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Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Center

SOINS PROGRAMMÉS À DES PATIENTS ÉTRANGERS: IMPACT SUR LE SYSTÈME BELGE DE SOINS DE SANTÉ

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HEALTH SERVICES RESEARCH

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Colophon

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PRÉFACE

La réglementation européenne sur la libre circulation des biens, des services, des capitaux et des personnes permet aussi une grande liberté de circulation des patients entre les pays membres. On observe par ailleurs certains flux de patients venant d'autres pays. Les flux sont-ils déjà importants, vont-ils encore s'accentuer ? Risquent-ils d'entraîner des déséquilibres ou des effets pervers ? Ces questions méritaient d'être posées et examinées.

Un audit de la Cour des Comptes a dénoncé il y a deux ans des doubles remboursements de dépenses hospitalières relatives aux patients étrangers. Un Observatoire de la Mobilité des Patients a été créé mais n'a été réellement installé que très récemment. Nous espérons que le présent rapport lui apportera une matière de départ utile à son déploiement.

Le démarrage de ce projet n'a pas été facile. Le KCE a en effet dû s'y reprendre à trois fois pour trouver une équipe de recherche qui accepte et qui soit capable de mener le projet à bien en collaboration. Ce sont finalement deux équipes de la K.U.Leuven – le Centrum voor Ziekenhuiswetenschappen et l'Instituut voor Sociaal Recht – qui ont relevé le défi. En outre, cinq hôpitaux ont été sollicités pour fournir des données complémentaires à celles que nous avons pu trouver dans les banques de données traditionnelles. Que tous ceux qui ont collaboré soient ici remerciés.

Jean-Pierre CLOSON
Directeur Général Adjoint

Raf MERTENS
Directeur Général

RÉSUMÉ

CONTEXTE

Les patients sont de plus en plus disposés à se rendre à l'étranger pour y bénéficier d'interventions médicales programmées. Dans ce domaine, la Belgique se révèle être un grand pôle d'attraction. Si la tendance vers plus de mobilité transfrontalière se confirme, cette évolution peut avoir des conséquences substantielles pour les patients belges, pour les hôpitaux belges et pour le système de soins de santé belge dans son ensemble.

OBJECTIF DE L'ÉTUDE ET MÉTHODES

La finalité première de l'étude est de quantifier les différents flux de patients étrangers vers la Belgique pour des soins médicaux programmés, et de mettre en lumière leur impact financier sur le système de soins de santé, plus particulièrement sur le financement des hôpitaux.

Cet objectif général a été traduit en plusieurs questions de recherche plus spécifiques. Une méthode appropriée a été appliquée pour apporter une réponse à chacune de ces questions:

- À quelles conditions les patients de l'Union Européenne (UE) et ceux hors UE peuvent-ils bénéficier de soins médicaux en Belgique?
  - Analyse de la législation, de la jurisprudence et de la doctrine belges et européennes.
- Combien de patients étrangers se rendent en Belgique pour y bénéficier de soins médicaux programmés et quelles sont leurs caractéristiques principales?
  - Analyse des données cliniques (RCM) et de facturation des hôpitaux (SHA/HJA)[a] les plus récentes disponibles.
  - Etudes de cas réalisées dans cinq hôpitaux.
- Quelles sont les conséquences financières sur le financement des hôpitaux?
  - Analyse de la législation belge relative au financement des hôpitaux
  - Développement de réflexions théoriques sur des alternatives au méchanisme de financement.
- La mobilité (croissante) des patients a-t-elle d'éventuelles conséquences non financières?
  - Enquête auprès des hôpitaux sur l'existence des listes d'attente.

RESULTATS

Trois types de flux de patients étrangers

Le cadre juridique qui régit la mobilité des patients est essentiellement fondé sur la jurisprudence de la Cour de Justice de l'Union européenne. Cette jurisprudence a été traduite récemment dans une Directive sur la Mobilité des Patients qui apporte une plus grande sécurité juridique.

On distingue trois catégories de patients étrangers, en fonction de l'itinéraire de financement :

- Les patients soignés dans les mêmes conditions que les patients affiliés à l'assurance maladie belge : patients règlementaires[b] (formulaire E112, converti aujourd'hui en formulaire S2) + patients de contrats pays limitrophes;
- Les patients qui avancent ou supportent eux-mêmes le coût des interventions (facturation directe);
- Les patients auxquels s'appliquent les contrats transfrontaliers.

Ces groupes de patients diffèrent en termes de législation applicable, d'obligation d'autorisation préalable pour pouvoir obtenir le remboursement ultérieur des frais, de la nature et de l'ampleur des soins dont ils peuvent bénéficier, de tarifs pouvant être appliqués et de méthode d'imputation des coûts.

[a] RCM : Résumé Clinique Minimum (2004-2008) ; SHA : Séjour Hospitalier Anonyme (2004-2009), HJA : Hospitalisation de Jour Anonyme (2006-2008)

[b] Patients dans le cadre du règlement européen de coordination

Nombre de patients étrangers

En 2008, 22 679 hospitalisations classiques de patients étrangers dans les hôpitaux belges ont été recensées (dans les RCM) . Bien que ce chiffre ne représente que 1,29% de l'ensemble des hospitalisations classiques, une tendance continue et croissante se dégage : + 60% en cinq ans.

Le nombre d'hospitalisations de jour de patients étrangers reste faible, mais on observe ici aussi une augmentation similaire. En 2008, leur proportion se montait à 0,98% du nombre total de ces hospitalisations.

L'enquête menée auprès des hôpitaux a mis en évidence une grande variation inter-hospitalière dans la part des patients étrangers, allant de moins de 1% à 7%, aussi bien pour les hospitalisations classiques que pour les hospitalisations de jour.

Caractéristiques des patients étrangers

Pays d'origine

La majorité des patients étrangers est originaire des Pays-Bas (60% des hospitalisations classiques et 71% des hospitalisations de jour en 2008) et de France (respectivement 14% et 12%).

Interventions les plus fréquentes

A la fois pour les hospitalisations classiques et pour les hospitalisations de jour, les interventions les plus fréquentes sont en rapport avec le système musculo-squelettique. Ensemble, les procédures pour le dos et la nuque (y compris la fusion vertébrale), la prothèse de la hanche, la procédure pour l'épaule, le coude et l'avant-bras, forment 25% des séjours. En hospitalisation classique, la problématique de l'obésité et la revascularisation coronarienne élective percutanée (PCI) arrivent en deuxième et troisième position. En hospitalisation de jour, ce sont la procréation assistée (cliniques de fertilité), le conseil génétique et la chimiothérapie.

Les patients réglementaires (E112/S2) et des contrats pays limitrophes

Seuls les patients bénéficiant du système réglementaire d'un contrat pays limitrophes peuvent être extraits des données de facturation (SHA/HJA). En 2009, ils représentaient ensemble environ 6 400 séjours classiques, soit 30% des hospitalisations classiques des patients étrangers. Dans cette catégorie, on dénombre quatre cinquièmes de patients règlementaires et un cinquième de patients qui viennent avec un contrat pays limitrophes.

En matière d'hospitalisation de jour (total = 11 021 séjours), la proportion est respectivement de 45% de patients règlementaires et 55% de patients avec contrat pays limitrophes.

Le nombre d'hospitalisations classiques de patients règlementaires et de patients avec contrat pays limitrophes varie d'une année à l'autre et a connu une tendance à la baisse depuis 2008. Cette variabilité d'une année à l'autre existe aussi pour les hospitalisations de jour, mais sans tendance marquée à la baisse.

Contrats transfrontaliers et facturation directe

Les patients qui se sont fait soigner en Belgique dans le cadre d'un contrat transfrontalier et les patients 'facturation directe' ne peuvent être tracés dans les données financières, car ils n'ont bénéficié d'aucune intervention de l'assurance maladie obligatoire belge. En conséquence, leur nombre ne peut être qu'estimé grossièrement. Ces catégories de patients représentent 62% du nombre total d'hospitalisations classiques des patients étrangers.

Gravité de la pathologie

Dans la plupart des catégories de patients, le degré de gravité de la maladie (dans les RCM) des patients étrangers est en moyenne inférieur à celui des patients belges.

Enregistrement des données des patients étrangers

Une analyse des RCM, des données de facturation et de FINHOSTA[c] a révélé des lacunes importantes dans l'enregistrement des données des différentes catégories de patients étrangers, des pays dans lesquels les patients sont assurés, du profil des pathologies et de la source de financement. En outre, il n'y a pas d'uniformité entre les bases de données dans leur cadre conceptuel utilisé pour désigner les patients étrangers, ce qui complique – voire rend impossible – une analyse fiable.

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[c] Collecte de données comptables

Incitants financiers pour attirer un grand nombre de patients étrangers

A part la nécessité d'occuper au maximum ses lits, le financement des hôpitaux, dont la caractéristique principale est un budget fermé des moyens financiers, ne donne pas d'importants incitants financiers aux hôpitaux qui les conduiraient à maximiser le nombre de patients étrangers. En outre, le prix moyen de la journée d'hospitalisation ne reflète pas nécessairement le coût réel de chaque hôpital, ce qui pourrait engendrer des problèmes pour les hôpitaux avec patients étrangers ayant une pathologie lourde. Les médecins hospitaliers par contre, peuvent trouver chez les patients étrangers un certain nombre d'avantages financiers ou autres.

Pas de listes d'attente

Aucun des hôpitaux interrogés ne fait état de listes d'attente. Comme stipulé par la Loi sur la Mobilité des Patients de 2007, une des missions légales de l'Observatoire de la Mobilité des Patients consiste à surveiller les délais d'attente des interventions hospitalières pour les patients belges.

CONCLUSION

Le nombre de patients étrangers qui se rendent en Belgique pour une intervention médicale programmée est actuellement plutôt restreint, mais est en augmentation. Une estimation précise de ce nombre est impossible en raison des lacunes des systèmes existants d'enregistrement des données. Dans l'hypothèse d'une intensification des flux de patients étrangers, une réflexion complémentaire sur la modification des modalités de financement des hôpitaux s'imposerait. Il n'existe actuellement aucun système permettant de mesurer les délais d'attente dans les hôpitaux belges.

RECOMMENDATIONS[d]

Amélioration de l'enregistrement des données

- **Le pays dans lequel le patient est assuré et l'itinéraire de financement devraient être enregistrés dans les RCM pour chaque hospitalisation de patient étranger.**
- **La liste actuelle des organismes d'assurance intégrée dans FINHOSTA devrait être complétée par l'indication du pays dans lequel le patient est assuré. Une nouvelle classification des patients étrangers devrait en outre être instaurée en fonction de leur statut d'assurance, conformément à ce qui est proposé pour les RCM.**
- **Il convient d'envisager d'enregistrer, dans un système d'enregistrement obligatoire similaire aux SHA/HJA, les données de facturation des patients qui bénéficient d'une intervention médicale dans un hôpital belge, mais qui ne sont pas couverts par l'assurance maladie obligatoire belge. La faisabilité et les modalités d'un tel système doivent faire l'objet d'un examen complémentaire.**
- **Les différents systèmes d'enregistrement contenant des informations relatives aux patients étrangers doivent être harmonisés.**

Modifications du financement des hôpitaux?

- **Si l'afflux des patients étrangers continue à augmenter, des mécanismes alternatifs de financement des hôpitaux et leurs implications légales devront être analysés.**

  Les options sont les suivantes:

  - **Prévoir un budget de moyens financiers distinct pour les patients belges et pour les patients étrangers.**
  - **Modèle de financement par cas, dans lequel un prix forfaitaire par pathologie (sur la base d'un système DRG) est calculé.**

Monitoring

- **L'Observatoire pour la Mobilité du Patient devrait surveiller les flux entrants et sortants des patients par arrondissement.**

Dans les arrondissements où les flux nets d'entrée augmenteraient brusquement de manière significative, un système de contrôle des listes d'attente devrait être installé, afin de préserver l'accès aux soins de santé pour les patients belges.

[d] Le KCE reste seul responsable des recommandations faites aux autorités publiques

SCIENTIFIC REPORT

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LIST OF ABBREVIATIONS

ABBREVIATION	ENGLISH	DUTCH	FRENCH
APR-DRG	All Patients Refined-Diagnostic Related Groups		
ARA	Anti-Racism Act of 31 July 1981		
AZV/SHA		Anonieme Ziekenhuisverblijven	Séjours Hospitaliers Anonymes
BFM	Budget of Financial Means		
CABG	Coronary Artery Bypass Grafting		
Cass	Court of Cassation (Belgian Supreme Court)		
Const. Court	Constitutional Court		
DOSZ/OSSOM		Dienst Overzeese Sociale Zekerheid	Office de Sécurité Sociale d'Outre-Mer
ECJ	European Court of Justice		
EEA	European Economic Area		
EFTA	European Free Trade Organization		
EU	European Union		
FPS	Federal Public Service		
FTE	Full-Time Equivalent		
HBD	Hospital Billing Data		
HDI	Health and Disability Insurance		
HDI-Act	Health and Disability Insurance Act of 14 July 1994		
HVKZ/CSPM		Hulp en Voorzorgkas voor Zeevarenden	Caisse de Sécours et Prévoyance en faveur

			des marins
ICD-9-CM	International Classification of Diseases, 9th version, Clinical Modifications		
IZOM		Integratie Zorg Op Maat	
IV-NIOOO/IV-INIG		Instituut voor Veteranen-Nationaal Instituut voor Oorlogsinvaliden, Oud-strijders en Oorlogsslachtoffers	Institut des Vétérans - Institut National des Invalides de Guerre, Anciens Combattants et Victimes de Guerre
MCD	Minimal Clinical Data		
MDC	Major Diagnostic Category		
MHD	Minimal Hospital Data		
MND	Minimal Nursing Data		
NBHI	National Board of Hospital Institutions		
NHS	National Health Service		
NIHDI	National Institute of Health and Disability Insurance		
OCMW/CPAS		Openbaar Centrum voor Maatschappelijk Welzijn	Centre Public d'Action Sociale
ODF	Occupational Diseases Fund		
OR	Operation Room		
PTCA	Percutaneous Transluminal Coronary Angioplasty		
ROM	Risk-of-Mortality		
SGEI	Services of General Economic Interest		
SIS	Social Insurance Status-code		

1. INTRODUCTION

Cross-border patient mobility involves people accessing healthcare services outside their own home state. It can imply a patient who deliberately travels to another country than the one he/she lives in and where he/she may or may not have health coverage. This is called "elective care". People may also need (emergency or urgent) care when they fall ill or suffer an injury while travelling for business or pleasure or staying temporary in another country, for instance to study.

When patients deliberately choose to go abroad for healthcare, their willingness is determined by different drivers. Usual triggers are availability in terms of quantity, timing or types of services, affordability, familiarity with a healthcare system in terms of language, religious beliefs, culture or history, trust in the provider and perceived quality. For particular patient categories, such as patients living in border regions, geographical location may also be a driver. Retired patients immigrated to another country may wish to use the healthcare system of the country they used to live in because of the familiarity with the system. The major concern for patients travelling abroad for planned or elective healthcare will mostly relate to the payment or reimbursement of the medical costs and possibly related travel costs and costs of stay. In this report, patients seeking elective care in another country are referred to as foreign patients. This does not refer to patients of foreign nationality but residing in Belgium. Depending on who pays the costs and when, different types of foreign patients can be distinguished. Some patients can claim their costs from the institution granting social coverage in the home state after having obtained prior authorisation (formalised through the so-called E112, now S2 forms), others have private insurance or pay the costs themselves. Important players on the "demand side", along with the patients, are foreign insurers sending their patients abroad to access elective care. Belgian hospitals are interesting partners for foreign insurers in the neighbouring countries because of geographical and linguistic proximity and because Belgian hospital prices tend to be cheaper compared to e.g. the Netherlands.

As some governments, such as in the UK, have set targets on waiting times, the National Health Service (NHS) systematically offers their affiliated members access to healthcare abroad in order to shorten waiting lists.[1]

Today patient mobility seems to be a relatively modest phenomenon in terms of number of patients. Generally, cross-border healthcare in the EU accounts for 1% of public healthcare expenditure, including emergency care.[2]

As numbers grow, however, different opportunities but also several threats may arise for the actors involved on the "supply side". For hospitals, cross-border patient mobility may be an opportunity to attract renowned physicians, to gain expertise and experience and to become a reference centre for certain treatments and pathologies. But for the same hospitals as well as for those treating no or few foreign patients, there might be a negative financial effect as the Belgian system of hospital financing is lacking some mechanisms to cope with an increasing number of (foreign) patients. As the number of foreign patients coming to Belgium for treatment increases or if treatment of foreign patients is more lucrative for physicians or hospitals, they might favour the treatment of foreign patients.

For the government, the loss of control on their healthcare system and equity implications are of major concern. In that scope the Belgian policy maker placed patient mobility high on the political agenda, as it moved towards a first analysis of patient mobility with the introduction of the Observatory for Patient Mobility.

1.1. Scope and objectives of the study

This study zooms in on patients who are not insured in Belgium, and who travel to Belgium with the intent of receiving elective healthcare. This is only a selection of the foreign patients group. Immigrants with a foreign nationality, who are not insured in Belgium but domiciled in Belgium, are in principle not included but are nevertheless described as they represent a quite large volume of patient stays in Belgium and thus may have an impact on hospital financing.

Foreigners needing urgent medical assistance or unplanned medical care while staying in Belgium are excluded from the scope of the study. Elective care succeeding an emergency admission, however, is included. We also focus on acute hospital stays (including the one-day stays but not the ambulatory care). Hence, psychiatric hospitals, nursing homes,

revalidation centres and services for the elderly are excluded. Elements related to the purchasing of products (such as pharmaceuticals and medical devices) or telemedicine, which are services provided to a patient, who does not travel to another country, also fall out of the scope of the study.

The primary purpose of the study is to describe the actual foreign patient flows for elective healthcare in Belgium and to analyse the financial impact on our healthcare system. Furthermore, potential non-financial consequences will be touched on. More specifically, the following research questions are addressed:

- What are the conditions according to which European Union (EU) and non-EU patients can benefit from elective healthcare in Belgium?

  The scope and the modalities of the entitlement to health insurance benefits in Belgium for foreign patients (is prior authorization needed?, who will cover the costs?, what costs are covered?, etc.) are clarified.

- How many patients come to Belgium for elective interventions and what are their characteristics?

  The aim is to quantify the different patient flows coming to Belgium for elective healthcare and to map the evolution over the last years (2004-2008). Furthermore, patient and treatment characteristics such as the patients' country of residence, the variability in pathology and case-mix of hospitals and the types of payment of the treatment are studied.

- What are the financial consequences of this migration of patients?

  The aim is to clarify how different foreign patient flows are/can be (legally) billed and to define the financial impact on our healthcare system, in particular with regard to hospital financing. In response to the potential problems for Belgian hospital financing, different options aiming at a more accurate billing of foreign patient flows and the necessity of adjustments to the existing Belgian law in case of implementation are presented.

- What are potential non-financial consequences of this patient migration?

  The possible impact of foreign patient flows on waiting lists and quality of care will be discussed.

1.2. Methodology and outline of the report

To address the objectives described above, multiple approaches were applied. In a legal analysis, the conditions according to which European Union (EU) and non-EU patients can benefit from elective healthcare in Belgium are elaborated (chapter 2). Chapter 3 analyses the actual hospital registration systems existing with the Federal Public Service (FPS) Public Health and the National Institute for Health and Disability Insurance (NIDHI) that can provide information on the inflow of the different types of foreign patient (coordination, direct billing, contract) identified in the first chapter.

The mapping of the different types of patients undergoing elective interventions in Belgium is based on an analysis of the most recently available clinical and hospital billing databases (chapter 4). Both databases have several limitations. The data for 2008 (most recent) will not be able to include the most recent developments in the field of patient mobility. Therefore, the study is complemented with case studies performed in different types of hospitals (cross-border and mainly contracting). These case studies make it possible to quantify the foreign patients into more detail and to identify certain categories of foreign patients who are not included in the clinical and hospital billing databases.

The evaluation of the financial consequences of the foreign patient flows, particularly on the hospital financing system, is based on a description of the legal framework regarding hospital financing (chapter 5). In response to the potential problems for Belgian hospital financing related to a growing flow of foreign patients, different theoretical options aiming at a more accurate billing of foreign patient flows and the necessity of adjustments to the existing Belgian law in case of implementation, are presented (chapter 6).

The non-financial consequences in terms of waiting lists and quality of care are theoretically discussed (chapter 7).

In different chapters, results from interviews with experts in the field (list of names available in Appendix 1) have been inserted.

2. LEGAL FRAMEWORK

2.1. Introduction

This chapter gives an actual overview of the state of the art in relation to patient mobility and treatment of foreign patients in Belgian hospitals. It gives a picture of the different ways under which foreign patients can be entitled to elective healthcare in Belgian hospitals.

2.1.1. Detailed structure overview

The legal chapter describes the actual European, international and Belgian legal framework concerning elective cross-border healthcare, often denominated as the phenomenon of 'patient mobility'.

The practical relevance of each framework will depend on the type of mobile patient. As such one has to distinguish between:

- socially insured patients coming from within the European Union(EU)/European Economic Area (EEA);
- socially insured patients coming from outside the EU/EEA;
- foreign patients who come for a hospital treatment without any legal or contractual refund basis.

The European subchapter starts with a brief reiteration of the competences of the European Union within the field of healthcare.

Subsequently an overview is given of the main legal instruments that allow or even enhance patient mobility within the area of the EU.

Our research first looks at the 'traditional' European way of organizing elective cross-border healthcare which is based on the fundamental right to free movement of persons (art. 20 Treaty on the Functioning of the European Union - TFEU) and its corollary instrument of coordination of social security rights.

Thereafter, an analysis is made of the *'Kohll & Decker'*-jurisprudence of the European Court of Justice (ECJ). These judgments opened up an additional track – parallel to the one of the Coordination Regulations – to receive elective healthcare in another Member State based on the fundamental right of free movement of services (art. 56 TFEU). By means of a structured oversight of the current case law this part illustrates how the ECJ gradually opened a common market for healthcare services. At the same time it forces Member States to deregulate measures that obstruct the patient mobility across the EU.

At the end of this jurisprudential overview, attention will be paid to some specific ECJ case law interpreting the Treaty articles on European citizenship (article 18 and 20 TFEU). One of the cornerstone principles underpinning European citizenship is based on the principle of non-discrimination of European citizens. In one specific case this principle has been applied upon the tariff setting of hospital care for foreign EU patients. The latter category of patients should not be discriminated as to the tariff setting of hospital care, even when the concerned patient is not taking part in the local social security system.

The abovementioned jurisprudential track of patient mobility is established on a case-to-case basis and therefore provokes continuous interpretational questions, and thus consequently, feeds legal uncertainty. The recent Directive '*on the application of patients' rights in cross-border healthcare*' of 19 March 2011 (hereafter called Patient Mobility Directive) establishes a legal framework to curtail these concerns on cross-border patient mobility.

We conclude the European subchapter with a closer look at some local cross-border initiatives between Belgian hospitals that build further upon the existing EU framework on patient mobility. Some of these initiatives develop further in border regions the cross-border healthcare track of the Coordination Regulations. Others deal with direct cross-border healthcare contracting between (Belgian) hospitals and (foreign) healthcare insurers.

The next subchapter will focus on the different ways of elective healthcare for social insured patients coming *outside* of the EEA. The existing legal framework in relation to scheduled treatments for this category of foreign patients is limited; certain possibilities exist through bilateral or multilateral social security coordination instruments or (possibly) even through international contracting.

The final subchapter deals with the residuary category of foreign patients coming outside of any funding contract of social security coordination instrument. Also here, an elaborated legal framework is absent, but certain fundamental principles should nevertheless be respected.

We conclude the legal chapter with a detailed schematic overview of the different identified patient mobility routes and their respective characteristics.

2.1.2. Methodology

The legal chapter has been written on the basis of classic legal methodology, which consists of the consultation and processing of legal texts, parliamentary documents, relevant jurisprudence and legal doctrine. Where necessary or useful, certain insights following from the in-depth expert interviews carried out within the scope of this study have been integrated.

2.2. Patient mobility in the EU/EEA

2.2.1. Patient mobility across different European fundamental rights and freedoms

Healthcare is primarily a competence of the Member States of the EU. Barring some exceptions, the competences given to the EU are mainly limited to the enactment of non-binding measures in the field of healthcare.

The division of competences in the field of public healthcare is governed by article 168 of the Treaty on the Functioning of the EU (TFEU). It recognizes *'the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care'*.[i] If we, furthermore, take into account the fact that the possibilities of adopting secondary EU legislation[ii] in the area of public health are limited to very specific areas, like blood derivatives, quality standards for medicinal products and similar[iii], we can see that EU Member States still retain significant legislative freedom to organize their health systems.

A similar situation exists in the area of social security, including social healthcare insurances. The legislative measures adopted by the EU in this area 'shall not affect the right of Member States to define the fundamental principles of their social security systems and must not significantly affect the financial equilibrium thereof'.[iv] Furthermore, adoption of EU secondary legislation in the area of social security is subject to the special legislative procedure, which includes the unanimous decision-making by the Council and only the consultation of the European Parliament.[v] Therefore, it is obvious that the Member States have retained the essential autonomy to define their own social security systems.

Despite the limited competences of the EU in this area, the ECJ repeatedly stated that, although healthcare and social security are competences of the Member States, the latter should respect – i.e. not hamper – the free movement principles of the EU. A salient example in this regard is the case law of the ECJ shaping gradually the free movement of patients across the EU.

This case law took a start in 1998 with the milestone *Kohll and Decker* judgments touching upon the issue of refund of healthcare treatment obtained in another Member State. The Court considering the cross-border purchase of healthcare as belonging to the scope of the free movement of services and goods, ruled that a national rule prohibiting the refund of these treatments as they were obtained in another Member States, obstructs in an unjustified manner the free movement principles relating to goods and services. The ECJ has, in the years following these two cases, expanded the scope of freedom to provide and receive health services and goods, in particular in situations where persons travel abroad for the purpose of obtaining health *treatments* there.

This development raised ambiguities about the possible consequences it could have on national healthcare regulation and the possibilities for individuals to receive social (public) coverage of health treatments obtained in a Member State in which they are not socially protected.

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i Art 168(7) Treaty on the Functioning of the European Union.[3]

ii With the notion of "primary law" one refers to the provisions of the Treaty on the Functioning of the European Union. The term "secondary law" refers to the subordinate legal instruments (Regulations, Directives, Decisions) meant to execute the competences given to the EU by the Treaty (art. 288 TFEU).

iii Art. 168 (4) TFEU.

iv Art. 153 (4) TFEU.

v Art. 153 (2) TFEU; Art. 21 (3) TFEU.

Yet, apart from this case law that shaped the patient mobility in the EU on the basis of the free movement of services, cross-border healthcare has been part of other regulatory frameworks as well. Already a long time before the reputed cases of *Kohll* and *Decker*, patients could obtain healthcare abroad (within the setting of the EU) on the basis of Regulations coordinating for the sake of workers mobility the various social security systems of the Member States (Regulations 1408/71[4] and 574/72[5], now replaced by Regulations 883/2004[6] and 987/2009[7]). Certain parts of these Coordination Regulations specifically deal with cross-border healthcare for migrant workers and more in general citizens moving within the European Union.

One must remark that these two major patient mobility routes (coordination-based and Treaty-based) not only apply to the 27 Member States of the European Union, but may also be of relevance for patients coming from states outside the EU:

- By means of extension agreements the European Coordination Regulations are made applicable to social insured persons of all 4 Member States of the European Free Trade Association (EFTA): Iceland, Liechtenstein, Norway and Denmark.[vi] However, these agreements still have to be amended in order to make the new Coordination Regulations applicable. In the meantime, the Regulations 1408/71 and 574/72 continue to apply here.
- Since Regulation 859/2003 the personal scope of application of the European Coordination Regulations (which are in principle restricted to nationals of EU-Member States) has been extended to third-country nationals who were not already covered by those provisions on the ground of their nationality, on condition they are legally resident in the territory of one Member State and are in a situation which is not confined in all respects within a single Member State (need of cross-border element between two EU Member States).
- The new Coordination Regulation 883/2004[10] first unintentionally omitted this category of social insured, leaving the old Reg. 1408/71 to apply. [11] This loophole has been remedied recently by Regulation 1231/2010 of 24 November 2010[12].[vii]
- The 4 fundamental internal market freedoms (free movement of goods, services, persons, capital) have been extended to the three EFTA-States Iceland, Liechtenstein and Norway. Together with the 27 EU-Member States they form the *EEA*.

In what follows both the legal rules concerning the coordination-based as well as the treaty-based patient mobility route will be thoroughly examined.

2.2.2. *Elective cross-border healthcare in the European social security coordination rules*

For quite some time now, the EU social security coordination rules serve as a legal basis for the entitlement to healthcare provision in another Member State for socially insured persons. These rules are to be found in the specific chapter on the coordination of sickness benefits in Title III of Regulation 883/2004 (articles 17 ff.) In general we discern three situations in which the Coordination Regulations grant access to the healthcare system of another EU Member State:

1. The insured person is residing in another Member State than the state where he is socially insured (the latter being labeled as “competent” state). In such a situation the person is also entitled to healthcare in the state of residence.
2. In case the insured person becomes in need of healthcare during a temporary stay in another Member State. In this situation he will have access to the healthcare system of the state where he is temporarily staying as long as we are dealing with healthcare services that become necessary on medical grounds taking into account the initial perspective of stay.
3. The insured person receives the prior authorization from the healthcare institution in order to get an elective healthcare treatment in another Member State.

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vi For Iceland, Liechtenstein and Norway: see art. 29 and Annex VI attached to Agreement of 2 May 1992 on the EEA (EEA).[8] For Switzerland: see art. 8 and Annex II attached to the Agreement between the European Communities and its member states and the Swiss Confederation on the free movement of persons of 21 June 1999.[9]

vii This Regulation does not apply to Denmark and the United Kingdom.

For the purpose of this overview, the focus will be on the third eventuality concerning an elective treatment. Before starting upon this description, the social security coordination rules first have to be introduced.

2.2.2.1. Introducing the coordination rules: remove national social security obstacles to enhance free movement of European socially insured citizens

Already in 1957 the European Member States foresaw that free movement of *workers* within the newly established internal market would be seriously hampered if no adapted measures were taken at the European level to coordinate social security.

Due to a different scope of application, *positive and negative conflicts of law* could rise between national social security systems resulting in no or double social coverage for the migrant worker.[13] A negative conflict of law arises e.g. when a person is living in a Member State which determines the scope of application of its social security system by reference to one's conducting of a professional activity (as an employed or a self-employed person, for instance),[viii] while working in a Member State which social security system applies to all its inhabitants.[ix] Without any supranational rule indicating the legislation applicable this person will be left without social protection. A same rule is needed for a positive conflict of law, in case a migrant worker qualifies for the social security law of both his country of residence and the country where he performs professional activities.

Also the *territoriality-principle* applied by many national social security systems could create serious obstacles for migrant persons. One can think of provisions prohibiting the export of benefits abroad. National rules frequently require that the person concerned should reside within the state of insurance in order to receive social benefits, thus preventing their payment outside of the national borders. Other obstructions may follow from national rules that make the amount or even the granting of a social benefit conditional upon the completion of periods of insurance. As a consequence, the non-recognition of insurance periods completed in another Member State could lead to the refusal or a reduction of benefits in the (new) Member State of insurance.

Taking into consideration all these potential obstacles to worker mobility, a specific legal basis was included in the Treaty on the basis of which European social security coordination measures could be taken.[x]

Coordination rules do not aim to harmonize national rules in the area of social security. It is their goal, rather, to provide technical solutions for situations in which a person, due to his cross-border movement, comes into contact with several national statutory social security systems, and consequently would result in the loss of social security entitlements. Coordination rules do not aim at replacing the (body of) national rules with EU rules; they only affect those national provisions which deal with migrants, specifically by overriding national rules which are disadvantageous for them.[13]

For a significant period of time, the main instruments of social security coordination between the Member States of the EU were Regulation 1408/71 and its implementing Regulation 574/72. As from the 1st May 2010, both have been replaced by Coordination Regulations 883/2004 (Reg. 883/2004) and 987/2009 (Reg. 987/2009). These new legal instruments adapted the coordination corpus to new evolutions that emerged in the national social security systems. A significant innovation in the last Coordination Regulations is e.g. the widening of the personal scope to all EU nationals who are or have been socially insured and move(d) between Member States, this in contrast to Regulation 1408/71 which from supported free movement of professionally active persons and thus defined its personal scope on a categorical basis (workers, self-employed persons, students and persons depending upon these categories). As such, Reg. 883/2004 and 987/2009 can be considered the social security components of the Treaty provisions concerning European citizenship.

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viii These systems can be characterized as "professional or occupational social insurances". See PIETERS, 2006, 21-22.[14]

ix These systems can be characterized as "universal social insurances". See PIETERS, 2006, 21-22.[14]

x See actual art. 48 TFEU (previous art. 42 EC).

Next to modernization the coordination rules were also in need of simplification, this mainly due to the growing diversity of the systems as a consequence of the ongoing enlargement process over the last 40 years. Also the administrative cooperation between social security institutions of different Member States received a lot of attention.

The European Coordination Regulations are developed around four major coordination principles: [15-17]

- *Only one state should be competent*[xi]: In principle this will be the state of employment (*lex labori locis*-principle) unless the Regulation provides otherwise (posting, simultaneous activities,…);
- *Aggregation of periods* of insurance, employment, self-employment or residence completed in another Member State than the competent state as though they were completed under the legislation to which it applies[xii], in case the entitlement to a social security benefit is made conditional upon the proof of a certain period of work, residence or insurance;
- *Exportability of social benefits*[xiii]: the competent state cannot make benefits subject to any reduction, amendment, suspension, or withdrawal on the basis the insured resides in another Member State;
- *Equal treatment*[xiv]: persons subject to the social security legislation of one Member State shall enjoy the same benefits and be subject to the same obligations under the legislation of another Member State as the nationals thereof.

Sometimes also *administrative cooperation* between social security institutions of different Member States is considered to be a coordination principle.

They further foresee in detailed rules for each of the covered social contingencies (Title III Regulation 883/2004). As such, also specific coordination rules apply for healthcare benefits or as they are called in the coordination terms “sickness benefits-in-kind”.[xv] One of these rules deals with the situation of elective care i.e. the case of a person socially insured in one Member State who obtains scheduled treatment in another Member State. This will be further elaborated in 2.2.2.2.

2.2.2.2. Coordination rules regarding elective healthcare: procedure of prior authorization

When an insured person and/or members of his family travel to another Member State to obtain healthcare, he must ask for prior authorization from the competent institution.[xvi] The authorization is only required to obtain coverage of the foreign treatment. As such, the patient can travel abroad to another Member State to receive a treatment at his own expense. If he wants to have the foreign treatment covered by his social security system, he will need though the prior authorization of his competent institution. This rule applies for both ambulatory and hospital care.

