The Directive on Cross-Border Health Care

Belgium and the implementation of the Directive on cross-border health care

Christian Horemans
International Affairs Expert
National Federation of Independent Health Insurance Funds
Member of AIM

Ladies and gentlemen;

Allow me to start by thanking the **Slovenian Insurance Association** and the Institute R&T for its hospitality and for inviting me to participate to this Workshop.

The Directive on Cross-Border Health Care is a big topic in Belgium, but it is only now that the debates for the implementation are really starting. In the next 20 minutes, I will present you some key elements of the situation in Belgium.

Structure

- Independent Health Insurance Funds
- The Belgian context
- The implementation of the Directive:
  - The coordination
  - The points of discussion
- The aspects of insurance
- Conclusion

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I will present you the following elements:

- I will give you some basic information about my organisation : **the Independent Health Insurance Funds**
- I will describe **The Belgian context** which is maybe a bit a-typical
- I will tell you what has been done en discussed until now concerning **The implementation of the Directive** in Belgium**:**
  - **The coordination**
  - **The points of discussion**
- I will present you some reflexions concerning some **aspects of insurance**
- And I will present you some first **conclusions**

1. Independent Health Insurance Funds

- **1 national federation + 7 mutual societies**
- **More than 2 million clients**
  - 3rd biggest group in Belgium
- **Active in:**
  - Compulsory health insurance
  - Complementary health insurance:
    - ➔Solidarity based
    - ➔Facultative (hospital care, dental care)
- **Member of AIM**
- **More info: www.mloz.be**

The group of Independent Health Insurance Funds (know as MLOZ) consists of 8 entities:

- 7 mutual societies active in the whole or a part of Belgian territory
- 1 national federation representing the 7 mutuals on national and regional level, and executing tasks of common interest. You could consider us as a Knowledge Centre or Back Office.

In Belgium, mutual societies are private organisations which are active in:

- Compulsory health insurance: we execute it for our members and participate in the management of it;
- Complementary health insurance: we offer 2 types of products
  - A package of services and products for which everybody is obliged to contribute to. So you could say is based on **solidarity**.
  - Facultative insurance products:
    - For hospital care
    - For dental care

We are member of the **Association International de la Mutualité** (AIM), so we have the pleasure of being in contact with our colleagues of **Vzajemna.**

2. The Belgian Context (1)

- **Cross-border health care has different "faces":**
  - Regulations 883/2004 and 987/2009 (S2/E112)
  - Reimbursements according to the decisions of European Court of Justice in the cases Decker & Kohll
  - Cross-border projects:
    - ➔To facilitate patient mobility (f.e. IZOM, Transcards, ZOAST)
    - ➔To facilitate collaboration between hospitals
  - Contracts between foreign actors and Belgian hospitals
    - ➔100 of the 180 hospitals have such a contract
  - Project HealthCare Belgium to attract foreign patients
    - ➔www.healthcarebelgium.com

➔ **And now: the Directive…**

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It is important that I tell you a bit more about the Belgian context before to start talking about the Directive.

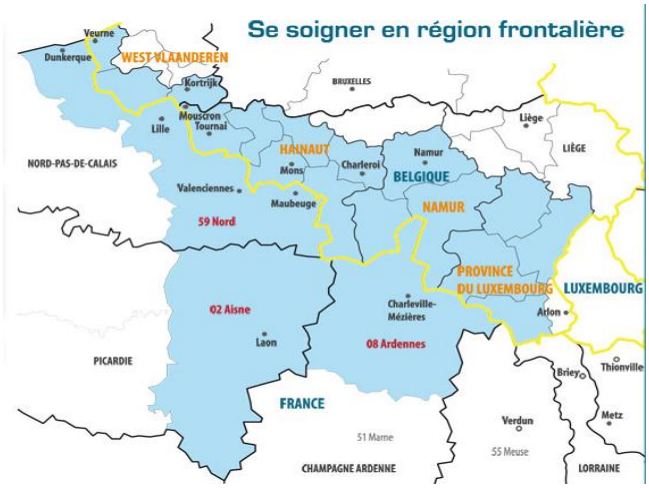
Because in Belgium, we have a long tradition in cross-border health care, it is not something new. And this cross-border health care has different "faces"

