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Cross-border Alliances in Health Care: International Co-operation between Health Insurers and Providers in the Euregio Meuse-Rhine

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On behalf of the European Commission, a Cross-Border Health Care Project was undertaken to explore how citizens living in the Euregio Meuse-Rhine can obtain improved access to health services in the Member States concerned: Belgium, Germany, and The Netherlands. Main attention of the project is focused on practical issues of cross-border health care. The first results have shown that the new cross-border health alliances resulted in improved possibilities for patients to access more health care facilities than before. The creation of health care alliances could also be an example for future collaboration between the countries in Western, Central, and Eastern Europe. This paper also analyses the rights of patients on cross-border care in the Euregion.

Keywords: consumer participation; costs and cost analysis; cost sharing; expenditures, health; health expenditures; health care surveys; health transition; medical care costs; patient participation; the Netherlands

On behalf of the European Commission, within the Interregional (INTERREG II) program, a Cross-Border Health Care Project was undertaken to explore how citizens living in the Euregio Meuse-Rhine can obtain improved access to health services in three member states of the European Union: Belgium, Germany, and the Netherlands. Main attention was focused on practical issues of cross-border health care: how to create and implement real possibilities for cross-border health care on behalf of the social insured patients in the Euregio Meuse-Rhine. The project is aimed at creating international co-operation between insurers and providers and at resolving impediments to the free movement of people. An alliance between hospitals and (social) health care insurers (sickness funds) has been created to investigate and stimulate existing and future possibilities for patients and insured persons in relation to cross-border health care. The participating hospitals and health care funds are: Ziekenhuis Oost-Limburg hospital in Genk (Belgium), academic hospital Center Hospitalier Universitaire de Liege in Liege (Belgium), Alliance Nationale des Mutualités Chrétiennes (Belgium), Union Nationale des Mutualités Socialistes (Belgium); academic hospital Universitätsklinik RWTH Aachen in Aachen (Germany), AOK Rheinland-Die Gesundheitskasse (Germany), Verband der Angestellten-Krankenkassen e.V. (Germany), Bundesverband und Landesverband der Betriebskrankenkassen, Betriebskrankenkasse VEGLA (Germany); academic hospital AZ Maastricht in Maastricht (The Netherlands), CZ groep Zorgverzekeringen (The Netherlands), and VGZ Zorgverzekeraar (The Netherlands). The project is supported by the governments of the member states. Representatives of the governments of Belgium, Germany (Nordrhein-Westfalen) and the provinces of Limburg (in The Netherlands and Belgium), Liege (Belgium), as well as non-governmental organizations, like the Euregion Foundation and l'Association Internationale de la Mutualité, participate in the Commission of Patronage.

“The Interreg II operational program is managed by an executive committee, consisting of a representative from each of the participating health care insurers or hospitals, general project coordinator, and scientific coordinator (Department of Health Policy and Management, Erasmus University, Rotterdam). The final responsibility is assumed by the Steering Committee, consisting of all the initiators of the alliance.

The operational program is subdivided into several subprojects, which have been undertaken by the participants in the alliance. The program has been partly based upon previous research also (partly) funded by the Interreg (I) program of the European Union. In the earlier program, the comprehensive descriptive analytical work was focused on a description of health care indicators on national level for the three member states, description of national hospital financing systems, an analysis of cross-border care issues and of the extent of care between hospitals joining the project, and a comparative analysis of hospital care on the basis of patient data.

Background and Characteristics
The Euregio Meuse-Rhine, is one of the 40 Euregions in the European Union, defined by the European Community (EC). It involves parts of Belgium, Germany, and The Netherlands, as well as three languages: Dutch, German, and French. Approximately 3.7 million people live in this Euregin and its central area is quite densely populated. More specifically, it consists of parts of the Dutch province of Limburg (Middle and South of Limburg); Province of Limburg (Belgium); Province of Liege, including the German speaking community and the former district of the Aachen federal state (ehemalig Regierungsbezirk Aachen) in Germany.

Convergence of health care systems could be seen as a long-term trend. Due to the growing importance of cost-containment in the member states, competition within national health care systems is also increasing. This places purchasers of care and insurers on an international scale (1).

