacles, strong cultural links, and where the physical frontier is gradually disappearing.

Health cooperation started in the mid-1990s, based on the idea of an integrated network between relatively small hospitals, with the aim of complementing each other’s activities. Eight hospitals take part in the cooperation (Avesnes, Liessies, Fourmies, Hirson, Nouvions, Vergins, Wignehies on the French side,

⁴⁶ More information on: www.espaces-transfrontaliers.org

⁴⁷ HOPE – Standing Committee of the Hospitals of the European Union, www.hope.be

and Chimay on the Belgian side). To develop this network, a legal instrument was established in 1996, leading to the creation of a joint association (EEIG).⁴⁸ Its objective was to identify common needs and promote joint projects and complementary initiatives, to develop formal agreements and to act with a single voice.

The instrument has allowed the creation of practical initiatives: joint emergency departments (ambulances and rescue teams); an image transmission network/image bank for teleradiology and neurosurgery, allowing for joint diagnostic and expertise sharing; equipment sharing (scanners, dialysis, echo doppler); and the exchange of professionals and collaboration in other areas such as cardiology, surgery, endocrinology, nuclear medicine, vascular surgery, paediatrics, gynaecology, etc. It included the referral of patients and the sharing of medical duties in several disciplines by professionals from both sides of the border. Many of these initiatives have been supported by different Interreg programmes.⁴⁹

This practical cooperation has been complemented by the introduction of a financial tool. The “Transcard” project extends the coverage of the French and Belgian sickness insurance funds in the Thierache zone to either side of the border, thus allowing patients to use facilities available on both sides of it. The project is coordinated by the EEIG Sesame Vitale in France and the Alliance Nationale des Mutualités Chrétiennes in Belgium.

After an initial study in 1998, financed by the European Commission, an experiment was launched in 2000 establishing a concrete “free zone of care”. By means of the mutual recognition of health insurance cards, access to hospitals was made easier for patients from the whole region. Thanks to the interoperability of information systems, French patients can use their social security card (Carte Vitale) and Belgian patients can use their card (SIS) to receive care in the other country without the need for prior authorization. This reduces the administrative burden for patients, who are covered by their national sickness fund as they are in their own system.

The aims of the cross-border area in Thierache are to:

- optimize the use of existing equipment and medical teams, as well as activities already in place;
- facilitate access and a high level of care for patients;
- improve the quality of care;

⁴⁸ European Economic Interest Grouping (European Regulation No. 2137/85 of 25 July 1985)

⁴⁹ Interreg – the Community initiative aiming to stimulate interregional cooperation in the EU: connecting Europe’s regions, www.europa.eu.int/comm/regional_policy/interreg3/index_en.htm

- further specialize existing units in complementary fields;
- strengthen cooperation between medical teams.

Two evaluations⁵⁰ were conducted in 2002 and 2003. Both note a difference in the use of health care facilities across the border. French patients account for about 88% of total individual movements under the Transcard regime.⁵¹ Paradoxically, Belgian patients spend much more money when going to France than the French do when coming to Belgium (an average of €1950 versus €150). This seems to be because French patients use mostly ambulatory care, while Belgian patients cross the border for hospitalization. This imbalance would seem to demonstrate real complementarity.

There is room for improvement. In France, the agreement has been signed by the general national sickness fund (*sécurité sociale*), so that only patients included within it are covered by Transcard. Patients affiliated to the Mutualité Agricole, the farmers' scheme, who are a much larger part of the population in this mostly rural area, are not yet covered. An extension of Transcard to other schemes is under review. Another problem is that under the "universal sickness coverage fund" (CMU – *couverture maladie universelle*), French patients receive their care free of charge (system of *tiers payant*), but they have to pay in advance when they receive care in Belgium.

Otherwise, however, the cooperation has proved to be a real success. The "free zone of care" can be considered as an integrated health zone, or life zone (*bassin de vie*) as it is termed in French. More activities are planned, including joint recruitment of doctors and joint purchasing of medical equipment through partnership with local authorities. In the longer run, some stakeholders have already envisaged the creation of a "European hospital of Thierache" (Colson, 2002). In July 2004, a geographical extension of the Transcard agreement both to the east, in the Ardennes region (Dinant-Bouillon in Belgium/Charleville Mezières-Sedan in France) and to the west, the area of Lille-Tourcoing, has been proposed. The extension would allow the coverage of nearly the entire French-Belgian border, corresponding to a population of 250 000 inhabitants.

Towards the first cross-border hospital in Cerdania

An interesting initiative has been established on France's southern border. Cerdania, with a population of 28 000 (14 000 in the French Cerdagne and another 14 000 in the Catalan Cerdanya, Spain), is an isolated region of 794

⁵⁰ Annual evaluation, Transcard, CPAM de Maubeuge/St Quentin.

⁵¹ 525 French patients in 2002; 608 in 2003 versus 70 Belgian patients in 2002 and 89 in 2003.

km², surrounded by the Pyrenees. Sinuous roads, impassable during winter, link the plateau to the cities of Perpignan (100 km) and further south, the Catalan capital Barcelona (140 km). Even though the “Pyrenees Treaty” artificially divided the territory in 1659 and created the national border that remains to this day, the two communities are historically, socially and culturally very close. They share a common language, Catalan, and are both important tourist attractions with a massive influx in both summer and winter: the population of Cerdania, which has a series of excellent ski resorts, can reach 130 000 in winter.

On the Spanish side, the hospital of Puigcerda,⁵² 1 km from the border, has 30 acute hospital beds for medicine, surgery and obstetrics as well as relevant facilities (radiology, scanner, laboratories, etc.). The hospital is under private management, by a group which also manages a further nine hospitals, eight primary care facilities and 10 socio-sanitary centres in Catalonia (1600 beds, with a total staff of 4000).

On the French side there are general practitioners, specialists and the Perpignan-based emergency service, and some convalescence and rehabilitation facilities, but from the mountain plateau access to hospitals with surgery and obstetric care is difficult and slow. The nearest surgery is an hour’s drive away in Prades, while for maternity care, women have to travel as far as the regional capital, Perpignan, which is a two-hour drive away.

These difficulties in ensuring adequate coverage have led the French authorities, namely the regional hospital agency, to develop initiatives with the hospital in Puigcerda, with the objective of improving their population’s care. Several initiatives have been launched (Bonnier and Morlon, 2003; Tobar and Mas Morillas, 2002).

