Cross-border contracting in practice:
Belgium – The Netherlands

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The research

Dutch insurers conclude cross-border contracts with Belgian hospitals to allow their affiliated members access to Belgian health care services


Case-study: March 2004 – July 2005
Who are the actors?

PURCHASERS
Dutch insurers
English NHS

PROVIDERS
Belgian hospitals & doctors

PUBLIC AUTHORITIES

MIDDLEMAN (CM)

PATIENTS

LOCAL / DOMESTIC PROVIDERS
(GPs & specialists)

To various degrees, at different levels, with different roles:
Active in patient mobility

To various degrees + at various levels:
Active in crossborder contracting
How does cross-border contracting work in practice?

**Dutch cross-border contracts:**
- Since late 1990s
- Contracts are based on Dutch contractual system
- Both in- and out-patient care
- Prices according to Belgian tariffs
- Quality according to Belgian rules
- Selection of Belgian hospitals
- Involvement of middleman (the CM)

→ **Hybrid arrangement combining both systems, new elements introduced in B**
Why contracting?
Why patient mobility?

→ The context
→ The actors
The context

**Fluid borders**
- Shared language Flanders – the Netherlands
- “Pockets of proximity”: culture, history

**Belgium**
- *One big border-region*
- A laboratory for relaxing access to cross-border care
- Health care system:
  - Oversupply and competition between providers
  - Fee-for-service payments

**The Netherlands**
- Waiting lists
- Selective contracting of providers
- Competition between health insurers

**ECJ**
- No unjustified discrimination of providers established in another Member State
Actors: Dutch insurers

- Selection of patients, providers, treatments
- Control of patient flows and the type, quantity, quality, cost of care
- Well-defined procedures, lighter administration
- Match between demand and supply
- Assistance by experienced local stakeholders (middleman)
Actors: Belgian providers

Hospitals
- Contracting: safest and simplest way to admit foreign patients
- Large university hospitals: patient mix - high fixed costs – reputation - European-wide recognition
- Smaller, provincial hospitals: competition - capacity - ‘on the periphery’ - extend their catchment area
- Border-region hospitals: natural patient mobility across **fluid borders**

Hospital doctors
- Fee for service
- Expertise, career development
- International recognition and cooperation
Actors: public authorities

Direct contracting allows better control

Priority for Dutch authorities: structured approach patient mobility
Priority for Belgian authorities: protect the national system against pressure on prices and potential waiting times → attempts to establish a B-NL bilateral framework agreement
Actors: the Belgian middleman

- Keeps an eye on the situation
- Guaranteeing that official tariffs are applied
- No ‘package pricing’, no ‘block purchasing’
- Protects the B system, promotes mobility
- Cooperation with foreign insurers and international positioning
- Establish preferential links with Belgian providers
Actors: Dutch patients

Results of patient survey:

People living in the border-region and who often go to Belgium did not have a preference as to whether they were treated in Belgium or in the Netherlands.

People living further away only preferred to be treated in Belgium when there were waiting lists 'at home'.
Numbers of Dutch patients

Carenet Schelndemond

a. Affiliates of two Dutch health insurers
b. Intra-mural and ambulatory care
c. +/- planned care
d. Direct contracting: direct payments (CZ) or 1408/71 (OZ)
Carenet Scheldemond 1999-2004
26,118 periods of care, 25,000 patients
Authorisations May-Dec 2004: CZ patients treated in Belgian hospitals

<table>
<thead>
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<th></th>
<th>N</th>
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<tr>
<td>Hospitalisations</td>
<td>265</td>
<td>4.0%</td>
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<tr>
<td>Ambulatory care</td>
<td>4499</td>
<td>67.1%</td>
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<tr>
<td>Ambulatory care and hospitalisations</td>
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<tr>
<td>Total</td>
<td>6706</td>
<td>100.0%</td>
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The numbers remain marginal compared to total number of patients treated in Belgium. Yet, Dutch patients tend to concentrate in some hospitals or in specific departments...
How marginal?

... patient mobility → new drive for commercialising among some stakeholders in the Belgian health care sector?
Impact: importing system

Contracting brings new elements

- Exporting of Dutch contractual arrangements
- Changes in relationships and power balances
  - Hospitals vs. hospital doctors
  - Providers vs. funding institutions
- Parallel commercial system?
- Risk of pressure on prices and shifts in priority setting

Risks when foreign purchasers are willing to pay above official national tariffs:

→ more lucrative to treat foreign patients
→ such scenarios have occurred
→ importance of a ‘guardian’ to protect the integrity of the system
Impact: exporting systems

Patient mobility leads to better performance due to increased competition…

• Cross-border contracting → cross-border competition
• Threat strategy against monopolistic behaviour
• Incentive for national providers to improve performance

… but possibly opens the door to unlimited demand

• Risk of expanding national health care consumption?
• Gatekeeper system and cost control
• Long-term planning vs. quick-fix solution?

... and can lead to cross-border rivalry

• Reluctant national doctors
• Important function as referrers and for pre/post care
• Information
Patient mobility can have benefits...

Supply and demand meet cross-border
Better performance and satisfied demand for health care in the sending country
Extra income and use of spare capacity for providers in the receiving country
BUT...
It must be structured and framed
Importance of involvement of all levels and of a guardian
  - Official/ Political
  - Grass-root
  - All health care stakeholders, at home and abroad
More info: www.ose.be glinos@ose.be or baeten@ose.be

Text under the drawing: “Foreign patients in Belgian hospitals”