Creating the Alliance

In the last decade, developments in the health care sector of the European countries working together in the Euregio Meuse-Rhine have taken place at a great pace. Cost control, increases in the scale of technological developments, and specialized care dominate the health care debate (2). Health care providers have to adapt their knowledge and skills to the changing circumstances of cross-border health care of patients and the pace of technological progress. Besides primary care providers, the organization and finance of secondary care providers will experience substantial changes in the three collaborating countries in the very near future. These and the aforementioned changes, stimulate contractual relationships between purchasers (Dutch sickness funds, German Krankenkassen, and Belgian mutualities) and providers to form new alliances (e.g., concerning agreements and contracts on highly specialized clinical care and trans-border use of medical equipment and personnel). Despite the existing divergences, the need for cost containment and the enhancement of the quality of care will also impel actors to co-operate with each other.

In the Euregio Meuse-Rhine, health care providers on the one hand and health care insurers (sickness funds) on the other, have collaborated during the past decade (3). This close cooperation has built the framework for the new health care alliance in the Euregion.

Theoretical Perspective of Countervailing Powers

This development towards a new kind of health care alliance could be seen in the theoretical perspective of countervailing powers. John Kenneth Galbraith (1952) introduced the theory of countervailing power (4). The establishment of more and more permanent groups that stand ready to pressure corporations has become the most important countervailing power to corporations in the United States (5). Light et al. transferred this concept into the health care sector by recognizing several parties, not just buyers and sellers in health care (6). In his opinion, this concept opens the door to alliances between two or more parties. Patients and consumers have so far had hardly any voice in how health care is organized, prioritized, funded, and monitored. However, patients and their agents health insurers or health care providers) behave increasingly as well-informed consumers, who want to have access to the best possible and available medical care (7). Therefore, changes in the organization, rules, and realization of patients' rights on cross-border care are necessary.

The first change in the concept of organizing health care is the strengthening of the position and influence of patients/insured persons, so that they can bring more balance into the health care system by countering the influence of health care professionals over decision-making. Basic principles and priorities for managing change (8) read that: (a) the citizen's voice and choice should make a contribution to shaping health care services as significant as the decisions taken at other levels of economic, managerial, and professional decision-making; (b) the citizen's voice should be heard on issues such as the content of health care, contracting, quality of services in the providers/patient relationship, management of waiting lists, and handling of complaints; and (c) the exercise of choice and of other patient's rights, require extensive, accurate, and timely information and education. This entails access to publicly verified information on the performance of the health services. In addition to these principles and priorities, basic needs of patients/insured persons and simplification of existing rules (less bureaucracy) relating to cross-border care have been chosen as benchmarks for the creation of the cross-border health care alliance in the Euregion.

From Contracting to Effective Relationships

The newly-formed health care alliance is focused on long-term success, moving from the mechanics of just contracting to new relationships between purchasers, providers, governments, patients (organizations), insured persons, and (other) health care authorities. Agreeing to the new health care alliance was difficult because the participants not only had to cross real borders but even more difficult cultural borders. They also had to move from (in most cases) an adversarial (contractual) approach to the system one based upon effective relationships (9). In several Western European countries, including Germany and the Netherlands in particular, the introduction of market forces were the result of the belief that choice, efficiency, and quality within the health care system would be
enhanced by competition between provider units for contracts from purchasers, and the purchaser-provider relationship should ensure that providers are challenged to meet purchaser objectives, and that they employ innovative and creative approaches in this direction. The necessary involvement of consumers, previously on the periphery of the contracting process adds a further dimension to the prioritization of resources. The emphasis on effective relationships takes the focus off the mechanism of contract sophistication and places it on health gain.

To reach agreement between purchasers and providers appeared to be time-consuming due to resistance among the different participating groups and individuals in particular in the complicated transnational health care arena. All actors in this health care arena started to recognize that earlier solutions were inadequate because they did not satisfy criteria of being effective (reaching health care policy objectives), efficient (doing so at the lowest possible cost), and equitable (sharing the burden among the members of the target group in a fair manner). New answers, satisfying these criteria, were needed that do. Such a shift was only possible if all actors brought their expertise together in the program. However, working together in this program could only work under strict and limited conditions. It had to offer advantages to all parties, safeguards had to be taken for third parties, and agreements had to be made within the decision-making structure of the program. These decisions should have binding effects on all parties (10). In developing program structure and creating the alliance, the process often is as important as the content. Therefore, a lot of time has been invested in creating the structure of the health care alliance.