- **Regulations 883/2004 and 987/2009 (S2/E112)**: these are what we call the classic cases. The patient asks and gets an authorisation for treatment abroad. We have about 900 of such cases a year.
- **Reimbursements according to the decisions of European Court of Justice in the cases Decker & Kohll**: since this jurisprudence in 1998, Belgium has applied these rules that are now codified in the Directive. In 2011, we had 3.266 cases that were reimbursed in this way.
- **Cross-border projects**: these serve to facilitate the cross-border health care with the neighbouring countries.
  - ➔ To facilitate patient mobility (f.e. IZOM, Transcards, ZOAST)
  - ➔ To facilitate cooperation between hospitals

  I will give some examples in a few minutes.
- **Contracts between foreign actors and Belgian hospitals:** this especially the case with the Netherlands
  - ➔ 100 of the 180 hospitals have such a contract (some have several)
- **Project HealthCare Belgium to attract foreign patients**: This project was launched a couple of years ago by the Belgian Federation of Enterprises and the Belgian Hospitals to promote Belgian health care and to attract patients from outside Europe. You could say the rich patients.
  - ➔ www.healthcarebelgium.com

And now we can add the **Directive** to this…

2. The Belgian Context (2) – BE and FR



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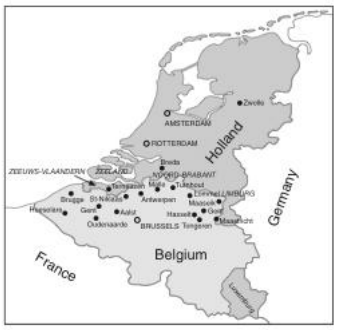
This is a map of the cross-border area between Belgium and France, the border is indicated in **yellow**.

All persons living in the blue areas have access to medical care in the other member-state. There are **7 projects** across the border with which the access to the hospitals on the other side of the border is facilitated. **No prior authorisation** is needed, and the reimbursements are according to the national tariffs of the country where the treatment took place.

More than **7.000 French patients** cross the border for this purpose, while 700 Belgian patients cross in the opposite direction.

Next to that, the **medical emergency services** are allowed to intervene on the territory of the other country if they can be there faster than the national services.

2. The Belgian Context (3) – BE and NL



- **Direct contracting between Dutch insurers and Belgian hospitals**
- **No use of European regulation**
- **Some hospitals: 4% = Dutch patients**

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Belgian health care is popular in the Netherlands. It all started in the **nineties** when there were long waiting lists. The Dutch insurers started to contract Belgian hospitals to guarantee access for its clients.

All the **black dots** are Belgian hospitals with such a contract. In some hospitals, 4% of the patients are Dutch.

Meanwhile, the number of dots has increased. But because of the **crises**, the Dutch insurers have announced to reduce this activity.

The Dutch insurers **do not use the European legal framework**: there is direct billing a direct payments without use of de S2 or E112-form.

2. The Belgian Context (4) – BE, NL, DE

This graphic does not represent a country, it represent the **Euregio Maas-Rhine**. They call it "Europe on a small scale".

At the left you see the Belgian provinces of Limburg and Liège. The little appendix in the middle represents a part of the Dutch province Limburg with Maastricht. And to the right you find Nordrhein-Westfalen in Germany.

In this zone, there the cross-border project **IZOM**, facilitating access to specialists and hospitals. Launched in 2001, this project had been very successful, not easy with three languages (NL, DE, FR). But the existence of 3 key hospitals in this zone is crucial: Maastricht, Aachen, Liège.

In 2011, MLOZ had more than **5.000 cases** in IZOM, Belgians going to the Netherlands or Germany for health care.

2. The Belgian Context (5)

- **More foreign patients to Belgium than Belgian patients abroad**
  - Lack of transparency!
  - Lack of data!
- **Creation of Observatory for Patients' Mobility**
  - Started in 2011
  - What's the impact of foreign patients in Belgium?
    - ➔Access to health care?
    - ➔Prices?
    - ➔Privatization of health care?