The competent institution giving authorization refers to the institution which will possibly bear the costs of the treatment.[xvii] In principle this will be the institution of the Member State under which legislation the patient is *socially insured* (through an individual or derived right).[xviii] In Belgium this will be one of the health insurance funds to which one is affiliated.

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xi Art. 11-16 Reg. 883/2004.

xii Art. 6 Reg. 883/2004.

xiii Art. 7 Reg. 883/2004.

xiv Art. 4 Reg. 883/2004.

xv Art. 17-20; 23-28; 31-35 Reg. 883/2004. Since its inclusion by Reg. 988/2009 of 16 September 2009, art. 1 (va) Reg. 883/2004 defines ‘sickness benefits-in-kind’ as benefits in kind provided for under the legislation of a Member State which are intended to supply, make available, pay directly or reimburse the cost of medical care and products and services ancillary to that care. This includes long-term care benefits in kind. Before this modification, the ECJ already ruled very early that cash-payments could constitute a sickness benefit-in-kind if they act as a restitution for medical costs. (Case (1965) C-62/65 Vaassen-Göbbels[18]).

xvi Art. 20 Reg. 883/2004 (old art. 22 (1) (c) i) Reg. 1408/71).

xvii Art. 26.1 Reg. 987/2009.

xviii Art. 1 (q) Reg. 883/2004.

Vice versa, patients from another EU Member State coming to a Belgian hospital have received the prior authorization from the institution which provides them statutory healthcare coverage.

If the scheduled treatment is authorized, the healthcare insurer will issue an S2 form (former E112-form). This form will indicate the provider(s), treatment(s) and duration for which the authorization is given.[xix] The state of treatment is bound by these specifications.

Obligation to grant authorization

In principle, the competent institution enjoys some discretion to grant authorization or not. Practice learns that in most Member States, like Belgium, authorization will only be granted restrictively.[xx]

Yet, the competent institution will have to grant authorization if the following two conditions are fulfilled[xxi]:

- If the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned *resides*
- *and* the patient cannot be given such treatment within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness.

Whether the time-limit is acceptable or not ("undue delay") is assessed on the basis of medical grounds. The mere existence of administrative waiting lists indicating the "normal" period patients have to wait in order to become entitled to a given health treatment – e.g. as a means of healthcare cost containment – cannot constitute a sufficient reason to refuse authorization[xxii].

To find out whether a treatment is among the benefits provided for by the legislation where the person resides, the ECJ specified[xxiii] that in case where a list of reimbursable medical benefits only broadly defines certain types of treatment, the competent institution of the Member State of residence will have to assess on the basis of *objective* and *non-discriminatory criteria* whether a certain treatment method is covered hereby, *taking into consideration all the relevant medical factors and the available scientific data*.[xxiv]

State of residence or competent state granting the authorization?

As was mentioned before, the competent institution giving authorization refers to the institution which will eventually bear the costs of the treatment. In principle this will be the institution of the Member State under which legislation the patient is *socially insured* (through an individual or derived right).

In the wording of art. 20.2 Reg. 883/2004 an obligation to grant authorization could exist if the sought benefit cannot be provided within a medically acceptable time-limit within the Member State of *residence*. In most cases this will be the state where the person is socially insured for healthcare. Yet, there are circumstances where these states do not coincide (e.g. a person working and socially insured in country A, whereas he resides with his family in country B; or a person receiving a benefit from country A which at the same time is also the state where the person is socially insured for healthcare, yet residing in country B). In this case request for authorization must be done with the institution of the Member State of residence which shall forward it to the competent institution after assessing whether the abovementioned conditions for an obligatory

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xix Art. 22 (1) (c) i) Reg. 1408/71 in fine explicitly stated that the length of stay during which sickness benefits-in-kind can be provided remains governed by the legislation of the competent state. In case a maximum period is foreseen, this should be specified in the E112-form issued by the competent institution (art. 22 (3) Reg. 974/52). The new Coordination Regulations 883/2004 and 987/2009 however make no longer mention of this condition.

xx See for Belgium the restrictions set by Circular NIDHI nr. 2008/284 on the application of art. 22 Regulation (EC) 1408/71 after the Kohll and Decker judgments[19].

xxi Art. 20.2 Reg. 883/2004.

xxii Here Reg. 883/2004 incorporates the jurisprudence of the ECJ made in the Inizan-case (Case (2003) C-56/01 Inizan[20]), in which the interpretation of undue-delay requirement of art. 20.2 was alienated with the ECJ case law concerning freedom of services (see further).

xxiii Case (2010) C-173/09 Elchinov v. Natsionalna zdravnoosiguritelna kasa.[21]

xxiv Elchinov, para 62[21].

authorization set out in art. 20 (2) Reg. 883/2004 are fulfilled. If so, the competent institution must grant authorization *unless* the *same* treatment can be provided in the *competent Member State itself* within a medically justifiable time-limit. The eventual decision must be communicated to the institution of the residence state within a certain deadline (set by national law). In absence of this reply, the authorization is deemed to have been granted.[xxv]

The authorization procedure of the Coordination Regulation compatible with EU primary law

Due to the fact that the entitlement to elective healthcare in another Member State depends on the prior authorization of the competent institution one cannot speak of a true patient mobility under art. 20 Reg. 883/2004. The ECJ was already asked several times about the rationale behind this coordination provision. More specifically the authorization procedure – which holds a rather restrictive nature towards mobility – was challenged on its compatibility with primary law, and more specifically on the Treaty dispositions concerning free movement of services (cf. also *infra*). The Court however held that art. 22, (i) c) i) Reg. 1408/71 (now art. 20 Reg. 883/2004) did not contravene this fundamental freedom.

The coordination procedure was considered to be a further application of another EU principle – i.e. the free movement of persons in general and the free movement of workers more specifically - guaranteeing the social insured person another access – sometimes in better conditions – to foreign healthcare providers than the one guaranteed by applying the free movement of services (cf. also infra).[xxvi]

This objective however does not preclude the Community legislator from imposing a condition such as the need of a prior authorization by the competent institution, as it is this institution that bears the eventual cost of the (potentially more beneficial) healthcare coverage in the end.[xxvii]

xxv See art. 26 (2) Reg. 987/2009.

xxvi Case (2001) C-368/98 Vanbraekel[22], par. 36; Inizan[20] , par. 21; [23], par. 135; Case (2006) C-466/04, Acereda-Herrera [24], par. 27.

xxvii Inizan [20], par. 22-24.

2.2.2.3. *Organizing* the *access to the foreign healthcare system (covered care, payment methods and tariffs)*

Entitlement to healthcare benefits according to the rules and conditions of state of treatment (covered care, level of coverage, covered tariffs…)

Once authorized, the patient will be entitled to healthcare benefits in the Member State of treatment, in accordance with the legislation it applies, *as though he were insured there*.[xxviii] This is what one calls the 'assimilation-principle'. Consequently, the patient has in the same manner access to the healthcare system as the insured persons of the state of treatment. This means among others that it is in accordance with the legislation of the latter state that the covered care will be defined, as well as the level of coverage and the applied provider tariffs.

In case the state of treatment works with a *refund* system, the insured person will have to advance the costs and recover them afterwards according to the reimbursement rates set by the legislation of the Member State of treatment.[xxix]

In case the state of treatment functions on the basis of a *benefits-in-kind* system, the patient will have access in-kind ("for free") and similarly will have to pay the own contributions as do locally insured patients. It is thus possible that by receiving treatment in another Member State the patient enjoys a higher protection level in the end; this could be when the given health treatment is covered at a higher level than in the state where the person is socially insured. However, the opposite can occur as well (see though for the *Vanbraekel*-supplement).

xxviii Art. 20 (2) Reg. 883/2004.

xxix The patient has an optional right to retrieve reimbursement whether from the competent institution or the institution of the member state of treatment itself: see Art. 26 (6) jo. art. 25 (4) and (5) Reg. 987/2009. It will however always be the competent institution who bears the financial cost of the provided sickness benefits in the end.

In a nutshell: the covered care, the degree of coverage, the way of coverage and/or the applied tariffs for the covered care follow, in the logics of the coordination rules, the system of the state of treatment.[xxx]

On behalf of the competent institution

The payment of the eventual covered care is done on behalf of the competent state, where the person is socially insured.[xxxi] This means that in the end the cost of these benefits must be fully born by the institution of the competent Member State.[xxxii]

This compensation of costs between the institution of the Member State of treatment and the competent institution can be done in different ways.

In principle, compensation of elective care costs between Member States should be done on the basis of the actual expenditure, as it is shown from the accounts of the institution of the state of treatment.[xxxiii] This is not done between institutions directly, but through the specific *liaison bodies* indicated for each Member State.[xxxiv]

For this matter, the creditor institution issues a specific E125 recuperation form containing the exact amount of the claim. This claim must subsequently be introduced to the *liaison body* of the debtor Member State within 12 months of the end of the calendar half-year during which the claim has been recorded in the accounts of the creditor institution.[xxxv] The debtor institution will pay to the liaison body of the creditor state as promptly, and at least within 18 months of the end of the month in which the claim has been introduced.[xxxvi] After expiration of this delay, interest can be charged.[xxxvii]

Important to notice is that art. 62.3 Reg. 987/2009 explicitly stipulates that the Member State of treatment cannot charge *higher tariff rates* than those applicable to national social insured.

This provision must be seen as an expression of the general assimilation principle which results in the equal treatment of Regulation patients. Because of their assimilation to national patients, the latter are deemed to be an integral part of the circle of solidarity of the Member State of treatment, prohibiting an unequal allocation of healthcare costs.

For reasons of administrative simplification, the Coordination Regulations provide that two or more Member States can fix different methods of

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xxx In principle this implies that also coordination patients could be eligible for preferential reimbursement schemes applied by the member state of treatment (such as the Belgian OMNIO-statute providing for a lower personal share for all persons with an household income below a certain fixed income limit or the Belgian Maximum Bill, limiting the amount of non-reimbursable (necessary) healthcare costs). It is, however, difficult to implement this in practice, as it often assumes that the institution of the member state of treatment disposes of documents attesting the fiscal income of the patient concerned.

xxxi Art. 20.2 Reg. 883/2004. As already said above, for certain patient categories residing in another Member State than the Member State of social insurance, it will be the Member State of residence which has considered to be the competent Member State bearing the costs in case of planned care (art. 20.4 and 27.5 Reg. 883/2004).

xxxii Art. 35.1 Reg. 883/2004.

xxxiii Art. 62 (1) Reg. 987/2009. If it happens that for some reason that any or part of the actual amount is not shown in the accounts of the institution of the state of treatment, a lump-sum will be charged calculated from all the appropriate references obtained from available data (art. 62 (2) Reg. 987/2009).

xxxiv Art. 66 (2) Reg. 987/2009. These liaison bodies are institutions, indicated by the Minister of Social Security or an equivalent authority of the competent Member State for one or more branches of social security, which will have the task to respond to requests of information and assistance for the purposes of the application of Reg. 883/2004 and be responsible for certain financial tasks assigned to them (art. 1 (c) Reg. 987/2009). For Belgium, this will be the NIHDI in the branch of sickness benefits which will act as a liaison body for the health insurance funds.

xxxv Art. 67 (1) Reg. 987/2009. This deadline must be strictly respected. Claims introduced after expiration shall not be considered! (art. 67.4 Reg. 987/2009).

xxxvi Art. 67 (5) Reg. 987/2009.

xxxvii Art. 68 (1) Reg. 987/2009.

reimbursement of costs between them or can even decide to waive all reimbursement between them.[xxxviii]

State of residence refunding state of treatment

For some patient categories residing in another Member State than the Member State of social insurance, it will be the Member State of *residence* itself bearing the cost of elective care in another Member State.

More specifically this applies in case of elective care for:

1. family members falling under art. 17 Reg. 883/2004xxxix residing in another Member State than the insured person they depend from.[xl]
2. pensioners and/or their family members falling under art. 24.1, 25 and 26 Reg. 883/2004 (residing in other Member State than under which legislation pension is received) [xli]

on condition the Member State of residence is listed in Annex III of Reg. 987/2009[xlii]. All Member States listed here offer free healthcare through a benefits-in-kind system or a national health service.

This type of healthcare system makes it often difficult to determine the actual costs of sickness benefits-in-kind offered to Regulation patients, which have to be reimbursed by the Member State of social insurance.

Therefore the Coordination Regulations foresee that for the abovementioned patient categories, healthcare benefits are to be reimbursed by the Member State of social insurance through monthly lump-sum payments.[xliii] According to the ECJ, these fixed amounts are deemed to cover all medical care needed by these patients, including possible care in another state than the Member State of residence.[xliv]

Recovery of healthcare costs in case of loss or refusal of S2 form

If the patient has borne the healthcare costs himself, art. 26 (6) Reg. 987/2009 now explicitly provides that it will be the competent institution who shall refund costs according to the rates of the Member State of treatment. In the old Regulations 1408/71 and 574/72 this procedure was foreseen only in the case of necessary medical care[xlv]. The old Regulations 1408/71 and 574/72 did not provide for a specific cost recovery procedure in case of elective care if under certain circumstances the patient was not able to fulfill the necessary formalities to get coverage in the Member State of treatment (e.g. when E112 has been forgotten, lost, refused,…), except when this was due for reasons of force majeure.[xlvi]

Art. 26(6) Reg. 987/2009 now seems to have remedied this legislative loophole.

Refund in case of higher level of coverage in competent state - the Vanbraekel-supplement

Within the context of the cost coverage, it is important to mention the judgment of the ECJ in the *Vanbraekel*-case and its subsequent implementation in the Coordination Regulations (art. 26 (7) Reg. 987/2009). This case was about a Belgian insured, who was refused authorization under Reg. 1408/71 for a hospital treatment in France, which she underwent anyway. When a Belgian judge ruled afterwards that this refusal had been unlawful, the question rose whether Mrs. Vanbraekel claim for reimbursement would still fall under the Coordination Regulations.

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xxxviii Art. 35.3 Reg. 883/2004. For Belgium, only with the Republic of Ireland such a mutual waiver of reimbursement is still in effect today: see Exchange of Letters of 19 May 1981.[25]

xxxix In accordance to art. 17 Reg. 883/2004 these patients are normally entitled to sickness benefits-in-kind in the Member State of residence, on behalf of the competent institution (i.e. Member State of social insurance), by the institution of the place of residence.

xl Art. 20.4 Reg. 883/2004.

xli Art. 27.5 Reg. 883/2004.

xlii This Annex comprises Ireland, Spain, Italy, Malta, the Netherlands, Portugal, Finland, Sweden and the United Kingdom.

xliii Art. 63.2 Reg. 987/2009.

xliv Case (2003) C-156/01 Van der Duin v. Onderlinge Waarborgmaatschappij ANOZ Zorgverzekeringen UA and Onderlinge Waarborgmaatschappij ANOZ Zorgverzekeringen UA v. T.W. van Wegberg-van Brederode[26], par. 44-45.

xlv Art. 34 Reg. 574/72.

xlvi See art. 22 (1) and (3) Reg. 574/72.

Here the ECJ ruled that the practical effect and the spirit of art. 22 (1) c) i. and 36 Reg. 1408/71 justify that an insured person could *directly* ask the competent institution for reimbursement of the amount that ordinarily would have been born if the authorization had been given immediately.[xlvii] An additional question rose however: if an authorized patient is only entitled to an amount of coverage offered by the legislation of the state of treatment which is *smaller* than the coverage offered in the competent Member State, could this form an obstacle of free movement of services?

The ECJ considered that such a situation can deter or even prevent people from seeking treatment in another Member State and thus forms a barrier to free movement of services.[xlviii]

As the state could not invoke a justifying reason to refund on the basis of the (lower) tariff of the state of treatment, the Court stated that the principle of the free movement of services "*is to be interpreted as meaning that, if the reimbursement of costs incurred on hospital services provided in a Member State of stay, calculated under the rules in force in that State, is less than the amount which application of the legislation in force in the Member State of registration would afford to a person receiving hospital treatment in that State, additional reimbursement covering that difference must be granted to the insured person by the competent institution.*"[xlix]

The facts in *Vanbraekel* were very specific: it dealt with a person who originally – due to the refusal of the competent health insurance fund to grant authorization – had to advance the costs herself but received a refund when the national court came to the conclusion that an authorization had to be provided.

Afterwards discussion raised whether this case had to be interpreted strictly and thus applied only to cases where the patient wrongfully had to advance the costs of authorized care or broadly as the Court came in rather general wordings to this conclusion.

The *Vanbraekel-principle* has eventually been incorporated in art. 26 (7) of the Implementing Regulation 987/2009.[l] However, this new provision does not grant an automatic right to additional reimbursement, but makes it depend on an explicit demand of the insured person.[29]

Reimbursement of travel and accommodation costs

Art. 26 (8) Reg. 987/2009 stipulates that 'where national legislation of the competent institution provides for the reimbursement of the costs of travel and stay which are inseparable from the treatment of the insured person, such costs for the person concerned, and, if necessary, for a person who must accompany him/her, shall be assumed by this institution when an authorization is granted in the case of treatment in another Member State.'

This provision forms the legal incorporation of the *Acereda-Herrera* case of 15 June 2006. This case was about a Spanish national who obtained authorization to get hospital treatment in France. Due to his bad health condition he was accompanied by a family member. When returning to Spain he asked the Spanish national health service for the reimbursement of travel, hotel and meal costs.

The ECJ came to the conclusion that the authorization procedure under the Coordination Regulation only refers to costs of *medical* services that have been received by the insured person. As such, this provision does not grant a right to reimbursement by the competent institution for the

xlvii Vanbraekel[22], par. 34.

xlviii Vanbraekel[22], par. 45.

xlix [22]par. 53. It is however strange to see that the ECJ did not apply the same reasoning in case of unscheduled treatment (art. 19 Reg. 883/2004) : see Case (2010) C-211/08 European Commission v. Kingdom of Spain[27]. See VAN DEN GRONDEN, 2010, 221-30[28].

l Art. 26 (7) Reg. 987/2009: "If the insured person has actually borne all or part of the costs for the authorised medical treatment him or herself and the costs which the competent institution is obliged to reimburse to the institution of the place of stay or to the insured person according to paragraph 6 (actual cost) are lower than the costs which it would have had to assume for the same treatment in the competent Member State (notional cost), the competent institution shall reimburse, upon request, the cost of treatment incurred by the insured person up to the amount by which the notional cost exceeds the actual cost. The reimbursed sum may not, however, exceed the costs actually incurred by the insured person and may take account of the amount which the insured person would have had to pay if the treatment had been delivered in the competent Member State."

costs of travel, accommodation and subsistence that the insured person and possible persons accompanying him incurred in the territory of the Member State of treatment, with the exception of the costs of accommodation and meals in the hospital for the insured person himself.[li]

However, a duty to cover these ancillary costs could exist for the competent institution if according to its *own* legislation these costs are reimbursed where treatment is provided by a healthcare provider of its own national healthcare system. Otherwise the competent state would infringe on free movement of services (art. 56 TFEU) (cf. *infra*).

2.2.2.4. Providers

To which providers the authorized patient eventually can be referred will depend on the system of the state where the treatment is provided. Due to the assimilation principle it is the state of treatment to define which provider has to be consulted in order to enjoy covered treatment. This could also mean that in case the state of treatment works with a strict referral procedure, this will have to be followed by the coordination patient.

In essence we can say that elective care under the Coordination Regulation only regards coverage of healthcare benefits provided under the *statutory* healthcare system of the state of treatment. A patient referred to a provider who functions outside the statutory healthcare system (e.g. when not having a license to work for the national health insurance, or when not contracted by the healthcare system), could thus face the risk of not having the treatment covered.

The Belgian health insurance system works e.g. on the basis of an inclusive convention system, meaning that, unless the provider officially declares otherwise within the set time limits (*opt-out*), the provider is assumed to be covered by the collective tariff convention, as negotiated between the health insurance funds and the representatives of the providers.

Nevertheless in case a deconventioned healthcare provider would be consulted, the patient from another Member State will still enjoy coverage. The Belgian system works with an integrated inclusive tariff system covering also, at the rate of the agreed tariffs, treatments provided by deconventioned providers. In such a situation though the own contribution will be of a higher level as normally the deconventioned providers will charge a higher tariff (than the one agreed in the collective convention).

[li] Acereda-Hererra [24], par. 27-28.

Key points

- **European Regulations 883/2004 and 987/2009 foresee in a comprehensive legal framework coordinating the social security position of social insured persons moving between Member States of the European Union (old Reg. 1408/71 and 574/72 still applying to EEA and Switzerland).**
- **When an insured person and/or members of his family travels to another Member State in order to obtain elective healthcare, he/she must ask for prior authorization from the competent institution (third-party payer) in order to obtain coverage of the foreign treatment.**
- **Authorisation must be granted if the treatment is among the benefits in the member state of residence and cannot be delivered there within a medically justifiable time-limit. If the scheduled treatment is authorized, the healthcare insurer will issue an S2 form (former E112-form). This form will indicate the provider(s), treatment(s) and duration for which the authorization is given.**
- **Healthcare costs are covered on the basis of the legislation of the state of treatment, as if the authorized patient was insured there (assimilation-principle). If costs are made by the state of treatment, these are subsequently recovered from the competent state.**
- **Supplementary coverage is possible if legislation of the competent Member State foresees in more favourable reimbursement conditions, without exceeding the real cost of treatment.**
- **Coverage is limited to costs for elective medical services. Travel and accommodation costs not inextricable to hospitalization remain on behalf of the patient, unless coverage is foreseen in the legislation of the competent state.**

2.2.3. Elective cross-border healthcare and EU primary law in relation to free movement of services

The Court of Justice has, since 1998, laid down several rulings on the social security coverage of health treatments obtained in a Member State in which the patient is not socially protected. These judgments have dealt with the application of the free movement rules - namely, freedom to provide and receive services (art. 56-57 TFEU)- on cross-border healthcare purchase. On the basis of this case law a free patient mobility gradually got shaped, allowing EU citizens to purchase healthcare in another Member State and have it refunded in their country of origin where they are socially insured. By doing so, the ECJ established a track for cross-border care, parallel to the one that is in place within the framework of the Coordination Regulations. However, as this is a jurisprudential creation, it is also prone to continuous refinement and (possible) evolution over time. As such, this subchapter will describe the general principles following from this case law at the time of this research.

In the following chapter this case law will be described in a cross-sectional way and not in chronological manner. In other words, the general rules underlying the principle of European patient mobility will be described in a structured manner.

We do so by explaining first this principle of patient mobility in its relation to the EU freedoms (of services and goods). After the introduction of the principle, the exceptions to the principle will be highlighted. Finally the concrete procedure of payment, covered care, refund and the position of the provider will be explained.

2.2.3.1. Principle of patient mobility based upon the EU freedoms (of free service provision and of free provision of goods).

In its *Kohll* and *Decker*-judgments of 28 April 1998 [lii] the ECJ established, probably for the first time in such a clear wording, that the economic rules regarding the free movement of goods and services within the EU could be applied to social security systems. [32]

[lii] Case (1998) C-120/95 Nicolas Decker v Caisse de maladie des employés privés[30] ; Case (1998)Raymond Kohll v Union des caisses de maladie[31].

Before embarking upon this, the facts of both cases should be highlighted. In essence they were quite straightforward: two Luxemburg citizens having purchased healthcare treatments in another Member State, and wanting to have the treatments refunded in their state of social insurance (where they resided).

More specifically the *Kohll*-case was about a Luxembourg national, insured with the Luxembourg health insurance fund, who asked authorization for an orthodontist treatment in Germany for his daughter; the competent Luxembourg authorities refused though to grant authorization as that specific treatment was available in Luxembourg. The question was raised before the ECJ about the compatibility of national rules conditioning the coverage of foreign treatments by obtaining prior authorization with the freedom to provide and receive services.

The *Decker-case* dealt with the situation of a Luxembourg national, as in *Kohll* insured with a Luxembourg health insurer, who was refused the reimbursement of costs of spectacles purchased in Belgium. The reimbursement was refused by the insurer, because the prior authorization had not been given.

Here, the question was if national provisions conditioning the coverage of foreign medical products by obtaining prior authorization, were compatible with free movement of goods.[liii]

Prior authorization as an obstacle to free movement of services

Both judgments were based on the same reasoning. At the outset, the Court concluded that the internal market provisions are applicable to social security. It started with emphasizing the Member States' freedom to organize their social security systems. However, in doing that, the Member States must comply with the Community (Union) law, since "the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement".[liv]

The ECJ considered that a national rule making the access to a treatment in another Member State subject to a prior authorization is obstructing the internal market rules of the EU, and more specifically the freedom of movement of services and freedom of movement of goods. Health treatments are thus to be considered as "services" for the application of article 56 TFEU, as medical devices are seen as transferrable "goods" on the EU market, which should not be hindered in their free circulation (article 34 TFEU).

Invoked grounds for justification

After determining that conditioning the reimbursement of every health treatment obtained abroad by prior authorization is contrary to the internal market rules, the Court analyzed the possible justifications for the national rules in question. Three main arguments justifying the application of a prior authorization rule were raised: the maintenance of the financial balance of the social security system, protection of public health and the protection of a balanced medical and hospital service open to all. After having assessed them for the two concrete cases, the Court turned them all down.

First, it dealt with the *argument of maintaining the financial balance of the social security system* as possible justification ground to refuse reimbursement. Here, the Court applied the rule of reason. For the application of the rule of reason three requirements need to be satisfied in order for the national measure in question to be justified: application without distinction of the national rule in question, public-interest requirement (presence of an overriding reason of general interest) and proportionality. [33] The conclusion was that, although the protection of the financial stability of the social security system can represent a ground for justification, reimbursing foreign treatments on basis of competent state's domestic tariffs cannot have significant financial consequences on the social security system; at least not for the two concrete cases which were at stake (orthodontic outpatient care and cross purchase of spectacles).[lv] The Court, thus, dismissed the national rule as being disproportional as to the invoked objective. [33]

[liii] Art. 28 EC (today's art. 34 TFEU).

[liv] Kohll [31], para 20.

[lv] Kohll [31], para 42; Decker[30], para 40.

Second, the Court rejected the *protection of public health* argument (justification ground provided explicitly by the Treaty itself[lvi]) that quality control of foreign health treatments and medical products can be made only at the time of the request for authorization (after the treatment, of course, it is too late). The Court's reasoning was based on the fact that the requirements for the healthcare professions in question (dentists and opticians) have been harmonized on the EU level,[lvii] implying that the quality of healthcare does not vary significantly between different Member States.[lviii]

Finally, the Court acknowledged that the *protection of balanced medical and hospital service open to all* can also be used as a public health justification for national rules on prior authorization. However, it dismissed that argument in the concrete cases, for the lack of evidence that the balanced medical service is jeopardized by allowing patients to obtain foreign treatments without the prior authorization. Again, the measure was deemed unnecessary here for achieving its objective.[lix]

Introduction of a parallel Treaty-based way to cross-border healthcare

With these cases the ECJ introduced a general European right to purchase healthcare in another Member State, while having it refunded by the healthcare system of the Member State of origin (in which one is socially insured). It launched in other words a track of patient mobility parallel to the one in place in the Coordination Regulations. Contrary to the Coordination Regulation it starts from the principle of free patient mobility, only allowing in exceptional circumstances an exception to the principle (cf. infra).

As a consequence national rules making cross-border treatments subject to a prior authorization are considered to be in conflicting nature with the internal market rules, more specifically with the right of free circulation of services (for health treatments; article 56 TFEU) and the right of free circulation of goods (for medical devices; article 34 TFEU).

This right for patients to obtain cross-border healthcare has been confirmed in long series of follow-up cases (see further), be it that the principle has been refined over the years and that some exceptions found their way in the case law.

Expanding the Kohll and Decker case law: free patient mobility whatever the type of healthcare system

Although the judgments in *Kohll* and *Decker* were as to the decision rather straightforward some questions remained unanswered though. For instance it was unclear whether the Court's reasoning could be applied in the context of benefits-in-kind healthcare systems and national health services, since *Kohll and Decker* both related to a reimbursement system.[lx] The cases *Geraets-Smits* and *Peerbooms* and *Watts* gave answer to this question.

Treaty-based patient mobility and benefit-in-kind systems

The case *Geraets-Smits* and *Peerbooms*[lxi] dealt with two cases of Dutch nationals insured in the Netherlands, who obtained complex hospital care in Germany (a multidisciplinary treatment for the disease of *Parkinson*) and Austria (a neurostimulant treatment for a comatose patient) without any

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lvi See art. 46 EC (actual art. 52 TFEU), art. 55 EC (actual art. 62 TFEU) for services; art 30 EC (actual art. 36 TFEU) for goods.

lvii Kohll [31], para 47; Decker [30], para 42.

lviii Currently harmonised by Directive (EC) 2005/36 of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications [34].

lix Kohll [31], paras 50-52.

lx Social healthcare systems can, generally, be divided into two main types. Social health insurance, in principle, covers economically active persons is mainly financed from contributions and the insurer and the provider are separate entities. National health services in principle cover all the inhabitants, are financed through taxation, with payer and the provider being a single entity. Insurance systems can further be divided into the reimbursement systems, where the patient pays to the provider on the spot, subsequently being reimbursed by the insurer, and the benefits-in-kind systems, where the insurer pays to the provider directly. The latter system can also be called 'third party payment system'. See PIETERS, 2006, 89. [14]

lxi Case (2001) C-157/99 B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen. [35]

prior authorization from their Dutch healthcare insurer. The reimbursement of costs was refused because it was claimed by the insurance funds that the statutory requirements relating to the procedure of prior authorization were not met.

One of the arguments uttered by the healthcare authorities not to apply the *Kohll-Decker* logics related to the nature of the health insurance system. The argument was that this jurisprudence only worked for a refund system as this particular kind of system is fitting well the situation where patients advance first the medical costs before claiming back the refund from their competent institution. Moreover doubts could be raised on the application of article 56 TFEU, as the patient did not pay for the health services in the Dutch "in kind" or third-partypayer system (based on agreements negotiated between health insurers and providers). Finally the national authorities referred to the specific nature of the exclusive contracting which is an essential part of the Dutch health insurance: the health insurers do only purchase care for their insured members from a selected group of health providers, this regardless the nationality of location of the provider. By allowing free movement, this particular type of contracting would be undermined.

The Court ruled that medical activities, whether provided in a hospital environment or in an ambulatory setting, fall within the ambit of the internal market rules on free movement of services, even when the national health system is considered to be a benefits-in-kind system where healthcare providers are remunerated directly by healthcare insurers on the basis of fixed rate.[lxii] Subsequently the Court concluded that the contested national rules did represent a barrier to freedom to provide services, since they deterred patients from applying to healthcare providers in other Member States. This was decided despite the fact that the Dutch health insurance funds could, potentially, enter into agreements with foreign providers. However, since it was unlikely that significant numbers of foreign hospitals would enter into those agreements, the effective barrier was clear for the Court.[lxiii]

[lxii] Smits-Peerbooms[35], paras 55-57.

[lxiii] Smits-Peerbooms[35], paras 62-69.

Treaty-based patient mobility and national health services

The case-*Watts*[lxiv] was the first judgment in the Court's jurisprudence to deal with a National Health Service (hereinafter: NHS).[lxv] The case was about a British national residing in the United Kingdom who underwent a hip replacement surgery in France. Prior to the treatment, the authorization for the treatment in France was refused by the relevant NHS body (Bedford Primary Care Trust), since, in their view, she could have received treatment in the UK within the government's NHS Plan targets, and, thus, without undue delay. After obtaining the treatment Mrs. Watts sought the reimbursement, which was refused.

During the judicial proceedings, the ECJ eventually found that:

Article 49 EC (now article 56 TFEU) applies where a patient such as Mrs. Watts receives medical services in a hospital environment for consideration in a Member State other than her State of residence, regardless of the way in which the national system with which that person is registered and from which reimbursement of the cost of those services is subsequently sought operates.[lxvi]

With this statement the ECJ stressed that the relationship patient-provider in the state of treatment, and not the relationship patient-provider or insurer-provider in the competent state, is the crucial factor for the application of freedom to provide services provisions.

It is thus not the nature of the system which is essential for the application of the rules on free service provision to social security coverage of foreign health treatments. The main argument that there can be no remuneration in the case of healthcare systems in which the providers and payers are not separate, independent entities (notably, the NHS) was not taken over by the ECJ. Nor did it follow another argument that was put forward, based on the distinction between the 'supply-side subsidy' and the 'demand-side subsidy'.

[lxiv] Case (2006) C-372/04 Watts[23].

[lxv] For a more detailed explanation of the judgement, see COUSINS, 2007, 183-93. [36]

[lxvi] Watts[23], para 90.

The reasoning here was that the supply-side subsidies are given by the state to the provider, and the amount is calculated by taking into account various circumstances, which may include specific treatments or number of patients. The recipient finally pays an amount which is significantly lower than the market value of the service provided. To the contrary, the demand-side subsidies are based on assistance with costs, meaning that the recipient of a service initiates the transaction the cost of which is covered by the payer (insurer). Therefore, the amount paid represents the real value of the service but, more importantly, the entire transaction, the flow of money, is controlled by the free will of the individual, giving a market character to the transaction, making the internal market rules applicable. [37]

In *Watts* the Court clearly stated that the way in which the national system reimbursing the costs is organized is irrelevant,[lxvii] the only important factor being whether the transaction in the Member State of treatment represents the real market value of the service.[lxviii] Therefore, the relationship between the payer of the health service, the patient and the provider in the competent state has no bearing on the applicability of internal market rules. Since the EU primary law applies only in the situation in which the patient pays to the provider directly and then seeks reimbursement from the competent institution, the payer (patient)-provider relationship in the state of treatment is crucial for defining the applicability of internal market rules.

2.2.3.2. Situations justifying an exception to the free patient mobility

Already in the original *Kohll-Decker* cases, the ECJ referred to possible justifying grounds allowing national rules that limit the free mobility of patients. The Court developed this line of idea in a series of case law. In these cases it mainly dealt with national rules shaping a national prior authorization system to obtain healthcare abroad. The ECJ accepted in some circumstances these rules at least when they serve a goal of general interest, such as e.g. public health policy or the safeguarding of the financial balance of the social security system. Whereas in the beginning these cases dealt mainly with hospital care, more recent case law shows us that non-hospital treatments, i.e. major medical equipment, can also be made subject to prior authorization rules, when the conditions for installation, operation and use of this kind of equipment is particularly onerous.

Following its established case law in these matters, the Court reminded us though that these justified obstacles should not go further than necessary; they should be stipulated in such a manner that they cause as little as possible obstruction to the internal market. Or to say it in a positive way: the obstructing rule should remain in proportion to the higher goal it wants to achieve; it should not go further than necessary.

In what will follow, we first describe the justifying grounds accepted by the court in the case of hospital care, followed then by the case law on major medical equipment. Subsequently attention will be paid to the conditions which need to be fulfilled when a system wants to make use of a prior authorization rule. We finalize this part with the prior authorization rule that is installed by the Coordination Regulations. Here as well the ECJ had to decide whether this European rule of prior authorization could be held compatible with the ECJ case law on free patient mobility.

