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# Border-crossing patients in the EU



*Reinhard Busse*

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Consumer choice for healthcare services across borders is a relatively new topic of research. Until 1998, attention focused on the free movement of persons and their potential healthcare needs when travelling to the ‘other side of the border’. This was particularly relevant for frontier workers who lived in one country but worked in another on a regular basis. But with the growing movement of workers from southern European countries to those further north, the issue of how to ensure their right to healthcare services while visiting their country of origin became an issue. The advent of mass tourism added a third group of persons to those in need of access to healthcare services in other countries.

It was with these groups in mind that, building on previous regulations as well as bi-lateral agreements, Regulation 1408/71 on the coordination of social security systems was passed. The original intention for Regulation 1408/71 was not to facilitate the free movement of services or goods but rather to facilitate the free movement of persons, more specifically that of workers. As the European Union (EU) is set to embark on its greatest enlargement to date, there is now additional interest in cross border provision of care.

## **EU legislation on cross border care**

From its inception, Regulation 1408/71 also contained an element of the free movement of services, namely the procedure of pre-authorised care with the E112 form. Under this procedure, people cross national borders specifically to receive healthcare services in the other country. In economic terms, services are imported to the country which authorises the patient to go abroad while the country providing the service is exporting it.

The famous Kohll ruling (as well as the concurrent Decker ruling) first challenged and then changed the general perception: in brief, Raymond Kohll had argued that a

restriction of consumer choice for healthcare services across borders – under Regulation 1408/71 and the respective procedures in Luxembourg – would violate Articles 49 and 50 of the Treaty Establishing the Community which regulate the free movement of services. As this conflict was new, the Luxembourg court referred it to the European Court of Justice which agreed with the plaintiff’s interpretation of the Treaty, basing consumer choice of healthcare services across borders directly on the Treaty:

“The fact that national rules fall within the sphere of social security cannot exclude the application of Articles 59 and 60 of the Treaty. While Community law does not detract from the powers of the Member States to organise their social security systems, they must nevertheless comply with Community law when exercising those powers, i.e. the fact that a national measure may be consistent with a provision of secondary legislation, in this case Article 22 of Regulation 1408/71, does not have the effect of removing that measure from the scope of the provisions of the Treaty.”

## **Trends in cross border provision of care**

Knowledge of the actual cross border movement of persons receiving healthcare services remains rather limited. In quantitative terms, it is mainly based on one study on the amounts and flows of financial transfers for cross border care within the EU,<sup>1</sup> which has been updated to 1998.<sup>2</sup>

According to these figures, the total amount for claims for reimbursement of cross border healthcare rose from €461 million in 1989 to €1103 million in 1993, but then fell to €894 million in 1997 and €758 million in 1998. In relation to public spending on healthcare in the European Union, these values are in the 0.1–0.2 per cent range of overall expenditure. The study carried out research into the flow of the three most important forms for cross bor-

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der mobility: E106 (migrant workers), E111 (temporary stay, for example, tourism and business travel) and E112 (pre-authorized care). Pre-authorized care accounted for nearly 60 per cent of the total cost of cross border care, while the transfer for temporary stay and migrant workers were financially less important with 25 per cent and 16 per cent respectively of the total expenditure. In terms of the number of forms submitted the ranking was in reverse order. With a share of 53 per cent, the E106 form (migrant workers) was most applied, while E111 (temporary stay) accounted for 33 per cent and E112 (pre-authorized care) for only 14 per cent. Only nine per cent of the forms referred to hospital care.

Luxembourg consistently had the highest per capita expenditure for cross border care (€150 per capita in 1993; EU average €3) but this fell in line with the EU average after 1993. Other countries with above average expenditures are Belgium (up to €9), Italy (€8) and Portugal (€7). Low expenditure figures can be seen particularly in the Nordic countries with less than €1 per capita and year.<sup>2</sup> According to the same study, France is the main exporter of services (= importer of patients) with a share of over 40 per cent in 1993. It receives its money from the other Member States exclusively through invoiced credits, i.e. does not use lump sum payments. The latter method is, for example, favoured by Spain.

The EU candidate countries are faced with a dilemma: On the one hand, they could attract (especially private) patients by providing cheaper services, on the other hand their statutory health insurance systems might be in financial difficulties if they have to pay for treatments in the current Member States (which, due to the price differentials, are reluctant to sign waiver agreements).<sup>3</sup>

#### **Improving access to care across borders**

The Kohll and Decker rulings of the ECJ established, probably unintentionally, a new type of cross border access to healthcare in the EU. European citizens covered by a statutory social protection scheme in one country now have, in principle, three ways to receive healthcare services in another EEA country. However, consumer choice across borders remains quite restricted under the two main options provided by Regulation 1408/71, mainly as a

result of administrative hurdles. The Regulation covers access to immediately necessary care during short term stays using the E111 form and pre-authorization to receive care in another Member State using the E112 form.