Cooperation started in the 1990s in a somewhat informal manner. From 1987 to 2002, the number of French patients visiting Puigcerda hospital increased by 84% (from 68 to 190 per year). The hospital of Puigcerda took care of French patients suffering from emergency conditions even though it had no certainty of being reimbursed. Indeed half the cases remained unpaid. Nevertheless, in most emergency cases the mobile unit from the Perpignan hospital was called, and in 2001, French general practitioners received special training in stabilizing patients in order to bridge the gap until the unit arrived.

In 2002, a first agreement was signed between the hospitals of Perpignan and Puigcerda and the French Regional Hospital Authority (ARH – Agence Régionale d’Hospitalisation). It was followed, in 2003, by a second agreement

⁵² www.hospitalpuigcerda.com

between the French and Spanish social security funds, with the objective of covering patients suffering from medical emergencies who are taken to Puigcerda hospital by the emergency services, with coordination from the unit in the Perpignan hospital. The agreement foresaw the payment of €138 000 to the hospital in Perpignan as payment for emergency care French patients would receive in Puigcerda. This had the great advantage that patients no longer have to pay their health care expenses directly. These agreements improved the services significantly and had the side-effect of supporting the development of increased cooperation between professionals (training, follow-up care, etc.).

Finally, in 2003, a study was launched, supported by Interreg III, with the aim of assessing the feasibility of a cross-border hospital, i.e. a French and Spanish partnership. On 11 January 2003, a cooperation project was signed by the presidents of the Catalan Government and of the Languedoc-Roussillon region. The project was to create a new common health care organization for the entire territory. The new hospital would employ staff from both sides, the first ever hospital to be planned, managed and funded jointly by two countries.

Based on the feasibility study, which determined population needs, it was decided that the future hospital should have 50 acute care beds, advanced technologies and supporting services: surgical blocks, radiology, laboratories, ICU beds, and telemedicine facilities. It should take care of emergencies, short stays, primary care, long-term and home care. The hospital would be able to perform diagnostic activities (scanning) and planned surgery as well as treatments for chronic disorders (chemotherapy, dialysis). Emergency services should work with the different agencies on either side of the border so that they are well organized, coordinated and regulated. Referral hospitals are in Montpellier, Perpignan and Toulouse on one side, and Manresa and Barcelona on the other. For decisions on where to refer, medical indications would be important criteria, alongside proximity and country of origin. The new hospital should also be integrated into and networked with local community care.

The Hospital Comun Transfrontèrè de la Cerdanya (public cross-border hospital of Cerdania) will be located in Puigcerda (Spain), the point of highest population density in the area. The total investment cost was estimated to be €25 million. Authorities on both sides of the border showed willingness to assume part of the costs, and an application for European funds was made to cover some of them.

The operational plan subsequently drawn up foresaw three areas of work:

- institutional and legal issues: elaboration of the legal basis for cooperation, integration into national planning schemes, information and communication directed towards professionals and the population;
- professional issues: training, professional rules to be applied, quality issues, clinical management;
- organizational issues: control and supervision by authorities, management, organization of patient care and structures.

Studies on these issues had been ongoing since October 2004. A first report on the legal framework and the financial implications at national, regional, and European level was presented in November 2004. An official ministerial declaration of intent was signed in October 2005.

A series of technical and organizational issues still need to be clarified, such as:

- the orientation and follow-up care of patients and their medical records (illnesses treated – defined according to PMSI (France) and DRGs (Spain));
- the organization, general and medical management (definition of constitutional matters, the status and functions of the boards);
- the organization of care;
- the financing of care and coverage of patients (global budget for the Spanish side and activity-based tariffs for the French side).

A draft architectural project is planned for 2006, and construction should start by the end of that year. In the meantime, a series of issues have been clarified. The legal status of the institution will be the one of a *consorcio* under Spanish law.⁵³ Partners in this association are the regional hospital agency, the regional sickness insurance funds (CRAM and CPAM), the region of Languedoc Roussillon, the county of the Pyrénées Orientales, the Consorci Hospitalari of Catalonia and the Generalitat of Catalonia.

Some challenges remain, such as the situation of maternity care in Puigcerda, where newborn babies of French parents are automatically granted dual nationality. The competent authority is the French consulate in Barcelona, some 90 km away. The nearest French municipality, located just a few hundred metres from the border, is not allowed to issue birth certificates for babies born on Spanish territory.

The collaboration gives interesting insights into how two completely different systems can find ways to work together. Some of these differences are laid out in Table 10.1.

⁵³ Consorcio = association, consortium.

Table 10.1

Issues	Catalan side	French side
System differences	Universality of Health Care, provision of service in kind	Good access, but upfront out-of-pocket payment by the patient, who is then reimbursed by the fund
	Inhabitants/patients are assigned to a referring GP	Patients have free choice of physician, although they should see their attending physician for full reimbursement (gatekeeper)
	Team work with a unique medical record (guarantees continuity)	Patients might have different records with different physicians
	Health professionals (physicians) contracted by a single organization, fixed retribution independent of the level of activity	Health professionals (physicians) as a liberal profession, income depending directly on the activity
	Fixed referral modalities	Doctor's implication in orientating/channelling patients to different hospitals/specialists
Cerdania care arrangements	Larger territorial distribution with centre of primary care	Centralized acute patient hospitals with low territorial distribution
Emergency care in Cerdania	Existence of hospital emergency service (at Hospital de Puigcerda), less developed pre-hospital emergency system	Structure and network of pre-hospital emergencies (general practice network, mountain doctors, etc.) – more sophisticated primary and secondary transport system

At this stage, many questions remain: issues of governance, the legal basis of the cooperation, quality of care and rights of patients, planning and funding schemes. What law will govern labour disputes and professional liability? How will the whole-time professional contracts in Spain be combined with those of part-time French physicians, and the subcontracting of a series of supporting services? How can the national planning schemes, such as the regional health organization⁵⁴ on the French side, and the Catalan Health Plan on the other, be granted equal respect? How can one project be created, with strong leadership, when it will operate in three languages – French, Catalan and Spanish? All documents are to be in the three languages. How will it ensure the training

⁵⁴ SROS – Schémas Régionaux d'Organisation Sanitaire.

of professionals, to create a culture of cooperation with the two different networks, systems of teamwork and registration, and how will it make optimal use of new technologies and best practices from both sides?