Prior authorization for hospital care

In the already quoted cases *Geraets-Smits and Peerbooms* the Court considered that a national prior authorization rule that obstructs the free movement principles, could be justified in the case of cross-border hospital care. As mentioned already in the description of the facts, these cases dealt with sophisticated specialist treatments delivered in a hospital setting in another EU- Member State. Reimbursement of costs was refused at the health insurance funds claiming that the national statutory requirements for coverage were not met.

These national rules made coverage of hospital care received abroad conditional upon the grant of a prior authorization, which would only be given if two conditions were met. First, the treatment concerned should be among the benefits for which the Dutch health insurance scheme assumed responsibility, which was only the case for treatments '*normal in the professional circles concerned*'. Both health insurers deemed this condition

[lxvii] Interpretation supported by VAN DEN GRONDEN, 2008, 711. [38]

[lxviii] Watts[23], para 90.

was not fulfilled. Second, it was prescribed that the treatment abroad must be necessary regarding the patient's medical condition, meaning that adequate care cannot be provided without undue delay by a healthcare provider contracted by the health insurance fund from the Netherlands. In both cases a treatment was available among the contracted healthcare providers, be it not the same as the treatment received abroad.

The fact that similar treatments could be obtained in the Netherlands was a crucial element in the turning down of the demand for refund of the foreign treatments.

Taking into account the complexity of the treatments, it was argued that a prior authorization was necessary to safeguard the financial sustainability of the social security system (i.e. the funding of hospital treatments in the health insurance). Allowing an overall free mobility in hospital care would put an unjustified financial pressure on our social healthcare systems. There would be a risk of the financial loss on major investments in hospital care, as patients may leave aside the own hospital infrastructures preferring specialized treatments in other (neighboring) Member States. This on its turn would jeopardize the objective of granting an overall access for the covered population to specialized hospital care. The Court eventually accepted that, in case of hospital treatments, a prior authorization procedure can be justified by reasons of:

1. Ensuring sufficient and permanent access to a balanced range of high-quality hospital treatment in the State concerned.[lxix]
2. Avoiding the waste of human, technical and financial resources.[lxx]

In contrast, the Court held that a prior authorization requirement for non-hospital care cannot be justified by the need to maintain the financial balance of the social security system. The argument used was that it is unlikely that significant numbers of patients would travel to seek non-hospital healthcare abroad, because of the linguistic barriers, distances, costs and the lack of information.[lxxi] The ECJ thus clearly made the distinction between "hospital" and "non-hospital" care, yet did not provide us with precise criteria on how to distinguish between both types of care. It similarly omitted to do so later on in the later case *Muller-Fauré*, when stating only ambiguously that "*certain services provided in a hospital environment but also capable of being provided by a practitioner in his surgery or in a health centre could for that reason be placed on the same footing as non-hospital services*"

Prior authorization for major medical equipment

In a recent case the Court seems to step away from the dichotomy "hospital" and "non-hospital" treatments as crucial distinction to prior authorization rules accepted or not. It rather seems to make the difference between cost-heavy medical treatments and treatments with minor financial consequences. In this case, the European Commission accused France of failing to fulfill its obligations under art. 56 TFEU, as some provisions of the French *Code de la Sécurité sociale* made the reimbursement of extramural treatments requiring the use of certain major medical equipment conditional upon the grant of a prior authorization.

In its judgment of 5 October 2010[lxxii], the Court of Justice starts by reiterating its settled case law that medical services fall within the scope of application of the Treaty, there being no need to distinguish between hospital care and care provided outside such an environment.[lxxiii] As a consequence, obliging people insured by the French social security system to obtain a prior authorization in order to get elective extramural care could constitute an impediment to the free movement of services, as this condition could deter people from getting healthcare abroad. Nevertheless this impediment could be objectively justifiable. As such, with regard to hospital care the Court already held several times that a prioritization of national healthcare could be justified due to, on the one hand, planning

[lxix] Smits-Peerbooms[35], para 78.

[lxx] Smits-Peerbooms[35], para 79; According to the Court, the mentioned arguments are intrinsically linked to the financial balance justification and should thus be analysed together. See Smits-Peerbooms[35], para 73.

[lxxi] V.G. Müller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and EEM van Riet v Onderlinge Waarborgmaatschappij ZOA Zorgverzekeringen [39], par. 75.

[lxxii] Case (2010) C-512/08 Commission v France [40].

[lxxiii] Commission v France[40], para 30.

requirements relating to the object to ensure a balanced and permanent access to high quality treatment in the competent Member State and, on the other hand, the wish to avoid the waste of financial, technical and human resources.[lxxiv]

In *Commission/France* the Court accepts for the first time that overriding reasons of public interest could also apply in particular cases of extramural healthcare requiring certain major medical equipment, as the conditions for installation, operation and use of this kind of equipment is particularly onerous.[lxxv] In absence of a prior authorization requirement, the risk exists that the (limitedly listed number of) major medical equipment installed and subsidized in the competent state is under-used.

At the same time, uncontrolled use of this kind of medical equipment in other Member States could lead to a disproportional burden for the competent state's social security budget.

Conditions monitoring the authorization procedure

Concretely the Court stipulated that a prior authorization rule can be accepted in some cases (hospital care and major medical equipment) when this safeguards the financial equilibrium of the social security system and/or guarantees a balanced and equitable access to high level healthcare treatments. Yet the obstructive rule should remain proportional to the goal(s) it wants to achieve. This has some consequences for the way these national rules establishing a prior authorization are to be designed. In what follows we gave a synthetic overview of the conditions which should be fulfilled when enacting (justified) prior authorization rules.

Criteria governing the assessment *of the authorization request*

In *Geraets-Smits* the Court stipulated that with regard to prior authorization rules, the competent authority's degree of discretion to take an authorization decision, is to be restricted by minimal substantial guarantees. As such the assessment of an authorization request has to be done on the basis of objective and non-discriminatory criteria. For instance a requirement that the treatment in question is considered to be necessary for the health disorder within the professional circles (e.g. medical specialists) concerned, is in itself not contrary to the EU law. However, the professional circles concerned must not be limited to the Netherlands' circles, since that would represent a discrimination of foreign treatments and providers. The criterion must be objective, based on the standards developed by international medical science.[lxxvi]

The Court also held that a system of prior authorization must respect certain procedural guarantees. As such it must be easily accessible and capable of ensuring that a request for authorization will be dealt with objectively and impartially within a reasonable time. In case of refusal, there must be a possibility to challenge this decision through judicial or quasi-judicial proceedings.[lxxvii]

In similar terms, the Court stated in the case *Watts*: the prior authorization scheme must be based on objective, non-discriminatory criteria known in advance, in a way that the national authorities' discretion is not used arbitrarily, and must be based on a procedural system which is easily accessible and capable of ensuring that a request for authorization is handled objectively and impartially within a reasonable time and refusals to grant authorization must also be capable of being challenged in judicial or

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lxxiv Müller-Fauré [39], para 76-78; Acereda-Herrera[23], para 108-110.

lxxv Commission v France[40], para 37-41. In a now pending case of Commission/Portugal (Case 255/09), the Court has to assess the conformity of a Portuguese Act making reimbursement of costs for the generally defined category of 'highly specialized ambulatory treatment' depend on the need for prior authorization by three doctors. In her advisory opinion of 14 April 2011, Advocate-General TRSTENJAK concludes to a breach of art. 49 EC (art. 56 TFEU), as the Portuguese government does not prove a risk for the financial balance of the national social security system, nor the proportional character of such a measure.

lxxvi Smits-Peerbooms[35], paras. 94-98. The Court however omits to define clearly what can be understood by such international standards. It points out that even though the institution of the home state should take into account all relevant available information, including, in particularly, *existing scientific literature and studies, the authorised opinions of specialists and the fact that the proposed treatment is covered or not covered by the sickness insurance system of the Member State in which the treatment is provided (Smits-Peerbooms[35], par. 98).*

lxxvii Smits-Peerbooms[35], par. 90. See also Muller-Fauré [39], par. 85 and Watts[23], para. 116.

quasi-judicial proceedings. Further the decision should be done within reasonable time.[lxxviii]

The authorization procedure and waiting lists

The authorization procedure is not justified if this results in a too long waiting period for the patient. A demand to receive treatment in another Member State may be refused "if the same or equally effective[lxxix] treatment can be obtained without undue delay from an establishment with which the insured person's health insurance fund has contractual arrangements."[lxxx] In doing so, the body deciding about granting the authorization must take into account a wide number of factors[lxxxi]. Mainly in the cases *Müller-Fauré* and *Watts* the Court gave more explanation about these factors indicating whether the waiting period has to be considered too long or not.

The case *Müller-Fauré* involved two ladies who were socially insured in the Netherlands making use of their right to receive cross-border medical care. Ms. Müller-Fauré underwent a dental treatment in Germany, while Ms. Van Riet was subjected to an arthroscopy in Belgium. Both patients obtained the treatments without prior authorization and the reimbursement was subsequently denied by their respective healthcare insurers. The question of legality of prior authorization procedure in the context of the freedom to provide services again came up.

In relation to the hospital treatment, the Court concluded in line with its previous case law that the prior authorization requirement is a justified barrier to free provision of services, because of the need to maintain the balanced allocation of hospital resources, which would be jeopardized in case of an uncontrolled outflow of patients to foreign hospitals.[lxxxii] However, it again emphasized, as part of the 'undue delay' requirement, the need to look at the individual situation of the patient concerned, taking into account his/her medical history, degree of pain and the ability to conduct a professional activity.[lxxxiii] In other words the assessment of the waiting period is to be carried out on the basis of the individual medical file of the patient and thus not on the basis of standard administrative procedures indicating what is to be considered as a normal waiting period in the concerned healthcare system.

A similar line of reasoning was upheld in *Watts.* Next to this, the Court explicitly aligned the interpretation of the term 'undue delay' in the context of coordination rules (Coordination Regulations: cfr. *supra* for a description) and the context of free provision of services.[lxxxiv] In addition to that, the Court restated[lxxxv] that the existence of waiting lists is in itself not sufficient for a person to be refused authorization.[lxxxvi] In that sense the Court pointed out that the waiting lists themselves need to be formed in a way that allows for the health treatment to be provided within the time 'which is acceptable in the light of an objective medical assessment of the clinical needs of the person concerned'.[lxxxvii] If the waiting time exceeds the 'medically acceptable waiting time', authorization must be granted.[lxxxviii] The Court dismissed e.g. in the *Watts* case the possibility that the primary law obligation to respect the Member States' responsibilities for the organization and delivery of health services would be contrary to the case law on social security coverage of foreign health treatments, because the Court took into account the need for maintaining the financial balance of the social security systems: here the presence of waiting lists were an indication of a justifiable exception (prior authorization for hospital care) that was disproportionally applied (creating waiting lists in the internal system).[lxxxix]

[lxxviii] Müller-Fauré[39], para 85.

[lxxix] The assessment of which is to be done on the basis of international medical standards.

[lxxx] Smits-Peerbooms[35], para 103.

[lxxxi] Smits-Peerbooms[35],para 104.

[lxxxii] Müller-Fauré[39], para 91.

[lxxxiii] Müller-Faur [39], para 90.

[lxxxiv] Watts[23], para 60.

[lxxxv] Müller-Fauré[39], para 92.

[lxxxvi] Watts[23], para 63.

[lxxxvii] Watts[23], para 68.

[lxxxviii] Watts[23], para 72.

[lxxxix] Watts[23], para 147; It has also been stated in the literature that the Court takes into consideration the consequences of its interference in the national

The common prior authorization rule of the Coordination Regulation – obstructing free movement?

In *Kohll and Decker* the ECJ dealt with the potential paradox that the authorization procedure, prescribed by the coordination rules (article 20 Regulation 883/2004), could in fact itself be contrary to the primary law (see also above 2.2.2.3). It interpreted the coordination rules as representing only one way of obtaining social security coverage of health treatments obtained in other Member States, the way being that the authorization is needed in order to obtain the coverage according to the legislation (including tariffs) applicable in the state of treatment. However, imposing only the coordination method represents a barrier against free movement of goods and freedom to provide services[xc], more precisely, the patient's freedom to travel abroad and receive the health service (but the primary law language of 'freedom to provide' services will be used further in the text). By doing so the European Court opened a parallel track to obtain healthcare in another Member State.

Unlike the Coordination Regulations, the patient can travel to another Member State for the purpose of obtaining health treatment there, without the need to receive prior authorization by the health insurer. The latter patient is entitled to the reimbursement based on the tariffs of the competent state.[xci] Consequently the patient who bases his/her claim for social coverage of a foreign treatment on primary law (the free movement principles), is obliged to advance the costs (pay on the spot), while claiming reimbursement *a posteriori* from the competent state's social insurer.

By linking the refund of the foreign treatment to the health system of origin, the patient cannot go abroad to obtain health treatment which is not covered domestically by his/her social health insurer. Community law cannot in principle have the effect of requiring a Member State to extend the list of medical services paid for by its social insurance system: the fact that a particular type of medical treatment is covered or not covered by the health insurance schemes of other Member States is irrelevant in this regard.[xcii]

welfare systems by allowing certain grounds for justification of barriers to free movement: LENAERTS and HEREMANS, 2006, 114. [41]

xc Kohll[31], para 35; Decker[30], para 36.

xci Kohll[31], para 27; Decker [30], para 29.

xcii Smits-Peerbooms[35],para 87.

2.2.3.3. Level of coverage and method of payment

Reimbursement following tariffs of state of affiliation

The Treaty-based track of patient mobility is differently conceived as the one applied in the coordination rules on elective care (cf. *supra*). In the Treaty-based procedure, the insured person advances the healthcare costs by paying it directly to the provider established in another Member State ('host state') after which he seeks refund in the Member State of affiliation ('home state' or 'competent state' in coordination terminology). This refund is done on the basis of its own reimbursement rates (in case of a refund scheme) or on the basis of its coverage tariffs granted to the healthcare provider (in case of an in kind system). As such the insured person will be "assimilated" to an insured person treated in the home state itself.

Conversely, this implies the patient will not be entitled go abroad to obtain health treatment which is not covered domestically by his/her health insurer.[xciii]

In case the national healthcare system does not foresee in reimbursement rates by nature (benefit-in-kind systems, NHS), the achievement of fundamental freedoms guaranteed by the TFEU inevitably oblige these Member States to adapt their social security system to this cross-border context (which it should already do on the basis of the Coordination Regulations to compensate the costs with the Member State of treatment).[xciv] The Member State is however free to fix the amounts of

xciii Müller-Fauré[39], para 87.

xciv Müller-Fauré[39], para. 102-105; See also Case (2011) C490/09 Commission v Luxemburg [42]: Here the court found a breach of art. 49 EC (art. 56 TFEU) as a Luxembourgian Act only foresaw statutory coverage of costs of laboratory tests and analyses exclusively on the basis third-party payment system, excluding reimbursement of clinical biology obtained in another member state.

reimbursement for healthcare received in another Member State, on condition this is based on objective, non-discriminatory and transparent criteria.[xcv] The latter seems to imply that different reimbursement rates than those applying to national healthcare services, could be justified if this a proportional measure to achieve a legitimate aim.

The Court refined this rule somewhat further in the *Watts*-case when it dealt with the situation of higher coverage applied in the home state. The Court distinguished between two situations. If the cost of the treatment is higher in the home state than in the state of treatment, the institution of the competent state needs to provide the higher reimbursement, up to the level of the real cost of the treatment (which the patient paid to the provider).[xcvi] This applies e.g. to the situation in which the competent state offers the treatment free of charge (like the NHS, meaning effectively 100 % coverage), while the state of treatment covers only part of the costs (the often used co-payments mechanisms).

If the cost is higher in the state of treatment, the institution of the competent state pays the amount that it would have paid if the treatment was provided by the competent state provider, and no more.[xcvii]

Travel and accommodation costs

The Court dealt with the possibility of coverage of travel and accommodation costs under the Treaty-based way in the already quoted case of *Watts.* Since, under the free provision of services rules, the competent (home) state provisions are applicable, the patient is entitled to the reimbursement of travel costs if that right is granted for the treatments within that state (thus avoiding disadvantageous treatment of healthcare obtained abroad).[xcviii] For comparison: the coordination rules do not entitle the patient to the coverage of those costs, except when they can be claimed on the basis of the free movement rules (cf. *supra*).[xcix]

2.2.3.4. Comparing care: what is covered care?

The principle that the patient cannot go abroad to obtain health treatment which is not covered under the legislation of the competent (home) state, has been further interpreted by the ECJ regarding the aspect of covered care. Much will also depend on how the competent home state describes the covered care. Whether this is done in a very detailed manner or in a rather general way can have consequences for the question whether the foreign care is to refunded or not.

Two cases are here of particular relevance: one of the EFTA-Court[c] (joined cases *Rindal* and *Slinning*)[ci] and one recent judgment of the ECJ (Elchinov)[cii].

Experimental care

In *Rindal & Slinning* the EFTA-Court had to deal with the question whether the search for experimental and/or more advanced care in another EEA-state could restrict a Member State's autonomy to define the medical package covered by its national social security system. Mrs. Rindal underwent special surgery in a private German hospital, after her Norwegian specialist had decided that no further surgical interventions were indicated to treat the patients' severe back pains. Particular here is

xcv Müller-Fauré[39], 107.

xcvi Watts[23], para 131.

xcvii Watts[23], para 132.

xcviii Watts[23], para 140; Confirmed by the Court in Acereda-Herrera[24], para 38.

xcix Watts[23], para 138. Cf. new art 26(8) Reg. 987/2009: 'Where the national legislation of the competent institution provides for the reimbursement of the costs of travel and stay that are inseparable from the treatment of the insured person, these costs for the person concerned and, if necessary, for a person who must accompany him/her, shall be assumed by this institution when an authorization is granted in the case of treatment in another Member State.'

c According to the European Free Trade Association (hereinafter: EFTA) Court, having jurisdiction with regard to EFTA States which are parties to the EEA-Agreement.

ci Case (2008) E-11/07 and E-1/08 Olga Rindal and Therese Slinning v The Norwegian State. [43]

cii Elchinov[21].

the fact the concerned operation was also frequently performed in Norway, but never in relation to the treatment of Rindal's medical condition. Back in Norway, Rindal applied for reimbursement. This was refused, as the national healthcare scheme only covered internationally recognized care, excluding *experimental care*. Mrs. Slinning, suffering from brain damage after a car accident, inscribed herself for a public rehabilitation program in Denmark. This was considered to be more intense and more advanced than the program offered in Norway. When she applied for reimbursement, the Norwegian health authorities refused on a double ground: sufficient and adequate treatment for the condition of Mrs. Slinning was available in Norway and the Danish treatment was considered to be experimental in Norway.

During the judicial proceedings that followed, the EFTA-Court was asked to answer two main questions. The first question the Court had to answer is whether the Member State of insurance (competent home state) can lawfully refuse the reimbursement of foreign treatments which according to international medical standards have to be considered as 'experimental', if national law excludes this type of treatment from coverage.

Here the Court reminds that Member States are in principle free to organize their social security systems.

When doing so however, they have to comply with EEA-law, in particular the fundamental freedom of services (art. 36-37 EEA). This implies that Member States cannot conceive rules and standards of reimbursement of healthcare costs in such a way this would discriminate against suppliers of medical services in other Member States. Here the Court does *not* find a restriction of art. 36 and 37 EEA if the law of the home state refuses coverage of expenses for treatment abroad which according to international medicine must be considered as experimental or test treatment, if this applies in an equal way to the patients who receive such care in hospitals forming part of the social security system of the home state.[ciii] In reference to *Geraets-Smits and Peerbooms*, the notion of internationally recognized care should be interpreted as what is sufficiently tried and tested by international medical science. This assessment must take into consideration all relevant information available, including existing scientific literature studies, the authorized opinions of specialists and the fact that the treatment in question is covered by the health insurance of the state of treatment. The presence of one or several of these elements is however not decisive.

The EFTA-Court additionally looked into the question whether it would be possible for EEA-states to impose an additional administrative burden (prior authorization) to patients searching for experimental care abroad, there were the home state provides the same care free of charge in domestic hospitals in the form of research projects or, exceptionally, on an *ad-hoc* basis. Despite the Court considers this to be a restriction of freedom of services, it could nevertheless be justified on the basis of an overriding reason of general interest, such as the risk of a serious undermining of the financial balance of the national social security system and the protection of public health. Moreover the Court points out that a right for patients who had not been selected for a national experiment or test, to receive treatment abroad and get reimbursed afterwards may lead to a reluctance in providing experimental and test treatment and thus seriously undermine medical research.[civ] Attention should be drawn to the fact that the Court does not distinguish between intramural and extramural care within its reasoning. [44]

More advanced care

A second important question dealt with in *Rindal & Slinning* was whether the home state can lawfully refuse the reimbursement of a more advanced (recognized) treatment abroad in case a sufficient and adequate treatment was available in the home state itself. Here the Court reiterates that EEA-states have the prerogative to decide which medical treatments are covered by their national health system, as long as this is done in compliance with EEA-law. If a patient fulfills the criteria of entitlement of the home state, prioritization of domestic (hospital) treatment cannot be justified unless an identical or *equally effective* treatment can be provided within a medically justified time limit. According to the Court this implies that once it is established according to international medicine that a

[ciii] Rindal and Slinning [43], paras 48-52.

[civ] Rindal & Slinning[43], para. 58.

treatment abroad has to be considered *more* effective, the home state cannot longer prioritize its own offer of recognized treatments.[cv]

Question remains to what extent the ECJ will follow the extensive interpretation of the EFTA-Court[cvi], as some argue this could mount up to a right to the best possible care for European citizens. [45] Very close in this respect has been the *Elchinov* case which concerned a Bulgarian patient (Bulgaria being the competent state) who obtained health treatment in Germany. Mr. Elchinov was diagnosed with a tumor in his eye. Unfortunately, the most advanced treatment available in Bulgaria was in fact a surgery to remove the eye. This treatment is covered by the national rules, which stipulate that a patient is entitled to the social coverage of 'other eyeball operations' and 'highly technical radiotherapy for oncological and non-oncological conditions'. The statutory definition is, thus, rather vague, and in that way, broadly stipulated.

Mr. Elchinov applied for an authorization under art. 22 (1) c) Reg. 1408/71 in order to undergo a highly advanced treatment in Germany. Due to his state of health however, he was already hospitalized in the German hospital before any authorization had been given. This authorization was later on refused by the competent health authority on the ground that this particular treatment was not covered by Bulgarian health insurance.

The essential issue is whether the social security systems are obliged to cover foreign medical treatments which are *not offered* by the domestic healthcare systems. On one side, there is the principle that the EU law does not require that the Member States extend the range of medical services they cover.[cvii] On the other side, there is the EFTA Court jurisprudence, according to which the (EEA) Member States cannot prioritize their own, less effective treatments. [cviii]

In its judgment of 5 October 2010[cix], the Court reiterates that in absence of any harmonization on the EU-level every Member State is in principle free to determine the conditions for the grant of social security benefits. When exercising this prerogative however, Member States will have to comply with Union law.[cx]

This means that in case where a list of reimbursable medical benefits only broadly defines certain types of treatment, the competent institution of the Member State of residence will have to assess on the basis of objective and non-discriminatory criteria whether a certain treatment method is covered hereby, *taking into consideration all the relevant medical factors and the available scientific data*.[cxi] If such is the case, a prior authorization cannot be refused on the ground that such a treatment method is not available in the Member State of residence. [cxii]

With regard to the question whether an identical or equally effective treatment could have been provided without undue delay in the state of residence, the Court specified that one has to look at all the elements relevant to the case. Doing this assessment the competent institution must not only take into account the patient's medical condition, or, where appropriate, the degree of pain or invalidity, which could make it impossible or very difficult to execute his professional activities, but also his medical history. As such, like in *Rindal & Slinning*, criteria which were at first only intended to assess the justification of waiting lists, are now transposed to assess the 'more effective' character of treatment provided in another Member State.

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cv Rindal & Slinning [43], para. 83.

cvi In principle art. 106 of the EEA-Agreement foresees that the ECJ and the EFTA-Court should adopt each other's jurisprudence, in order to come to a uniform legal interpretation of the fundamental freedoms throughout the EEA.

cvii Smits-Peerbooms[35], para 87.

cviii Rindal and Slinning[43], para. 83.

cix Elchinov[21].

cx Elchinov[21], para. 57 and 61.

cxi Elchinov[21], para 62.

cxii In this case an administrative presumption was applied that if a certain medical treatment was not provided in Bulgaria, it could be presumed that it was not included in the medical treatments reimbursable by the competent institution. According to the Court, this type of presumption constituted a restriction of the scope of art. 22 par. 2 of the Coordination Regulation 1408/71, and moreover a non-justifiable restriction of the free movement of services. See Elchinov[21], para 71-72.

From all this follows that the competent institution will *have to authorize* a patient to obtain medical treatment abroad that cannot be provided in the competent state in case:

- this medical treatment could fall within the generally defined categories or types of treatment that are reimbursable by the legislation of the competent state (even this treatment is not available in the latter state);
- an alternative treatment that could be given within a reasonable time in the competent Member State is not considered to have the same level of effectiveness[cxiii].

As such, the ECJ accepts that a right to more advanced care could exist in the form of an obligation to grant prior authorization (both under the Coordination as the Treaty-based route) when a treatment offered in another Member State falls within the benefit package of the statutory health insurance and is considered to be more medically effective. This jurisprudence will most probably urge Member States to define their national coverage packages more precisely and strictly. [46]

2.2.3.5. Providers

To what extent can the competent (home) state refuse the refund for a consult when the latter seems to have been granted by a foreign provider that normally would not have been accepted (or contracted) in the own system? One could e.g. think of a private pro-profit provider which in the concerned competent state would not be part of the social healthcare system, as the latter system only works with public providers or non-profit providers.

In its *Stamatelaki*-judgment the Court dealt with the question on the application of free provision of services rules on social security coverage of elective healthtreatments obtained with private healthcare providers located in another Member State.[cxiv] Here certain Greek rules prohibited the reimbursement of health treatments provided by foreign private hospitals, except for children under 14 years old.

The Court found that the rules in question gave preferential treatment to the private non-contracted hospitals in Greece, because the existence of an emergency was an exception to the no-coverage rule for Greek non-contracted private hospitals, but not for foreign non-contracted private hospitals. This discrimination of foreign private hospitals, therefore, constituted a violation of freedom to provide services rules, even clearer than was the case with indistinctly applicable measures imposing prior authorization requirement to all treatments by non-contracted providers (*Geraets-Smits*). Even more importantly, the complete ban on coverage of treatments obtained in foreign private hospitals was found to be disproportionate, since prior authorization procedure could have been set up, in order to control the healthcare costs.[cxv]

2.2.3.6. Conclusion

In conclusion on this subchapter one could say that *post Kohll & Decker* two distinct patient mobility tracks emerged at the European level. Both tracks, respectively based on social security coordination and free movement of services, have their own logics, and more precisely, their particular ways of (re)funding the healthcare treatments that one enjoyed in another Member State. While in the *Kohll-Decker* logics the patient advances the costs and receives a refund a posteriori from the healthcare system in which he is covered in accordance with the tariffs applied there, the coordination system organizes a possibly more favorable coverage by the competent state on the basis of the rules and tariffs of the state where treatment has been provided. The Court of Justice however interconnected these two tracks by alining its interpretation several common notions, such as the conditions to grant obligatory prior authorization [cxvi].

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cxiii Elchinov [21], para 67.

cxiv [47]

cxv [47]paras 27-35.

cxvi [20] para 21 ; [23], para. 60.

Key points

- **Based on the fundamental principle of freedom of services and goods enshrined in the Treaty on the functioning of the European Union, the European Court of Justice has set the guiding principles for the free movement of patients across the European Union through several law cases. In that way, it organised a parallel, but compatible mobility track next to the Coordination Regulations.**
- **In the Treaty logics, the patient is treated as though the healthcare were provided in the state of affiliation. Consequently, the benefit package, the applicable tariff and the type of provider (public or private) will depend on what is offered there. The patient advances the costs and receives a refund from the healthcare system in which he is covered on the basis of its reimbursement rates (in case of a refund scheme) or on the basis of its coverage tariffs granted to the healthcare provider (in case of a benefits in kind system).**
- **National rules conditioning reimbursement of healthcare services abroad, such as a prior authorisation requirements, can be justified by reason of safeguarding the financial balance of the national social security system and the need for government planning of these sectors (hospital services, out-patient services requiring major medical equipment, experimental care,…) to ensure sufficient and permanent access to high quality healthcare. Prior authorisation as a condition for reimbursement may be refused if the treatment in question is 1) covered by the legislation of the Member State of affiliation according to international medical standards and 2) no identical or equally effective (/more advantageous) treatment can be provided within a medically justifiable time-limit.**

2.2.4. EU-citizenship, non-discrimination and healthcare tariffs

Apart from the free movement principles and other provisions shaping the internal market, EU citizenship is one of cornerstones of the European Union. This citizenship is largely shaped around the general EU non-discrimination clause which is set out in Article 18 TFEU. It prohibits any discrimination on grounds of nationality, within the scope of application of the Treaties and without prejudice to any special provisions contained therein. Prohibition of any discrimination on grounds of nationality is thus one of the basic principles of the EU law.

Its application in the area of healthcare came to the fore in the ECJ-case *Angelo Ferlini v Centre Hospitalier de Luxembourg.*[cxvii] The case dealt with the wife of an EU official who gave birth in Luxembourg. Since Mr. Ferlini and his family were not affiliated to the Luxembourg social security system, they had to pay the medical fee which was considerably higher (71.43%) than the flat rate fee that would have been charged for the same medical treatment to a person affiliated to that system.

The Court considered the Treaty provisions on European Citizenship prohibiting discrimination on basis of nationality[cxviii] to be applicable.[cxix] The Court concluded that Mr. Ferlini was in a *comparable position* to that of a person affiliated to the national social security system in question, despite the fact that he did not pay any taxes or contributions to that system. The basis for the decision was the fact that he did not ask for the social coverage but only for non-discriminatory tariffs to be applied.[cxx]

Furthermore, the Luxembourg rule providing for higher tariffs being applicable to persons not affiliated to the social security system, than to the affiliated persons, was deemed to represent indirect discrimination, the reason being that only a small number of foreign nationals are affiliated to the national system.[cxxi] Since no grounds for justification of the rule were put forward, it was considered to be contrary to the EU law.[cxxii] Therefore, imposing higher tariffs (than for the domestic patients) on foreign patients is prohibited by the EU law, unless justified by some legitimate reason

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cxvii Case (2000)C-411/98, Angelo Ferlini t. Centre Hospitalier de Luxembourg[48]

cxviii Art. 12 EC (actual art. 18 (1) TFEU)

cxix Ferlini[48], paras 41-50.

cxx Ferlini[48], paras 54-56.

cxxi Ferlini [48], para 58.

cxxii Ferlini[48], paras 60-62.

independent of nationality of the patient with the measure in question being proportionate to that legitimate objective.

The Court mentioned as well that the non-discrimination clause as it is enshrined in the Treaty provisions of the free movement of workers[cxxiii] and its application Regulation 1612/68[cxxiv] was not at stake to the issue of different scales of fees for healthcare, since those provisions only applied to conditions of work and social advantages, not including hospital fees. Yet the application of different (i.e. higher) tariffs for other EU nationals is considered to be contradictory to the anti-discrimination clause ad enshrined in the European Citizenship provisions of the Treaty.

One could remark that the ECJ seemed to have skipped a step using art. 18 TFEU to assess the presence of a forbidden discrimination on the basis of nationality. Since its Kohll-judgment of 28 April 1998 the court has continuously stated that the provision of all types of medical care, no matter in which way it is organized or financed, should be considered a 'service' within the meaning of art. 56 TFEU.[cxxv] This lex specialis provision should thus be used in case a healthcare provider treats patients differently on the basis of their to the national social security scheme, while giving them an identical service. [50] In Ferlini, however, the necessary cross-border element seems to be somewhat absent to trigger the application of art. 56 TFEU. [51]

Ferlini makes clear that an obligation to equal treatment on the basis of nationality can also apply on the horizontal level. When assessing the fact that the discriminatory tariffs had been set by a group of Luxembourgian hospitals, the Court referred to its Walrave & Koch-jurisprudence and stated that art. 18 TFEU is also applicable in case a private group or organization has a certain power over individuals and is in a position to impose on them conditions which adversely affect the exercise of the fundamental freedoms guaranteed under the Treaty. Does this obligation also touches individual healthcare providers? This remains unclear. [50] One could however point at the Angonese-judgment[cxxvi] where the ECJ accepted the application of art. 45 TFEU within a relation between two private actors (work offering bank and candidate-employee).

Key points

- **The general principle of equal treatment on the basis of nationality, as laid down in the Treaty provisions on free movement of services and European citizenship, prohibits the application of different healthcare tariffs to patients coming from other Member States, irrespective of the fact they are not paying taxes or social security contributions in the Member State of treatment.**
- **Tariff discrimination indirectly touching foreign patients however could be justified as a necessary and proportional measure to safeguard a legitimate aim (protection of public health, safeguard financial balance of social security system by covering additional costs.**

cxxiii Art. 48 EC Treaty(after amendment art. 39 EC Treaty and today's art. 45 TFEU).

cxxiv Regulation (EEC) 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community [49]hereinafter 'Reg. 1612/68'.

cxxv Kohll[31], para. 29; Smits-Peerbooms [35], para. 55 ; Müller-Fauré[39], para. 38 ; Watts [23], para. 89.

cxxvi Case (2000) C-281/98 Angonese. [52]

2.2.5. Patient Mobility Directive

2.2.5.1. Reasons for adopting a Patient Mobility Directive: codification and legal certainty

As the case by case approach of the ECJ led to legal uncertainty and regulatory gaps, the Commission took the initiative to codify the case law principles behind Treaty-based patient mobility.[cxxvii] On the other hand, this would also force Member States to apply this case law, as interpretational issues still gave the opportunity to keep off from a correct implementation.

The initiative however went further than mere codification, and also contained innovative provisions on until then underexposed issues, such as the introduction of patients' rights in cross-border healthcare and a duty of mutual cooperation and assistance between Member States on several aspects of cross-border care. As such it aims to be a framework that provides clarity on rights to reimbursement of costs of healthcare received in another Member State, as well as it assures that the received care is highly qualitative, safe and efficient. [54]

According to SAUTER, this harmonizing supranational initiative is quite daring, as Member States generally consider healthcare reforms to be politically sensitive issues which are better left to national politics (cf. art. 168 TFEU). The author esteems nevertheless that an elaborate legislative framework on patient mobility is necessary to overcome solidarity and accessibility deficiencies actually present in national healthcare systems because of cost control measures (e.g. personal shares) and rationing of treatment (e.g. waiting lists). [55]

It thus does not surprise that reaching a political agreement on the Commission's initiative was a difficult trajectory. Three heavily altered versions followed the original Commission proposal on a directive on patients' rights from 2008[cxxviii]. The Directive 2011/24 of 19 March 2011 on the application of patients' rights in cross-border healthcare was published on 4 April 2011. It must be transposed into national law by 25 October 2013.