In the first phase of the project, much effort has been invested into creating a network of co-operating initiators and participants. The (academic) hospitals had already participated in the INTERREG I project aimed at identification the complementarities and possibilities for co-operation with respect to the supply of hospital care. The first phase of the INTERREG II project (April 1997 until September 1997) was focused on creating a level of collaboration between health insurers and providers, as well as between hospitals and the ambulatory care sector. The second phase, which started in September 1997, was the crucial phase of implementing the cross-border program by starting different subprojects and focusing these on the accrual improvements for patients/social insured persons. This phase has been accomplished on the January 1, 1999. In the third phase, the report to the European Commission will be finished but, more importantly, the rebuilding of the program as a permanent policy of participants should be accomplished.

Methodology and Subprojects

Health care is structured differently in the neighboring countries of this Euregion. The initiators therefore decided to join forces and work together on the improvement of the present situation concerning cross-border care. For the inventory of the current situation three important information sources have been used. First of all, information has been gathered by a literature study and completed by a study of the relevant legal sources (national and international legislation and agreements, jurisprudence and legal doctrine). The second information source for the inventory were surveys relating to the main issues of different subprojects. Questionnaires were developed and distributed among patients and insured persons at the same time that they received their authorization for cross-border health care. The third information source, and perhaps the most important in this program, was the stimulation of the (improvement of) involvement of participating and non-participating health care practitioners, hospitals, and governmental and non-governmental authorities. So far the project has been conducted as a form of action research with a strong component for creating and strengthening health care alliances. Concrete action-research pilot projects have been started on the initiative of providers for the reduction of waiting lists for patients on specific health care provisions like ophthalmology and orthopedics. These projects have been agreed both by co-operating health insurers and providers. Health insurers have started action-research initiatives to reduce barriers for patients, like creating possibilities of a flexible application of the existing forms E111, E112 and (recently E128), which were needed in cases of cross-border health care. The results of these alliances have been tested by the observed improvements in patient care. Health care reforms on the procedures and legislation of the different E-forms (E111/E112) have been proposed and explored.

The program was divided into several subprojects, which had to be worked out in two and a half years. The first subproject involves an inventory of the current situation of traumatology, ambulance care and emergency care. In this project, mainly carried out by the participating hospitals, a platform of involved health care practitioners, hospitals, and competent authorities had been created to investigate and level existing barriers to cross-border ambulance care, trauma care, and emergency care.

A second subproject was introduced by transforming an existing project in the Netherlands called
“Zorg op Maat” into the Interreg II program on a reciprocal basis. In the existing “Zorg op Maat” project, a registration system of the existing cross-border health care had been created by monitoring Dutch patients who received pre-authorized care in the neighboring countries on the basis of an experimental move in which the existing regulations (E112) had been eased (by creating an E112+). This project has been intensively monitored by the Dutch research institute NZI which also participates in the monitoring of the implementation of the “Zorg op Maat” project into Interreg II. The reciprocal will monitor Dutch patients but also Belgian and German patients. The third subproject handles the similarities and differences in health insurance schemes of the different countries, as well as the co-payments with regard to the different health services patients are entitled to in the program.

The fourth subproject includes the investigation for possibilities for cross-border health care based on the principle of reciprocity. In this subproject high care technologies should be made accessible for patients coming from the other parts of participating countries in the Euregion. The examples are, oncology treatment for children in Germany, The Netherlands, and Belgium in the cooperating hospitals in Aachen, Maastricht, Liege, and Genk (for Belgian, German, and Dutch patients), kidney-dialysis (in particular for Dutch patients) and rehabilitation facilities (for Belgian and German patients) in Hoensbroek in The Netherlands. An analysis on differences in regulation, financing and quality of medical devices in the three countries has also been performed. Health insurers (sickness funds) are particularly interested in purchasing medical devices in other participating countries for their insured persons.

Finally, concrete improvements in transparency have been elaborated for instance in case of co-payments which have to be paid by patients crossing the borders of the Euregion. In Belgium it is sometimes quite unclear for foreigners, and even Belgian insureds, which co-payments have to be paid for which health care benefits. The program has stimulated sickness funds (mutualities) to develop lists of contracted or preferred providers (practitioners/medical specialists) and (additional) prices for co-payments of health care services can be expected for which health care benefits.

Basic Rights of Patients to Cross-Border Care in the Euregion

Strengthening the position and influence of patients/insureds has been chosen as one of the priorities for the creation of the cross-border alliance in the Euregion. The rights of patients to receive health care in other participating countries of the Euregion are dependent upon the rights of patients as entrenched in the legislation of the three states and the recognition of these rights in international (particularly European) legislation (11).

