

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

Where? Who? How? Why? Impact?

Case-study: March 2004 – July 2005

Patient survey: Feb 2005 – Dec 2005



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Who are the actors?

To various degrees,
at different levels,
with different roles :

Active in patient
mobility

PURCHASERS

Dutch insurers
English NHS

PROVIDERS

Belgian hospitals
& doctors

PUBLIC
AUTHORITIES

MIDDLEMAN
(CM)

PATIENTS

LOCAL / DOMESTIC PROVIDERS
(GPs & specialists)

To various degrees
+ at various levels :

Active in crossborder
contracting



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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



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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)



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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



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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'



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Numbers of Dutch patients

Carenet Scheldemond

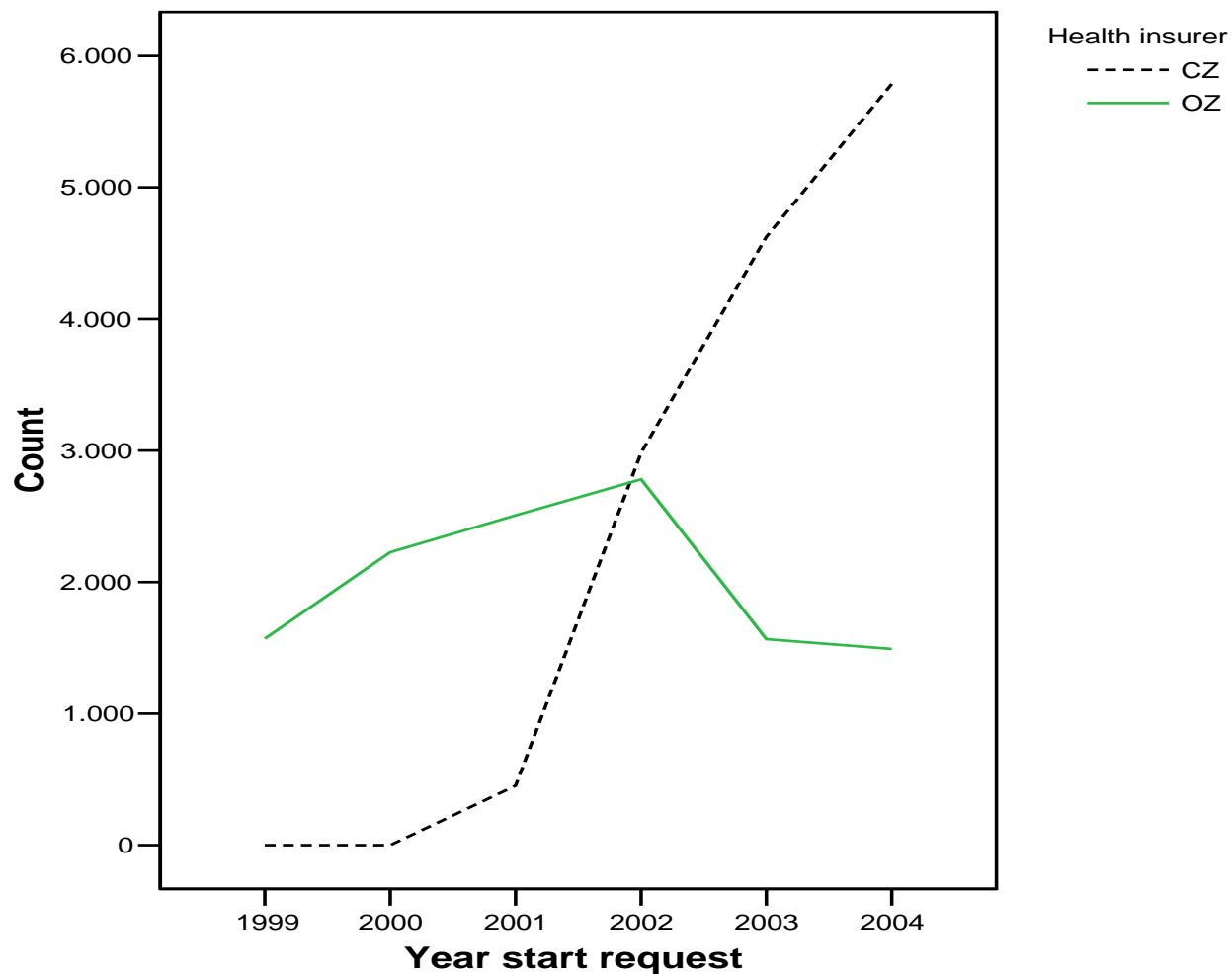
- a. Affiliates of two Dutch health insurers
- b. Intra-mural and ambulatory care
- c. +/- planned care
- d. Direct contracting: direct payments (CZ) or 1408/71 (OZ)



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Carenet Scheldemond 1999-2004

26.118 periods of care, 25.000 patients



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Authorisations May-Dec 2004:

CZ patients treated in Belgian hospitals

	N	%
Hospitalisations	265	4.0%
Ambulatory care	4499	67.1%
Ambulatory care and hospitalisations	1513	22.6%
Other	429	6.4%
Total	6706	100.0%

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...