Studies are still under way. After the official signature of the agreement of intent by the ministers in October 2005, working groups were established and experts asked to propose how to go about the unresolved issues to bring about full implementation of the project. Considerable work still has to be done in this area.

Briançon: the Olympic Games as a catalyst for health care cooperation between France and Italy

At first sight, the French-Italian border does not seem to be an ideal place for cross-border cooperation, as the Alps are a significant geographical hurdle. Yet there have always been numerous transalpine roads and railways allowing for movement of people, goods and commodities. Tourist developments, particularly winter sports, have led to the creation of shared territories across the border. These zones include cities and some very urbanized sites. But the mountains are still a significant barrier in the management of critical situations, such as medical emergencies resulting from road crashes, ski injuries and avalanches.

Despite radical differences in the organization of and access to health care services on the French and Italian sides, common initiatives have been launched. Although considered experimental, some cross-border areas are integrated zones in which health care facilities and services are complementary. Since 2000, cooperation projects have been actively developed along the border, such as those between the sanitary agency of Imperia (Italy) and the hospital of Menton (France) on the Cote d'Azur, the setting up of networks for oncology, emergencies and medical treatment between Nice (France) and Cuneo (Italy), or the cooperation initiated in the field of emergency between hospitals in Sallanches (France) and the Aosta valley (Italy).

To facilitate cooperation, a study (MUTIF – Medicina d'Urgenza Transfrontaliera Italia–Francia) was launched by the French and Italian partners with the aim of assessing the critical points of cooperation in the field of emergency care, in order to propose some solutions. Areas of work include administrative procedures, organization of services, communication tools, human resources, and quality and cost issues.

This cooperation has been intensified in the run-up to the 2006 Winter Olympic Games in Turin. Competition facilities were spread over various ski resorts in the region and the Italian authorities have needed to establish a

network of health care and emergency facilities corresponding to the requirements of such an important international event.

Because of its proximity, 25 minutes from Turin and 15 minutes from the main Olympic locations, the 175-bed Briançon hospital has been the only one on the French side to be included in the medical coverage for the Games by the Turin organizing committee (TOROC), together with a mobile emergency unit team.

Previously it had been very difficult for the hospital to obtain additional resources for maintenance and modernization from the French authorities, but the partnership with the Games suddenly meant the allocation of an additional €20 million by the French Regional Hospital Authority, for extending the building and to construct a helicopter landing pad in accordance with international standards, to be fully functional for the Winter Games. It is hoped that, after a successful collaboration during the Games, strong links will be the basis for more long-term French-Italian cooperation, particularly for emergencies, a demand likely to increase with the strong tourist presence in the area, both in winter and summer.

A network of excellence: the university hospitals of Strasbourg, Luxembourg and Liege

An interesting three-country cross-border cooperation is taking place in the north-eastern corner of France: a network of centres of excellence has been created between the university hospitals of Strasbourg (France), Luxembourg (Luxembourg) and Liege (Belgium). The collaboration is different from the earlier examples in so far as it is more transnational and does not directly cross neighbouring borders. It involves university hospitals with advanced technologies in more urban settings. Luxembourg is two hours by car from Strasbourg, and Liege four. The three hospitals, with a total of 14 500 employees serve a combined area of 27 710 km² with a total of 5.5 million inhabitants. Their collaboration was primarily driven by the common language, French, excluding hospitals in neighbouring Germany in these early stages. This will allow a better understanding of concepts and will avoid misunderstandings from the start, as a common language makes cooperation easier when dealing with complex issues, such as the comparison of regulations, the setting up of common patient records, or training activities.

The initial idea was that new information and medical technologies are better promoted, implemented and learned where there is a shared experience in dealing with them, and that quality of care will increase when professionals have an opportunity to exchange their experiences. In January 2003, the three

university hospitals signed an agreement to develop a network of excellence, supported over the next five years by European Interreg III funds, representing half of the total budget of €3 million to cover a total of six areas. The fact that European regional development funds subsidize hospital projects illustrates how the European Commission believes that hospitals can play a major role in regional development and national planning, as much as roads and other infrastructures. The three regions each assume responsibility for a proportion of the financing.

Medical, human, technological, scientific and intellectual capacities, as well as know-how, will be pooled; networking will produce economies of scale and avoid duplication. Besides general cooperation and use of information technologies and a shared information technology network, a focus is placed on human resources and continuous training (exchange of information, development of guidelines for quality in operating theatres and training for senior nurses). The initiative will allow professionals to extend their knowledge and competencies. Areas of cooperation have been defined around different diseases, whereby the use of information technologies and networking experience can be exchanged in innovations of technologies and treatment:

- liver transplants (developing an IT network between the three hospitals with common patient records, with the view to developing joint diagnosis and identifying the best available treatment in the network; student exchange, information for the public, staff meetings);
- cell therapy, haematology and oncology (centre of excellence in the field of oncology, exchange of cell products, care networking, exchanges, remote consultation of medical records);
- new methods of care for patients with schizophrenia and Alzheimer's disease (centre of excellence involving research laboratories, sharing of information, mutual audits).

The project is supported by the respective authorities at national, regional and municipal level, backed up by financial contributions, with the object of allowing better care for patients. It is conceived as a pilot project, to be used as a template for future collaborations.

Initial results of the cooperation show real benefits, such as in the field of liver transplants, where work on a joint medical record has been launched, video conference facilities have been installed in each hospital and it seems that the experience-sharing has proved to be beneficial for patients, professionals and students alike. Patients from Luxembourg, who had no access to liver transplants in their own country, can now be treated throughout the network, by institutions in Liege and Strasbourg who have world class performance records and who

are keen to share their experience. Progress was made in most areas, such as the introduction of common electronic patient records. Initial results will be presented at a mid-term meeting in Strasbourg in September 2005.

Once stabilized, the network will open up to other partners, for example university hospitals in other countries, and to other areas (the Liege burns unit is a promising candidate). Opening up to other neighbouring countries, such as Germany, the Netherlands and Switzerland, will be a challenge in terms of languages and different cultural approaches.

Development of tools aimed at making cooperation easier

The extensive and diverse experiences of cross-border hospital cooperation on French borders provide a wealth of knowledge on the various challenges and how they can be overcome. At a national level, tools are developed, such as bilateral agreements, cross-border structures and planning instruments.