The legal system of the state itself assures patients of a certain level of access to medical care. The claimed right to health care abroad is regulated by a complex web of laws and regulations which govern the action of patients, health care providers, govern-ments, and third-party payers. These laws and regulations, both on the national and European level, serve diverse purposes. The most important of these is to strike a balance between individual freedoms and public needs and interests. The interpretation of these laws and regulations, which allow patients to receive treatments in other EU states, reflects the balance between the different governments’ desires to help patients and realize individual patients rights and the general social desire to allocate and utilize resources efficiently both within and between the EU health care systems.

Within the Interreg II program, a general trend can be distinguished. It seeks to reaffirm the right to treatment and care abroad, to adequate social coverage (including access to foreign care) and adequate information about the available health services in the other member states. In other words, this implies the existence of a right to benefit from the supply of health care facilities within the whole Euregio Meuse-Rhine. This right forms the basis of the rights of patients to cross-border health care in the Euregion.

Despite these established principles, it is undeniable that users’ expectations in the different countries can not be completely met. Access to care is limited by choices that have been made in the project and treatments that have been postponed by existing waiting lists (in particular in The Netherlands). This is attested by several petitions and claims made by patients, particularly in emergency cases, to receive treatment outside their country of origin.

The central position of the patient in the program has been stressed in working papers and basic documents. In specific situations administrative procedures and covenants are still required because (until recently) health insurers and providers had (in most cases) to be authorized by governments to permit patients to be treated abroad. Multilateral and bilateral agreements were also the proper instruments for the regulation of rights in the legal social security systems.

The social dimension of the right to access to care means a right to benefit from the supply of health services. This right, based upon administrative legislation of the different Euregio member states, forms the basis of the right of patients to cross-border health care in the Euregion.
The patients are dependent upon the benefits available within the particular health care system and the entitlements deriving from public health care legislation. In the Treaty of the European Communities (EC Treaty), the free movement of goods, services, capital and persons is regulated. The law of the EC rests on the basic principles of freedom and equality, non-discrimination, proportionality, and subsidiarity. They find expression in the EC Treaty’s provisions on the free movement of goods (Article 30 and 36) and workers between member states (Article 48), on the coordination of national social security systems (Article 51), and on the provision of services (Article 59 and 60).

Crucial Role of the Court of Justice of the European Community

The Court of Justice of the European Community has played an important role in this respect in realizing patients’ rights and entitlements in the Euregion. It has produced a number of cases in which common rules and principles, which also apply to migration and cross-border care within the Euregion have been established.

Workers and the self-employed (according to the Court’s rulings this also includes part-time workers, unemployed economically inactive persons with voluntary insurance), including their family members, have a fairly wide coverage under EC law coordinated according to EC regulations. In practice, competent institutions in the member states appeared not to be reluctant to authorize treatments in other states of the EU. However, the court has consistently held that a free movement of workers would be frustrated if a migrant were to lose social security benefits, including health care benefits, guaranteed under the law of a member state.

The rights of patients are based upon free movement of both persons and services. Within the context of free movement of services (defined by the Articles 59 and 60 of the EC Treaty), the Court of Justice of the European Communities, in the Luisi and Carbone case from 1984 (12), also extended the coverage to cases where it is not the person providing the services who moves, but the person who wishes to receive the service does so by moving to the state where the provider is established. This interpretation allows tourists, recipients of medical treatment, and persons on study and business travel to be covered by regulation relating to the free provision of services (13).

In Article 51 of the EC Treaty, the principle of co-ordination of the national social security systems is expressed. Regulations 1408/71 and 574/72 and, in particular, Article 22 of EC Regulation 1408/71 form the legal basis for the rights of patients to (pre-)authorized care. According to Article 22, a (worker) or his/her family member who wishes to go to another member state in order to receive treatment must obtain an E112 form from the competent health insurance institution and present it to the institution in the place of stay. Issuing of the E112 form was so far almost always subject to the condition of prior authorization. The European Court has ruled in the cases Costa vs. Enel (14) and Amministrazione delle Finanzo dello Stato vs. Simmental (15) that treaty provisions and regulations take precedence over any conflicting national legislation.

Finally, the question arises whether national rules governing the authorization of treatment abroad are compatible with the EC Treaty provisions on the free movement of goods (Articles 30 and 36) and services (Article 59 and 60) (16).