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How marginal?

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



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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

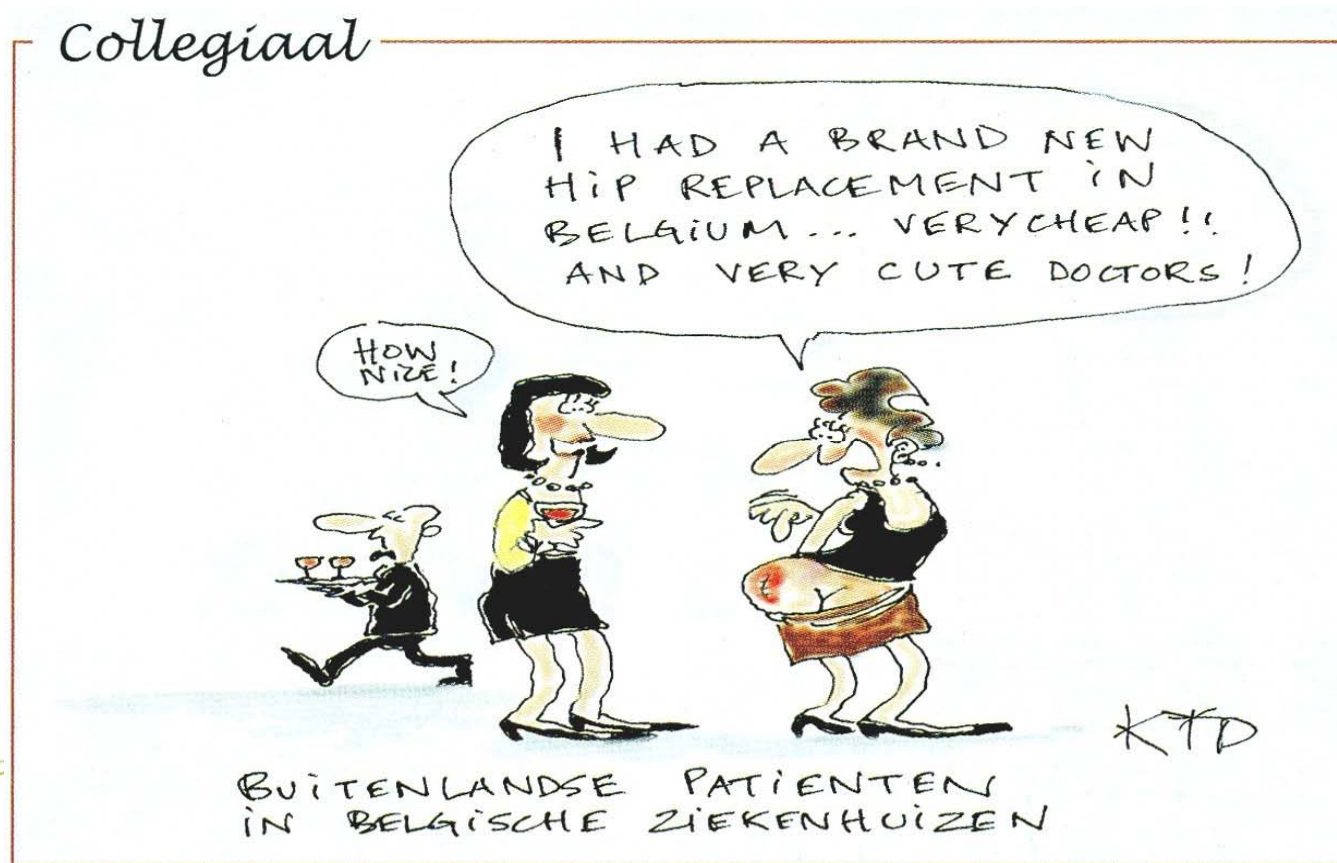
BUT...

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



Artsenkrant, 1776, 15/09/2006

Text under the drawing: "Foreign patients in Belgian hospitals"



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