Bilateral agreements

One of the first conventions to be signed between neighbouring countries was the health convention of 12 January 1881, between Belgium and France, revised on 25 October 1910, which “authorized Belgian doctors of medicine, surgery and childbirth established in the Belgian districts bordering France to practise their art in the same way and to the same extent in any neighbouring French district, in which there is no doctor residing” and vice versa (Coheur, 2001). In 1956, another agreement allowed French women in childbirth in the commune of Halluin to give birth in the Belgian maternity hospital of Menin (Lewalle, 2003). Despite the existence of the European Union, bilateral agreements are still very useful, or even necessary, in order to remove obstacles of national competence in health care. Indeed, in practice, partnerships always require derogation of the principle of territoriality of service, which otherwise limits use of infrastructures outside national borders.

The development of cooperation across French borders over recent years has encountered a set of difficulties. Usually cooperation has been the result of bottom-up processes, led by a group of enthusiastic people who then encountered problems arising from differences in national organizations or from administrative barriers which were difficult to resolve. With a better knowledge of and exposure to ongoing cooperation, and a greater awareness on behalf of policy-makers, it was clear that only the involvement of authorities at national level could help to resolve some of these difficulties.

Bilateral agreements emerged as one of the main tools for removing hurdles of national legislation. In the same way that international treaties are signed by governments and ratified by national parliaments, these agreements are the only instruments that allow national laws to be circumvented. Two initial agreements were signed in 2005 by France and Belgium and Germany on areas of intense cross-border activity between hospitals. Negotiations have started with Spain and Italy to try to reach similar agreements. In some cases, according to national organizations and bodies responsible for hospital care, bilateral agreements might need to be discussed with partners of different levels. In the case of the French-German agreement, for example, the German *Länder* concerned took part to the discussions, although the signature was done country to country.

With physical borders increasingly disappearing all over Europe, these agreements recognize that the border areas are valuable for the development of cooperation between Member States.⁵⁵ Main objectives include a better response to population needs, concrete benefits for citizens, allowing access to a high level of care close to home and a swift return home, a key factor for those with chronic diseases in particular.

Concrete objectives of the agreement already signed are:

- ensuring better access to a high level of care for populations in border areas;
- guaranteeing continuity of care;
- optimizing the organization of care provision by promoting the sharing of capacities, equipment and human resources;
- fostering a sharing of knowledge and practices.

One of the main challenges the agreement tries to address relates to national planning, mobility of health professionals, quality and safety of care, and funding. The agreements are geographically limited to explicit areas, on both sides of the border.

On the basis of this bilateral treaty, specific agreements are to be signed by hospitals and health authorities at local level, in order to define the means of implementation. Practical arrangements at local level respond to patients' needs and must include patient transportation, facilitation of physical access across the border, continuity of care (information for patients, patient records, admission rules, etc.), evaluation and control of the quality and safety of care, and financial resources for developing cooperation.

One area in need of clarification is the derogation of the status of health professionals. The issue is particularly crucial, as according to French law (where

⁵⁵ French Belgian border agreement, April 2005.

only a treaty could create an exception), hospital doctors are not allowed to practise in another country. Based on bilateral agreements, doctors will be allowed, when necessary, to depart from the rigid rules of professional regulation, authorizing temporary practice on the other national territory, while still being covered by the French hospital system.

With regard to funding of patient care, the bilateral agreements follow European rules and state that authorization for care in another country should automatically be granted by the relevant social security institutions, while specific tariffs should be established as appropriate. Finally, the agreements help to clarify the rules concerning liability issues and provides a degree of legal certainty for patients and professionals, stipulating the law applicable in case of liability to be the one of the country where the medical act is carried out. The agreements oblige health professionals and health care institutions to have insurance coverage.

Towards more integrated planning of cross-border health activities

Striving for greater efficiency in health care has led many countries in Europe to limit their health care costs. Here cross-border cooperation can bring real benefits to individual countries and their health care systems by generating economies of scale, avoiding duplication, and allowing the sharing of resources. However, national systems are generally governed by rules of planning designed to allow access by all citizens to a high level of health care services in whatever territory they are located. By definition, planning exercises stop at the frontier of the territory and ignore health care facilities and equipment located just across the border that could potentially bring some benefit. This generates costly duplications. It is still too premature at this stage to envisage joint planning exercises, the systems being too diverse, as are structures, installation and rules, such as the certificate of need required before scanners can be purchased in France.

Although concrete joint planning exercises in border regions with the neighbouring country is far from becoming a reality, little by little French authorities have started to include cross-border activities in the scope of assessment in national planning exercises. According to the director of the Regional Hospital Authority of Nord-Pas de Calais, in charge of planning health care provision, at this stage cross-border initiatives are more “like a collection of cooperations between hospitals, patiently designed, addressing local needs, rather than a comprehensive policy” (Paulot, 2003). This is due to the fact that previous legal planning instruments did not, until now, take provision of care located across the border into account.

The French instrument for planning health care facilities and equipment is the SROS, the regional care organization scheme.⁵⁶ In its newest version, SROS III foresees that the planners, the regional hospital authorities, take health care services provided across the border into account. A 2003 law, concerning the simplification of the organization of the health care system, explicitly mentions that “the SROS takes into account the articulation of the resources/means of health care institutions with community medicine and the social and medico-social sector, as well as the supply of care provided in the neighbouring regions and territories along the border” (CSP L.6121-1). These perspectives have already been applied in French regions on the border with Belgium, Germany and Italy.

The idea of considering available health care resources across the border has recently been supported by the French Minister of Health, Mr Xavier Bertrand, who announced that patients living in border regions will be able to register, as their attending physician,⁵⁷ with a doctor from another country of the European Union, under the same conditions as for a French doctor: “If you have to get a scanner or MRI exam, for which waiting time is four or five weeks in France and only a few days across the border, I still prefer to authorize patients to do it in the neighbouring country, as they will be reassured and cared for more rapidly”, the minister said.⁵⁸

Finally, a new French regulation of April 2005⁵⁹ will make free movement of patients across the border easier. Following the decisions of the European Court of Justice, this regulation amends the Public Health Code, by forcing sickness funds to reimburse care received in another Member State. Authorization for hospital care cannot be refused if the care in question is not available in France, or if a similar treatment cannot be provided without undue delay in France, bearing in mind the patient’s condition and the evolution of the disease. Refusal decisions should be justified and a legal appeal is possible. The regulation allows for the signature of agreements between French health insurance bodies and their counterparts in other EU Member States, in order to exempt patients from prior authorization. Such a regulation, not especially aimed at cross-border situations but complying with the European jurisprudence, will play a crucial role in making patient mobility across borders easier, indeed all over French territory, but primarily in border regions.