As the Directive aims to be a framework that provides clarity on rights to reimbursement of costs of healthcare received in another Member State, as well as it assures that the received care is highly qualitative, safe and efficient, its legal basis is formed by the harmonizing art. 114 TFEU (former art. 95 EC) and art. 168 TFEU. The former article governs the approximation of Member States' laws for the establishment and functioning of the internal market, prescribing the ordinary legislative procedure (co-decision) for adoption, whereas the latter forces the European institutions to ensure a high level of health protection when implementing Union policies and activities.

2.2.5.2. Scope of application

Material scope

The new Patient mobility Directive applies to the provision of (elective) cross-border *healthcare* to patients, regardless of the manner how it is organized, delivered or financed.[cxxix] The notion of healthcare is defined broadly as *'all health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation of medicinal products and medical devices'*. As such the curative nature of the care provided seems to be essential.

Certain types of healthcare are however explicitly excluded:

Long term care: this only concerns personal assistance provided for carrying out activities of daily live (shopping, preparing meals, personal hygiene,…).[cxxx] In parallel to ordinary sickness benefits, it is thus not

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cxxvii A previous attempt to regulate this issue by including an article on healthcare in the 'General Services Directive' (Directive 2006/123/EC of the European Parliament and the Council of 12 December 2006 on services in the internal market [53]) failed after much criticism.

cxxviii European Commission, Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, 2008. [56]

cxxix Art. 1 (2) Patient Mobility Directive.

cxxx One can note that contributory or non-contributory long term care benefits, provided in cash or in kind, have been considered to be sickness benefits

excluded that the ECJ directly applies the Treaty provisions on (passive) free movement of services on insured persons in need of care who go for special treatment to another Member State and claim reimbursement of costs afterwards. [63]

Allocation of and access to organs for the purpose of organ transplants (which seems to exclude organ transplants itself)

Public vaccination programs exclusively aimed at protecting health of the population of a Member State (infection diseases)

Territorial scope

The rights and obligations contained by the Patient Mobility Directive presently apply only to cross-border healthcare delivered in the 27 Member States of the European Union. A decision of the EEA Joint Committee (composed of members of the European Commission and representatives of the EFTA-countries) is still expected to extend the territorial scope of the Directive to the other EEA –countries.[cxxxi]

2.2.5.3. Maintaining the parallel system and introduction of rules of prioritization

The Patient Mobility Directive maintains the parallel existence of two different systems of social security coverage of foreign health treatments: the one based on the coordination rules and the other based on the Court of Justice case law and the directive itself. The coexistence of these two instruments should be coherent: only one of the two can apply in a given situation.[cxxxii] Since those systems contain disparities, the choice of method is important both for the patients and the national social security systems.

The Patient Mobility Directive acknowledges that it should not deprive patients from the more beneficial rights that could follow from the Coordination Regulations. As such, when dealing with a request for prior authorization to obtain care abroad, in situations justified according to art. 8.2 of the Patient Mobility Directive (cf. *infra*), the Member State of affiliation should ascertain whether an obligation to grant authorization exists under art. 20.2 Reg. 883/2004.[cxxxiii] If this is the case, preference should be given to the Regulation, unless the patients request otherwise. As such the patient retains the right to choose his preferred patient mobility route. [64]The state of affiliation should nevertheless draw the attention of the patient to the fact that the application of the Coordination Regulations could be more advantageous.[cxxxiv]

2.2.5.4. Authorization requirements

In principle, the Member State of affiliation cannot make the reimbursement of healthcare services provided in another Member State depend on the condition of prior authorization, unless for one of the reasons enumerated in art. 8 (2), which extend the overriding reasons of general interest already allowed by the ECJ case law:

- In case the sought healthcare concerns hospital care or the use of major medical equipment, that the Member State of affiliation made subject to planning requirements in order to ensure sufficient and permanent access to a balanced range of high-quality treatment and avoid any waste of financial, technical and human resources. These types of care should be communicated to the European Commission.

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under the Coordination Regulations, causing several problems of coordination: Case (1998) C-160/96 Molenaar [57]; Case (2001) C-215/99 Jauch [58]; Case (2007) C-Commission v. European Parliament and Council[59]; Case (2009) C-208/07 Von Chamier-Gliszczinski v. Deutsche Angestellten-Krankenkasse[60] and also EFTA-Case (2007) E-5/06 EFTA Surveillance authority v. Principality of Liechtenstein [61]. See SPIEGEL, 2010. [62]

cxxxi Art. 102 EEA-Agreement.

cxxxii Consideration 30 of the Patient Mobility Directive.

cxxxiii For reminder, such an obligation exists if the requested treatment is among the benefits provided of by the legislation of the competent member state and this cannot be provided within a medically justifiable time-limit, taking into account the patients' current state of health and the probable course of his disease (cf. supra).

cxxxiv Consideration 31 in fine Patient Mobility Directive. Art. 3 (2) original commission proposal and art. 9 (3a) of the First Council Proposal did not leave the patient a possibility to choose the regime applicable: if the conditions for applying the coordination rules were met, only the Regulation would apply. See also SAUTER, 2009, [65] p119.

- In case the sought healthcare presents a particular risk for the patient or the population
- In case the sought healthcare is given by a healthcare provider which, on a case-by-case basis, could raise serious or specific concerns relating to the quality and safety of care[cxxxv]

The assessment of an authorization request should be done on the basis of objective, non-discriminatory criteria, which do not go further than necessary to attain the abovementioned goals. The Patient Mobility Directive further reiterates certain procedural guarantees already set out by the ECJ (easily accessible, objective and impartial treatment, possibility of administrative and judicial review), adding that Member States must set out reasonable time limits within which requests for cross-border healthcare should be dealt with.[cxxxvi]

In any case attention should be paid to the specific medical condition of the patient, the urgency of the request and possible individual circumstances. As such, prior authorization may ***not*** be refused if the patient is entitled to the requested healthcare in the Member State of affiliation when this cannot be delivered within a medically justifiable time-limit, based on an objective medical assessment of the patient's medical condition, the history and probable course of the illness, the degree of pain and/or the nature of his disability at the time the request is made or renewed.[cxxxvii]

However, even where in principle an obligation to grant authorization would exists, art. 8 (6) Patient Mobility Directive still provides for a limitative number of reasons in which case authorization may still be rightfully refused. They mainly relate to the existence of an even higher safety risk than the one which already allowed the institution of the prior authorization procedure itself:

- In case a clinical evaluation points out with reasonable certainty that the patient will be exposed to a patient-safety risk that cannot be regarded as acceptable, taking into account the potential benefit for the patient in the sought cross-border healthcare
- In case of a risk that cross-border healthcare will result in the exposure of the general public to a *substantial safety hazard*
- In case healthcare is provided by a healthcare provider that raises serious and concrete concerns related to the respect of standards and guidelines on quality of care and patient safety, including provisions on supervision, whether these standards and guidelines are given by laws and Regulations or through accreditation systems established by the Member State of treatment.[cxxxviii]

[cxxxv] One could ask on which basis this assessment of care quality and safety should be made in practice. According to art. 4.1 provides that cross-border healthcare should be given in accordance with standards and guidelines on quality and safety laid down by the Member State of treatment and Union legislation on safety standards. At the actual state of legislation, no European minimal legal standards on quality and safety of care exist. Moreover the Member State of affiliation asses quality concerns according to their own legislation and is thus not rely on standards and controls by mutual trust (if it even exists), possibly resulting in a refusal of reimbursement for the patients who underwent treatment without asking prior authorization. This exception constitutes a possible gateway to systematically submit healthcare offered by *private* health providers outside of the statutory health system to prior authorization. See on this issue: BAETEN and PALM, 2011, [66] 272-274.

[cxxxvi] Art. 9 Patient Mobility Directive.

[cxxxvii] Art. 8 (5) Patient Mobility Directive.

[cxxxviii] Art 9(4) Patient Mobility Directive.

2.2.5.5. Level of coverage and method of payment

Level of coverage

As a main principle the *insured person*[cxxxix] who received healthcare in another Member State is entitled to reimbursement in the Member State of affiliation, on condition that the healthcare received is among the benefits to which he is entitled in that state. In this case costs of care must be covered up to the level that would have been assumed if the healthcare would have been provided on the territory of the Member State of affiliation itself.

The Patient Mobility Directive however sets certain *limits* to this general rule:

- Member States remain free to determine the benefit package to which insured persons are entitled, regardless of the place where the healthcare is provided.
- Reimbursement may in principle not exceed the actual cost of the healthcare received (no possibility for 'profit making').
- The Member State of affiliation *may* apply the same conditions, criteria of eligibility and administrative formalities for reimbursement as would have been the case when healthcare was provided in the Member State of affiliation itself (e.g. necessity of prior medical assessment by general practitioner) on condition they are objective and not-discriminatory in nature.
- Reimbursement criteria may further not pose obstacle to the fundamental freedom of free movement of services, unless this is justified by an overriding reason of general interest related to planning requirements or the avoidance of financial, technical or human capital.
- The Member State of affiliation may limit the amount of reimbursement for cross-border healthcare for reasons of overriding general interest related to ensuring sufficient and permanent access to a balanced range of high-quality treatment as well as to avoid waste of financial, technical and human resources.
- This may however not go further than necessary and may not constitute a means of arbitrary discrimination or an obstacle to free movement of services or goods. Moreover, if the Member State has already chosen to install a prior authorization procedure based on the same overriding reasons of general interest (e.g. in case of hospital care), the full amount of reimbursement must continue to apply.

On the other hand, the Patient Mobility Directive also offers a possibility to *go further* than the general rule:

- As such, the Member State of affiliation may decide to reimburse the *full cost* of healthcare received in another Member State, even if this exceeds the level of costs that would have been assumed if the healthcare had been provided on its own territory.
- The Member State of affiliation may decide to reimburse ancillary costs, such as travel and accommodation costs or extra costs for persons with a disability, even where these costs are not covered for treatments provided in its own territory.

Method of payment

In principle the insured person will advance the costs of healthcare received in another Member State and subsequently ask for reimbursement in the Member State of affiliation, up to the amount of coverage to which the insured person is entitled. This reimbursement should be done without undue delay.

The Patient Mobility Directive however also foresees a possibility for Member States to pay this amount *directly* to the concerned health provider. In this case it is even made possible to apply the financial compensation mechanism from art. 35 Reg. 883/2004 to organize direct payments on a mutual basis.

[cxxxix] 'Insured person' here refers to art. 1 c) Reg. 883/2004, meaning that the articles on reimbursement of cross-border healthcare (art. 7-9 Patient Mobility Directive) do not concern purely privately insured persons.

2.2.5.6. *Providers*

The Patient Mobility Directive applies to any natural or legal person or any other entity legally providing healthcare on the territory of a Member State.[cxl] Despite the application of national reimbursement conditions on healthcare provided in another Member State (art. 7 (7) Patient Mobility Directive), one has to reiterate the *Stamatelaki*-case law of the ECJ which found a denial of reimbursement for foreign private or non-contracted providers to be disproportionate to the sought objective.[cxli]

2.2.5.7. *Responsibilities of Member State of treatment: ensuring equal treatment and patient rights on information and accountability*

One of the most important aspects of the Patient Mobility Directive is the introduction of patients' rights in cross-border healthcare which the Member State of treatment has to respect. These rights build upon the principles of *universality, access to good quality care, equity and solidarity* identified as common values underpinning all European health systems, and are mainly centered around the aspects of *patient information, accountability* and *privacy protection*.[cxlii] As such the Member State of treatment must, upon request, provide patients with the relevant information concerning standards of quality and safety (its standards being applicable in cases covered by the Patient Mobility Directive) and supervision of healthcare providers. It needs to make sure that healthcare providers provide patients with information on safety standards, prices and professional liability insurance. Systems of professional liability insurance must be in place in the state of treatment, which is also obliged to set up a complaints procedure and remedies for patients who suffer harm arising from the health treatment in question.[cxliii]

The Patient Mobility Directive contains an obligation imposed on the Member State of treatment not to discriminate against the incoming patients from other Member States.[cxliv] However, the Member State of treatment can impose access restrictions justified by overriding reasons of general interest.[cxlv] The rationale of these restrictions is to prevent the increase of waiting times, due to the potentially large number of patients coming from other Member States to get treatments.[cxlvi]

No derogations from the principle of equal treatment seem possible with regard to the fees charged to foreign patients. Here art. 4 (4) Patient Mobility Directive explicitly states that:

"Member States shall ensure that healthcare providers apply to patients from other Member States the same scale of fees for healthcare that is paid for domestic patients in a comparable medical situation in the Member State of treatment, or charge a price calculated according to objective, non-discriminatory criteria if there is no comparable price for domestic patients.

This paragraph shall be without prejudice to national legislation which allows healthcare providers to set their own prices, provided that they do not discriminate against patients from other Member States."[cxlvii]

Therefore, the principle of non-discrimination with respect to healthcare fees is given a strong emphasis, since no derogations on basis of general interest seem to be allowed. This approach is in line with *Ferlini.* What remains unclear however, is whether using different methods for calculating the fees for domestic and foreign patients (which do not necessarily mean that prices charged to foreign patients will be higher every time), would be contrary to the Patient Mobility Directive.

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cxl Art. 3 g) Patient Mobility Directive

cxli This does not alter the fact that nothing obliges Member states to reimburse healthcare costs provided by healthcare providers established on its own territory if those are not part of the national social security system (art. 1 (4) Patient Mobility Directive).

cxlii Council Conclusions (2006) on common values and principles in European health systems, OJ L 146, 1-3.

cxliii Art 4(2) Patient Mobility Directive.

cxliv Art 4(3) Patient Mobility Directive.

cxlv Art 4(3) Patient Mobility Directive.

cxlvi Preamble to the Patient Mobility Directive, para 11(a).

cxlvii Art. 4 (4) Patient Mobility Directive.

The question remains which impact art. 4 (4) of the Patient Mobility Directive has on the contractual freedom healthcare providers and foreign healthcare insurer when it comes to the stipulation of higher hospital tariffs for cross-border contract patients. It could be defended that the Patient Mobility Directive only concerns the individual patient level.cxlviii As such art. 4 (4) Patient Mobility Directive does not oppose the contractual stipulation of a higher tariff in relation with a foreign insurer, as long the patient does not feel a disadvantage. This, however, does not detract it from the fact that charging a higher tariff could give cause to the development of waiting lists and access problems. In this case Member States can decide to prioritize national patients by directly limiting the inflow from abroad .

2.2.5.8. National contact points and cross-border cooperation between Member States

The Patient Mobility Directive imposes the installation national contact points for cross-border healthcare. These should be set up in every Member State (both for outgoing and incoming patients) and provide patients and providers with all the relevant information in relation to cross-border healthcare.[cxlix] Member States further have a far-reaching obligation to give mutual assistance and to cooperate on patient mobility issues, including the establishment of European reference networks (especially for cross-border cooperation on rare diseases) and the institution of voluntary networks on E-health and health technology assessment.

Key points

- **The Patient Mobility Directive offers a comprehensive legal framework centred around three major aspects of cross-border care within the European Union: 1) reimbursement of costs for elective healthcare obtained by socially insured in another Member State outside of the European Coordination Regulations, 2) the introduction of patients' rights in cross-border healthcare and 3) the organisation of several obligatory and voluntary cooperation networks on several cross-border care related issues (national contact points, rare diseases, e-health, health technology assessment).**
- **The Directive provisions on coverage of costs related to cross-border care set an end to legal uncertainty and Member State's reticence by codifying the patient mobility case law of the ECJ based on free movement of services. Additional grounds to restrict the possibility (prior authorization) and amount of reimbursement have been introduced. The Directive maintains the distinction with the European Coordination Regulations 883/2004 and 987/2009, however the latter has been given priority.**
- **The introduced patient rights or common principles in cross-border care obliges the Member State of treatment to ensure the information of patients on availability, quality and safety of care, the accountability of healthcare providers and the protection of patient data. Also the general European principle of non-discrimination on the basis of nationality is specified, being absolute in nature in relation to setting of fees for patients coming from another Member State.**

cxlviii See consideration 11 of the Patient Mobility Directive: 'This Directive should apply to individual patients who decide to seek healthcare in a Member State other than the Member State of affiliation'

cxlix Art. 6 Patient Mobility Directive.

2.2.6. Cooperation agreements in border areas

During the two last decades, several cooperation agreements [67-69] on cross-border healthcare have been concluded between healthcare actors (insurers, providers) in Belgium and its neighboring countries in order to overcome healthcare deficiencies in border areas.[cl]

Most of these agreements have been concluded within the framework of the EU Coordination Regulations yet do foresee in more patient friendly procedures to enhance the cross-border mobility for healthcare. Many of these agreements resulted from experiments set up within the framework of the European INTERREG-programs.

These cooperation agreements aim at realizing different goals:

- Making *better and more efficient use* of existing healthcare infrastructure (e.g. filling in existing overcapacity in Belgian hospitals), human resources and financial means.
- Creation of a transnational and *complementary* healthcare offer to supply local healthcare deficiencies (e.g. lack of certain specialized treatments).
- *Improving proximity of care* by granting access to nearer foreign doctors or hospitals.
- Meet the therapeutic needs of the *entire* border population, which otherwise find themselves in a disadvantageous position compared to frontier workers and members of their family (double access to healthcare systems of state of residence and state of employment guaranteed by art. 18 Reg. 883/2004).
- Improve patient mobility and measure the impact of the *Kohll & Decker*-jurisprudence on the national health system

Mentioned agreements mainly grant the population of specific geographically demarcated border areas a form of simplified access to (certain types of) ambulatory and/or hospital care in the neighboring state. The Belgian legislator here provided for an explicit exception to the territoriality-principle of the Belgian statutory health insurance by introducing a new art. 136 §1 b) HDI-Act.[cli] This provision now states that benefits can be accorded for healthcare received abroad under the conditions set by arrangements agreed upon by the competent NIHDI committees and foreign institutions in order to promote mobility of socially insured in border areas. Most cooperation agreements rely on a system of simplified authorization and Regulation of costs, both following the logic of the European Coordination Regulations.[cliii]

[cl] 1) One must point out that in Belgium all persons insured by the statutory Sickness and Invalitity Insurance (HDI) residing in a border region are already unilaterally entitled to coverage of cross-border hospital care on the basis of Belgian tariffs:

when this is received in a hospital lying within 25 km of the border and on condition no similar care is available in Belgium within a closer range (art. 294, §1 7°[70]).

For HDI-insured residing in the cantons of Arlon and Messancy, the administrative districts Virton and Bastogne and the municipalities Mellier, Léglise, Ebly, Juseret, Witry and Anlier, a right to coverage on basis of the Belgian tariffs exists for specialized care, deliveries, hospital care, dental care and certain pharmaceutical products received in *Luxembourg* (art. 294 §1, 9° a) Royal Decree 3 July 1996).

The above applies also for HDI-insured residing in the cantons of Bouillon, Chimay, Couvin, Florenville, Gedinne and Virton, if this care is received in *France* within a range of 50 km from their residence (art. 294 §1, 9° b) Royal Decree 3 July 1996).

2) Another *unilateral* right to cross-border for HDI-insured living in border areas can be found in the already mentioned Circulaire 2008/284 of the NIDHI. This circulaire establishes a flexible prior authorization procedure (within the meaning of art. 20 Reg. 883/2004) for hospital care , dialysis or certain specific ambulatory care given within 25 km of the border, on condition the patient resides no further than 15 km from the border. The latter limit is extended to the whole area of the East Cantons (Eupen, Sankt-Vith and Malmédy), to the cantons of Arlon, Messancy, Bouillon, Chimay, Couvin en Gedinne, the administrative districts Virton and Bastogne and the municipalities Mellier, Léglise, Ebly, Juseret, Witry and Anlier.

[cli] Coordinated Act of 14 July 1994 concerning the statutory sickness and invalidity insurance [71], further indicated as 'HDI-Act'.

[cliii] Cf. art. 8 (2) Reg. 883/2004.

2.2.6.1. *Euregio Meuse-Rhine (situation as from 1 January 2007)*[cliii]

Socially insured and their family members living in the Euregio Meuse-Rhine[cliv] may receive certain medical care in a country in which they are not socially insured when presenting an 'IZOM EMR R. 112+ form'. This is an S2 form (former E112 form) delivered automatically by the healthcare insurer on the patient's request. The period of validity of this form is set at min. 1 full trimester and max. 1 year, in order to ensure continuity of care.

Once this formal condition is fulfilled, the cooperation agreement entitles the patient to:

- general specialist care[clv], on the domain of both diagnosis and treatment.[clvi]
- the prescribed medicines and medical aids the abovementioned treatment requires
- the hospital care this treatment necessitates

The cooperation agreement will be executed according to the relevant provisions of the European Coordination Regulations 883/2004 and 987/2009. This implies that patients will receive medical care and healthcare coverage according to the legislation of the country of treatment. Regulation of costs between states however must be done through a simplified and accelerated procedure, based on the international settlement agreements that have been concluded between them.[clvii]

2.2.6.2. *Cooperation agreements on the French-Belgian border*

During the two last decennia several projects on cooperation between French and Belgian healthcare actors have been set up to meet the needs of the French-Belgian border population and to ensure a real complementarity in healthcare provision on both sides of this border. Among the most notable early examples of this extensive cooperation are the conclusion of (still-standing) bilateral cooperation agreements between Belgian and French hospitals, the creation of an 'Observatoire franco-belge de la santé' (1999)[clviii] and the successful Transcards-project in the Tiérarche region (2000), which foresaw in a mutual recognition of national health insurance cards when getting medical care in the neighbouring state. Incited by the emerging case law of the ECJ on patient mobility, several new project initiatives were taken but sometimes difficulties arose in concern to their legal validity due to the absence of a global framework.[clix]

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cliii See Circulaire H.I. NIHDI nr. 2007/132 -83/358 of 20 April 2007 concerning the cooperation agreement on the subject of cross-border healthcare delivered within the framework of the 'Healthcare without borders in the Euregio Meuse-Rhine'-project0. [72] For an historical overview of this project: Year Report NIDHI 2001, 97-98. [73]

cliv The Euregio Meuse-Rhine is composed of the Belgian provinces Limburg and Liège (incl. the Germans peaking Community), the Dutch provinces Limburg and Northern-Brabant and the German Aachen Region (including the districts of Bitburg, Daun and Prün).

clv For Belgium, see chapter V of the HDI-nomenclature (art. 10 Royal Decree 14 September 1994).

clvi If national law however explicitly prescribes a 'normal' prior authorization (S2-form) for certain specialist care, these provisions will prevail. For Belgium, see [19] and the annexed lists of highly specialized treatments.

clvii In practice however, the impact of the simplified authorization procedure of the IZOM-Regulation will be rather limited in relation to patients coming from the Netherlands in order to have planned hospital care, as most patients living in the Dutch-part of the Euregio Meuse-Rhine are insured by healthcare insurers which have concluded direct cross-border contracts with Belgian hospitals (information gathered from the Christian health insurance funds).

clviii The OFBS, created in 1999, is a European economic interest grouping composed of representatives of principle actors of the statutory health insurance, doctors, pharmacists and hospitals active in the French-Belgian border region. Its principal missions are: 1. Gaining insight in the expectations of the frontier population and get a good knowledge of the healthcare offer in the border regions; 2. Doing studies in order to discover potential axes of cooperation and complementarity in healthcare provision; 3. Giving support and legal advice to the actors of cross-border healthcare projects. See www.ofbs.be.

clix See also: HARANT, 2006, 157-177. [74]

French-Belgian Framework Agreement on cross-border healthcare cooperation of 30 September 2005

On 30 September 2005, the Ministers of Health of both countries signed an '*Accord cadre franco-belge de coopération sanitaire'*.[clx] This framework agreement wants to provide a legal basis for future and existing projects on cross-border healthcare cooperation on the French-Belgian border. It further wants to provide the minimal validity conditions, as well as a method of evaluation of these projects. Only recently all competent Belgian legislative levels have ratified this convention.[clxi] As a consequence it only entered into force on 28 February 2011.Here we will briefly and schematically touch upon those parts of the Framework Agreement which are most relevant within the scope of this research project.

Personal and territorial scope of application (art. 2)

- The framework agreement applies to all persons covered by the statutory health insurance of one of both contracting parties residing or temporarily staying in one of the following border regions:
  - o France: regions of Champagne–Ardenne, Lorraine, Nord-Pas de Calais and Picardie
  - o Belgium: border districts of Veurne, Ypres, Kortrijk, Mouscron, Tournai, Ath, Mons, Thuin, Philippeville, Dinant, Neufchâteau, Virton and Arlon

Conclusion of cooperation convention on healthcare (art. 3)

- Competent authorities: For Belgium, the persons and authorities that can conclude a cooperation convention are: the NIDHI, the health insurance funds and healthcare providers[clxii], each within their field of competence.[clxiii]
- Subject of cooperation convention: agreements should organize cooperation between the healthcare structures and means situated in border areas. This can be done by extending existing healthcare structures, or by setting up new cooperation organs or communal structures.
- Minimal provisions: cooperation conventions must foresee in *obligatory* conditions and Regulations in relation to the interventions of healthcare structures, social security institutions and medical practitioners.

Depending on the scope of the convention, these conditions and Regulations relate to:

- Cross-border intervention of medical practitioners
- Organization of ambulance services
- Continuity of care, including the relief and information of patients
- Criteria concerning the evaluation and control of quality and safety of care
- Provision of necessary financial means to set up the cooperation

With the exception of the evaluation of quality and safety of care, it is not quite clear who and at what level these obligatory conditions and rules should be determined.

Amount of financial coverage for care provided (art. 5)

- The Framework agreement clearly states that the provisions of the European Coordination Regulations are applicable to the execution of cooperation conventions. However, if a patient applies for prior authorization, this has to be delivered *automatically* by the competent

clx Framework Agreement 30 September 2005 concluded between the government of the Kingdom of Belgium and the government of the French Republic concerning cross-border healthcare cooperation [75]

clxi Flemish Community: Ratification Decree of 13 March 2009 (BS 16 April 2009); French speaking Community: Ratification Decree of 27 May 2009 (BS 24 June 2010); Walloon Region (in concern to transferred Community competences): Ratification Decree of 3 June 2010 (BS 16 June 2010); Federal level: Ratification Act of 9 February 2009 (BS 18 February 2011).

clxii Within the meaning of art. 2 n) HDI-Act.

clxiii Art. 1 Administrative Arrangement concerning the terms of application of the Framework agreement on cross-border healthcare cooperation between the government of the Republic of France and the government of the Kingdom of Belgium[76]

social security institution.[clxiv] In this case costs will be covered according to the tariffs of the place of treatment.

- If patients do not ask for prior authorization, costs will be covered according to the tariffs of the country of affiliation as follows from the *Kohll & Decker*-jurisprudence of the ECJ.[clxv] It is not clear if this also implies the distinction between outpatient and hospital care applies here. Given the objectives of the framework agreement (search for complementarity), and the fact it nowhere distinguishes among the nature of care, it can be defended that Belgian health insurance funds will have to provide coverage for non-authorized hospital stays.
- Interesting is the fact that art. 5.3 of the Framework Agreement stipulates that in case cooperation agreements foresee a direct financial intervention of the competent institution (third-party payer), it is possible to negotiate *specific* tariffs, *in case this would seem necessary*. This is the case if certain types of care are not covered by the statutory sickness insurance.

Evaluation of the Framework Agreement by a mixed commission

- A mixed administrative commission composed of representatives of national healthcare and health insurance authorities of both countries, will be charged with the follow-up and the evaluation of the Framework Agreement. It could also solve certain interpretative questions.

Creation of 'ZOASTS'

Since 2008, five '*Zones Organisés d'Acces aux Soins de santé Transfrontaliers' (ZOAST)* have been created on the legal basis provided by (and even anticipating on the entry into force of) the Framework Agreement of 30 September 2005.[clxvi] The objective of these zones is to offer patients of certain border areas the possibility to get medical care across the border without encountering any financial or administrative difficulties. Some of these ZOASTS are based on already long existing axes of cooperation between certain Belgian and French hospitals. At the same time also the *Transcards*-project has been confirmed and converted in a specific ZOAST. When it comes to applicable tariffs and methods of cost settlement, all these conventions follow the logic of the European Coordination Regulations.

The object and scope of these different cooperation conventions (ZOAST 1 to ZOAST 6) is summarized in appendix [77] In the future one intends to harmonize the functioning of these separate conventions.

Key points

- **Several cross-border cooperation agreements have been setup during the last decade(s) with a view to overcome certain healthcare deficiencies experienced people living in the border areas of both Belgium and its neighboring countries. Improving access to healthcare providers across the border improves the complementarity and proximity of the available healthcare offer, as well as the efficient use of healthcare infrastructure.**
- **A special legal basis has been created in the HDI-Act to allow cross-border healthcare cooperation between the NIHDI and foreign social security administrations (e.g. IZOM-project in Euregio Meuse-Rhine). A special bilateral framework agreement has been concluded laying down the minimal conditions for future healthcare cooperation in the French-Belgian border area (e.g. the conclusion of agreements creating '*Zones Organisés d'Acces aux Soins Transfrontaliers*').**

[clxiv] Art. 5.2 Framework Agreement.

[clxv] Art. 5 Administrative Arrangement.

[clxvi] See also art. 136 §1 c) HDI-Act.

- **Cooperation agreements in principle rely on a simplified application of the European Coordination Regulations to organize coverage for patients making use of them (automatic authorization, simplified compensation of costs *between neighbouring states).***

2.2.7. Cross-border contracting between Belgian hospitals and foreign health insurers with the EU

This section is based on several articles. [78-81]

2.2.7.1. Interest in purchasing healthcare in Belgium

During the last decade, health insurers from neighboring countries found their way to Belgian hospitals by concluding direct cross-border contracts. As for the UK and the Netherlands, this search for care abroad founds its origin in the growing dissatisfaction of national patients with long-waiting lists existing in their national healthcare system (UK, NL) and the scarce number of healthcare providers in certain border areas (NL). Moreover, one was afraid of growing costs that an emerging patient outflow based on the ECJ jurisprudence could create. At the same time direct contracting healthcare has the advantage to preserve supervision on the quality of care provided abroad.

Contracting foreign healthcare providers could have several beneficial effects for the own national healthcare market. While national healthcare systems as such extend their capacity across-borders, at the same time pressure is relieved from healthcare providers at home, resulting in a reduction of waiting lists and expands the national accessible volume of care. At the same time this extension introduces a form of cross-border competition, giving national providers an important incentive to improve their own performance.

Nevertheless, the incentive to conclude cross-border contracts should not only be related to the concern to remedy national capacity problems. Also here one can retrieve the intention to improve access to high-quality hospital care, especially for people living in border regions.

Also the Belgian hospitals have certain interests in closing cross-border contracts with foreign healthcare insurers. It gives the opportunity to increase their expertise and to establish an international reputation. Cross-border contracting does guarantee more *financial security* as it installs a direct form of cost Regulation between the hospital and the foreign insurer compared to the collection risk in case of an individual foreign patient coming outside of a social security coordination context.

From a national perspective the Belgian authorities are not always involved in this process of cross-border contracting, yet there is growing concern on some potential dangers. Hospitals, but hospital doctors in particular, may have a financial interest. Some hospital doctors may be starting to prioritize foreign patients over national patients as they both would have a financial interest in receiving as much patients as possible, which could give rise to waiting lists for Belgian patients. This risk of cutting down on numbers of Belgian patients will be even bigger if contracting parties were free to negotiate higher hospital prices for contract patients. To discourage these kinds of practices potentially endangering the access to hospital care, the Belgian authorities already intervened in the past by concluding *bilateral framework agreements* with the public authorities of the country where the contracting health insurer is located[clxvii] Cross-border contracts concluded in application of these agreements should respect some key principles. As such they should follow the technique and methods of the European Coordination Regulations. Furthermore contracted patients should be assimilated to Belgian patients, with as consequence that the same healthcare tariffs are to be applied.

Further these agreements imposed that contracts should provide explicitly that foreign patients would only serve to fill a hospital's overcapacity.

Interesting is the fact that the Belgian-English framework agreement foresaw a possibility for the NHS-representative (*Lead Commissioner)* and the Belgian hospital to negotiate an *additional reimbursement* in case certain costs were not covered by Belgian tariffs.[83]

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clxvii Bilateral framework agreement for cross-border patient mobility and exchange of experience in the field of healthcare between Belgium and England [82] Since 2007, this became defunct because of budgetary problems and increasing hospital capacity in England. The few contracts concluded were no longer extended; the flow of patients effectively coming to Belgium using these contracts already stopped in 2004 however).

2.2.7.2. Cross-border contracts with Dutch healthcare insurers

Currently, several Flemish hospitals concluded cross-border contracts with Dutch healthcare insurers. Some of them were negotiated with the help of the Christian health insurance funds (CM/MC), who acts as a sort of middleman. This intervention however will be at the request of one or both contracting parties and is thus not legally obliged. All attempts to conclude a bilateral framework agreement with Dutch authorities have failed until now.

In principle these contracts will contain provisions on:

- Number of foreign patients (unlimited inflow or limited to fill hospital's overcapacity)
- Types of pathologies. Most contracts cover both in and out-patient care. For medical specialist care an authorization of the healthcare insurer can be required
- Quality of care: Medical procedures and practices as well as legal aspects of care provision are carried out according to Belgian norms, including the respect of patient rights[clxviii]
- Applicable tariffs: in principle Dutch healthcare insurers will always stipulate that hospitals must charge Belgian tariffs for hospital stays. For hospitalization costs this will be the average 100% patient day price determined according to the relevant provisions of the Hospital Act of 10 July 2008 (cf. *infra*-Chapter 6). In relation to medical costs, hospitals commit themselves that their doctors will charge the official convention tariffs, agreed upon within the framework of the Belgian health insurance. Here the personal share of the patient will be at charge of the health insurer. Hospitals will further have the obligation to inform contract patients about the possibility to charge them certain supplements in case of specific preferences related to the hospital stay.
- Regulation of costs: Can be done through the ordinary Coordination Regulation technique on the basis of S2 forms (here a Belgian health insurance fund will act as an administrative intermediary), but mostly a system of *direct billing* between the Belgian hospital and the Dutch healthcare insurer applies, which constitutes a large administrative simplification.
- On demand of the parties, the Belgian Christian Mutuality will intervene to control the invoice to see if the hospital has applied Belgian tariffs correctly. Certain contracts organize this invoice control on a *permanent basis*. Others only provide for an optional control by a Belgian health insurance fund of choice.

2.2.7.3. Cross-border contracting and the European Union

Up till today the phenomenon of cross-border contracting between national healthcare authorities and foreign healthcare providers has drawn limited attention at the European level. Also the Patient Mobility Directive remains silent on this particular aspect of patient mobility. One could however point at the work done by the High Level group on Health Services and Medical Care in 2005 by order of the European Commission. This group of experts developed a set of (not legally binding) guidelines serving as a framework which 'commissioners of healthcare' (including ministries of health, national, regional, local or other public authorities, health insurance institutions and hospitals) should take into account when purchasing or offering medical treatments in another Member State by means of contracts and agreements.[83]

The abovementioned document distinguishes between two types of guidelines.