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- **In general, you could say there are more foreign patients coming to Belgium than Belgian patients going abroad for health care**
  - BUT: there's a lack of transparency and data
  - Nobody knows exactly about how many patients were talking (by the way, this is not only a Belgian problem, European data hardly exists).

- That's why Belgium decided to create **the Observatory for Patients' Mobility**
  - The activities of the Observatory started in 2011.
  - The Observatory has to analyse the impact of the inflow of foreign patients in Belgium:
    - ➔ Access to health care?
    - ➔ Prices?
    - ➔ Privatization of health care?

The Health Insurance Funds participate to the activities of this Observatory.

3. The implementation of the directive
The coordination

- **In BE: 7 ministers with competence in health care**
- **An inter-ministerial task force was created in 2012**
  - With representatives of federal en regional level
  - Key priorities:
    - ➔Inventory of laws that need modification
    - ➔National contact point

- **A task force "cross-border health care"**
  - With representatives of health insurance funds, ministries, national institute of health insurance
  - Goal: implementation of art. 7, 8 and 9 of the Directive (reimbursement & authorisation)
  - First meeting: 25/10

Lack of interaction with stakeholders in the field!!!

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- Belgium is a small but **complicated country** with 1 federal and 6 regional governments. So there are **7 ministers** with competence in health care.
  - So coordination is needed! 2 task forces were created:

- **An inter-ministerial task force was created in 2012**
  - With representatives of federal en regional level
  - Their key priorities are:
    - ➔ To make an inventory of laws that need modification to be in line with the directive
    - ➔ The creation of a National contact point

- **A task force "cross-border health care"**
  - With representatives of health insurance funds, ministries, national institute of health insurance
  - Their goal is to prepare the implementation of art. 7, 8 and 9 of the Directive concerning the reimbursement & authorisation procedures.
  - The first meeting is planned for 25/10

Nevertheless, you can say that there is **not enough debate and interaction** concerning the Directive. Until now, the stakeholders are not invited to give their opinion about the different topics of the Directive.

3. The implementation of the directive
The points of discussion

Complexity

- New procedure of authorisation makes the legal framework even more complex
  - ➔Directive could create high expectations, feeling of "everything is possible", BUT: big risk of no or limited reimbursement in compulsory health insurance
  - ➔Risk of new jurisprudence?
- Idea of making one procedure for:
  - ➔Authorisation based on European regulation 883/2004
  - ➔Authorisation based on the Directive
- Guidelines EC invites member-states to think about this option

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Let me tell you a bit more about the some of the points that are discussed in Belgium.

Complexity

- The new procedure of authorisation of the Directive makes the legal framework even more complex
  - ➔ ON TOP OF THAT: the Directive could create **high expectations**, feeling of "everything is possible", BUT: there is a big risk of no or limited reimbursement in the compulsory health insurance
  - ➔ Everybody agrees that there is a **risk for new European jurisprudence** as the Directive will not be implemented the same way in all member-states…

- In Belgium, there is the idea of making **one procedure** for:
  - ➔ Authorisation based on European regulation 883/2004
  - ➔ Authorisation based on the Directive

  This would simplify things for the patients and for the health insurance funds.

- It is also a suggestion that you can read in the **Guidelines** of the European Commission.

3. The implementation of the directive
The points of discussion

National Contact Point

- WHAT?
  - ➔Incoming patients: information about healthcare providers, patient rights, quality of care, procedures in case of medical error
  - ➔Outgoing patients: information about the rights of the mobile patient (regulation and directive)
- WHO?
  - ➔Probably federal ministry of public health
  - ➔With website and call centre
- Role of health insurance funds? => already partly responsible for this…

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The creation of the **National Contact Point** is another big topic of discussion. Who will do this job?