⁵⁶ SROS – *schéma régional d’organisation sanitaire*.

⁵⁷ By 1 July 2005, the reform of French health insurance obliges citizens to declare the name of their attending physician, who should act as a gatekeeper that they consult before visiting any other physician; otherwise they would not get full reimbursement of health care expenses.

⁵⁸ Interview *La Voix du Nord*, 30 April 2005; AFP press release, 30 April 2005.

⁵⁹ *J.O.* 27 April 2005, http://www.legifrance.gouv.fr/imagesJOE/2005/0427/joe_20050427_0098_0009.pdf

Cross-border health care observatories

Cross-border health care observatories are good tools for contributing to the process of cooperation. The main aim is to improve the health of border populations, by facilitating better access to good quality care and good cross-border cooperation. They improve access of border populations to health care through a more effective matching of needs and available infrastructure on both sides, and a better use of facilities by sharing capacity and achieving economies of scale. On one side they assess the demographic and epidemiologic characteristics of the population in border regions and then the available resources (medical demography, potential shortage of health professionals, or the conditions of practice, etc.) and health care provision (distribution of health care facilities). They help to point out priorities and to study potential complementarities in health care provision, to maintain up-to-date databases and lists of indicators and to play a leading role in projects as an interface with European authorities.

A good example is the Franco-Belgian Health Observatory (OFBS).⁶⁰ This network was launched in 1992, when Belgian mutualities and the French regional sickness funds met in order to resolve problems encountered by citizens in the reimbursement of care. An initial agreement was signed in 1995, and cooperation ran informally until 1999, when OFBS was established on the legal basis of an EEIG.⁶¹ The EEIG is not a substitute for its members, and respects the autonomy and specificities of each partner. As a cooperation tool, decisions are taken unanimously. The OFBS consists of participants and decision-makers in the health sector and provides an impetus for cross-border studies and initiatives.

The OFBS aims to bring better responses to regional needs in terms of health. Priorities are:

- to ensure the follow-up of demand for and provision of health care;
- to foster studies on potential complementarities;
- to serve as an adviser and assessor for local players and policy-makers;
- to coordinate and support projects, providing legal monitoring and assistance;
- to monitor the development of European regulations on health care (Darcy, 2003).

⁶⁰ <http://transfrontalier.netlorconcept.com/ofbs/index.php>

⁶¹ EEIG: European Economic Interest Grouping (European Regulation No. 2137/85 of 25 July 1985). According to the European regulation, an EEIG is aimed at facilitating or developing the activities of its members by the pooling of resources, activities and capabilities.

Today, the OFBS comprises 41 active members: health insurance funds and mutualities as well as local health observatories. Their knowledge of health situations across the border are of great interest for national planning bodies involved in cross-border planning exercises. One example is the Regional Hospital Authority of Nord-Pas de Calais, an associated member of the OFBS. The OFBS is one of a series of cross-border projects, and is an administrative and financial leader of three initiatives funded by the EU (Interreg III).

Other health care observatories worthy of mention include LuxLorSan,⁶² set up in July 2002 on the French-Belgian-Luxembourg border. Another cross-border health care observatory has been planned since 1999 in the Basque country on the Spanish border, but has not yet been implemented. It is striking that the borders with the more dynamic and structured projects, such as the French-Belgian borders, have cross-border health care observatories or institutionalized umbrella structures comparable to the CAWT on the Irish-United Kingdom border, or the Euregio Meuse-Rhine steering committee. In France and Belgium, observatories have played a major role in the setting up of free zones of care, for example, or in the development of cooperation, such as the Mouscron-Tourcoing agreement for the mutual treatment of patients.

Trends and perspectives

Even though most cross-border experiences consist of grass-roots developments, they are not sustainable without some top-down support, particularly concerning the adaptation of national laws and regulations, and functions carried out at national level, such as national planning exercises and the regulation of professional exercise, liability issues, etc. A slight change of perspective can be observed. For many years, cross-border cooperation has almost exclusively been developed by local players, in order to respond to population needs, which in most border regions are very similar. Cooperation has been a “bottom-up process”, which probably explains both the diversity of projects and the areas reviewed, and is a better response to population needs, less likely to be achieved by overly standardized projects.

According to the HOPE study (Harant, Hastert and Scheres, 2003), areas of cooperation range from emergencies, planned care, telemedicine, equipment sharing (*in situ* facilities as well as mobile equipment) to the sharing of services (laboratory exams), research activities and exchange of professionals. The objectives cover not only the treatment of patients, but also a higher level of care, the sharing of experiences and best practice, the reduction of waiting lists, the setting up of centres of reference, and training.

⁶² <http://transfrontalier.netlorconcept.com/luxlorsan/main.htm>

In many cases, projects are dynamic and complex, with multiple themes and partners (hospitals, funding institutions, authorities at local and/or national level). Their size may vary greatly, depending on the aims and the importance of partners. Mapping exercises can therefore only give a snapshot at any given time, which may change considerably, either by new activities being developed, or by some elements of the cooperation coming to an end, as some of the activities are set for a limited period and are not continued.

These “bottom-up processes” have their limitations, however, as many projects have relied heavily on an enthusiastic leader’s personal involvement. Because of their limited institutionalization, there are many examples of initiatives relying on the personal initiatives of individuals (doctors, managers, administrators), which go downhill if not carried on by their successors.

Difficulties crop up at both micro and macro level. At micro level, they concern language differences, remuneration of doctors, availability of professionals, compatibility of medical protocols, continuity of care, medical liability, nosocomial infections, etc. At macro level, they are linked to historical and legal developments of social models, organization and financing of health insurance, legislation in the field of public health, national and European regulations, etc. (Coheur, 2003). While local partners can only try to resolve difficulties at micro level, national governments can have an impact on both micro and macro levels.