General guidelines identify common principles deriving from national and European legislation which commissioners of healthcare should take into consideration when drawing up the content of a cross-border healthcare contract. As such they relate to issues as applicable legislation (state of treatment), liability for medical malpractice, applicable tariffs, sharing of information and the protection of personal data.

Specific guidelines give further indications on which concrete provisions a contract on the purchasing of medical care abroad should at least contain. As such contracting parties should agree upon:

- Types of healthcare covered, expressed in number of bed days, procedures, diagnosis or treatment
- Indicative number of patients, treatments or procedures

[clxviii] Patient Rights Act of 22 August 2002. [84]

- Duration of the contract and method of renewal
- Exchange of certain types of data between healthcare commissioners and providers at different moments (admission, treatment, follow-up, complications)
- Provision of clear and understandable information and communication to patients
- Financial arrangements (moment of payment, amount of coverage, personal share)

The general guideline on *price-setting* is particularly interesting within the scope of this research project. Here the High Level group puts forward that the price stipulated for the purchased healthcare should in principle reflect the tariffs applicable in the country of provision. However, it is acknowledged one could derogate from this principle if this can be 'objectively justified'.

As such the experts esteem contracting parties only could agree upon a different tariff mechanism, if this is based on legitimate reasons and does not go further than necessary. It is not certain if this limitation of freedom of contract only stems from the principle of equal treatment on the basis of nationality as firmly confirmed by the ECJ in its *Ferlini*-judgment (cf. *supra*).

As long as a commissioner of healthcare and a foreign healthcare provider agree on a higher tariff *without* passing any of this additional expense to the contract patient, it does not form a forbidden discrimination on the basis of art. 18 (and 56) TFEU. The High Level Group however stresses that cross-border healthcare contracts should not serve lucrative goals. On the contrary, they should reflect the fundamental principles of every European health system: universality, equity and solidarity.[clxix] As such the general guideline of charging equal tariffs to contract patients should prevent the risk of healthcare at different speeds, where healthcare providers turn themselves towards more lucrative foreign patients, causing problems of accessibility for own national patients.

Key points

- **Health insurers from Member States struggling with national healthcare access problems (waiting lists, border area deficiencies,…) have concluded several cross-border contracts with Belgian hospitals, organising a structural inflow of foreign patients.**
- **Hospitals can have several interests in concluding these agreements: expanding their international expertise, fill-in existing overcapacity, financial reasons, …**
- **In the past the Belgian authorities already intervened by concluding bilateral agreements with other Member States imposing certain key principles which hospitals and insurers from both Member States should respect when concluding a cross-border contract (e.g. application of identical tariff scales to both domestic as foreign patients)**
- **Presently no bilateral framework agreement exists with the Netherlands. Several Dutch health insurers have expanded their national healthcare system across the border by contracting Belgian hospitals. Contracts specify the number of contract patients and the pathologies for which they will be sent, quality and safety of care. In principle, Belgian healthcare tariffs will apply, however without charging the contract patient a personal share. Regulation of costs is mostly done by directly billing the invoice to the Dutch health insurer. Certain contracts foresee the possibility or even the obligation of a prior invoice control by a Belgian health insurance fund**
- **In 2005, the European High Level group on Health Services and Medical Care issued guidelines on purchasing healthcare abroad: general guidelines containing the general principles of cross-border contracting (e.g. identical tariff setting unless objectively justified) and specific guidelines on minimal contractual provisions**

[clxix] See also Council Conclusions 22 June 2006 on common values and principles in European Health systems. [85]

2.2.8. *Patients coming from outside EU/EEA under bilateral or multilateral coordination treaty*

Also for patients coming outside of the EEA, certain possibilities exist in order to have scheduled treatment in Belgian hospitals. As such these patients could come under the provisions of a bilateral or a multilateral coordination treaty. It is also possible that Belgian hospitals have concluded a direct contract with an international healthcare insurer. The practical relevance of these specific patient mobility routes is however limited.

2.2.8.1. *Bilateral coordination of healthcare coverage*

Up till today Belgium is bound by several bilateral social security conventions coordinating the social security rights of migrating workers and the members of their family. Where it concerns Member States of the European Union these conventions became obsolete, as their function has been taken over by the Coordination Regulations in order to ensure free movement within the European internal market.[clxx]

Several[clxxi] of the 22 bilateral social security conventions in force today entitle beneficiaries and their relatives to healthcare coverage during:

- their residence in the Member State other than the Member State of affiliation
- a (legitimate) temporary stay in the Member State other than the Member State of affiliation. Here some of the conventions explicitly limit the scope of the right during this stay to urgent or immediately necessary care[clxxii].

In principle, these bilateral social security conventions do **not** provide coverage in case one has travelled to the other Member State in order to get medical care (elective or *elective* healthcare).

This could be nuanced a bit for some of the older social security conventions concluded with the Maghreb-countries Morocco, Algeria and Tunisia. These conventions do not distinguish between urgent or non-urgent medical care during a temporary stay, nor do they explicitly exclude the possibility of elective treatment. It could give opportunities to avert procedures originally meant to provide healthcare coverage in case of short 'tourist' stays to elective medical treatments.[clxxiii]

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clxx These conventions could however subsist if they contain provisions which are more favourable for the beneficiaries (art. 8 Reg. 883/2004). Here one could point at the Belgian-Luxembourgian Convention of 24 March 1994. [86] This convention foresees in an additional reimbursement on top of Belgian tariffs for frontier workers and family members at charge residing in Luxemburg who let themselves treat in Belgium.

clxxi See bilateral conventions concluded with Morocco, Turkey, Tunisia, Algeria, Croatia, Australia, Québec and Macedonia. For Serbia, Bosnia-Herzegovina, Montenegro and Kosovo the old social security convention concluded with Yugoslavia remains in force.

clxxii See for ex. art. 11, 1st par. Belgian-Turkish convention [87]; art. 13.1 Belgian-Croation Convention [88]; art. 13.1 Belgian-Macedonian Convention [89]; art. 5 Australian-Belgian Convention [90].

clxxiii For Tunisia: In case a beneficiary wants to apply for planned healthcare in Tunisia or Belgium, he needs a form BTUN11 granting healthcare coverage valid for a period of 60 days. With this form one can ask the health insurance fund of the Member State of treatment or affiliation according to tariffs and conditions set by the legislation of the Member State of treatment (See art. 10 Tunesian-Belgian Convention [91] and art. 11-12 Administrative Arrangement [92]); For Morocco: No specific form exists. Costs of healthcare provided during the first 45 days of stay in Morocco will be reimbursed afterwards by the Belgian health insurance funds according to the tariffs and conditions of the Belgian legislation (!) (See art. 11 Moroccan-Belgian Convention [93] and art. 7 Administrative Arrangement [94]); For Algeria: A beneficiary applying for programmed care must be in possession of a specific form issued by the health insurance fund of the Member State of affiliation. This form is valid for a maximum of 45 days. During this period, costs of healthcare will be covered by the institution of the Member State of stay, according to the legislation it administers, on condition the type of care is also covered by the legislation of the Member State of affiliation (See art. 11 Algerian-Belgian Health Insurance Convention [95]and art. 7 Administrative Arrangement [96]).

The personal scope of application of these conventions ,however, is limited. They only apply to salaried workers or assimilated persons that have the nationality of one of the two Member States.

The majority of recent bilateral conventions now explicitly exclude this type of improper use of rights to coverage, by stipulating that the convention provisions on urgent medical care 'do not apply if a person travels (without authorization of the competent authority) to the other contracting state in order to get medical care.[clxxiv]

2.2.8.2. Multilateral coordination treaties

One has to point out that Belgium has signed and ratified the *European Convention of Social Security* (ECSS) of 14 December 1972[clxxv] together with some other EU-Member States and Turkey. This multilateral treaty, concluded within the lap of the Council of Europe, contains a system of social security coordination which bears much resemblance with the European Coordination Regulations[clxxvi]. The provisions on healthcare are in fact almost identical to the text of the original Reg. 1408/71, which were in some cases less strict than the actual Community provisions.[clxxvii] As such art. 21, 2 b) ECSS states that authorization for elective care in another Member State may *not* be refused when the requisite treatment *cannot be given* in the territory of the Member State in which the person concerned resides, whereas the corresponding art. 22 Reg. 1408/71 has been made a lot more stringent after the famous *Pierik*-judgments[clxxviii] of the ECJ. The implementation of art. 19-25 ECSS relies however on the existence of bilateral or multilateral executive agreements. Up till today, Belgium did not yet conclude this type of agreements causing this multilateral coordination instrument to be of only limited practical importance.[clxxix]

Key points

- **The actual bilateral coordination conventions to which Belgium is bound in principle do not foresee in a possibility to have elective healthcare in either of the two contracting parties.**
- **Certain older bilateral conventions only foresee a temporal limit to coverage when staying in the other state (without a condition of urgency), which could indirectly offer possibilities to obtain elective care**
- **Multilateral coordination conventions (outside the EU-framework) contain provisions on elective care, but are inoperable due to the lack of executing agreements**

2.2.9. Cross-border contracting at the international level

Sometimes Belgian hospitals have also contracts running with (mostly private) healthcare insurers situated outside of the European Union. This can for example be the case for hospital care provided to diplomatic or military personnel of non-EU countries posted in or near Belgium. It can happen that these contracts let direct billing between hospital and insurer depend on the presence of a *payment warranty* issued by the insurer, which the patient must request at the latest at the moment of hospitalization. Without warranty (which will mostly be valid for only a

clxxiv See for example: art. 13.3 a) Croatian-Belgian Social Security Convention [88]; art. 13.3 a) Macedonian-Belgian Social Security Convention [89]; art. 5.3 Australian-Belgian Health Insurance Convention [90].

clxxv European Convention on Social Security of 14 December 1972 [97]

clxxvi At the time of signature, one could say the ECSS was even more ambitious than Reg. 1408/7 . The universal personal scope of application of the ECSS contained all persons subject to the social security legislation of one or more Member States, whereas Reg. 1408/71still departed from a categorical approach. Art. 2 Reg. 883/2004 overcame this gap.

clxxvii Art. 19-25 ECSS. See SCHOUKENS, 1993, 14-21. [98]

clxxviii Case (1978) C-117/77 Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v G. Pierik{, 1978 #86} (Pierik-I); Case (1978) C-182/77Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v G. Pierik [99] (Pierik-II).

clxxix https://www.socialsecurity.be/CMS/nl/about/displayThema/about/ABOUT_7/ABOUT_7_3/ABOUT_7_3_2/ABOUT_7_3_2_1.xml (consulted on 25/1/2011).

limited period of time), the insurer will refuse to intervene, leaving the patient to pay the entire hospital bill.

Neither at national, nor at international level a legal framework exists in concern to this type of cross-border contracting. It does seem, however, that contract parties dispose of a large amount of contractual freedom. Even though art. 191 of the Belgian Constitution proclaims a general principle of equal treatment of foreigners, this provision mainly applies on the vertical relationship between the public authorities and citizens staying on Belgian territory. As such, Belgian judges will be reluctant to apply it in a purely horizontal manner (i.e. in a relationship between private actors).

One could nevertheless point at the fact that hospitals in general fulfill a service of *general interest* in order to secure and protect the health of the persons residing or staying on Belgian territory.

This gives hospitals at least some public characteristics, arguing that the constitutional obligation of art. 191 of the Belgian Constitution could also apply to them. This would also imply that only a formal legal act could allow hospitals to introduce a system of tariff differentiation, on condition this legal derogation presents a legitimate aim and its necessary and proportional character.

This legal discussion becomes less important when one points at the Anti-Racism Act (ARA) of 30 July 1981, as revised by the Act of 10 May 2007.[clxxx] The ARA contains a general prohibition of discrimination on the basis of nationality within a broad number of fields, including social security and *healthcare*.[clxxxi] This provision is applicable to *all* (natural and legal) persons of both the public as the private sector, as such implying its application between private individuals.

Here art. 7 §1 ARA states as a general principle that every distinction directly based on nationality should be considered as a forbidden form of direct discrimination. However, according to the second paragraph of the same article, no discrimination is present when this distinction can be *objectively justified* by a legitimate aim and the means to achieve this aim do not go further than what can be considered appropriate and necessary (*proportionality-principle*).[clxxxii]

One could wonder what this legitimate aim could be in relation to e.g. the negotiation of higher tariffs for international patients. Moreover, even if higher tariffs are applied in order to cover certain extra costs (and as such wants to establish 'price equality'), one must still be aware the applied tariff mechanism does not go further than necessary (for example by creating certain accessibility problems for national patients). As such one could think of the situation where hospital records show that international contract patients *systematically* suffer from heavier pathologies compared to the average (Belgian) case mix of a the hospital.

clxxx Law of 31 July 1981 punishing certain racist or xenophobic deeds [100] transposing the European Racism Directive (Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin [101]) and the International Convention against Racism (International Convention on the Elimination of All forms of Racial Discrimination of 21 December 1965 [102]).

clxxxi Art. 3 jo. 5 §1, 2° ARA.

clxxxii Art. 7 §2 ARA, which further explicitly states that no direct distinction on the basis of nationality prohibited by European law can be justified.

Key points

- **Certain Belgian hospitals have concluded contracts with (mostly private) international healthcare insurers for the coverage of e.g. diplomatic or military personnel.**
- **Because of the absence of an international legal framework, one has to look if certain national provisions could limit the freedom of contract of the parties involved.**
- **The horizontal application of art. 191 of the Belgian Constitution (fundamental right) and the non-discrimination on the Anti-Racism Act of 31 July 1981 in principle proclaim the equal treatment of foreign nationals (legally) staying in Belgium for healthcare matters.**
- **Differences of treatment (e.g. tariff discrimination) could be justified by a legitimate aim (e.g. protecting the financial balance of the national healthcare system), on condition that the implementing measures are necessary and proportional to the sought objective.**

2.3. Foreign patients without any funding contract and/or convention

It can happen that foreign patients arrive at the hospital in order to have scheduled treatments outside of a contract and/or a legal provision whether from the EU or the non-European level. Also then certain principles regarding equal treatment and non-discrimination will have to be observed. Here one has to distinguish between EU-nationals *without statutory healthcare coverage* and non EU-nationals.

Even when European patients fall outside of the scope of application of the Coordination Regulations and the Patient Mobility Directive, they could still enjoy the fundamental freedoms and rights granted to them by the TFEU. Being European citizens exercising their free movement of services, also these patients are concerned by the *Ferlini*-jurisprudence of the ECJ (see above). Moreover, also these patients fall under the non-discrimination principle of art. 4 (4) of the Patient Mobility Directive, which excludes tariff differentiation between European and domestic patients in an absolute manner.[clxxxiii]

Non-European patients coming outside of a social security coordination framework (whether they enjoy any statutory healthcare coverage or not) will enjoy the protection of art. 191 of the Belgian Constitution, in relation to the Belgian State, and the Anti-Racism Act, the latter providing for a horizontal application of the principle of equal treatment on the basis of nationality within the field of healthcare (see above).

Also here however, a different treatment directly based on the nationality of the patient could be justified, if objectively justified and proportional to the pursued goal.

Nevertheless here a wider possibility to differentiate exists compared to patients coming from the European Union. At the Belgian level, the justification test can be considered to be less strict than the one applied by the ECJ, where only very strong justification grounds related to the general interest should make it possible to derogate from fundamental market freedoms.

In relation to the question of possible tariff differentiation, one should point at the fact that the Constitutional Court already judged several times that a difference of treatment of (non-EU) foreigners could be justified if *no sufficient bond* with Belgium can be proved.[clxxxiv] This is certainly the case for international patients only staying in a Belgian hospital for the period needed to receive a scheduled treatment. Even then, charging a higher tariff may not result in an unnecessary or disproportional measure in

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clxxxiii Art. 4 (4) Patient Mobility Directive talks about 'patients from another Member State'. The notion of patient is here defined as 'any natural person who seeks to receive or receives healthcare in a Member State' (art. 3. h) Patient Mobility Directive). One remembers that the personal scope of application for the Directive provisions on reimbursement of healthcare costs (art. 7-9 Patient Mobility Directive) are attached to the notion of 'insured person'.

clxxxiv This jurisprudence mainly related to the access to non-contributory social benefits: Const. Court 12 December 2007 nr. 153/2007 [103]; Const. Court 10 June 2010 nr. 69/2010 [104].

relation to the aim for e.g. a more equal division of financial charges between national and foreign patients.

Key points

- **In concern to foreign patients coming outside of a social security coordination context or a cross-border contract, a distinction must be made between not socially insured EU-nationals and third-country nationals.**
- **European law prohibits that not socially insured European patients would be treated differently on the basis of their nationality, which becomes absolute when determining the applicable healthcare tariffs.**
- **By virtue of art. 191 Constitution and the Anti-Racism Act, third-country patients in principle cannot be treated differently from domestic patients because of their nationality. Derogations are possible however if justified by a legitimate aim, and necessary and proportional to the sought objective. The Belgian Constitutional Court already upheld differential treatment of foreigners with regard to access to social benefits if no sufficient bond with Belgium exists.**

2.4. Overview identified patient tracks

With regard to elective hospital care, three general types of foreign patients can be identified that Belgian hospitals will meet in practice:

- Coordination patients: patients who will be assimilated to a Belgian social insured under the provisions of a European or international social security coordination instrument. Here one must add the cross-border cooperation agreements in border regions which rely on a (simplified) application of the European Coordination Regulations
- Direct billing (advanced payment) patients: individual patients that in principle will cover the cost of hospital treatment themselves. This includes patients with statutory healthcare coverage in a EEA-Member State who are making use of their free movement of services; as well as European and non-European patients with no or only private health insurance.
- Contract patients: patients coming under the provisions of contract concluded between the hospital and a foreign European or non-European healthcare insurer

For every patient type one further has to distinguish on the basis of the origin of the patient (EU(EEA) or non-EU) and their social security status (statutory healthcare coverage or not).

With use of the following table 2.1 this final chapter wants to give a schematic summary of the essential characteristics of the different patient tracks identified.

Table 2.1: Summary of patient mobility routes from the Belgian hospitals point of view

Patient type	**Coordination patients**			**Direct billing patients**				**Contract patients**	
Origin	Outside EEA	EEA	Neighboring country	Outside EEA	EU (without statutory coverage)	EEA	EU	EU	Outside EU
Patient mobility instrument	Bilateral or multilateral coordination treaty	EU Coordination Regulations	Cross-border cooperation agreements			Free movement of services (TFEU/EEA-Agreement)	Patient Mobility Directive on patients' rights in cross-border healthcare	Cross-border contracting	Cross-border contracting
Authorization	Always required	Always required	Automatic deliverance (possibly *a posteriori*)	Not required	Not required	Hospital care; major medical equipment	Hospital care; major medical equipment; Patient or population safety risks	Possible (automatic deliverance for cost Regulation)	Possible
Level of coverage	Legislation of Member State of treatment	Legislation of Member State of treatment + *Vanbraekel*-supplement	Legislation of Member State of treatment Specific negotiated tariffs possible	Possible statutory of private coverage in home country	Possible private coverage in home country	Legislation of Member State of affiliation (up to level actual cost)	Legislation of Member State of affiliation (up to level actual cost)	Belgian tariffs apply (Coordination or direct billing- logic) (BUT absence of extra financial charge for patient)	
Payment method	Third-party payer or reimbursement Cost Regulation between Member States	Third party payer or reimbursement Cost Regulation between Member States	Third party payer or reimbursement Cost Regulation between Member States	Direct billing to patient	Direct billing to patient	Direct billing to patient	Direct billing to patient	Simplified E112/S2 or Direct billing to foreign healthcare insurer (for all treatments covered by the contract)	Direct billing to foreign healthcare insurer

Patient type	Coordination patients			Direct billing patients				Contract patients	
Travel & accommodation costs (TAC)	Generally not foreseen Possible coverage of TAC by legislation of competent state	Coverage of TAC by competent institution if *inseparable* from treatment	Coverage of TAC by competent institution if inseparable from treatment	Possible, if covered by legislation of state of insurance	TAC for patient himself	Coverage of TAC if also foreseen for national treatments	Member States are free to reimburse TAC, even if this does not apply for healthcare provided on their territory		
Provider	Providers affiliated to statutory system	Providers affiliated to statutory system	Providers affiliated to statutory system	Statutory and private providers	Statutory and private providers	Statutory and private providers	Statutory and private providers	Contracted provider	Contracted provider
Provider tariffs	Assimilation-principle	Assimilation-principle	Assimilation-principle	Equal treatment, unless justified	Equal treatment unless justified	Equal treatment unless justified	Equal treatment (at patient level)	Equal treatment (at patient level)	Equal treatment, unless justified

3. HOSPITAL DATA REGISTRATION SYSTEMS

3.1. Overview structure

This chapter analyses the actual hospital registration systems at the FPS Public Health and the NIDHI that can provide information on the inflow of the three types of foreign patients (coordination, direct billing, contract) identified in the previous chapter.

After a short clarification on the purpose, scope and content of each registration system, it analyses in which way these systems provide information on the following patient mobility aspect[clxxxv]:

- The number of foreign patient stays, in terms of both hospital admissions and patient-days (length of stay)
- Insurance status
- Pathology profile
- Treatments offered
- Financial dimension

Considering the goals of every registration system, a number of adjustments are proposed to remedy (as much as possible) the registration gaps.

3.2. Hospital data available with the FPS Public Health

According to art. 92 Hospital Act, every Belgian hospital has the obligation to inform the FPS Health, Food Chain Safety and Environment ('FPS Public Health') about its financial situation and operating profits and must further provide certain statistical data on the functioning of the institution in general and its medical activities in particular.[clxxxvi]

If data on medical activities are collected on an individual basis, Belgian privacy law formally prohibits any possibility of 'direct' identification of the patient (unless authorization of the patient itself), leaving only the possibility of indirect contextual recognition to consider. In this respect, art. 92, 2nd par. Hospital Act explicitly prohibits any possible attempt of re-identification by anybody handling those data (with the exception of authorized FPS auditors and NIDHI advisory physicians[clxxxvii]). This allows registration of medical data on hospital patients in other ways than merely 'anonymously'. It nevertheless supposes that at least a manner of 'pseudonimisation' (by means of codification) should be applied.

3.2.1. Transfer of financial and accounting data through FINHOSTA

The Royal Decree of 14 December 1987[clxxxviii] regulates the transfer of the hospital's financial and accounting data[clxxxix] as well as the transmittal of certain hospital statistical data.[cxc] Whereas the latter are obtained through a yearly survey[cxci], the former are uploaded by the hospitals through a specially designed registration program called FINHOSTA.

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clxxxv A lot of useful information was gained from the Draft Note of the Observatory on Patient Mobility of 10 June 2011 giving an overview of the current state of data registration of foreign patients in Belgian hospitals.

clxxxvi Art. 92 Coordinated Act of 10 July 2008 concerning the hospitals and other care institutions [105], further indicated as 'Hospital Act'.

clxxxvii Art. 127 Hospital Act.

clxxxviii Royal Decree 14 December 1987 determining the rules and terms according to which the hospital manager must communicate the hospital's financial situation, its operating profits, the auditing report and further all statistical data concerning the institution.[106]

clxxxix Listed up in art. 1-2 Royal Decree 14 December 1987.

cxc Art. 3 Royal Decree 14 December 1987.

cxci See Annex V attached to Royal Decree 14 December 1987. After modification by the Royal Decree of 27 March 2008, this survey is now composed of 4 main sections: a) General Data on the hospital institution, b) Data relating to 28 types of care programs, medical and medical-technical services (from medical imaging to psychology), c) Data related to ambulatory activities (polyclinic, day hospital, day surgery) and d) Data related to performance, quality, safety and patient orientation. The complete survey can be found at: http://www.health.belgium.be/eportal/Healthcare/Healthcarefacilities/Registrationsystems/Hospitalstatistics/Questionnaire/853837 (last visited on 20/6/2011).

With regard to the retrieval of information on foreign patients, one has to point at the following aggregated data hospitals have to transfer within the framework of the FINHOSTA-registration:

- Every year hospitals must transfer an overview of the number of realised patient days per payment institution (art. 1, 5°).
- Every quarter hospitals must give an overview per month of the number of realised patient days, hospital admissions and discharges. For every of these aspects a comparison must be made between the overall number of patients and the number of patients for which a statutory health insurance fund intervened (art. 1, 14°).
- In practice the quarterly transfer of mentioned data can be retrieved in Table 4 of FINHOSTA. The yearly transfer of these numbers is done through Table 8 of FINHOSTA. Despite the different wordings of the transfer obligations, both tables are identical in structure. As a consequence, Table 8 concerns the transfer of the aggregated quarterly numbers.

Explanatory overview FINHOSTA

Sections marked with X must be filled in for this record with a alphanumeric or numeric (A or N) code from which the length is specified in the second last column. To retrieve possible information on foreign patients, the following records have to be clarified:

- *Record_type_cd:* T0402: number of recognized beds; T0403: number of patient-days; T0405: number of admissions; T0407: number of discharges, deaths included; T0408: number of deaths
- *Insurance institution (item_01):* in this row a numerical three-digit code should be filled out which corresponds to one of the insurance institutions showed below

Table 4 FINHOSTA[cxcii]

PARAMETER	DESCRIPTION	T402	T0403	T0405	T0407	T0408	Length	A or N
Record_type_cd	**T0402→T0408**	X	X	X	X	X	5	A
sender_cd	hospital recognition number	X	X	X	X	X	3	A
Year	year of registration	X	X	X	X	X	4	N
Period_cd	trimester (3, 6, 9 or 12)	X	X	X	X	X		N
item_01	INSURANCE INSTITUTION		X	X	X	X	3	N
item_02							0	
item_03	PATIENT TYPE		X	X	X	X	1	A
item_04							0	
item_05	MONTH	X	X	X	X	X	1-2	N
item_06							0	
item_07							0	
item_08							0	
item_09							0	
item_10							0	
item_11							0	
item_12							0	
item_13	SITE	X	X	X	X	X	4	A
item_14	Type of admission/discharge/transfer			X	X	X	1	A
item_15	COST CENTRE	X	X	X	X	X	3	A
Value	**NUMBER or AMOUNT**	X	X	X	X	X	1-13	N

cxcii See FINHOSTA Manual [107], p. 12-27, available at http://www.health.belgium.be/eportal/Healthcare/Healthcarefacilities/Registrationsystems/Finhosta%28HospitalFinancing%29/Publications/index.htm (latest update March 2011).

CODE	INSURANCE INSTITUTION	CODE	INSURANCE INSTITUTION
100	Christian health insurance funds	930	Overseas Social Security
200	Neutral health insurance funds	940	Public social welfare Centre
300	Socialist health insurance funds	950	Labour accident insurer
400	Liberal health insurance funds	960	Absence of social insurance
500	Independent health insurance funds	970	Occupational Diseases Fund
600	Auxiliary health insurance fund	980	Special Assistance Fund[cxciii]
900	Belgian Railways	985	International conventions outside NIHDI
910	War-Victims	990	Other
920	Seafarers		

- *Patient type (item_03)*: here a one-digit code (0 or 1) should be filled to make a distinction between patients who pay social contributions for statutory health insurance coverage in Belgium and *foreign patients*[cxciv]

CODE	PATIENT TYPE
0	Belgian patients and/or patients paying social contributions in Belgium
1	Foreign patients

The rules to classify a person as a national or a foreign patient differ however depending on the insurance institution covering healthcare costs.

1. For the seven large payment institutions of the statutory sickness insurance (100, 200, 300, 400, 500, 600 and 900) the patient type is determined by means of the three-digit SIS1 insurance code[cxcv] used for hospital invoices. Patients contributing to the Belgian statutory health insurance (irrespective of their nationality), indicated with SIS1 code 11x, 12x, 13x, 14x, 15x, 16x or 17x, are to be qualified here as patient type '0'. Patients assimilated to Belgian insured (coordination patients), indicated with SIS1 code 18x, are then to be classified as patient type '1'.
2. For the other insurance institutions (910-990) hospitals are asked to distinct Belgian and foreign patients on the basis of their nationality.

- *Site (item_013):* Indication of the relevant hospital campus
- *Type of admission, discharge, transfer (item_014):* indicates whether the indicated amount or value concerns an initial *budgetary* admission ('large gate') or a subsequent transfer to another *budgetary type of hospital service*.[cxcvi] It is however only possible to have one budgetary discharge.

[cxciii] The mentioning of the Special Assistance Fund (SAF) is striking. This old social assistance institution foresaw in coverage of medical costs of needy people suffering from TBC or Cancer. Due to the federalisation of Belgium, competences of the SAF have long been transferred to the regional authorities, which all have abolished its regulatory act of 27 June 1958 (the last one being the Brussels Capital Region in 2004). Possibly some old beneficiaries of the SAF still claim assistance as part of a transitory measure.

[cxciv] This distinction between Belgian and foreign patients, which is not foreseen in the Royal Decree 14 December 1987 or Annex 6 attached to it, was introduced in FINHOSTA in the aftermath of the Kohll & Decker-rulings of the ECJ, in order to get a first view on patient mobility.

[cxcv] For further explanation on these codes, see section 4.2.1.2 of the Data analysis.

[cxcvi] For general hospitals, one must distinguish between four possible budgetary types of hospital services, which are each financed out of a distinct budget of financial means: Acute care (A), rehabilitation service (Sp), palliative care (PAL) and heavy burns (BRA).

- *Cost service (item_015):* three digit number which corresponds to the cost centre of relevant hospital service (for which a number of beds is officially recognized)[cxcvii]

3.2.1.1. FINHOSTA-elements relevant for the identification of foreign patients

When trying to retrieve information on the different patient mobility dimensions mentioned above, one must conclude that FINHOSTA Tables 4 (and 8) actually only provide useful information on the number of patient days, admissions and discharges of coordination patients i.e. patient type '1' registered by the seven main statutory health insurance funds. Certain indications on pathology and/or medical treatment of these patients can only be derived very indirectly on the basis of the hospital service acting as cost centre to which these patients are assigned.[cxcviii] Further one has to state that also for coordination patients this information remains quite general as the used manner of patient type qualification based only on the SIS1 invoicing code does not allow further specification whether it concerns e.g. patients coming through cross-border cooperation agreements functioning on the basis of coordination mechanisms or other coordination patients.

When it comes to other types of foreign patients coming for elective care in Belgian hospitals, identification is only possible in a (very) indirect way. As such foreign *nationals* coming for elective care outside a coordination context could possibly be found under insurer categories 980 ('without social coverage'), 985 (through an international convention *outside* NIHDI) or 990 (other). According to the administrative FINHOSTA manuals 'pseudo insurer' 985 concerns agreements that have been concluded between a Belgian hospital and a foreign hospital or (insurance) institution, 'for which no data have to be transferred to the NIHDI as they are not involved in the agreement'.[cxcix] The FPS Public Health clarified this category was introduced to overcome a certain gap indicated by hospitals in those particular cases where patients enjoyed coverage through cross-border agreements in which the NIHDI is not involved.[cc] Most likely this refers to cross-border contracts which apply a system of direct billing between the hospital and a foreign health insurer. The FINHOSTA manuals further clarify that residuary insurer category 990 may serve to classify individual patients using their free movement of services within the European internal market (indicated as patients making use of the *Kohll & Decker case law*).[cci]

3.2.2. Transfer of individual medical statistical data

Since 1991, registration of the 'Minimal Clinical Data' (MCD) is mandatory for every hospital in Belgium. The MCD form *a standardized summary based on the medical file of the patient*. This registration system was completely revised by the Royal Decree of 27 April 2007 introducing a more integrated registration of Minimal Hospital Data (MHD) at the time of patient discharge. As the data-analysis following on this chapter will make use of individual medical statistical data registered during the period of 2004 till 2008, it is necessary to focus on both databases.

3.2.2.1. Legal purpose of the MHD registration

The official purpose of MHD-registration has not been changed. As was the case for the MCD, Minimal Hospital Data are in principle registered to provide the authorities with statistical individual patient data helping the design of future health policies. At macro level, these data will serve in particular to determine the needs of hospital institutions, design new quantitative and qualitative recognition standards for hospitals and hospital services and determine medicinal and epidemiologic policies.[ccii] Their most important use at this moment lies in the organisation of hospital financing component through the APR-DRG based BFM.

The new MHD-Decree added that MHD should not only be used to design new health policies at macro level. It is now explicitly stipulated that they

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cxcvii See the hospital services listed in Annex 3.1 attached to Finhosta 3.0 Manual.

cxcviii According to the experience of the authors, assigning costs however is not always done correctly.

cxcix Finhosta manual 2.6, 2006, 25. [108]

cc Personal communication FPS Public Health d.d. 23 June 2011.

cci Finhosta 2.6 manual, 25.

ccii Art. 3.1 Royal Decree 27 April 2007.

are also meant to be used to adapt internal hospital policies, amongst others by providing general and individual feedback.[cciii] This allows hospitals to compare themselves with similar hospitals and adjust internal policies if necessary.

3.2.2.2. Scope of MHD-registration

As was the case under the former MCD-Decree of 1994, MHD-registration is obligatory for all types of classic or one-day hospital stays, whether they are financed through the BFM or not.[cciv]

Nevertheless, art. 4, 6° new MHD-Decree now specifies that MHD should also be registered for all hospital stays of foreign patients, which would fall under one of the previous categories as if they were a resident of Belgium. According to the explanatory report this provision was added to stress the all-inclusive character of the MHD-registration.

This seems to imply that one wanted to deal with a certain (unlawful) practice where hospitals omitted (non-coordination) foreign patients from MCD-registration in the past (possibly inspired by the fear of budget revisions due to overriding the non-variable part of the BFM). Their presently explicit assimilation to Belgian residents seems a bit awkward however, as place and country of residence was an explicit part of registration under the old MCD-Decree of 1994. Assimilating them to Belgian patients not covered by the NIHDI-Act would have been more logical.

3.2.2.3. Elements of MHD-Registration

The old MCD-Decree already distinguished between three types of data: the administrative data, the minimal clinical data and the minimal nursing data. Within the new MHD-dataset, these three data-types have been more integrated and more refined.

Administrative data[ccv]: data identifying hospital and patient (via irreversible hashing code = pseudonym), patient data (age, year of birth, place of residence, country code, nationality and insurance status) and data related to hospital stay (type of stays, nature of admission, the referral, stay before admission, destination at discharge, the date/month/year of admission and discharge, readmissions, specialism, bed index, nursing ward, clinical length of stay and charged length of stay).

Minimal Clinical Data[ccvi]: this MHD-component is composed out of two main registering domains 'diagnosis' and 'medical treatment'.

For the registering domain 'diagnosis', the hospital must indicate the principal and secondary diagnosis using the international ICD-9-CM codes (International Classification of Diseases, 9th version, Clinical Modifications). For the registering domain 'medical treatment' the hospital must indicate the performed surgical interventions, invasive and risk-bearing techniques and medical-technical interventions are given in the domain of medical treatment.