Rights of Patients in the Euregio Meuse-Rhine

The EU regulations mentioned above establish conditions under which an E112 cannot be refused by the competent national authorities. The participating countries in the Euregion more or less follow the EU rules.

To obtain (reimbursement of) medical treatment in another Euregion member state, the patient must, in most cases, gain the approval of a competent health insurer (third-party payer). In the Euregion, starting in The Netherlands, patients received an extended authorization (during the time-span of the project “Zorg op Maat”) for treatments abroad. Patients in Germany and Belgium could be referred on the existing conditions under which the E112 forms were issued. Patients had to follow different procedures in the various Euregion member states to obtain an E112 form. Not only did the procedures vary from country to country, but the criteria to acquire authorization were also different in the participating member states. The program focused on eliminating these differences and improving the process of obtaining access to health care services abroad.

When and how authorization to receive treatment in another EU member state was granted was (until recently) dependent on the coverage criteria for health insurance within the country of stay. Because of the judgements of the Court of the European Communities, free movement of goods and the freedom to provide services is not absolute and reasons to control health expenditure must be taken into consideration (17).

Within each health care system of the Euregion member states, rules have been developed to limit coverage for services under public or private insurance. These rules refer to “screening criteria” or “referral criteria” which are (so far) also dependent on relevant clinical indications or findings. Patients
who wish to obtain services but have failed to meet the relevant criteria of the insurer in their own member state, generally have to do so at their own expense. However, patients (usually through their physicians) can try to obtain special authorization from designated neutral physicians. In effect, they plead extenuating circumstances and ask for an exemption from the rules. Similar coverage criteria were in place for in-patient acute medical, surgical, or psychiatric treatment.

One can readily see that the thresholds contained in the coverage rules largely determined the number of patients who received the desired care under the health insurance of the member states. As such, these rules served to balance the patients’ freedom to obtain desired services against the overall costs imposed on the beneficiaries of the health care system as a whole.

The above mentioned procedures and criteria differed a great deal across the Euregion member states. To improve the confusing situation, a general outline of new procedures have been described in the program. In the health care systems of the Euregion member states, a patient with a perceived health need for a particular treatment could seek the advice of a professional, generally a physician or another provider who counsels the patient. Generally this must be done within the context of the health insurance coverage of the patient.

The next step in the process is for the provider to determine by referencing to the criteria whether the patients’ health insurance covers the desired procedure. If the patient’s condition matches the applicable insurance rules, the procedure is covered and may be obtained within the health insurance cover. If the patient does not match these coverage rules, the patient may either forego the recommended service despite the professional's advice or may obtain the service using private funds. Alternatively, the patient and the provider may elect to appeal for coverage within the health insurance, setting forth their reasons to an ostensibly neutral third party physician on whose opinion the desired procedure should be provided. A judgement that the service should not be provided is, as a rule, not final and can be appealed against by the patient to a second-level judge or court which can either uphold or overturn the denial of coverage.

Conclusions and Future Perspectives

First results show that new cross-border health alliances have resulted in improved possibilities for patients to have access to more health care facilities than before. Alliances between health insurers and providers have been approved and facilitated by the different governmental organizations, which are also involved in this project.

This paper also analyzed the rights of patients on cross-border care in a Euregion. Although the EU and the EC Treaty form a small legal basis for the realization of the patients' rights, the impacts of EC regulations and EC Court decisions are considerable, particularly because of the most recent decision in the Decker and Kohll cases of the Court of Justice of the European Communities. In the case of cross-border health care, a balance can be found between the rights and the criteria to allow patients, sometimes on the basis of pre-authorized medical (hospital) care or by themselves in other cases (ambulatory care) to receive treatment in other Euregion countries. This could also be an example of future collaboration between the present member states of the European Union and the countries in Central and Eastern Europe.

Areas of tension can be found in the practical realization of the rights of patients to be treated in other Euregion member states. The rules of authorization were different and the interpretation of these rules also varied from state to state. A solution for these problems, which have been complicated by the recent European court decision, can be found in the creation of a more uniform and simple procedure. Ultimately the main purpose of the program will be the strengthening of the position and the influence of the patient to stimulate and to create real possibilities for cross-border health care for social insured patients not only in the Euregio Meuse-Rhine but also with a future perspective of collaboration between the countries in Western, Central, and Eastern Europe. Euregions could be a new and appealing platform to realize patients' rights. Building up the mentioned alliances could also form a practical first step in this direction.

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