Because they have gained greater exposure, cooperation initiatives have in the last few years attracted greater interest from local and national authorities. However, in the French context, for historical, cultural and political reasons, decisions remain very centralized. Regional hospital authorities are in fact an imperfect form of decentralization, as these authorities are not reporting to locally elected communities, but directly to the central government. It is then sometimes difficult, on the French side, to manage cross-border cooperation with the same flexibility as most of France’s neighbouring countries, which are usually more decentralized and where decisions regarding hospital activities are taken at local or regional level. The main problem for the national ministry is to be kept informed by regional authorities, while at the same time decisions taken at national level might have little to do with local needs.

Having national institutions fully involved in projects obviously marks a positive step, as they can bring official support to initiatives and remove some of the obstacles linked to administrative differences between countries. More and more, cross-border cooperation is seen as a tool for making up for national insufficiencies, or for creating economies of scale. Integrating cross-border cooperation within overall planning of care is seen by authorities as a way of avoiding duplication, optimizing the use of scarce resources by sharing facilities

and professionals, and providing better care to citizens in areas where national provision would be inadequate.

The risk might be that cross-border cooperation would only be used as a tool imposed on hospitals. Although such interference could be beneficial in attributing greater legitimacy to cooperation and in institutionalizing it more, it could also undermine one of the main pillars of the success of such operations, namely the personal involvement of the partners. From a voluntary basis, aimed at responding to local needs, cooperation would become a more bureaucratic and standardized instrument that hospitals would be obliged to develop, in order to respond to centralized planning schemes. It is therefore necessary, while lending support, to keep cooperation arrangements as flexible as possible.

As health care is a national competence, the European Union could certainly bring added value by providing a better knowledge of ongoing cooperation and related networks. A networking mechanism in Europe would be useful in order to disseminate best practices and to avoid hospitals at local level having to reinvent the wheel each time, as some of the problems may have already been resolved by others, in different contexts. As an example, feasibility or cost studies, which are always conducted when a new cooperative venture is launched, could be of great benefit if databases and contacts for gathering information on other similar projects were available.

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Chapter 11

Conclusions

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Who, how and where?

As the case studies in this book reveal, mobility of patients across Europe's borders is a somewhat marginal phenomenon as most patients prefer to be treated as near to home as possible, close to their relatives, in a system they are familiar with, and with providers who speak their language, where they know what they can ask for and what they can expect to receive. Going abroad for treatment is almost never the first option, but is rather the result of specific circumstances.

Nevertheless, as the case studies also demonstrate, patient mobility can be an important phenomenon in certain areas and contexts, such as in tourist areas and border regions, and where providers have developed specific strategies to attract foreign patients. Furthermore, while the overall level of activity may be small, it can entail large expenditures for some economic units within health care systems because of the extra costs incurred for transport and accommodation, and the transaction costs involved in ensuring cooperation between providers to facilitate quality and continuity of care. In some settings, therefore, there is a need for enhanced mechanisms to support planning, implementation and monitoring of the process, with actions to ensure transparency and to reduce legal ambiguity.

What are the characteristics of the mobile patient? The case studies have confirmed that the available data are fragmentary and incomplete but they do indicate that elderly people make up a significant element of the patient population, especially in the tourist regions or in areas that are particularly attractive for long-term residents (mainly regions bordering the

Mediterranean). This is a group that is now numerically much more important than in the past and that now commands the necessary financial resources and can avail of new opportunities to travel extensively. They are, however, more likely to need health care, not least because modern health care has enabled many of them to lead normal lives despite the presence of often multiple chronic diseases. This has led to an extension of the formerly narrow interpretation of emergency care for a condition occurring while abroad to include exacerbations of pre-existing diseases. This, coupled with growing awareness of the right to care, is likely to increase the demand for health care by patients from other countries, especially in regions attracting larger numbers of older people. Furthermore, those people who, in the past decade, have chosen to spend their retirement in southern Europe are continuing to age and, when one partner dies, may lack the support that enabled them to remain independent. This can be expected to create a growing need for long-term care facilities, home care and other types of end-of-life care.

The situation is different for those patients who are sent abroad by their health care systems within the framework of an organized programme. This care is usually specialized and the package is very specific and clearly defined. Patients must meet certain conditions such as being fit to travel. As the case studies reveal, patients may be required to bear some of the additional costs associated with obtaining the treatment abroad.

Where patients cross the borders on their own initiative, the picture is much less clear. The type of treatment that these patients obtain abroad is often influenced by the ease with which the service in question can be accessed in their home country. Even when the cost of obtaining care is higher abroad than at home, some patients still prefer to cross the border to obtain care that is perceived to be of better quality or more convenient. Those taking this course seem likely to be younger, better educated, and with higher incomes. Proximity is clearly important, with those living in border areas more likely to go abroad for a wider range of treatments. As the Slovenian example shows, there are particular factors related to price differentials across borders between “old” and “new” Member States, especially where the treatment is not or only partially covered by their domestic benefit package, such as spa treatments, dental care and cosmetic surgery.

In the case studies we identified a wide range of *ways in which cross-border care is organized, managed and funded*. In tourist areas, procedures based on Council Regulation (EEC) No. 1408/71 are common, with patients using E111 and E121 forms and, more recently, the new European Health Insurance Card. However, it is apparent that, in reality, these procedures do not always work as efficiently as they should, both for patients and care providers.

In some cases providers do not accept the forms and demand the patient should pay out of pocket, as was reported in the Netherlands in the German case study. Spanish health care providers obtain no tangible benefit from completing the paperwork associated with the E111 as the foreign reimbursements remain at the national level. As a consequence, some ask patients to pay out of pocket and reclaim from their travel insurance policy.

Some funding organizations, such as German health insurance funds, have begun to agree contracts with providers in tourist areas abroad, for example with German physicians based in Majorca. This is of particular interest because it creates a precedent whereby the insurance funds engage directly with practising physicians, without the German physicians' association playing an intermediary role. This could potentially have implications for governance mechanisms in place in Germany and it would not be the first time that arrangements put in place to facilitate cross-border care have stimulated changes in domestic policies.

The examples in which care is provided to a population that straddles a national frontier provide many interesting experiences. These have often emerged from grass-roots cooperation based on local agreements between providers and purchasers, as seen in the cases of Belgium, France, Ireland and Slovenia. These forms of cooperation are often within a broader framework of cross-border cooperation, often supported by EU Interreg funds (or in Ireland, Peace and Reconciliation Programme funds). These projects often seek to achieve optimal use of capacity on both sides of the border, with patients and health professionals crossing in both directions.