For the processing of these data, diagnosis related groups (DRG) are used. DRG is a patient classification system developed in the United States of America. Based on a principal diagnosis and medical procedures, each hospital stay is grouped into a specific patient group.

There are 25 major diagnostic categories (MDC) – which cover mostly one organ or functional system. From 2002 on Belgian hospitals use the All-Patients Refined DRG-version (APR-DRG version 15) in which 355 patient groups are identified. After assigning a principal diagnosis, this is afterwards refined by the severity of illness (SOI) and the risk of mortality (ROM), based on secondary diagnosis with the age, presence of complications and associated disorders.

Minimal Nursing Data[ccvii]: give information on the amount and type of nursing care provided per patient, per nursing department and per day as

[cciii] Art. 3.2 Royal Decree 27 April 2007. This feedback will be mostly given on the basis of the coupled MHD-AHD analysis performed by the Technical cell on the processing of hospital data.

[cciv] See art. 4 Royal Decree 27 April 2007. This article specifies also that all contacts at emergency care should be MHD-registered. This leaves only mere ambulatory care (such as consultation of a hospital doctor/specialist) fall outside the scope of the MHD.

[ccv] Art. 11 Royal Decree 27 April 2007 (former art. 5 §1, 1°-3° MCD-Decree).

[ccvi] Art. 12 Royal Decree 27 April 2007 (former art. 5 §1, 4°-7° MCD-Decree).

well as the nursing staff present at the nursing departments ((theoretical) number of persons and hours worked).[109]

3.2.2.4. Registration period and transfer

The Minimal Hospital Data are registered for a period of six months. Five months after the end of this period (serving data control and validation), the MHD are transferred to the FPS Public Health using a secure internet application (Portahealth). At the FPS, the MHD are stored into a secured database for a period of 30 years.

3.2.2.5. MCD and MHD-registration records relevant for the identification of foreign patients

The administrative registering items (possibly) relevant for the identification of foreign patients now are:

Residence

As was already the case under the former MCD-Decree, also the new MHD-Decree obliges hospitals to register a patient's place and country of residence.[ccviii] In practice, for Belgian and foreign nationals residing in Belgium, the place of residence has to be indicated by the postal code of their residence (code 0000 if residing outside of Belgium). The country of residence is indicated by a country code. As from 1st of January 2011, the former three-digit country codes (e.g. '150' for Belgium) have been replaced by the internationally recognized ISO-3166 country codes, composed of two letters (e.g. 'BE' for Belgium).

Nationality

Already under the former MCD-registration, hospitals had to register a patients nationality, despite the fact this registration marker was not mentioned in art. 5 of the former MCD-Decree. The level of detail for this registration record was very limited however. As such, hospitals only had to indicate whether it concerned a Belgian, an EU or a non-EU national.

The new MHD-Decree now explicitly provides for the registration of the patient's *nationality* at the time of admission (*A2_CODE_INDIC_NAT*-Table 3.1*).*[ccix] To prevent possible risks of re-identification, three levels of detail have been maintained[ccx]:

Table 3.1: Registration of a patient's nationality within the MCD database

Code	Description
BE, DE, FR, LU, NL, UK	Belgian, German, French, Luxembourgian, Dutch or British if citizen of one of these six countries
EU or ER	'Citizen of the European Union' or 'European non-EU' in case a foreign national is no citizen of one of the abovementioned neighbouring countries
AF, AM, AZ, OC	All other foreign nationals have to be indicated by the continent they are originating from

ccvii Art. 13-14 and Annex I attached to the Royal Decree of 27 April 2007 (former art. 7ter-7quater MCD-Decree).

ccviii Art. 11, 1° c) Royal Decree 27 April 2007. For Belgian and foreign patients residing in Belgium, the place of residence (domicile) has to be indicated by the postal code of their residence (code 0000 if residing outside of Belgium). The country of residence is indicated by a three-digit country code ('150' for Belgium).

ccix Art. 11, 1° d) Royal Decree 27 April 2007.

ccx MHD Registration guidelines: administrative data, 2011, 23.

Insurance status

Since 1 January 2008 hospitals should register whether a patient stay is socially covered according to '*Belgian, European or foreign law*' (*A2_CODE_STAT_INSURANCE*).[ccxi] This novelty in principle should allow far better identification of the different foreign patient types instead of the preceding registration records of residence and nationality. The explanatory report preceding the new MHD-Decree specifies this was mainly done with a view to 'organise hospital financing'. As such, one already anticipated on the distinct financing mechanism for foreign patients introduced not long after by the (original) Patient Mobility Act of 4 June 2007

The broad notions of 'Belgian', 'European' and 'foreign law' are not further defined (or refined) by the MHD-Decree itself. One could thus wonder if the administrative guidelines to register the insurance status make it possible to retrieve the different types of foreign patients identified in the legal framework. This seems not to be the case. Hospitals can only indicate the insurance status with a code A, B, C or D, which correspond to the following patient types[ccxii] (Table 3.2):

Table 3.2: Registration of insurance status of patients within MCD database

Code	Description
A	Not insured: it is specified that this category also includes patients covered by the Public Centres for Social Welfare (Openbare Centra voor Maatschappelijk Welzijn/Centres publics d'action sociale)
B	Patients affiliated with a Belgian health insurance fund. The instructions of the FPS Public Health however specify that also patients insured by the National Institute for war invalids, war-veterans and war victims (IV-NIOOO/IV-INIG), the Relief and Provident fund for seafarers (HVKZ/CSPM), victims of labour accidents or occupational diseases,... should be included in this category
C	'International agreements'. Here the administrative MHD-instructions specify that it concerns patients with a European Health Insurance Card. Seen its limitative phrasing, only persons insured in another European Member State who are in need of urgent medical care while temporarily staying in Belgium fall under this category
D	'Specific Agreements'. Here the administrative MHD-instructions specify that it concerns bilateral agreements for the treatment of certain diseases (with the example of cross-border cooperation between certain French and Belgian hospitals)

It is clear that this manner of classification is too incomplete and does not take into account the complex reality of cross-border patient mobility. Where do hospitals have to classify coordination patients coming for elective care (E112/S2), as insurance category C only seems to concern foreign patients in need of urgent care? How do hospitals have to classify individual patients using their free movement of services, as foreign healthcare insurers in principle do not directly intervene here to cover costs and hospitals thus do not have a clear view whether the patient is entitled to reimbursement when returning to his home state. Further it also remains

[ccxi] Art. 11, 1° e) Royal Decree 27 April 2007.

[ccxii] See MHD Registration guidelines: administrative data, 2011, 24. [110]

unclear under which category one has to classify patients coming through a cross-border contract with a foreign healthcare insurer.

Hospitals however mentioned during the interviews that they were given the advice to register cross-border contract patients under the insurance category D ('specific agreements').

Seen the above, one must conclude that the flawed typology of foreign patients used by the administrative MHD-instructions raises serious doubts on the trustworthiness of MHD registered during the period 2008-2011 when selecting on the basis of 'insurance status'.

3.3. Data available with the NIHDI

3.3.1. *Hospital invoice data registered within the framework of the statutory health insurance*

Art. 351 of the HDI-Decree of 3 July 1996, adopted in execution of art. 205 HDI-Act, regulates the obligation of the health insurance funds to transfer certain statistical data on the *costs invoiced by Belgian hospitals for hospitalized patients covered by the Belgian statutory health insurance*. These are the so-called 'Anonieme Ziekenhuisverblijven/Séjours Hospitalières Anonymes' (further indicated as Hospital Billing Data or HBD). The HBD have to be transmitted every year for all costs booked during the last eight trimesters.

The HBD play an important role for many aspects of hospital financing, acting as an indicator to measure the intensity of hospital activity (e.g. supplementary activity-points, surgical day-care, lump-sum fees for medical imaging and clinical biology,…). Furthermore, the HBD data are used to track wrong invoicing methods or a maladjusted usage of public means.[111]

The HBD are composed of the following 'record types'[ccxiii]:

- a certain index number composed of the following 'zones': (**1**) the identification of the health insurance fund, (**2**) the identification of the hospital where the patient has stayed, (**3**) a unique code number for the patient assigned by its health insurance fund, (**4**) a serial number indicating whether it concerned a new admission (code 0) or a readmission (code=1, 2, 3,...). It must further indicate (**5**) the date of discharge. This index number must be indicated for every one of the record types listed below.
- characteristics of the hospital stay and the patient, and more in particular: the hospital service into which the patient was admitted; his insurance code (SIS1/SIS2); his year of birth; the interval between two admissions expressed in days; date of admission or readmission; sex of the patient
- number of patient-days and the invoiced cost per date and place of treatment
- detailed data concerning pharmaceutical products, blood and blood plasma (indicated by product code and by place and date of delivery)
- detailed data concerning the provided medical care (indicated by nomenclature number, hospital and place and date of provision)[ccxiv]
- detailed data concerning clinical biology and nuclear in vitro medicine (indicated by date and place of delivery).

The HBD only indirectly provide information on the pathology for which the patient in question was hospitalized. In combination with the MHD, coupled at the level of the so-called Technical Cell for Processing of Medical Hospital Data, differences of medical practices and invoices per pathology can be identified between hospitals possibly resulting in modification of hospital financing instruments.

3.3.2. *Identification of foreign patients in HBD*

The HBD record on patient characteristics contains a code 'SIS1/SIS2' (social insurance status-code, the so-called 'codes gerechtigde/codes titulaire') that indicates the social insurance status of the HDI-patient. On the basis hereof healthcare providers could easily determine the scope of coverage of each HDI-patient (e.g. for ratifications and invoicing matters).

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ccxiii Draft circular nr. 2010/57 on SHA-instructions.[112]

ccxiv Before the modification of art. 351 HDI-Decree by the Royal Decree of 20 December 2007, data on medical imaging formed a separate part of the HBD. They are now integrated in the detailed data concerning the provided medical care.

For Belgian patients, the distinction between SIS1 and SIS2 relied on the distinction that the Belgian statutory health insurance used to make between coverage for major risks (include hospital care, delivery of babies, major surgery, dialysis functional rehabilitation care, implantable medical devices and specialist care) and minor risks (include physicians' visits, dental care, minor surgery, home care and pharmaceuticals for outpatient care). In practice, this distinction was only of relevance when dealing with self-employed (and members of their family) who, despite certain exceptions, traditionally had a separate HDI-scheme only insuring them for major risks.[ccxv] The Act of 26 March 2007 changed this situation by including self-employed in the general HDI-scheme, socially insuring them for both major and minor risks as from 1 January 2008.[ccxvi]

Before this date, foreign self-employed for which the Belgian statutory health insurance intervened in application of international social security conventions, in principle always were assimilated to 'workers' in the general HDI-scheme (insuring them for both major and minor risks).[ccxvii]

The SIS1-code for 'international conventions' (18x) is in particularly useful in this study, as foreign patients coming to Belgium for elective interventions will be classified within this category. Digit 'Y' equaling 8 indicates that this person has the right to statutory healthcare coverage in Belgium, at the expense of a foreign country.

Example: HBD containing the insurance code '180' relate to a general HDI-patient who is entitled to healthcare coverage in Belgium within the framework of an international convention assimilating him to a domestic HDI-patient which does not enjoy preferential reimbursement.

As a consequence, by selecting HBD on the basis of CT1 'international conventions' (180, 181), one has already gathered all the assimilated foreign patients making use of the European Coordination Regulations or a bilateral social security coordination convention to be entitled to healthcare coverage in Belgium (Belgian residents working in another Member State, frontier workers, urgent care during temporary stay, elective care during temporary stay,…). Here one must however point out that in the data-analysis also codes '480' and '481' were retrieved. This is in principle due to a flawed codification by the health insurance fund in question.

To narrow down this initial HBD-selection (180,181, 480, 481) to HBD concerning coordination patients coming to Belgium for elective treatment, one has to look at social insurance status code 2 that can possibly be linked hereto.

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ccxv See the old Royal Decree 29 December 1997 determining the conditions under which the scope of application of the statutory health and disability insurance act, coordinated on 14 July 1994, is extended to self-employed and member of monastic communities. Most self-employed took out voluntary insurance for minor risks with its health insurance fund or a private insurer to cover this statutory coverage gap.

ccxvi See art. 32, 1°bis HDI-Act.

ccxvii See art. 35 Reg. 1408/71: '(...)Where the legislation of the country of stay or residence contains several sickness (…)schemes, the provisions applicable under art. (...)22 shall be those covering manual workers in the steel industry'. In absence of a specific scheme for these workers, the general workers scheme applied. See SCHOUKENS, 2000, 489-493. [113]

3.3.2.1. Social insurance status-code 1

The social insurance status-code SIS1 consists of a combination of three digits 'XYZ' (see Table 3.3).

Table 3.3: Overview of SIS1-codes

Digit 'X' = statutory HDI-scheme	Digit 'Y' = insurance statute	Digit 'Z' = right to preferential reimbursement[ccxviii]
1 = general HDI-scheme	0= residents 1= professionally active (worker, civil servant) or students 2= invalid or disabled 3= pensioner 4= widow(er) 5= orphan 8= international convention	0= no right to preferential reimbursement 1= right to preferential reimbursement
4 = HDI-scheme for self-employed	1= active 2= invalid or disabled 3= pensioner 4= widow(er) 5= orphan 7=member of monastic community	

[ccxviii] Traditionally pensioners, widowers, invalids, unemployed and orphans (and their family members) with an income below a certain threshold have to pay lower co-payments (user charges). Since 2007 this category has been extended to families with an income below a fixed income limit (the so-called Omnio-statute). People living from social assistance are always entitled to preferential reimbursement (aforementioned income condition is here presumed to be fulfilled).

3.3.2.2. Social insurance status-code 2

The social insurance status-code SIS2 is also composed of three digits 'ABC'. Contrary to Belgian HDI-patients, the SIS2-code for international conventions corresponds to an accounting code which is completely unrelated to the distinction between major and minor risks.

The interpretation of digit A will indicate the manner of reimbursement by the competent Member State (Table 3.4).

Table 3.4: Overview of the SIS2-code (digit Axx)

Digit A	Interpretation
3	Healthcare costs are reimbursable by the competent country
6	Healthcare costs are not reimbursable by the competent country in case of an bilateral agreement stipulating a waiver of costs (like e.g. Belgium and Ireland or Belgium and Québec)
7	Special categories of coordination patients where the competent state will reimburse the healthcare costs (e.g. cross-border cooperation agreements on the French-Belgian border)

The two remaining digits 'BC' taken together will indicate the social security coordination reason for which the Belgian statutory health insurance is obliged to intervene on the expense of the competent country (no specific logic is maintained here (Table 3.5).

Table 3.5: Overview of the SIS 2-code (digits xBC)

Digit BC	Interpretation	Digit BC	Interpretation
X01-x02	Frontier worker	X21	Pensioners (former frontier workers)
X03-x04	Mariners	X22-x23	International transport (European convention of 5 July 1956)
X05-x06	Belgian residents but insured in other EEA-Member State	X24-x25	Rhine boatsmen (Agreements of 7 July 1950 and 30 November 1979)
X07-x08	Temporary stay in BE (competent state)	X26	Reimbursement in BE (art. 34 (4)
X09	Necessary care (art. 22 Reg. 1408/71)	X27	Reimbursement in BE Kohll & Decker
X10-x11	Transfer of residence	X28	Pensioners (art. 8)
X12-x13	Elective treatment in BE	X29	Posted workers in BE (Tunesia)
X14	Unemployed (art. 25 Reg. 1408/71)	X30	Pensioners in BE (Tunesia)
X15	Family members unemployed	X32	Temporary Stay (Morocco)
X16	Pension claimants (art. 26 Reg. 1408/71)	X33	Belgian-Swiss social security Convention (only labour accidents)
X17	Pensioners	X34	Reimbursement in BE ECJ Vanbraekel (additional supplement)
X18	Family member pensioners	X35	Reimbursement in BE ECJ Herrera (travel and accommodation costs)
X19	Family members social insured residing in other Member State	X61	Former frontier worker (art. 28 (1) Reg. 1408/71)
X20	Benefits	X62	Former frontier worker (art. 28 (2) and (3) Reg. 1408/71)

Given table 3.6, it will be necessary to look at the SIS2-codes ‘x12’ and ‘x13’ to filter down the initially selected HBD to EEA and Swiss patients coming to Belgium for elective treatment using the European Coordination Regulations (which is the only international social security coordination instrument providing for a possibility to have elective treatment in another Member State). When SIS2 is equal to ‘x12’, this refers to the general situation described in art. 22 (1) c) Reg. 1408/71 (actual art. 20 Reg. 883/2004) where a socially insured is entitled to entitled to sickness benefits in kind in Belgium, at the expense of the competent Member State from which the patient obtained prior authorization. When SIS2 equals ‘x13’ this refers to the particular situation described in art. 55 Reg. 1408/71 (actual art. 36 Reg. 883/2004). According to this provision a victim of a labour accident or occupational disease coming to Belgium for appropriate treatment is entitled to healthcare coverage in Belgium at the expense of the competent institution of the Member State from which the victim has obtained prior authorization.

For the reasons of this study, one has opted to take only in account the first ‘classic’ situation of elective healthcare under the European Coordination Regulations (the amount of victims of professional risks coming for planned care being very marginal).

The table below (Table 3.6) summarizes the combinations of the SIS-codes that are relevant within the framework of this study. These codes allow us to identify foreign HDI-patient-stays for elective care within the HBD.

Table 3.6: Summary of social insurance status-codes used to identify coordination patients coming for elective treatment

SIS 1 ('CG1/CT1')	SIS 2 ('CG2/CT2')	Examples
x8x right to a healthcare coverage in Belgium, at the expense of the competent country	312 Patient who has the permission of his health insurer to go abroad for a healthcare treatment, and the costs related to this treatment will be reimbursed by the competent country	- A Spanish patient comes to Belgium for an elective hip replacement, and used the corresponding document E112/S2 that indicates he has a prior authorization from his health insurer. - A Dutch patient comes to a Belgian hospital for an elective inguinal hernia procedure by means of a cross-border contract concluded with his Dutch healthcare insurer functioning on the basis of simplified application of the Coordination Regulations (cf. former contracts of hospitals in Bruges and Ghent with the Dutch healthcare insurer OZ for people living in Zeelandic Flanders)
x8x right to a healthcare coverage in Belgium, at the expense of the competent country	612 This code is only used for Irish patients coming to Belgium for a planned elective intervention by means of a prior authorization	- Irishman comes to a Belgian hospital for a prosthesis of the knee.
x8x right to a healthcare coverage in Belgium, at the expense of the competent country	712 Foreign patient who lives in an geographical area for which a special cross-border healthcare cooperation agreements has been concluded	- French patient, living in Lille, goes to the hospital of Tournai to receive radiotherapy, under the ZOAST agreement

3.4. Suggestions to adapt current hospital data registration systems to improve transparency on foreign patient inflow in Belgian hospitals

3.4.1. Need for further transparency

The macro-analysis which follows on this chapter will be based on the coupled MCD-HBD databases for the period of 2004-2008. It soon became clear that could only provide valuable information on the characteristics of cross-border healthcare offered to *coordination* patients staying in Belgian hospitals. Identifying individual and contract foreign patients revealed to be quite problematic however. Since the Belgian statutory health insurance does not intervene for these latter patient categories, coupling failed because of absence of HBD. Moreover, they could neither be distinctively retrieved in the non-coupled MCD, which for the period 2004-2007 yet provides (*in se* irrelevant) information on a patient's *domicile along with country of residence and nationality (however limited to the options 'Belgian', 'EU' and 'non-EU').*

It became clear that actual hospital registration processes require further specification to give a clear image of the numerical, medical and financial dimensions of patient mobility to Belgium, and this not only with a view to future in-depth studies on this subject, but also to adequately adapt Belgian health policies to a cross-border context.

This need for more transparency also follows from recent (or future) national and European legal initiatives in the area of patient mobility:

The Patient Mobility Act of 4 June 2007 lists 'collecting data on patient mobility' as one of the main tasks of the new Observatory on Patient Mobility, in support of its general mission to advise the government on patient mobility related problems. More specifically it concerns data on the *number* of (foreign) *non-HDI patients* treated in Belgian hospitals, the *treatments* offered and their *country of origin.*[ccxix] This data collecting task can be extended by Royal Decree. The Health Act of 19 May 2010 specified however that it did not lie within the legislator's intention that the Observatory would gather these data itself. As this would require substantial investment in material and technical expertise, it seemed more efficient to grant the Observatory access to the already existing hospital registration mechanisms administered by the RIZIV/INAMI and the FPS Public Health.[ccxx] As will be shown below, these registration systems are presently not fit to fulfil this task.

The legal framework of the new Patient Mobility Directive 2011/24 of 9 March 2011 provides an additional justification to organise a system of data collection on patient mobility characteristics, and this mainly with an eye to enhance the *operability* of the rights and obligations of the Member State of treatment foreseen in art. 4 of the Directive. As such, to ensure efficient and permanent access to healthcare within its own territories, the Directive allows in exceptional cases to derogate from the fundamental principle of equal treatment with regard to the accessibility for patients coming from other Member States, implying that access restrictions could be imposed if waiting lists for national patients arise. This implies that certain data on patient flows should be available to trigger and justify this safeguard measure. Within a more extensive view on the prevention of waiting list, one could even argue that public authorities should also have insight in the tariffs charged. Here one could think of the possible risk of hospitals and hospital doctors attracting more wealthy patients from abroad for treatments not covered by the Belgian statutory health insurance (implying a larger freedom to set tariffs).

The Patient Mobility Directive also foresees that as from 15 October 2015 the European Commission should report every three year to the European Parliament and the Council on the operation of this directive.[ccxxi] More in particular, this report should include information on *patient flows,* the *financial dimensions* of patient mobility, possible reimbursement restrictions based on overriding reasons of general interest (planning

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ccxix Art. 4 §2, 1° Act of 4 June 2007 modifying the legislation with a view to improve patient mobility, BS/MB 25 July 2007., further indicated as 'Patient Mobility Act'.

ccxx Bill for diverse provisions in concern to health, Chambre of Representatives, nr. 52/2486/02, 11. [114]

ccxxi Art. 20.1 Directive 2011/24/EU of the European Parliament and of the Council of 19 March 2011 on the application of patients' rights in cross-border healthcare [115], further indicated as 'Patient Mobility Directive'.

requirements) and possible prior authorisation schemes, the functioning of the European reference networks and the national contact points. To carry out this report obligation, the Commission should do an assessment of systems and mechanisms put in place in the Member States, for which the latter must provide assistance and *all available information*.

Here one can also point at the fact that art. 18 of the original Commission proposal of the Patient Mobility Directive[ccxxii] foresaw an obligation for Member States to *collect statistical and other additional data needed for monitoring purposes on the provision of cross-border healthcare, the care provided, its providers and patients, the cost and the outcomes*. These data had to be collected as *part of their general systems for collecting healthcare data*, in accordance with national and Community law for the production of statistics and on the protection of personal data.[ccxxiii] According to the explanatory memorandum, these data are '*vital to be able to monitor cross-border healthcare and its impact on health systems overall, in order to ensure that an appropriate balance is struck between free provision of health services, a high level of health protection and respecting the responsibilities of the Member States for ensuring the overall objectives of their health systems*.'

This provision has eventually been dropped from the Council proposal, as one was of the opinion that collecting data on patient mobility constituted an overlap with Member States' general data collection obligation under *Regulation 1338/2008/EC*[ccxxiv] which provides a common framework for the systematic production of statistical information required for Community action supporting national strategies in the field of public health and the development of high-quality, universally accessible and sustainable healthcare.[ccxxv] Indeed, Annex II attached to this Regulation clarifies as one of the subjects included in the data collection in the domain of 'healthcare' should be '*the mobility of patients, namely their use of healthcare facilities in a country other than their country of residence'.* These data must be compiled mainly from administrative sources.

Future legal initiatives in the area of patient mobility could still lawfully introduce a *different hospital budget* for non-HDI patients (among them contract or individual patients coming from outside the EEA, provided the principle of non-discrimination on the basis of nationality is respected). This would however imply these patients should be easily identified and excluded from the calculation of the general budget of financial means (BFM).

An initial step has yet been taken with the renewed Minimal Hospital Data which as from 1st January 2008 provides for a more extensive registration of a patient's nationality as well the registration of his insurance status. It was shown above that also here certain data gaps or flaws persist.

3.4.2. Possible adaptations of current hospital registration systems

In order to improve transparency on patient mobility in all its forms and corresponding dimensions, one could propose the following adaptations for the future (listed per hospital registration system):

ccxxii Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, European Commission, 2 July 2008 [56]

ccxxiii Further art. 18.2 also foresaw in an obligation to transfer these data to the Commission, as one of the big difficulties faced when coming up with this proposal (and also for the ECJ when ruling on objective public interest justifications) was the lack of robust data on patient flow across-borders (HERVEY, 2011, 181 [116]).

ccxxiv Regulation (EC) 1338/2008/EC of the European Parliament and of the Council of 16 December 2008 on Community statistics on public health and health and safety at work [117].

ccxxv Art. 1 Reg. 1338/2008.

3.4.2.1. FINHOSTA

In the future one could propose to modify (or clarify) the current list of insurance institutions in tables 4 and 8 of FINHOSTA in order to explicitly include foreign healthcare insurers (possibly indicated by country of origin). When it comes to the registration of the 'patient type', it is advisable to abandon the actual manner of indirect classification of foreign patients on the basis of nationality. Instead, a renewed manner of patient type classification based on their insurance status should be introduced. Here it would be coherent to use the same manner of classification as proposed for the MHD-registration (see further).

Moreover, FINHOSTA offers a possibility to give an indication on the financial dimensions of patient mobility realized by the hospital outside of the RIZIV/INAMI circuit. As such it could be suggested to extend table 4 with a number of record types (T411, T412,..) revealing the (aggregated) amount of patient day prices, room supplements, day care lump-sums, …. charged per different insurance institution and patient type.

3.4.2.2. Minimal Hospital Data

One could wonder if it would be possible to apply the first level to all foreign nationals. This will probably be encountered by arguments based on privacy protection and more precisely concerns of possible re-identification of the individual patient. As such, precisely registering the nationality of patients coming from non-neighbouring countries could certainly increase the risk of exposure, as they probably constitute only a very minimal percentage of a Belgian hospital's patient population.

As MHD have to be considered as 'sensitive' personal data related to health[ccxxvi], a prior authorisation of the Sector Committee of Social Security and of Health (healthcare division) of the Privacy Commission will be necessary to implement a further specification of nationality.[ccxxvii] The Committee will have to assess whether this level of detail is *pertinent* to improve the view on foreign patient flows in Belgian hospitals.

It seems however to be more advisable to focus on a more detailed registration of a patient's insurance status, as nationality as such is an irrelevant criterion to classify foreign patient categories. Registering nationality can be of indirect use, however, in those situations where a hospital is unable to get a clear view on the insurance status of foreign patients, which is most likely the case for individual patients paying upfront and then (possibly) get reimbursement afterwards by the country of insurance.

Here one could propose a different, more transparent approach, which departs from the three main patient routes for foreign patients to arrive in a Belgian hospital (coordination, contract, individual). It should nevertheless remain easy to determine the insurance category an incoming patient belongs to. Below we have tried to design a basic proposal which could serve as a starting point for a renewed registration of a patient's insurance status within the MHD-dataset.

[ccxxvi] Art. 7 Act of 8 December 1992 safeguarding privacy during personal data processing. [118]

[ccxxvii] Art. 42 §2 jo. 46 Act 15 January 1990 concerning the foundation and organisation of the cross-roads bank for social security. [111]

Proposal for Code insurance status patient during stay in hospital (A2_CODE_STAT_INSURANCE):

No insurance or lack of clear information on insurance status (0)

Socially insured in Belgium:

- Patients covered by Belgian statutory health insurance (health insurance fund) (including Belgian insured residing in another Member State)
- Victims of occupational risk
- Other categories of Belgian patients (OCMW/CPAS, seafarers, war victims, overseas social security)

Socially insured in other EEA-Member State or Switzerland

- Individual coordination context (Reg. 883/2004 or 1408/71)
  - Patients residing in Belgium and insured in other Member State
  - European Sickness Insurance Card
  - Planned care with authorisation (S2-form)
  - Cross-border cooperation agreements (e.g. ZOAST)
  - Frontier workers, …
- Cross-border contract with foreign health insurer from the EEA
  - Coordination mechanism
  - Direct billing mechanism
- Individual patient (Treaty-based) *

Socially insured in non-EEA Member State

- Coordination context (bilateral treaty)
- Cross-border contract with foreign health insurer outside the EEA
- Individual patient*

**This information is not always easy to gather for the hospital as the foreign patient pays upfront and (possibly) asks reimbursement afterwards when returning to his home country. Most hospitals will however ask these patients if they have social insurance to make sure that hospital bills will be paid in the end.*

This extended model of insurance classification per patient stay offers several advantages and possibilities for all stakeholders. As such, it would give the competent authorities much clearer view on the dimension and medical characteristics of the cross-border healthcare offered to all types of foreign patients treated in Belgian hospitals, and this without any need to adapt the Royal Decree of 27 April 2007. Here, the Observatory for Patient Mobility easily could make use of this refined MHD to fulfil its task to collect data on patient mobility.

Fine-tuning the actual MHD-Registration moreover saves hospitals from another separate registration system for foreign patients.

This would also allow the competent authorities to easily select those foreign patients for which a different financing mechanism could be set up and which then would no longer be taken into account for the calculation of the hospital's general Budget of Financial Means (as was still the case with the system introduced by the original Patient Mobility Act).

One has to remark however that this way of specification, combined with the registration of the patients' nationality, could entail a risk of possible re-identification (e.g. in case of the few foreign patients coming outside of the EEA). In this case it is advisable to make the classification less specific or to take the procedure before the Sector Committee of Social Security and of Health.

3.4.2.3. Hospital Billing Data

Because of the necessary intervention of the Belgian statutory health insurance, the financial dimension of patient mobility at patient level will only be clear for coordination patients. As such, no clear financial information is available for foreign patients which find themselves outside the so-called 'NIHDI-circuit':

- Contract patients (direct billing)
- Included in MHD, but at present not clearly identifiable (see proposal adaptation insurance status)
- No equivalent of HBD available.
- Individual patients (own initiative)
- Included in MHD, but at present not clearly identifiable (see proposal adaptation insurance status)
- No equivalent of HBD available

Here the question rises whether a *similar compulsory registration of invoicing data* should be installed for foreign patients, which are presently not retrieved in the HBD, and whether these data could serve to control if hospitals apply different tariffs to foreign patients? Because of its controversial nature (transfer of data on the purely private contractual relationship between healthcare service provider and non-HDI patient), the finality of such a new registration system should be clearly defined (e.g. the protection of a permanently and equally accessible hospital care open to all). Such a new registration system may not go further than needed to reach the searched objective (*proportionality*-principle). Art. 351 HDI-Decree would not offer a proper legal basis to introduce this system, as this article was primarily introduced to provide data allowing the control of expenses made by the statutory *health insurance*. As mentioned earlier, a broad interpretation of the rights of the Member State of treatment under the Patient Mobility Directive could offer the necessary legal leeway to control a correct application of tariffs by Belgian healthcare providers in relation to individual and contract foreign patients.

However the scope of this research project does not allow for a further in-depth investigation, one should point at several questions arising in concern to the modalities of such a new invoice data transfer and control mechanism:

- Does this new registration of invoicing data for non-HDI patients should be done by extending the scope of an actually existing registration system (e.g. the MHD-dataset but only for non-HDI patients) or would it take the form of a whole new registration mechanism?
- Who would be the recipient of these data and perform the control operation? The Observatory on Patient Mobility would be a logic answer, however its legal duty to collect data on patient mobility seems to be limited to data on numbers of foreign patients, their treatments and their country of origin (art. 4 §2 Patient Mobility Act mentions 'meer bepaald/ plus précisément'). Although one could extend the Observatory's legal tasks by Royal Decree, it was already mentioned above that for the collection of data the Observatory can only make use of the hospital registration systems *actually available* with the FPS and NIHDI.

An interesting suggestion is the implementation of certain contractual 'best practices' at a more general level. Here one could think of the possibility to have a Belgian health insurance fund (e.g. the Auxiliary Health Insurance Fund (HZIV/CAAMI)) or the NIHDI act as a statutory 'middleman'. Here it remains the question if one could oblige a hospital and an individual patient or foreign healthcare insurer to accept this intervention. Even when this intervention of the AHIF would remain optional for both parties, one could ask what incentive there is to have this tariff validation done.

- Will the assessment of the transferred invoice data be limited to a global evaluation on their validity, quality and completeness for the whole hospital sector or will they serve to perform a case-by-case control whether hospitals or hospital doctors apply a differentiated price for certain categories of foreign patients?
- Which mechanism will be used to control whether different tariffs are charged? This seems to imply that invoice data of Belgian non-HDI patients also need to be asserted to make the necessary comparison.
- One can point out that art. 4 (2) b) of the Patient Mobility Directive obliges healthcare providers to provide individual patients coming from another Member State with 'relevant information on prices'. At least for this patient category this provision can be used to oblige hospitals to officially publish prices charged by the hospital and hospital doctors (which actually already exists for supplements[ccxxviii]). This however does not alter the fact that non-conventioned hospital doctors remain free to set their fees.
- Further one should also mention that art. 92/1 Hospital Act obliges hospitals to transfer their cross-border healthcare contracts with foreign healthcare insurers to the Observatory on Patient Mobility. As such already certain insight exists on the contractual tariff mechanisms stipulated.[ccxxix] One remembers however that these contracts can only be used to gain insight on the number of contractual patients, seen the

[ccxxviii] Art. 99 Hospital Act.

[ccxxix] One remembers that these contractual mechanisms can provide for a possible higher tariff if no extra financial charge is laid on the contract patient himself.

limited duty of the Observatory. It is further not certain whether the Observatory can transfer this information to the institution assessing the validity of the transferred invoice data.

- Which would be the sanction when hospitals fail to live up to their obligation to (correctly) transfer hospital billing data?[ccxxx]

Key points

- **Adjusting the actually existing hospital registration systems is needed for the operability of the Observatory on Patient Mobility, the Patient Mobility Directive, Regulation 1338/2008 and the implementation of future (financing) initiatives related to foreign patients coming outside the RIZIV/INAMI circuit. These modifications should however respect the legal finality of each registration system.**
- **At hospital level, the quarterly and yearly overviews sent in through tables 4 and 8 of FINHOSTA could give a clear indication on the number of admissions and patient-days of different types of foreign patients previously identified. To do this however, the actual classifications of 'insurer institutions' and 'patient stay types' have to be further clarified and refined.**
- **The FINHOSTA overviews could possibly serve to shed a light on the financial dimension of patient mobility taking place outside the RIZIV/INAMI circuit, by adding additional registration records showing the amount of charged patient-day prices, supplements,.... per insurance institution and patient type. This would however need a modification of Royal Decree 14 December 1987.**
- **The new MHD-Decree of 27 April 2007 now explicitly states that MHD must also be registered for all foreign patients (as should have always been the case). As such, information on pathology and offered medical treatment for these patients is in principle available.**
- **It is strongly advised to further specify the newly introduced administrative data items 'nationality' and (certainly) 'insurance status' to distinguish between different foreign patient categories. These (administrative) modifications should however as much as possible avoid any risk of re-identification of the patient.**
- **Practical and legal difficulties rise to set-up invoice registration system for non-HDI patients parallel to the existing registration of AHS by the health insurance funds. With an eye to control on tariff discrimination of foreign patients, it could be advisable to organize the possibility of a conformity check by a Belgian health insurance fund.**

[ccxxx] One could remark that also art. 92/1 Hospital Act does not define a sanction when hospitals fail to transfer their cross-border contracts concluded with foreign healthcare insurers.