- **WHAT** will be there job?
  - ➔ For incoming patients: the NCP will have to give information about healthcare providers, patient rights, quality of care, procedures in case of medical error
  - ➔ For outgoing patients: the NCP will have to give information about the rights of the mobile patient (regulation and directive)

- But **WHO** will do this?
  - ➔ It will probably be done by the federal ministry of public health
  - ➔ They will create a website and a call centre

- And what will be the role of the **health insurance funds**?
  - ➔ They are already partly responsible for this…
  - ➔ Until now, nothing has been communicated officially.

3. The implementation of the directive
The points of discussion

Impact for the hospitals

- Information to be provided by healthcare providers:
  - ➔Art. 4: …*relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability*.
  - ➔**Need to screen the information offered today!**
  - ➔**Belgian patients will also benefit from this obligation**

- Network of references:
  - ➔Who will/can participate? Only University hospitals?
  - ➔Hospitals are not involved in this debate….

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What will be the impact for the hospitals ?

- The Directive stipulates that the health providers have to be motivated to provide **information**. The list of this information is long, just have a look at art. 4:

  ➔ …*relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability*.

  ➔ Do the health providers offer this kind of information today? There is a need to screen the information offered today!

  - There is a high probability that there's work to be done.

  ➔ On thing is sure: Belgian patients will also benefit from this information obligation.

- **Network of references**:

  ➔ The hospitals do not know what will happen, but they are interested. Who will/can participate? Only University hospitals?

  ➔ Hospitals are not involved in this debate (until now)….

3. The implementation of the directive
The points of discussion

Rare diseases:

- The Directive = opportunity to create more mobility for these patients + more financial security
- Possibilities:
  - ➔Possibility to give authorisation based on regulation even if treatment does not exist in own country
  - ➔Possibility to reimburse more than the national tariff
  - ➔Develop expertise en best practices (reference networks)
- Member-States are not very interested…

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Rare diseases:

- The Directive is an **opportunity** to create more mobility for these patients and to organise more financial security for a group of vulnerable patients.

- There are several possibilities:
  - ➔ Possibility to give authorisation based on regulation even if treatment does not exist in own country
  - ➔ Possibility to reimburse more than the national tariff
  - ➔ Develop expertise en best practices (reference networks)

- But until now, Belgium and other member-states have shown little interest.

4. The aspects of insurance

- **Cross-border health care: only for the rich?**
- **Procedure:**
  - Payment of medical costs by the patient
  - Reimbursements afterwards by health insurance fund in home country (risk of limited or no reimbursement)
- **Critics: "only the rich patients will be able to use the possibilities of the Directive"**
- **Solution in the Directive: "the voucher" (art. 9,§5)**
  - Consensus in BE: impossible to organize in reality
- **Other solutions?**

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- Some say: **"Cross-border health care: only for the rich?"**

- Because if you look at the **procedure** of the directive**:**
  - Payment of medical costs by the patient
  - Reimbursements afterwards by health insurance fund in home country (risk of limited or no reimbursement)

- Critics say: "only the rich patients will be able to use the possibilities of the Directive"

- The European Parliament has tried to foresee a solution in the Directive: "the **voucher**" (art. 9,§5):
  - The patient would inform the health insurance fund in his home country about the treatment abroad.
  - The health insurance fund would then give a "voucher" with the amount of reimbursement according to the national tariff.
  - The patient can pay with this voucher in the other member-state.

  - **Consensus in BE**: impossible to organize this in reality! It will be impossible to know in advance what the treatment will be exactly. The translation of foreign health care into "Belgian" health care is a complex issue and no exact science.

- **Other solutions?**

4. The aspects of insurance

- **Is it "fair" to reimburse cross-border health care?**
  - Compulsory health care insurance:
    - ➔In BE: compulsory health insurance reimburses 75% of medical costs
    - ➔Those who have the same treatment in Belgium: not all medical costs are reimbursed
    - ➔Equal treatment!
  - Complementary health care insurance:
    - ➔A lot of Belgians have an insurance for hospitalisation care, often without reimbursement of ambulatory care
    - ➔Little interest to develop product focussing on cross-border health care
      - Mutual societies: also equal treatment in complementary insurance

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- **Is it "fair" to reimburse cross-border health care?** That is a question that is discussed.