While these projects frequently provide pragmatic solutions to specific local problems, there may be problems once the exchange of patients takes place, often because of a lack of a sound legal basis. This observation highlights the importance of establishing ways by which those involved in cross-border collaboration can communicate their difficulties to legislators and ways by which legislators can respond appropriately to these difficulties. In many cases those involved have taken advantage of the provisions of Council Regulation (EEC) No. 1408/71, even if the precise mechanisms related to the E112 are not used. Difficulties also relate to the development of shared approaches to quality assurance, continuity of care, information sharing, or compliance with regulatory systems.

Particular issues arise in cases where administrations seek to share common infrastructure in a border area. This volume includes several examples: one from the north of Europe, on the Estonian-Latvian border; a second from the south, on the French-Spanish border; and a third from the east, on the Italian-Slovenian border. In all these cases the process of establishing cooperation was

protracted and complex. Problematic issues included matters related to ownership and legal authority, for example as applied to employment contracts. Thus, on the Slovenian-Italian border an attempt to invest jointly in a magnetic resonance scanner failed because of unresolved administrative problems. Eventually one of the hospitals proceeded with the investment and offered access to radiologists on the other side of the border.

More recent developments include direct contracting by public purchasers, for example where sickness funds enter into agreements with foreign health care providers. Examples are drawn from Germany and the Netherlands. While initially these were concentrated in border areas, their coverage is now extending further afield. These contracts are often based on an interpretation of European Court of Justice rulings that care provided abroad should be under the same terms and conditions as that provided domestically. Thus, a Czech provider contracting with a German sickness fund is expected to apply German quality standards.

The principle of exporting domestic standards is also apparent in the case of English patients treated in Belgium and France, as part of a short-lived attempt to reduce waiting lists. Thus, the English NHS undertook a separate, thorough assessment of the quality of providers, with contracts prescribing the care to be delivered in great detail, with the result that Belgian providers viewed the assessment procedures as unnecessarily bureaucratic and, in frustration, some withdrew from the process. In passing, it should be noted that while there was undoubtedly an element of media presentation, with English ministers reassuring patients that they would be able to get cups of tea and English newspapers, this may also reflect an important cultural difference in relation to the acceptability of different degrees of state involvement in the detailed delivery of health care.

The English Department of Health strove to maintain tight control over this process, portraying it as quite distinct from the mobility permitted by the rulings of the European Court of Justice. Indeed, in the one case where a British patient cited the precedents established by the Court she received treatment before the case could be heard. As a consequence, the precise interpretation of “undue delay” set out in the directive remains unclear in the British context.

An interesting phenomenon to emerge in some settings is the use of brokers. These can have different functions; in general they are actors familiar with the system in the providing country and function as a kind of “system translator”. This can help to ease negotiations, clarifying tariff-setting systems, and managing invoices. The involvement of such brokers seems especially useful when the health care systems involved are very different.

Experiences and expectations

This section examines the *experiences and expectations* of those involved in the processes whereby patients receive treatment abroad. It is, however, necessary to reiterate an observation made earlier. There is remarkably little systematic information about the perspectives of those involved, and in particular of patients, as there are few surveys of their views. However, what evidence does exist is fairly consistent.

The available, albeit limited, evidence suggests that *patients* obtaining care abroad tend to be reasonably satisfied with what they receive, although the evidence relates largely to those whose care is obtained within the framework of specific purchasing agreements, in which an informed purchaser is acting on their behalf to ensure the quality of care provided. Patients describe the importance of access to information at all stages in obtaining care. This is particularly great before they go abroad, with questions about the available options for care, their rights and entitlements, cost implications, administrative procedures involved, transport arrangements, and management before and after the main treatment. During their stay they seek information on their progress, in a language that they can understand. After discharge they seek information on follow-up arrangements.

While the available information is even patchier, it does seem that the situation is much less satisfactory for those obtaining care as tourists. Here there is no informed purchaser to act on their behalf. They are faced with the difficulty of selecting a provider in the public scheme who will accept their E111 or European Health Insurance Card. Their difficulties are exacerbated by the many individuals with vested interests in diverting them to private providers.

A key issue is continuity of care. While some minor disorders can be managed as a single episode of care, many, especially where they involve an aggravation of a pre-existing condition, require communication with the individual's usual health care provider. This means that medical records must be accessible and understandable by different providers, there must be access to prescribed pharmaceuticals, and arrangements must be in place for follow-up assessments and rehabilitation. This provides another justification for active management of the process.

The case study also revealed the needs of *providers*. Providers treating foreign patients must be reimbursed appropriately, where relevant taking account of any extra workload and costs involved. They also require ready access to patients' past medical history. These require effective systems for data management. Furthermore, there is a consistent demand from providers involved in cross-border contracts for more legal certainty about what they are

allowed to do, which procedures they should use, what prices they can charge, and what happens when things go wrong.

Referring providers play a crucial role in guiding patients in their choice of treatment abroad. The information needs of the referring providers are thus similar to those of patients. They need to be involved actively and positively in cross-border cooperation. When domestic providers feel they are insufficiently involved, they can obstruct arrangements for cross-border care. Also, domestic providers may complain about unfair competition when prices charged for care abroad are lower than those at home. In some cases this arises because governments explicitly use the potential to send patients abroad as a means of challenging domestic providers that are perceived as inefficient (whether or not this is actually the case), as happened with the short-lived overseas treatment initiative developed by the English Department of Health. In some cases, such as in the Netherlands, providers may be concerned because they must fund capital investments from their income, while in their neighbours', as in Germany, these costs are borne by regional governments and are thus excluded from the pricing formula.

Purchasers are concerned about transparency of tariff-setting, guarantees of accuracy of invoicing, and systems to assure quality. This will often require specific mechanisms to be put in place but, as in the Netherlands, one possibility is to establish brokers who can concentrate this experience and make it available to multiple smaller purchasers.

Potential impact on health care systems

Public health care systems aim to guarantee high-quality care accessible to all citizens in the most efficient way. Patient mobility can provide additional *opportunities* to achieve this objective. Patients can be treated close to home, but on the other side of a border, or treated abroad when on holiday. For smaller countries, or regions with low population densities, it can make available treatments that would otherwise be unavailable. In border regions it facilitates a more rational use of scarce capacities. The country providing care will have the opportunity to make use of spare capacity, so generating additional income to cover their fixed costs or to support new capital investments.