4. VOLUME AND CHARACTERISTICS OF FOREIGN PATIENT STAYS: DATA, METHODOLOGICAL ISSUES AND RESULTS

4.1. Introduction

In this chapter, we intend to map the different types of foreign patients undergoing elective interventions (inpatient care and day-care) in the Belgian public healthcare infrastructure by means of a macro analysis of the clinical and financial database and a micro analysis at hospital level.

As described in detail in the legal framework, three types of foreign patients can be identified:

- Coordination patients

  These patients can use the following administrative and financial routes: bilateral or multilateral coordination treaty, EU coordination rules and cross-border cooperation agreements (see section 2.2.2).

- Direct billing patients

  Patients who pay the costs of the healthcare treatment themselves, can ask reimbursement of these costs (according to the tariffs of the Member State of affiliation) by the appliance of the free movement of services-principles (TFEU/EEA-Agreement) or in the future for patients from the EU, by means of the Directive on patients' rights in cross-border healthcare (see section 2.2.3).

- Contract patients

  The legal basis for contracted care are cross-border contracts, concluded between a foreign healthcare insurer and a Belgian hospital (see section 2.2.7 and 2.2.9).

The ideal situation would be to quantify separately the abovementioned three types of foreign patient flows in Belgium. But preliminary analyses revealed that only a partial insight can be obtained on the flow of coordination patients, because direct billing and contract patients cannot be identified in the administrative databases. Therefore, case studies were performed in a selection of Belgian hospitals (hospital reports). Among other things, we asked the hospitals for data on the volume of the different types of foreign patient stays. These data were afterwards compared with the volumes in the linked clinical and financial data. This allowed us to check whether the clinical and financial database provide a factual picture of the existing flows of foreign patients. The hospitals gave perusal to some of their contracts they concluded with foreign healthcare insurers.

4.2. Methods

4.2.1. Macro analysis of national hospital discharge data

The purpose of the macro analysis is to provide information on volumes and characteristics of foreign patient stays, based on clinical (MCD) and financial (HBD) databases. These two databases have been described in the previous chapter, and their linkage is detailed in the Appendix.

For inpatient care, MCD were available for the years 2004-2008 and HBD for the years 2004-2009. For day-care, data were only available from 2006 onwards.

4.2.1.1. Identification of foreign patients (all flows grouped) based on the MCD

We estimate the volumes of foreign patient stays based on the MCD database, by using the following criteria (all technical codes given in appendix):

1. The patient does not reside officially in Belgium AND
2. The patient does not have a Belgian nationality.

The results of this selection are compared to available national statistics (i.e. the Maxi Feedback from the Federal Public Service[119]), to confirm the validity of our results.

By adding the second selection criterion (no Belgian nationality) on top of the first one (Belgium is not country of residence), we exclude stays of patients with a Belgian nationality, not living in Belgium, but who come to Belgium for a healthcare treatment (for example, Belgian cross-border workers). This decision was taken as the scope of the study was to investigate the 'real' foreign patients (those without a Belgian nationality and living outside Belgium) that come for elective interventions or

treatments to Belgium. By taking the first and the second selection criteria together, we also exclude hospitalizations from foreign patients living in Belgium, again which makes sense with regard to our scope. Details on this last group of patients can nevertheless be found in appendix, as they constitute large volumes for Belgian hospitals.

Obviously, these criteria are just a way to try to circumvent the absence of reliable data on the country of insurance. In the chapter concerning the data registration, some recommendations were made to refine the registration of the insurance status in the future. Thus, selecting on this variable is not done in these analyses.

The characteristics of stays analyzed include:

1. The patient country of residence
2. The patient nationality
3. The type of admission (elective or urgent). This variable was NOT used as a selection criterion, as preliminary analyses showed that this variable was not completely reliable. Details on this variable are presented in appendix.
4. The type of treatment (principal diagnosis, intervention); see explanation below.
5. The information available on the insurance status of the patient.

The types of treatments of foreign patient stays in Belgium can be described by using several classifications:

1. Major Diagnostic Categories (MDC) There are 25 major diagnostic groups which cover mostly one organ of functional system. Within each MDC, a distinction can be made between a medical and a chirurgical MDC [120].
2. All Patient Refined- Diagnosis Related Groups (APR-DRGs).[121] From 2002 on, Belgian hospitals use the APR-DRG version 15 in which 355 patient groups are identified.[120]
3. Diagnoses and interventions, based on the Health Data Project-2 (HDP2).[122] The HDP2 classification is based on the chapters of the ICD-9 codes for diseases and injuries and procedures. The ICD-9 codes selected in the HDP2 project are presented in appendix.

4.2.1.2. Identification of coordination patients in the HBD

Volumes of patients with a prior authorization (by means of a E112/S2 document or within the context of specific agreements) are based on the HBD database. Reasons of admissions and treatments are based on linked MCD-HBD.

The selection is done on the social insurance status-codes (SIS1 and SIS2). By combining SIS1 with SIS2, it is possible to identify these patients coming to Belgium under an international convention (by means of SIS1) and making a distinction between foreign patients coming with a prior authorization document E112/S2 and foreign patients coming within the context of specific agreements (like ZOAST, INTERREG and IZOM). Table 4.1 describes the SIS-codes used for the identification of the foreign patient stays of patients coming to Belgium for elective surgery with a prior authorization.

Table 4.1: Codes used to select coordination patients (foreign patients with a prior authorization) in HBD

	SIS1-codes used	SIS2-codes used
Patients with prior authorization by means of E112 or S2 document	180, 181, 480 or 481	312 (old code: 796) 612 (707)
Patients within the context of ZOAST, INTERREG and IZOM agreements	180, 181, 480 or 481	712 (786, 788)

No exclusion of emergency and unplanned care is made based on the MCD database. Instead, the exclusion of these stays is done based on a selection for patient stays with the SIS2 codes for planned interventions abroad (312, 612, 712) of the HBD. As such, the volumes of the identified foreign patient stays based on the MCD database (and based only on a foreign nationality and a foreign country of residence) still include some emergency and unplanned care.

For the HBD databases, a selection is made for stays within one specific year, by using the variables that describe admission and discharge date, to include certain stays for which the admission occurs in the last quarter of year T-1 but for which the discharge is in year T. By doing so, prolonged hospital stays are excluded, but stays that exceed the year are included.

4.2.1.3. Comparison of case mix between coordination patients and national data

Linked MCD-HBD allow to compare the severity-of-illness levels for the top seven of APR-DRGs of Belgian and foreign coordination patients.

The severity-of-illness (SOI) levels at a national level are obtained from the website of the FPS Public Health, Food Chain Safety and Environment. The volumes of foreign patient stays (E112/S2 patient stays) within each SOI-category per APR-DRG were obtained from the linked MCD-HBD database, based on a foreign nationality and a foreign country of residence. The volumes of patient stays obtained from the FPS were reduced with the numbers of foreign patients based on the linked HBD-MCD database, to calculate the volumes of Belgian patient stays per SOI-level per APR-DRG.

4.2.1.4. Volume of foreign patients residing in Belgium

We also present an overview of the volumes, insurance status and nationality of patient stays from patients with a foreign nationality but living in Belgium. As these patients fall out of the scope of the study, they are briefly discussed in appendix because they represent large volumes of stays.

4.2.1.5. Other types of patients falling under the international conventions categories

A description of the other categories of patients that are grouped into the category of 'international conventions' (based on SIS1 selection criterion) is also presented.

Summary of definitions and selection codes

Table 4.2 summarizes the selection criteria used for the different parts of the macro analysis.

Table 4.2: Summary of the selection criteria used for the macro analysis of the national databases

Database	Selection criteria for foreign patient stays
MCD (RCM/MKG)	Foreign nationality (not Belgian – based on the variable 'nationaliteit' in MCD) AND foreign country of residence (not Belgium – based on the variable 'landcode' in MCD)
HBD (SHA)	SIS 1 codes to select stays within context of an international convention (x8x) AND SIS2 codes to select coordination patient stays (312, 612, 712)

4.2.2. Hospital reports

4.2.2.1. Description of the survey

Based on the macro analysis on the MCD and HDB databases, only a partial insight can be obtained into the different foreign patient flows. Only foreign patients coming to Belgium within the context of the EU Coordination Regulations and cross-border agreements can be identified, as for the other categories (i.e. contract patients and direct billing patients) no specific codes for the social insurance status (SIS) are used within the HBD database. Therefore, case studies were performed in a selection of Belgian hospitals to estimate the volumes of the other types of foreign patient flows. These hospitals are selected based on:

- A preliminary analysis of the clinical and financial data on the macro level;
- Suggestions made by different experts that were interviewed during the first phase of this study.

Two types of hospitals were included in the case studies:

- Belgian hospitals at the border with neighboring countries, that are therefore interesting to include in this study;

- Hospitals which have mainly contracts with foreign healthcare insurers. These hospitals are not necessarily located within border regions in Belgium.

Selection was also made based on regional variability (Dutch speaking, French speaking, Brussels region). No difference was made according to size of the hospital (number of beds), private/public status and academic versus non-academic status. Ten hospitals were contacted for participation: six "border" hospitals (three participated, and three refused) and four "contract" hospitals (three participated and one refused).

These hospitals were asked to complete an excel file with questions concerning the volumes of different types of foreign patient stays for the years 2004-2010 (see appendix) for:

- Contracted foreign patients;
- Foreign patients by means of cross-border cooperation agreements and bilateral or multilateral agreements;
- Foreign patients coming by means of the EU Coordination Regulations (by appliance of the E112/S2 document);
- A remainder category if applicable for the hospital, with other categories of foreign patients they did not mention in one of the abovementioned categories.

We asked the hospitals to distinguish between outpatient, planned day-care and planned inpatient care stays and between residents of the EEA and residents from outside the EEA.

Tariffs charged to patients were also asked, for two cases: one for arthroplasty and one for menisectomy.

4.2.3. Comparison between hospital reports and administrative data

These volumes of foreign patient stays, based on the data of the individual hospitals were afterwards compared to the volumes of patient stays identified within the MCD and HBD database for this hospital, to see if these databases provide a factual picture of the existing foreign patient flows.

4.3. Results of the macro analysis

4.3.1. Stays for foreign patients not residing in Belgium, based on the MCD

4.3.1.1. Estimation of global volumes (the three patient flows)

General estimates can be made at the macro level on the basis of the Minimal Clinical Data (MCD), in which stays for patients with foreign nationality and having their residence outside Belgium can be identified. This is the best approximation that can be done in absence of reliable information on the country of insurance of the patient.

Based on these selection criteria, 22,679 inpatients were admitted in Belgian hospitals in 2008, which is the most recent year for which the MCD are available (Table 4.3). Compared to the total number of inpatient admissions, this represent a limited share of 1.29% in 2008, but continuously growing: over a time period of 5 years (2004-2008), the percentage of foreign inpatients has grown from 0.85% to 1.29% (+60%).

Interpreting trends about day care results is less straightforward. First, our time series is shorter as linked day-care data are only available from 2006 onwards. Second, the financing and registration rules for one-day admissions have changed drastically over this period. Third, the total number of stays was not yet available in the maxi-feedback, and thus was based on own KCE calculations (thus probably not exactly according to the same methodology).

Overall estimations are comparable to the results for inpatient stays, namely a low share of foreign patient stays (around 1% to 1.4%) and a small increasing tendency between 2006 and 2007. In the remaining of this section, only the latest available MCD day-care data will be presented.

The stays in Table 4.3 still include expats, living in Belgium but with official residence abroad, and unplanned care.

The next section describes some characteristics of those stays: the distribution of foreign patient stays in Belgian hospitals, the evolution of the share of foreign patients over years, the countries of residence of the foreign patients, the main diagnosis (based on APR-DRG and MDC version 15), severity-of-illness levels and the variable that describes the insurance status of patients (as from the MCD database of 2008).

Table 4.3: Number of stays for patients with foreign nationality, residing abroad and hospitalized in Belgium, compared to the total number of hospitalizations in Belgian hospitals – Inpatient and day-care (source MCD, 2004-2008)

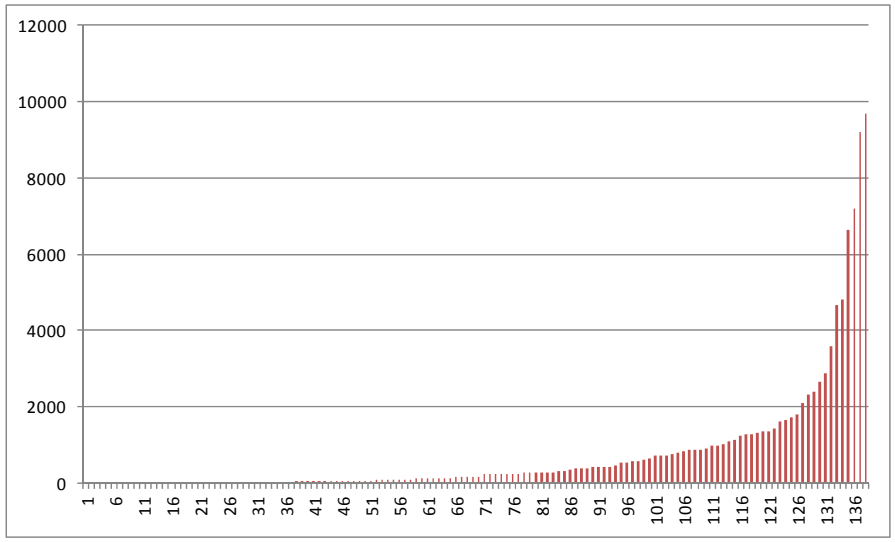
	Inpatient care			Day-care*		
	Foreign residing abroad	**All patients****	**% of total**	**Foreign residing abroad**	**All patients****	**% of total**
2004	14,369	1,681,415	0.85	NA	1,046,169	NA
2005	17,970	1,691,122	1.06	NA	1,086,171	NA
2006	19,224	1,693,793	1.13	12,884	1,128,445	1.14
2007	21,072	1,679,380	1.25	15,794	1,219,634	1.29
2008	22,679	1,757,615	1.29	15,880	1,609,525	0.98

**: does not include short stays in the emergency care department*
*** all denominators from maxi-feedback (FPS Public Health) except for 2008 (own KCE calculations).*
NA: not available

4.3.1.2. *Volume by hospital*

Figure 4.1 presents the distribution of hospitalizations in Belgian hospitals from foreign patients not residing in Belgium. It shows that those stays are highly concentrated in a small number of hospitals: half of the stays occurred in 10 hospitals.

Figure 4.1: Distribution of stays from foreign patients not residing in Belgium (classic 2004-2008, day-care 2006-2008, source MCD)



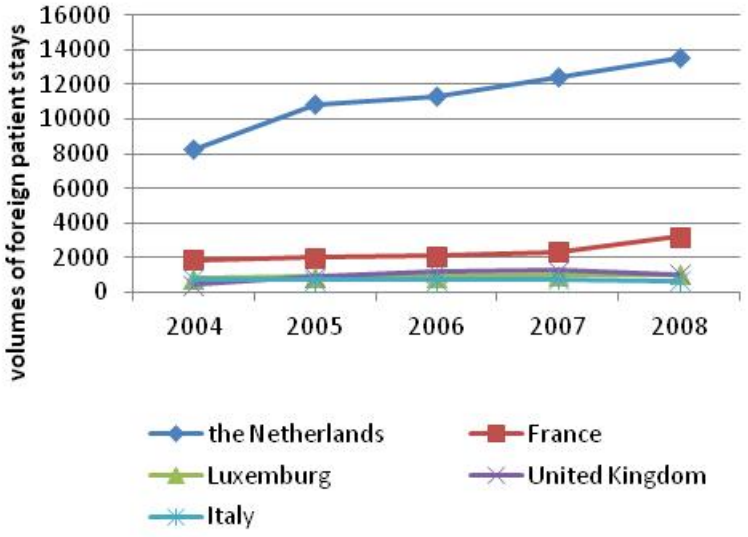
4.3.1.3. *Country of residence*

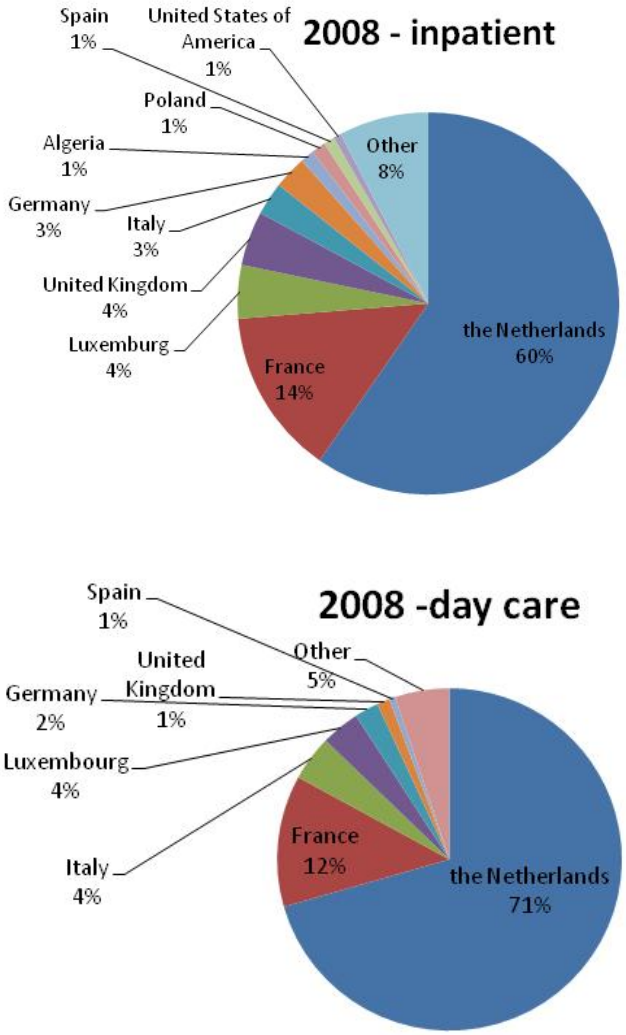
Figure 4.2 gives an overview of the top five of countries of residence of the foreign in patients who are not residing in Belgium, over the years. Pie chart for 2008 data is also presented for day care and inpatient stays.

The majority of foreign patients (identified based on the country of residence and nationality) come from neighbouring countries, such as the Netherlands (in 2008, 60% of inpatient stays, 71% of day-care) and France (14% and 12% respectively).

Figure 4.2: Top five of countries of residence for stays of foreign patient not residing in Belgium, evolution over the years

A. Inpatient care





The nationality of those patients has also been studied, but as the nationality code in the MCD gives less specific information (EU or non EU) than the country of residence, those results have been presented in appendix. The main results is that approximately 80 % of foreign patient stays were from patients with a European nationality, as well for inpatient as day care.

4.3.1.4. Types of admission

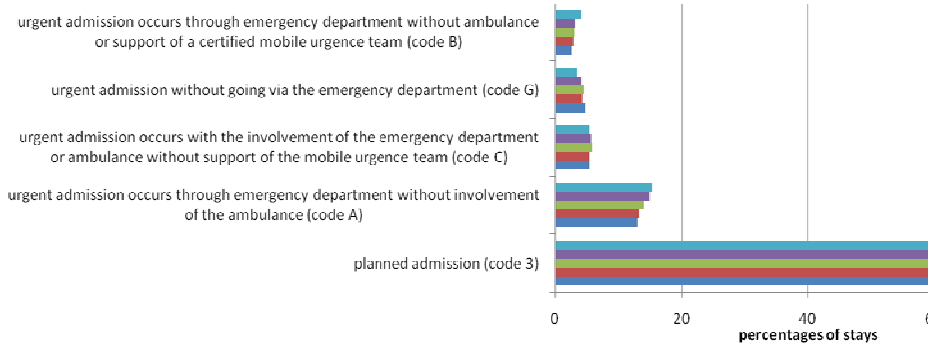
Figure 4.3 describes the top five of types of admission for foreign patient stays (based on a foreign country of residence and a foreign nationality) for years 2004-2008.

More than 60 % of the inpatient care and 95% of the day care are planned admissions.

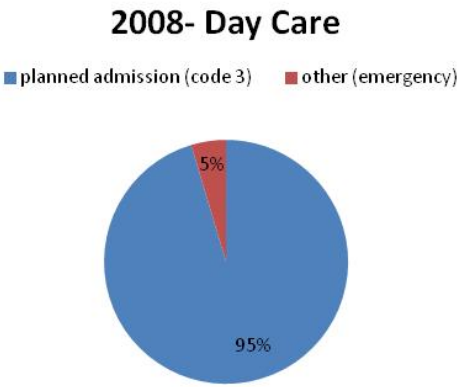
For the analysis based on the MCD database, we did not exclude emergency and unplanned patient stays. Only true emergency day care visits were excluded. As one will see in the analysis of the linked MCD-HBD database, the types of admission for urgent admissions (codes A, B, C, G) are also present for inpatient and day care stays for coordination patients (see figure 4.11). Based on the selection criterion “authorization for a healthcare treatment abroad” (based on SIS 2 equals 312, 612 or 712), some patient stays that occurred via the emergency department are still included. Thus selecting patient stays based on the SIS2 codes is not sufficient to exclude emergency and unplanned admissions. This reveals that foreign patients, who have an authorization for a treatment abroad (coordination patients, whether this authorization is given by a document E112/S2, or is based on a cross-border cooperation agreement) still sometimes enter a Belgian hospital through the emergency department.

Figure 4.3: Types of admission of foreign patient stays

A. Inpatient care



B. Day care(2008)



4.3.1.5. Treatments

Treatments of foreign patient stays are first described by using the MDC classification system, second with the APR-DRG classification and at the end by using the ICD-9 classification

Table 4.4 gives an overview of top ten MDCs for foreign patient stays in Belgium, over years 2004-2008. The number given in the table represents the relative percentages of foreign patient stays, based on a foreign country of residence and a foreign nationality within each MDC. The row with N(total) represents the volume of all foreign patient stays in the corresponding year for all MDCs.

MDC 8 (musculoskeletal system and connective tissue) constitutes the most popular MDC for foreign inpatient patient stays in Belgium with 23.25 % of the patient stays in 2008 and 23.25% of day care stays.

Table 4.4: Top 10 of MDCs of foreign patient stays

A. Inpatient care

MDC	2004	2005	2006	2007	2008
N (total)	14,369	17,970	19,224	21,072	22,679
08 - Musculoskeletal System and Connective Tissue	18.12	20.43	20.82	22.70	23.25
05 - Circulatory System	15.07	13.21	13.73	13.06	12.87
10 - Endocrine, Nutritional and Metabolic Diseases and Disorders	7.46	11.41	11.34	10.50	8.71
06 - Digestive System	7.04	6.49	6.63	7.12	7.42
01 - Nervous System	7.18	6.22	6.42	6.40	6.93
09 - Skin, Subcutaneous Tissue and Breast	4.75	4.84	3.49	3.48	3.21
04 - Respiratory System	3.93	3.81	3.59	3.71	3.95
23 -Rehabilitation, Aftercare, Other Factors Influencing Health Status and Other Health Service Contacts	4.54	3.70	3.70	3.14	3.51
14 - Pregnancy, Childbirth and the Puerperium	3.77	3.63	3.84	3.34	3.16
11 - Kidney and Urinary Tract	3.84	3.08	3.46	3.05	3.30

B. Day care (2008)

MDC	% (total 15,880)
08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue	23.25
05 Diseases and Disorders of the Circulatory System	12.87
10 Endocrine, Nutritional and Metabolic Diseases and Disorders	8.71
06 Diseases and Disorders of the Digestive System	7.42
01 Diseases and Disorders of the Nervous System	6.93
04 Diseases and Disorders of the Respiratory System	3.95
23 Rehabilitation, Aftercare, Other Factors Influencing Health Status and Other Health Service Contacts	3.51
11 Diseases and Disorders of the Kidney and Urinary Tract	3.30
09 Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	3.21
14 Pregnancy, Childbirth and the Puerperium	3.16

Treatments of foreign patients by means of DRG classification

Table 4.5 gives an overview of the top ten of the APR-DRGs for foreign patient stays in Belgium, based on MCD and nationality (not Belgian) and country of residence (not Belgium). The table gives the relative percentages of foreign patient stays in years 2004-2008 for each APR-DRG. The row with N (total) represents the volume of all foreign patient stays in the corresponding year for all APR-DRGs.

The most popular APR-DRGs for inpatient care are 403 (procedures for obesity – 7.38 % of stays in 2008), and several APR-DRGs related to MDC 8 (diseases or disorders of the musculoskeletal system and connective tissue) like 310 (back and neck procedures except dorsal and lumbar fusion – 4.55 % in 2008), 302 (major joint and limb reattach procedures of lower extreme except for trauma – 4.49 % in 2008), 313 (knee and lower leg procedures except foot – 2.37 % in 2008), 315 (shoulder, elbow and forearm procedures – 2.33 % in 2008) and 304 (dorsal and lumbar fusion procedures except for curvature of back – 2.43 % in 2008). In 2008 there were 1.7 % of patient stays for vaginal delivery (APR-DRG 560).

As expected, the reason for one day hospitalisations are different, but also a quarter of the hospitalisations relate to the musculoskeletal system. Most frequent reasons are grouped in APR-DRG 850 "procedure w diagnosis of rehab, aftercare or other contact w health services (incl. procreative management and genetic counselling)) and chemotherapy (APR-DRG 693).

Table 4.5: Top 10 of APR-DRGs of foreign patient stays

A. Inpatient care

APR-DRG	2004	2005	2006	2007	2008
N (total)	14,369	17,790	19,224	21,072	22,679
403 - procedures for obesity	4.93	10.01	9.94	9.12	7.38
310 - back and neck procedures except dorsal and lumbar fusion	3.80	4.72	4.72	4.97	4.55
175 - percutaneous cardiovascular procedures w/o AMI	3.44	3.04	2.98	3.10	2.84
302 - major joint and limb reattach proc of lower extrem exc for trauma	3.16	2.99	2.91	2.94	4.49
862 - other factors influencing health status	3.51	2.63	2.63	2.21	2.10
315 - shoulder, elbow and forearm procedures	1.88	2.35	2.14	2.61	2.33
313 - knee and lower leg procedures except foot	1.73	1.99	2.03	2.11	2.37
560 - vaginal delivery	2.07	1.93	2.07	1.83	1.70
304 - dorsal and lumbar fusion proc except for curvature of back	1.22	1.51	2.14	2.53	2.43
693 - chemotherapy	1.90	1.75	1.78	2.01	2.19

B. Day care (2008)

APR-DRG	% (total 15,880)
850-Procedure with diagnoses of rehab, aftercare or other contact with health services*	13,57
693-Chemotherapy	12,34
347-Medical back problems	11,26
313-Knee &lower leg procedures except foot	5,52
073-lens procedures with or without vitrectomy	5,38
862-Other factors influencing health status	3,58
250-Other digestive system diagnoses	3,07
192-Cardiac catheterization for ischemic heart disease	2,35
114-Dental &oral diseases	2,01
175 - Percutaneous cardiovascular procedures w/o AMI	1,73

**this includes procreative management and genetic counselling.*

Diagnoses of foreign patients by using the Health Data Project-2

The results presented in this section are part of a working report prepared by the FPS for the Observatory on Patient Mobility. This explains why the selection criteria (based on country of residence) and the years of analysis (200-2006) are slightly different from the previous selection.

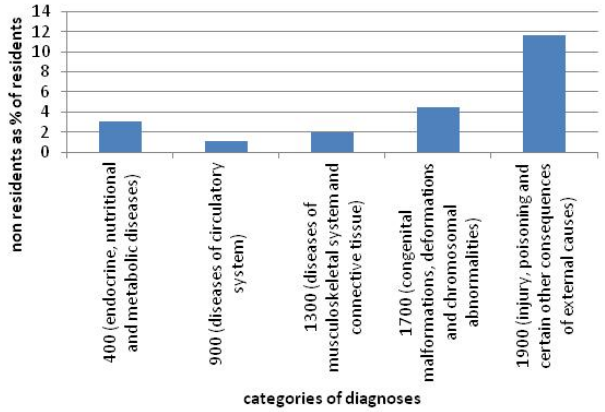
Diagnoses

Figure 4.4 gives an overview of the importance of diagnoses for non-residents in comparison to residents for the number of inpatient care (A) and the number of day care stays (B) for years 2000-2006. The distinction of resident-non-resident is made based on the variable 'NIS-code' in the MCD database.

In the top five of the volumes of non-resident inpatients weighted to the number of resident inpatient stays are presented: injury, poisoning and certain other consequences of external cause (category 1900) endocrine, nutritional and metabolic diseases (category 400), congenital malformations, deformations and chromosomal abnormalities (category 1700), diseases of the musculoskeletal system and connective tissue (category 1300) and diseases of the circulatory system (category 900). Three of these categories are also present in the top 5 of the number of day care stays for non residents weighted to the numbers of residents.

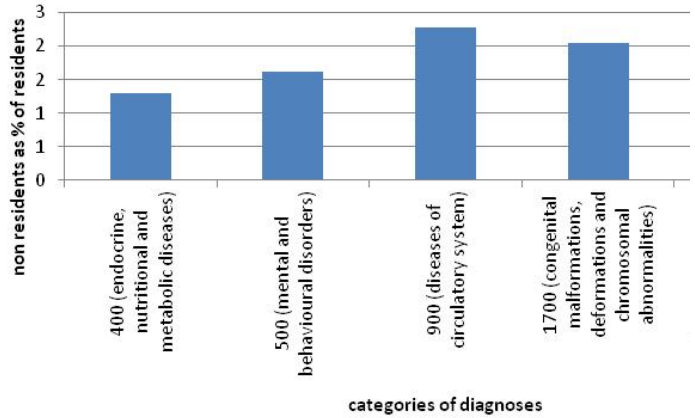
Figure 4.4: Diagnosis with the highest relative importance for non residents

A. Inpatient care



Source: working report prepared by the FPS for the Observatoy on Patient Mobility

B. Day care



Source: working report prepared by the FPS for the Observatory on Patient Mobility

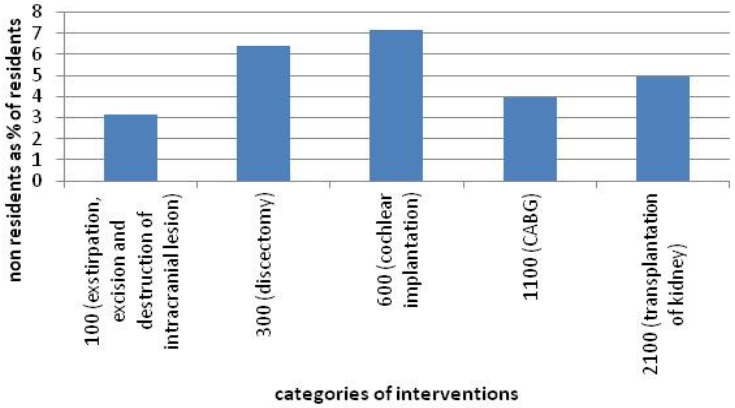
Interventions

Figure 4.5 gives an overview of the top five of the main interventions for non residents in comparison to residents for the number of inpatients (A) and the number of day cases (B) for years 2000-2006. The distinction between resident and non-resident is made based on the variable 'NIS-code' within the MCD database.

In the top five of the volumes of non-resident inpatients weighted to the number of resident inpatients are presented: cochlear implantation (category 600), discectomy (category 300), transplantation of kidney (category 2100), CABG (category 1100) and exstirpation, excision and destruction of intracranial lesion (category 100). PTCA (category 1000) and total knee replacement (category 2800) are popular for day cases.

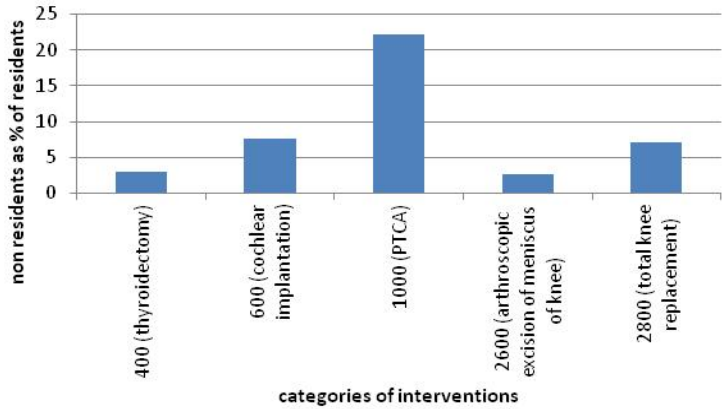
Figure 4.5: Interventions with the highest relative importance for non residents

A. Inpatient care



Source: working report prepared by the SPF/FOD for the Observatorium on patient mobility

B. Day care



Source: working report prepared by the SPF/FOD for the Observatorium on patient mobility

4.3.1.6. Information related to the insurance status

As from the MCD database of 2008, a new variable was introduced (Cfr. Description of MCD database).

Table 4.6 presents the insurance status of stays of foreign patients not residing in Belgium. The majority of those stays (37% for day care and 41% for inpatient care) were from patients which were apparently socially insured by a Belgian health insurance fund. Only 29% of the inpatient stays and 23% of the day care occurred under the 'international convention' status.

This category can (normally) only be used for stays by means of the European Health Insurance Card. This category thus (normally) does not include stays for planned care. There might be some confusion in Belgian hospitals on the use of the different codes that describe the insurance status. We think that foreign patients who are assimilated (the so-called coordination patients), are also categorized under the category 'socially insured by a Belgian health insurance fund. This data seems thus not reliable. The chapter of the data registration proposes some refinements for the registration of the insurance status of patients in Belgian hospitals.

Table 4.6: Insurance status for the patient with foreign nationality and residing abroad (source MCD 2008)

	Type	
	Classic (N = 22679) %	Daycare (N = 15880) %
A- Patient is not socially insured	22.88	28.82
B - Patient is socially insured by a Belgian health insurance fund	40.79	37.06
C - International convention	29.19	22.76
D - Specific agreements	7.14	11.36

Table 4.7 gives a detail of the volumes of foreign patient stays within each category of insurance status by nationality. We can see that in 2008 most of patients that came under the status 'international convention' had a Dutch nationality.