The new ‘Kohll/Decker’ procedure also has its limitations. One such potentially serious one is that direct payment is required and that a lower rate of reimbursement in the country of insurance affiliation may lead to a co-payment which would otherwise not arise (and which does not arise under the E111 and E112 procedures due to the benefit-in-kind principle). In addition, the range of available benefits is not only limited to those covered in the country of insurance, but is even limited to a subset of benefits, namely ambulatory services.

Two promising options to improve access to healthcare services across borders are therefore to ease the administrative procedures and to extend contracts for providing benefits-in-kind across borders. Both options have been and are used in certain border regions within the EU, most notably in the context of the ‘Euregios’. These are regions divided by borders between EU Member States which benefit from EU’s INTERREG initiative to improve their economic and social situation.

Euregios that have included health services arrangements in their activities include Meuse-Rhine (Belgium, Germany and the Netherlands), Rhine-Waal (Germany and the Netherlands), Scheldemond (Belgium and the Netherlands), Hainaut/Nord-Pas-de-Calais (Belgium and France), Schleswig/Südjylland (Denmark and Germany), Eems-Dollart and Rhine-Eems-Ijssel (Germany and the Netherlands).<sup>2</sup>

Classical examples of easing the administrative burden for patients can be found in the Euregios Scheldemond and Hainaut/Nord-Pas-de-Calais. In the former, a simplified E112 procedure using a form called ‘E112+’. This idea was then adapted in the latter region where an ‘E112TF’ form can be printed using the French insured person’s *Vitale* card or the Belgian insured person’s S/S card. Form E112TF is then filled out by the hospital where the insured person seeks treatment and is sent directly with the request for payment to a sickness fund in the country of the hospital.

All these activities, with the exception of Scheldemond, involve rather small numbers of patients, usually not exceeding a few hundred. Evaluation of their work reveals

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some, important lessons: firstly, waiting lists are cited as the major force contributing to cross border care which might become an even more relevant factor in the future.<sup>4</sup> Secondly, proximity of the provider to the place of residence of the patient is another major factor stimulating cross border care.

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### Beyond the Euregios

The subject of easier access to healthcare services across borders is gaining increasing attention outside the Euregios. In Germany, the Working Group of Federal Associations of Sickness Funds, which comprises all groups of sickness funds, is urging the government to amend social legislation in order to allow German sickness funds to contract selectively providers in the EEA. The reasons for this are threefold. First of all, the sickness funds do not desire a ‘Decker/Kohll solution’ since this would entail the abolition of the benefit-in-kind principle. The benefit-in-kind principle establishes a close link between payers and providers not only on prices and volumes but also on quality.

The price issue is not of primary concern since reimbursement would be limited to the domestic level. And the volume issue does not matter much, since cross border care still occurs in rather small numbers. The quality issue seems to be more tricky because it assumes that quality abroad is lower than in Germany, an assumption which is difficult to base on evidence. The political reason for the contracting solution is to evade the collective contracts sickness funds hold with providers inside Germany. Provider associations, especially associa-

tions of physicians affiliated to statutory health insurance, would lose power if German sickness funds could contract providers abroad.

The Federal Chamber of Physicians (representing all physicians in Germany) is also supporting a more liberal approach to cross border care according to a resolution ratified at the annual congregation in 2000. German physicians (or at least their representatives) do not seem to be afraid of cross border patient mobility. On the contrary, they seem to expect a net win since Germany has a very comprehensive health-care basket and no severe capacity problem.

The first three British pilots of sending patients overseas confirm this hope: except for one French hospital, all EU providers treating British patients during the period 2001/02 were based in Germany.<sup>5</sup> After the accession of new Member States, areas such as the Czech-German-Polish border region (around the divided town of Görlitz) could become the focal point for new Euregios. Candidate countries may also benefit from British patients if they provide good quality services at a lower cost than in Germany.

Accession therefore poses new challenges and opportunities for both current and new Member States. Before the likely effects can be predicted, however, better data on current movements, their financial implications and patient preferences are essential.

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### NOTE

The article is based on the chapter: Consumer choice of healthcare services across borders. In: Busse R, Wismar M, Berman PC (eds). *The European Union and Health Services: The Impact of the Single European Market on Member States*. Amsterdam: IOS Press, 2002.