Patient mobility can provide an incentive for improvements in health care delivery in both sending and receiving countries, for example by creating pressure to reduce waiting times. Patient mobility can also reveal weaknesses in administrative processes, such as patient registration and data flows.

On the other hand, patient mobility can also entail *risks* for health care systems, especially if the process is not managed effectively and if authorities in both countries are insufficiently involved. The principle of equity can be jeopardized if patients going abroad on their own initiative thwart domestic priority-setting systems. Patients unable to meet additional costs for treatment abroad may have reduced access to care.

For the receiving country, there is a risk that foreign patients will be given priority over domestic patients if foreign purchasers are willing to pay above official tariffs. This could also exert upward pressure on tariffs and increase waiting times in the receiving country.

Where cost-containment policies are based on restriction of supply (leading to waiting lists), patient mobility can threaten cost-containment policies in the sending Member State by circumventing constraints on supply. Patient mobility can also put pressure on established organizational arrangements, with unpredictable consequences. Examples include the corporate system of contracting in Germany, referral systems in the Netherlands, collective agreements between providers and purchasers in Belgium, and relationships between local and national authorities in France, Spain and Italy. Additionally, patient mobility can lead to pressure for a greater role to be played by the private/commercial sector.

While patient mobility can clearly bring benefits, it can also be very expensive, for example for small countries such as Malta. It can also delay the inclusion of new treatments when patients can receive them abroad. In all these cases, it is important that public authorities ensure that benefits from patient mobility are realized, while challenges are dealt with.

Realizing the scope for all to benefit

If the potential benefits from enhanced patient mobility are to be achieved, we argue that there is a need for a shared view on certain issues. As a starting point for achieving consensus among Member States, we propose the following potential principles.

- Patient mobility should be *managed*. The scope for market failure in health care is well recognized, in particular because of the extent of information asymmetry. Even those purchasers who might be expected to be well informed, such as sickness funds, often find it helpful to employ brokers to ease the process. Except in the most straightforward of circumstances, there will be dangers in relying simply on market forces.

- Patient mobility requires *trust*. Purchasers must be able to rely on standards being upheld by providers. It is not always feasible simply to export national standards and this can provoke resistance from the providers and public authorities abroad. We believe that it will be necessary to establish some mechanism to ensure adequate standards of health care quality across the EU. In reality, the principle of mutual recognition, in which it is assumed that standards in place in any part of the European Union are universally acceptable, is not accepted by everyone involved in purchasing care. It would be unrealistic to advocate the same standards, not least because of the rapid pace of change in medical knowledge, but rather there should be systems in place that can ensure that this changing knowledge is identified, synthesized, disseminated and adopted.
- Patient mobility should clearly define *specific arrangements* necessary to support the mobile patient, in relation to matters such as transport, language and accompanying persons.
- Patient mobility should ideally be integrated into *larger forms of cooperation involving providers of both countries*. Referring providers may need to assume responsibility for care prior to and subsequent to travel.
- Patient mobility should be based on prices set in a manner that is *transparent and which minimizes perverse incentives and distortions of the market*. A more transparent system would address questions such as: how should prices be calculated in benefit-in-kind systems? Should they include costs of infrastructure or not? How does one reconcile exchanges between systems with and without fees-for-service? What is the role of state aid in this sector? How can extra costs, such as translation, accommodation for accompanying persons, etc., be dealt with?
- The competent authorities or *purchasers* should *define explicit eligibility criteria for patients who go abroad specifically to obtain treatment*.
- The right to treatment abroad should be consistent with what is included in the *benefit package of the Member State that funds the care*. In other words, obtaining care abroad should not be a mechanism to circumvent restrictions of treatments unavailable on grounds of their lack of effectiveness.

These principles do not coincide precisely with either those in Council Regulation (EEC) No. 1408/71 or the procedure established by the *Kohll* and *Decker* cases. Instead, they propose creative answers to the new reality that is reflected in the case studies, which is a hybrid of both procedures.

For these processes to work, full *involvement of the public authorities* in the relevant countries is essential. There can be much flexibility in the systems adopted for cross-border purchasing of care, but an overall framework is essential. A system of *cross-border contracts* between providers and purchasers, based on the principles set out above, seems to offer a means of giving patients better access to high-quality care while at the same time providing greater certainty for providers.

One important point we have not yet touched upon is the involvement of the patients. In many European countries there is a move towards greater patient involvement in the planning of health services. In some regions experiencing mass tourism, such as the Veneto region or some parts of the Spanish coast, foreign patients can outnumber domestic ones. Yet tourists are, by definition, a transitory population, subject to seasonal fluctuations. There is a need to identify some way in which someone acting on their behalf could play a role in the planning process, although this will be far from easy.

The involvement of patients is equally important in border areas. This may involve establishing mechanisms to incorporate foreign patients into the planning exercise. However, this raises further questions, such as how this should be paid for. This process will also have to take account of public concerns that increased cross-border care could be an opportunity to close facilities in which local communities have a strong sense of ownership.

Enhanced patient mobility within the EU can bring benefits for all involved but to do so it requires an effective overall framework. Once established, it is important that its operation is evaluated and monitored regularly, although this is likely to require a substantial investment in data systems in many countries. We hope that, by bringing together these diverse experiences across Europe, we can stimulate the necessary discussions that will facilitate this process.

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Nowadays people can travel across Europe with greater ease than ever before. In much of the Continent, border checks are a thing of the past. Budget airlines have made possible cheap holidays abroad, and some people have even decided that their quality of life is improved if they work in one country and spend the weekend in another. Also, more and more people from northern Europe have opted to retire in the warmth of the Mediterranean.

All of these developments have implications for health systems. The freedom of movement granted by the European Treaties to Europe's citizens can only be a reality if those citizens know that they will receive high-quality, appropriate care if they fall ill when abroad. And those responsible for delivering health care may want to take advantage of the opportunities created by the European Union, sharing capacity in sparsely populated border areas or ensuring access to highly-specialized care for people living on small islands.

The Europe for Patients project, financially supported by the European Union's Sixth Framework Programme for Research, is seeking to understand how the opportunities offered by the European Union can be maximized, and how any potential problems can be overcome. This collection of case studies provides a wealth of experience of collaborating across borders in all parts of Europe.

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