- You have to make a **distinction** between:
  - Compulsory health care insurance:
    - ➔ In BE: compulsory health insurance reimburses 75% of medical costs
    - ➔ Those who have the same treatment in Belgium: not all medical costs are reimbursed
    - ➔ Equal treatment!
  - Complementary health care insurance:
    - ➔ A lot of Belgians have an insurance for hospitalisation care, often without reimbursement of ambulatory care
    - ➔ Little interest to develop product focussing on cross-border health care
      - **Mutual societies think there should also be equal treatment in complementary insurance.**

4. The aspects of insurance

Nature of cross-border health care:

- Today: jurisprudence Decker & Kohll
  - ➔only ambulatory care (specialists, dental care, medicines, medical devices)
  - ➔MLOZ: 3.266 cases in 2011 (790 in 2004)
- After 25/10/2013:
  - ➔Mostly ambulatory care
  - ➔Increase of medical devices
  - ➔Hospital care: depends on national procedure for authorisation

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What is and will be the nature of cross-border health care?

- Today: In Belgium we apply the jurisprudence Decker & Kohll. This means:
  - ➔ only reimbursements of ambulatory care (specialists, dental care, medicines, medical devices)
  - ➔ MLOZ: 3.266 cases in 2011 (790 in 2004)

- After 25/10/2013:
  - ➔ Mostly ambulatory care
  - ➔ Increase of medical devices
  - ➔ Hospital care: depends on national procedure for authorisation

So it is possible that with the directive, there will also be a focus on ambulatory care, but with an increase of medical devices. It's unclear what will happen with the hospitalisation costs.

4. The aspects of insurance

- **Directive: also for urgent medical care in private hospitals or by private providers**
- **Today: European regulation 883/2004**
  - In case of private provider: European Health Insurance Card (EHIC) can not be used
  - Limited or no reimbursement in compulsory health insurance => most cost reimbursed by travel insurance
- **Tomorrow: Directive**
  - Reimbursement according to national tariffs in compulsory health insurance
  - Less expenses for travel insurance!

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- **The Directive also concerns urgent medical care in private hospitals or by private providers. Why is this important?**

- **Today: European regulation 883/2004**
  - In case of private provider: European Health Insurance Card (EHIC) can not be used
  - Limited or no reimbursement in compulsory health insurance => most cost reimbursed by travel insurance. This has always been a problem.

- **Tomorrow: This will change with the Directive**
  - Because the reimbursement of those costs will happen according to the national tariffs in the compulsory health insurance.
  - This means fewer expenses for the travel insurance offered by the mutual societies!

5. Conclusion

- **Implementation in Belgium:**
  - Complex operation: a lot of actors in a lot of domains
  - 1 year to go: challenge for Belgium
  - Need to increase involvement of stakeholders
  - Need to simplify where possible
  - Need for clear communication towards public
- **But: the directive will not be used for a lot of cross-border health care cases in the cross-border areas**
- **Opportunities:**
  - More transparency and legal security for the patients
  - European reference networks
  - Mutual recognition of prescriptions
  - More collaboration around eHealth and HTA
  - Support for cooperation in cross-border healthcare at regional and local level

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- **Implementation in Belgium:**
  - Complex operation: a lot of actors in a lot of domains
  - 1 year to go: challenge for Belgium – NO TIME TO WASTE!
  - Need to increase involvement of stakeholders
  - Need to simplify where possible
  - Need for clear communication towards public

- **But: the directive will not be used for a lot of cross-border health care cases in the cross-border areas**
  - Remember all existing possibilities in the Belgian cross-border area. Thanks to those projects, a lot of patients will not have to use the Directive.

- **Opportunities:**
  - More transparency and legal security for the patients
  - European reference networks
  - Mutual recognition of prescriptions
  - More collaboration around eHealth and HTA
  - Support for cooperation in cross-border healthcare at regional and local level

Thank you for your attention.

Christian Horemans

18/10/2012