Table 4.7: Nationality of foreign patient stays within each category of insurance status for 2008, inpatient care

Nationality	Insurance Status				Total
Frequency Col Pct	**A**	**B**	**C**	**D**	
Dutchman	3118 60.10	3698 39.97	4534 68.49	1288 79.51	12638
Frenchman	206 3.97	884 9.56	708 10.69	38 2.35	1836
Englishman	161 3.10	590 6.38	121 1.83	42 2.59	914
Luxemburger	83 1.60	213 2.30	231 3.49	0 0.00	527
German	151 2.91	131 1.42	227 3.43	14 0.86	523
Other country of Europe	455 8.77	708 7.65	508 7.67	34 2.10	1705
Europe, non EU	138 2.66	72 0.78	50 0.76	12 0.74	272
African	186 3.59	332 3.59	29 0.44	17 1.05	564
American	158 3.05	55 0.59	8 0.12	13 0.80	234
Asian	102 1.97	40 0.43	23 0.35	18 1.11	183
Oceania	13 0.25	6 0.06	4 0.06	3 0.19	26
unknown	417 8.04	2522 27.26	177 2.67	141 8.70	3257
Total	5188	9251	6620	1620	22679

4.3.2. Foreign patients with prior authorization or within the context of specific agreements (coordination patients)

This part will describe the flows of foreign patient stays of patients with a prior authorization or within the context of specific agreements. Foreign patient coming to Belgium with the intent of receiving a healthcare treatment by means of a prior authorization document E112 or by means of specific agreements like ZOAST, INTERREG and IZOM can be identified in the HBD database and in the linked MCD-HBD database (based on the SIS1 and 2 codes – see methods).

Glinos et al. showed that in 2004 1,492 patients from the Dutch insurer OZ and 5,775 patients from Dutch insurer CZ came to Belgium. The OZ patients are treated in Belgium through the procedures based on EU Coordination Regulation 1408/71 whereas treatment of CZ patients is directly paid by the insurer to the hospital. Glinos et al. showed that OZ and NHS patients are included within the volumes of coordination patient stays {Glinos, 2005 #510}.

4.3.2.1. Global Volumes

Foreign patient stays are selected within the HBD database by using the SIS1 code for 'international convention' and the SIS2 code for coordination patient stays and stays under specific agreements (312, 612, 712) (see also Table 4.2).

Table 4.8 describes the volume of patients stays from coordination patients (patients coming to Belgium by means of an E112/S2 document and patients under specific agreements). In 2008, 11,132 stays for day care and 6,886 stays for inpatient care were realized for coordination patients by means of a prior authorization document E112/S2 or within the context of specific agreements. In 2009 both the volumes for inpatient and day care decreased.

Table 4.8 also presents the data split by those coming with a prior authorization document E112/S2 and those patients coming within the context of specific cross-border cooperation agreements (C.B.C.A. – like ZOAST, INTERREG and IZOM). The flows of patient stays within the context of these cross-border cooperation agreements are increasing in the last years (2008-2009), as well for inpatient as day care. Especially for day care, these agreements are used frequently. One can notice a shift from patient stays by means of prior authorization document E112/S2 towards patient stays within the context of cross-border cooperation agreements and toward more contracted care (see chapter hospital reports).

Table 4.8: Volume of patient stays of by means of E112/S2 and patients coming within the context of cross-border cooperation agreements, based on the HBD database (coordination patients)

	SIS1	number of patient stays											
		2004		2005		2006		2007		2008		2009	
		E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.
day care	180	9,153	235	9,004	208	12,617	66	11,866	54	10,978	150	4,951	6,050
	181	0	0	1	0	15	0	6	0	4	0	11	3
	480	115	1	188	0	260	0	7	0	0	0	5	1
	481	0	0	0	0	0	0	0	0	0	0	0	0
	Total	9,268	236	9,193	208	12,892	66	11,879	54	10,982	150	4,967	6,054
inpatient care	180	6,314	720	7,190	538	8,231	82	9,129	62	6,805	63	5,108	1,297
	181	3	0	4	0	15	0	23	0	11	0	5	1
	480	40	5	37	2	52	0	35	0	7	0	7	0
	481	1	0	1	0	0	0	0	0	0	0	0	0
	Total	6,358	725	7,232	540	8,298	82	9,187	62	6,823	63	5,120	1,298

C.B.C.A.: cross-border cooperation agreements (like ZOAST, INTERREG and IZOM agreements)

4.3.2.2. *Linkage with MCD*

The information on the pathology for those stays being collected in the MCD, it is thus necessary to use linked MCD-HBD data. Unfortunately the linkage was very poor, especially for day care, but nevertheless increasing over the years, as shown in Table 4.9.

Table 4.9: Linkage percentage of coordination patients over the years (HBD-MCD)

		2004		2005		2006		2007	
		E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.	E112/S2	C.B.C.A.
day care	total	9,268	236	9,193	208	12,892	66	11,879	54
	in linked data	NA	NA	NA	NA	1,107	10	2,156	10
	% linkage					8,59	15,15	18,15	18,52
acute care	total	6,358	725	7,232	540	8,298	82	9,187	62
	in linked data	3,304	322	4,056	151	4,444	18	4,938	24
	% linkage	51,97	44,41	56,08	27,96	53,56	21,95	53,75	38,71

Based on the linked MCD-HBD database, 4,121 inpatient E112/S2 stays and 40 stays within the context of cross-border cooperation agreements are identified for 2008. This linked MCD-HBD database is used in the subsequent analysis to describe some characteristics of these patient stays, but it only covers 60 % of all coordination patient stays (identified based on the HBD database only).

We will describe the distribution of the coordination patients who come with a prior authorization document E112/S2 in the Belgian hospitals, the countries of residence of the foreign patients, the nationality, the main diagnosis (based on APR-DRG and MDC version 15) for coordination patients, and severity-of-illness levels for the top five of the APR-DRGs for patients coming by means of a prior authorization document E112/S2, and not for the patients coming by means of cross-border cooperation agreements, as those volumes are marginal.

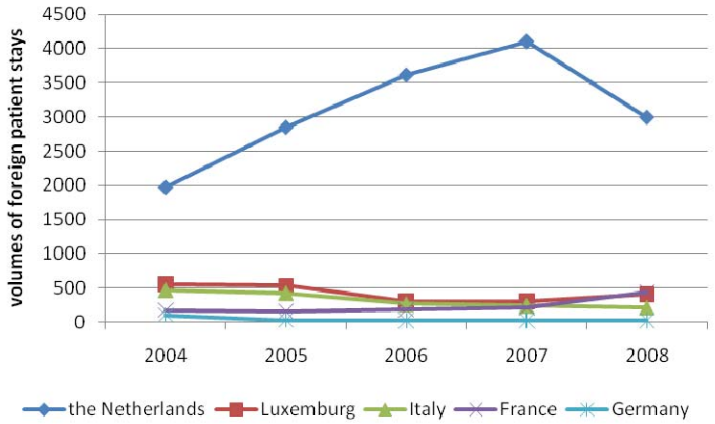
We also compare the distribution of patient stays of E112/S2 coordination patients for the top seven APR-DRG for coordination E112/S2 patients with Belgian patients. Finally, we will describe the insurance status of coordination patients based on the linked HBD-MCD databases, for 2008.

4.3.2.3. *Country of residence*

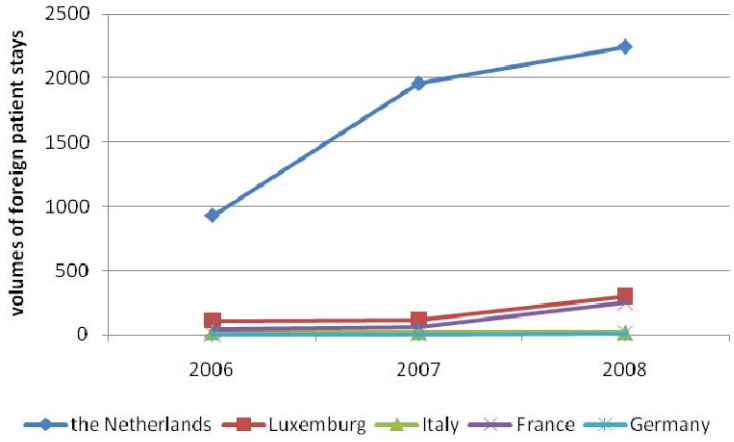
Figure 4.6 describes the top five of countries of residence of coordination patient stays. A distinction is made between patient stays of patients coming to Belgium by means of a prior authorization document E112/S2 (A en B) and patients coming by means of cross-border cooperation agreements (C and D).

Figure 4.6: Top five of countries of residence of coordination patients (linked MCD-HBD)

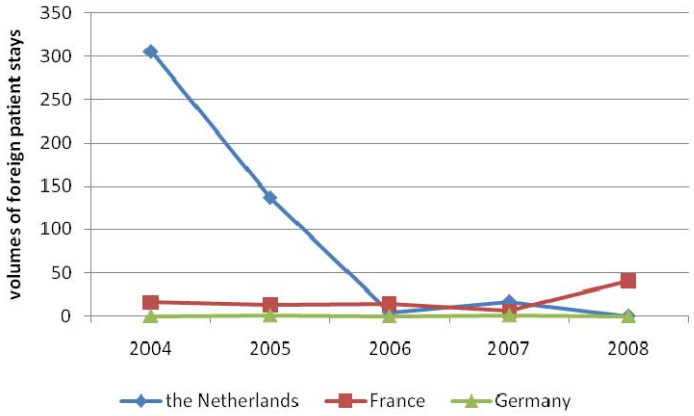
A. E112/S2 – Inpatient care



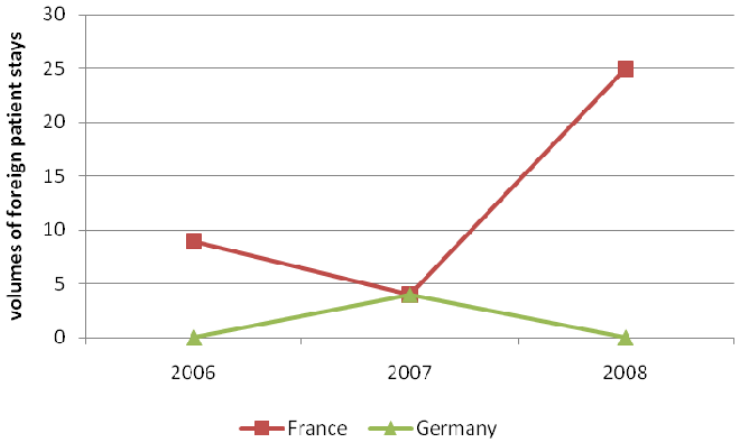
B. E112/S2 – Day care



C. Cross-border cooperation agreements – Inpatient care



D. Cross-border cooperation agreements – Day care



The Netherlands is the most frequent country of residence for both inpatient and day care for E112/S2 patient stays. The amount of Dutchman increases over time, both for inpatient and day care, until 2007, when there is a drop in the number of Dutch patients coming with a prior authorization document. This might be because of increasing number of contract patients (cfr. Infra). The total volume of E112/S2 patients increases also until 2007 and then decreases.

Patients coming to Belgium by means of specific cross-border cooperation agreements have a French, German or Dutch nationality. In 2004-2006 there is a large decrease in the number of patient stays for inpatient care from Dutchman. This might be due to the increasing importance of direct billing and contracted patient care that might replace coordination patient stays from patients from the Netherlands. The volume of day care stays increases over time for patients from France. This indicate the growing importance of ZOAST agreements.

Nationality was also studied, but has it gives less specific information than country of residence, this information is presented in appendix. A small volume of foreign patients have a non-European nationality, which is made possible because of the additional Regulation 859/2003, which enables residents of third countries to come to Belgium under the conditions of Regulation 883/2004, if two provisions are met: (i) residents of a third country reside on Belgian territory in a legal way and (ii) a cross-border aspect is involved between the two countries. An example of this provision is a Russian person (nationality is Russian) who lives in Estonia (country of residence is Estonia) but who works in Latvia and is insured there. This person has the opportunity to come to Belgium for elective healthcare under the E112 scheme.

4.3.2.4. Types of admission of (linked MCD-HBD)

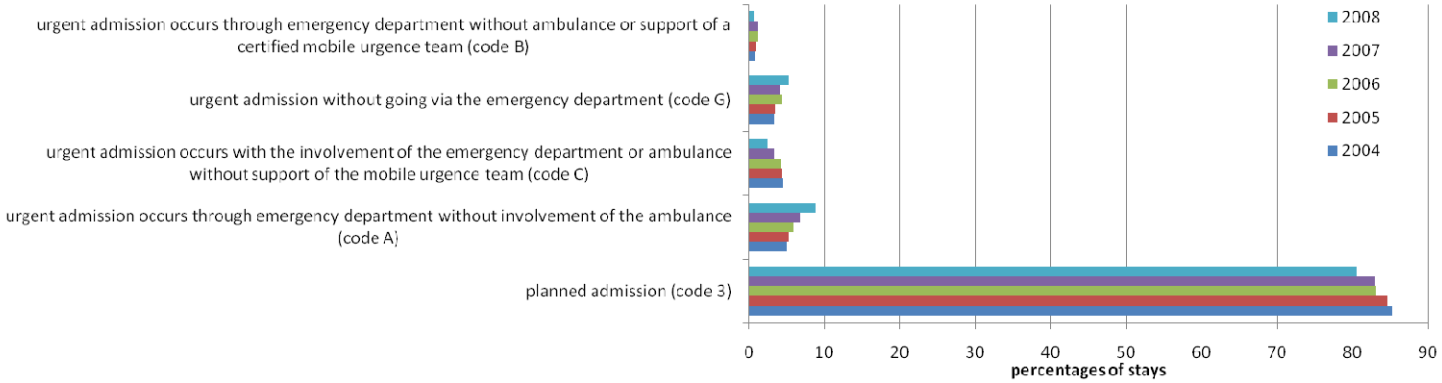
Figure 4.11 gives an overview of the five most frequently used types of admission in the hospital for coordination patients. A distinction is made between E112/S2 patients (A and B) and patients coming to Belgium by means of cross-border cooperation agreements (C and D).

The patient stays selected for in the analysis of the linked MCD-HBD database are those stays with a prior authorization for a healthcare treatment abroad, based on SIS2 codes (see table 4.5). As the volumes of these selected stays still include patient stays that occurred via the emergency department (codes A, B, C and G in Figure 4.7) this selection criterion is not sufficient to exclude emergency and unplanned admissions. It does indicate that some patients, who have a prior authorization from their foreign healthcare insurer to come to Belgium for a treatment or intervention, apparently enter the hospital via the emergency department.

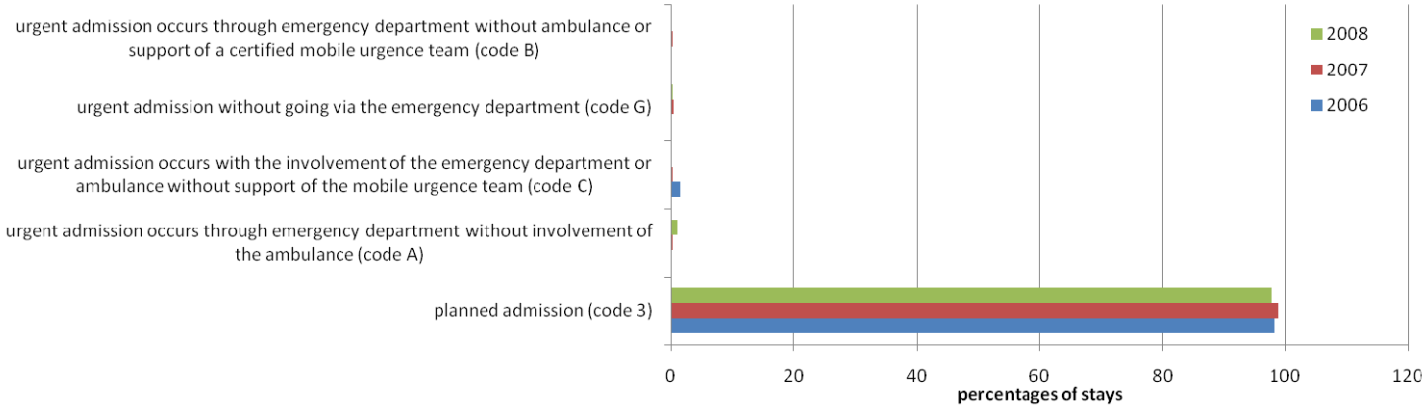
For cross-border cooperation agreement patient stays (figure C and D), admissions via the emergency department are more frequent than for coordination patients with a prior authorization document E112/S2.

Figure 4.7: Types of admission of coordination patients in Belgium

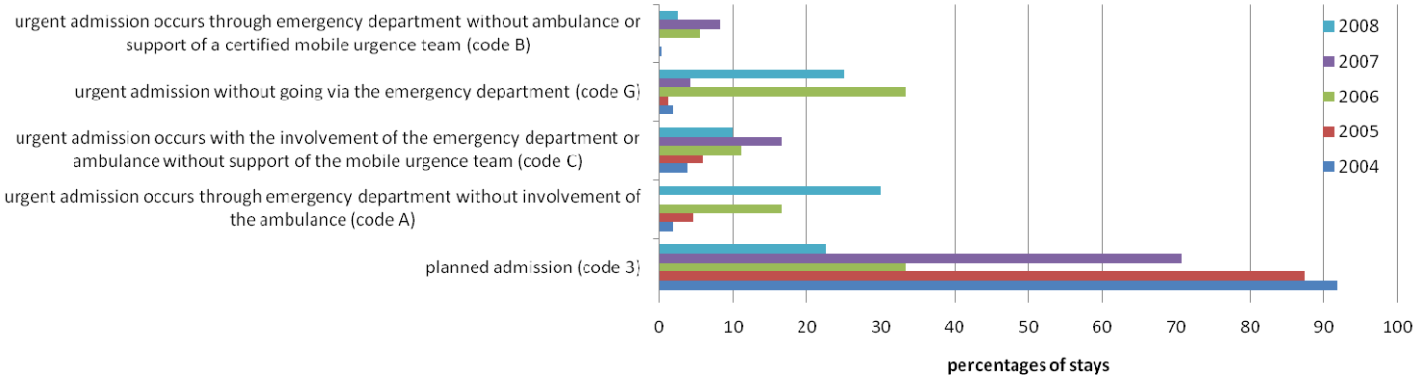
A. E112/S2 – Inpatient care



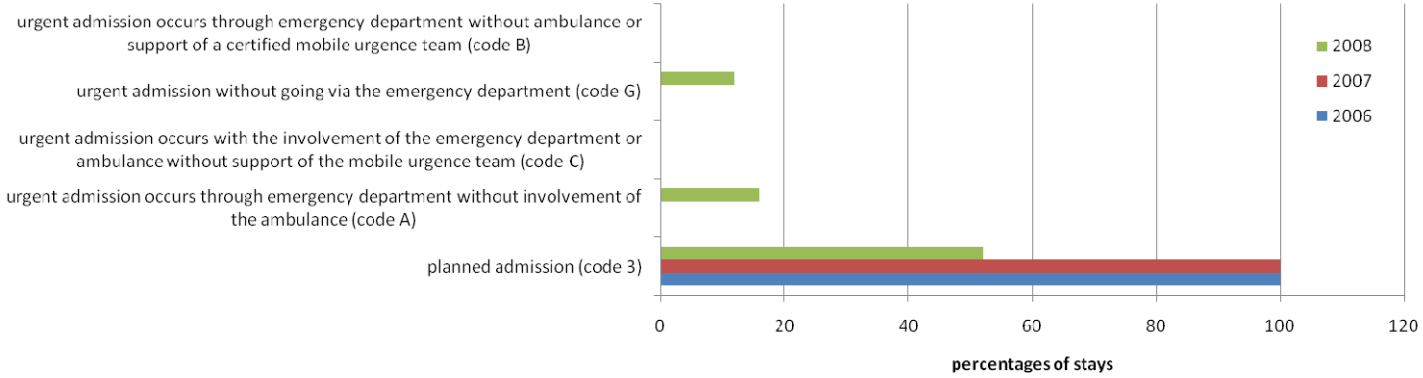
B. E112/S2 – Day care



C. Cross-border cooperation agreements – Inpatient care



D. Cross-border cooperation agreements – Day care



4.3.2.5. Types of treatments (linked MCD-HBD)

Major diagnostic categories (MDC's) and all-patient refined diagnosis related groups (APR-DRG's) are used to describe treatment.

Treatments of coordination patients by means of DRG classification

Table 4.10 gives an overview of the top ten APR-DRGs for inpatient care (A) and day care (B) for coordination patients coming to Belgium by means of a prior authorization document E112/S2. The numbers in the row with N (total) represent the volumes of all foreign patient stays of all APR-DRGs, the other numbers represent the relative percentages of patient stays within each DRG. The same information for cross-border cooperation agreements is available in appendix.

The top five for inpatient care for patients coming to Belgium by means of a prior authorization document E112/S2 consists out of APR-DRG 310 (back and neck procedures except dorsal and lumbar fusion – 7.89 % in 2008), 302 (major joint and limb reattach procedures of lower extremities except for trauma – 4.49 % in 2008) and 304 (dorsal and lumbar fusion procedure except for curvature of back – 5 % in 2008), all related to MDC 8 (musculoskeletal system and connective tissue). APR-DRG 862 (other factors influencing health status – 4.15 % in 2008) is also a common APR-DRG for foreign patients. Percutaneous cardiovascular procedures without AMI (APR-DRG 175 – 3.91 % in 2008) is also present in the top five. For day care patient stays for patients coming to Belgium by means of a prior authorization document, chemotherapy (APR-DRG 693 – 17.91 % in 2008) and medical back problems (APR-DRG 347 – 8.14 % in 2008), as well as a special substitute APR-DRG code "MMM" (with 22.27 % of patient stays in 2008) are present in the top 5. This special code is used in cases of small day care procedures where no diagnostic coding is required (e.g. miniforfait patients) The volumes of this special APR-DRG MMM are rapidly increasing since 2007.

Table 4.10: Top 10 APR-DRGs for patient stays of coordination patients by means of E112/S2 document in Belgium

A. Inpatient care

APR-DRG	2004	2005	2006	2007	2008
N (total)	3,304	4,056	4,444	4,938	4,121
862 - other factors influencing health status	10.47	7.20	4.84	3.99	4.15
310 - back and neck procedures except dorsal and lumbar fusion	2.18	4.64	6.77	7.98	7.89
175 - percutaneous cardiovascular procedures w/o AMI	6.23	4.31	5.11	5.81	3.91
302 - major joint and limb reattach proc of lower extrem exc for trauma	2.54	3.43	3.42	3.73	4.49
304 - dorsal and lumbar fusion proc except for curvature of back	0.67	1.87	4.34	4.41	5.00
693 - chemotherapy	1.73	2.07	2.93	4.05	3.45
166 - coronary bypass w/o malfunctioning coronary bypass w/o cardiac cath	2.94	1.60	1.78	1.86	1.21
315 - shoulder, elbow and forearm procedures	1.03	1.48	1.85	2.19	2.26
403 - procedures for obesity	2.30	2.49	1.91	1.13	0.49
313 - knee and lower leg procedures except foot	0.88	1.41	1.49	1.44	1.72
347 - medical back problems	0.97	1.60	1.46	1.52	0.95

B. Day care

APR-DRG	2006	2007	2008
N (total)	1,107	2,156	2,825
693 - chemotherapy	12.56	19.25	17.91
MMM	0.00	2.23	22.27
347 - medical back problems	5.42	10.02	8.14
850 - procedure w diagnosis of other contact w health services	9.67	6.17	6.16
862 - other factors influencing health status	3.16	5.06	4.07
313 - knee and lower leg procedures except foot	6.14	3.57	3.86
073 - lens procedures w or w/o vitrectomy	4.16	3.71	3.54
114 - dental and oral disease	4.34	3.06	1.31
250 - other digestive system diagnoses	2.17	1.72	2.65
691 - lymphoma and non-acute leukemia	3.07	2.97	0.53

Treatments of coordination patients by means of MDC classification

Table 4.11 describes the top ten of MDCs for coordination patients coming to Belgium by means of a prior authorization document E112/S2 for inpatient (A) and day care (B). The numbers represent the volumes of foreign patient stays. The same information is available in appendix for cross-border cooperation agreement patients.

For inpatient care, MDC 8 (musculoskeletal system and connective tissue – 27.35 % in 2008), MDC 5 (circulatory system – 12.59 % in 2008) and MDC 6 (digestive system – 7.67 % in 2008) are present in the top five as well for foreign patients coming to Belgium by means of a prior authorization document E112/S2 and patients within the context of cross-border cooperation agreements. The volumes of stays for MDC 8 and 9 are increasing for E112/S2 patients, but are decreasing for patient within the context of cross-border cooperation agreements, but as mentioned before (Cfr. DRG classification), the total volumes of patients within the context of cross-border cooperation agreements were decreasing between 2004-2006. For day care, MDC 17 (lymphatic, hematopoietic, other malignancies, chemotherapy and radiotherapy – 20.25 % in 2008) and MDC 2 (eye – 4.39 % in 2008) are present in the top five for E112/S2 patient stays. For cross-border cooperation agreements, the most important MDCs for inpatient care are MDC 4 (respiratory system – 17.5 % in 2008), MDC 5 (circulatory system – 15 % in 2008) and MDC 1 (nervous system – 17.5 % in 2008). For both E112/S2 coordination and cross-border cooperation agreements patient stays, the special MDC ‘SS’ is of growing importance (22.27 % inpatient and 72 % day care in 2008). This represents the extension of day care hospital in 2007.

Table 4.11: Top 10 MDCs for patient stays of coordination patients by means of E112/S2 document in Belgium

A. Inpatient care

MDC	2004	2005	2006	2007	2008
N (total)	3,304	4,056	4,444	4,938	4,121
08 - Musculoskeletal System and Connective Tissue	12.32	19.33	24.26	26.75	27.35
05 - Circulatory System	19.98	15.41	17.93	17.36	12.59
23 -Rehabilitation, Aftercare, Other Factors Influencing Health Status and Other Health Service Contacts	11.96	8.65	6.10	4.98	5.80
06 - Digestive System	6.33	5.60	6.35	6.60	7.67
01 - Nervous System	7.05	6.41	6.53	6.32	6.41
11 - Kidney and Urinary Tract	6.42	3.97	4.84	4.03	4.90
17 - Lymphatic, hematopoietic, other malignancies, chemotherapy and radiotherapy	3.00	4.09	4.34	5.29	4.30
07 - Hepatobiliary system and pancreas	5.21	4.59	3.51	4.37	3.59
04 - Respiratory System	3.84	3.62	2.75	3.32	3.93
03 - Ear, nose, mouth, throat and craniofacial diseases and disorders	3.30	3.23	2.93	3.00	3.08

B. Day care

MDC	2006	2007	2008
N (total)	1,107	2,156	2,825
17 - Lymphatic, Hematopoietic, Other Malignancies, Chemotherapy and Radiotherapy	17.34	25.09	20.25
08 - Musculoskeletal System and Connective Tissue	22.22	21.10	17.91
23 -Rehabilitation, Aftercare, Other Factors Influencing Health Status and Other Health Service Contacts	13.19	11.41	10.34
SS - special APR-DRGs (DDD, MMM, UUU, UAA and AAA)	0.00	0.00	22.27
02 - Eye	9.39	7.00	4.39
06 - Digestive System	5.96	5.19	6.65
03 - Ear, Nose, Mouth, Throat, and Craniofacial	8.04	4.64	2.62
11 - Kidney and urinary tract	3.61	4.17	2.51
05 - Circulatory System	2.62	5.24	1.98
01 - Nervous System	4.43	3.34	2.55

4.3.2.6. Comparison of severity-of-illness levels between E112/S2 coordination patients and national patients

Table 4.12 describes the relative volumes of patient stays of the different SOI-levels for Belgian and foreign patients with a prior authorization document E112/S2 for the top 7 APR-DRGs for coordination patients.

In the most recent year for which data was available (2008) foreign patients; coming to Belgium by means of a prior authorization document E112/S2 have a less severe casemix than Belgian patients for the top 7 APR-DRGs (all p-values in appendix).

Table 4.12: Comparison of the relative importance (%) of the different SOI-levels within each APR-DRG for foreign coordination patients with an E112/S2 document

		relative percentages of patient stays									
		2004		**2005**		**2006**		**2007**		**2008**	
APR-DRG	SOI-level	Belgian	F.P. E112	Belgian	F.P. E112	Belgian	F.P. E112	Belgian	F.P. E112	Belgian	F.P. E112
862 - other factors influencing health status											
	minor	64.97	8.38	62.96	7.88	63.14	14.42	62.77	15.23	63.46	15.79
	moderate	27.44	17.63	29.24	21.23	29.29	44.65	29.42	58.38	28.43	71.35
	major	6.50	69.36	6.78	68.49	6.64	39.53	6.84	25.38	6.95	11.70
	extreme	1.09	4.62	1.02	2.40	0.92	1.40	0.97	1.02	1.16	1.17
310 - back and neck procedures except dorsal and lumbar fusion											
	minor	68.79	66.67	69.35	76.06	68.46	71.10	68.25	81.98	68.89	81.85
	moderate	26.92	29.17	26.64	22.87	27.94	26.25	28.40	16.75	27.83	16.31
	major	3.93	4.17	3.46	1.06	3.18	2.66	2.89	1.02	2.72	1.85
	extreme	0.46	0.00	0.55	0.00	0.42	0.00	0.46	0.25	0.56	0.00
175 - percutaneous cardiovascular procedures w/o AMI											

	minor	48.53	69.42	47.63	72.00	47.29	69.60	48.64	73.17	48.59	62.11
	moderate	39.04	23.30	40.11	21.14	40.35	22.47	39.82	19.16	41.30	36.02
	major	10.75	6.31	10.18	6.86	10.23	5.73	9.60	6.27	8.45	1.86
	extreme	1.69	0.97	2.08	0.00	2.13	2.20	1.94	1.39	1.66	0.00
302 - major joint and limb reattach proc of lower extrem exc for trauma											
	minor	47.02	70.24	46.36	71.22	45.96	71.71	48.87	71.20	51.36	66.49
	moderate	41.67	22.62	42.47	25.18	43.51	21.71	41.42	25.54	40.29	26.49
	major	10.29	5.95	10.19	3.60	9.56	5.92	8.75	3.26	7.58	7.03
	extreme	1.02	1.19	0.98	0.00	0.97	0.66	0.96	0.00	0.76	0.00
304 - dorsal and lumbar fusion proc except for curvature of back											
	minor	68.24	68.18	65.35	69.74	65.63	73.58	68.30	69.72	68.76	79.13
	moderate	23.43	31.82	24.84	26.32	24.86	23.83	23.35	27.06	23.83	16.99
	major	7.49	0.00	8.81	3.95	8.20	2.59	7.27	2.75	6.72	3.88
	extreme	0.84	0.00	1.00	0.00	1.32	0.00	1.08	0.46	0.69	0.00
693 - chemotherapy											
	minor	54.75	43.86	53.72	55.95	51.02	68.89	52.61	60.98	51.93	84.10
	moderate	33.78	31.58	34.82	32.14	36.46	17.84	35.55	31.38	35.97	13.58
	major	8.65	19.30	8.22	9.52	8.80	6.69	8.15	6.99	7.90	1.54
	extreme	2.83	5.26	3.23	2.38	3.72	5.58	3.70	0.65	4.20	0.77
347 - medical back problems											
	minor	61.01	68.75	59.86	76.92	56.84	80.00	55.80	92.78	55.21	90.71
	moderate	30.48	28.13	31.59	18.46	33.18	18.40	33.94	6.53	34.42	9.29
	major	7.52	3.13	7.29	4.62	8.62	1.60	8.80	0.69	8.96	0.00
	extreme	0.96	0.00	1.27	0.00	1.37	0.00	1.45	0.00	1.42	0.00

F.P. E112 = foreign patient (not Belgian nationality/country of residence) coming to Belgium by means of a prior authorization document E112/S2

4.3.2.7. *Insurance status of foreign patient stays in Belgium*

Since 2008, a variable that describes the insurance status, is introduced into the MCD database.

Table 4.13 gives an overview of the volumes of foreign patient stays within each category of insurance status for 2008. Most of the patient with a E112/S2 document come within the context of emergency care by means of the European Health Insurance Card (which is classified as insurance status 'international convention'). The second most common category is those of patients socially insured by a Belgian health insurance fund. For patients coming to Belgium within the context of cross-border cooperation agreements, almost all patients are socially insured by a Belgian health insurance fund. But as mentioned before in the analysis of the characteristics of foreign patient stays, based on the MCD database, this variable is not reliable, as there exist some confusion about the use of the different codes for the insurance status in Belgian hospitals.

Table 4.13: Overview of volumes of patient stays within each category of insurance status for year 2008

A. Patient stays with a prior authorization document E112/S2

category of insurance status	inpatient	day care
A- Patient is socially insured by a Belgian health insurance fund	1,387	773
B- Patient is not socially insured	10	17
C- International convention	2,722	2,034
D- Specific agreements	2	1
TOTAL	4,121	2,825

B. Patient stays within the context of cross-border cooperation agreements

category of insurance status	inpatient	day care
A- Patient is socially insured by a Belgian health insurance fund	37	23
B- Patient is not socially insured	0	0
C- International convention	3	2
D- Specific agreements	0	0
TOTAL	40	25

4.3.2.8. *Other categories of foreign patients within the context of an international convention, besides the prior authorization patients*

Coordination patients constitute a part of all patients classified under 'international conventions' (24 % for inpatient and 26.78 % for day care). Part 4.3.3 described the characteristics and volumes of foreign patients coming to Belgium with a prior authorization (by means of a E112/S2 document of within the context of ZOAST, INTERREG or IZOM agreements). All these patient stays are classified within the category of 'international convention', meaning that the person has the right to obtain a healthcare treatment in Belgium at the expense of another foreign country. There are also other categories of patients that are classified within the category of 'international convention', besides the coordination patients.

Based on the HBD database, Table 4.14 provides an overview of the different categories of persons coming to Belgium within the context of an international conventions which are not coordination patient stays (not by means of a prior authorization document E112/S2 or within the context of a cross-border cooperation agreement) for 2004 – 2007.

Table 4.14: Overview of categories of patients (except coordination patients) within the context of an international convention, based on the HBD database

A. Inpatient care

		Numbers of patient stays					
SIS2	**categories of patients**	**2004**	**2005**	**2006**	**2007**	**2008**	**TOTAL**
301	cross-border worker, costs refundable by competent country	8,468	11,535	12,283	10,409	9,289	51,984
307	temporary stay, costs refundable by competent country	6,897	8,868	9,459	10,696	7,525	43,445
317	pensioner, costs refundable by competent country	6,571	8,236	9,237	4,683	3,244	31,971
305	employee, costs refundable by competent country	812	1,003	1,114	1,221	900	5,050
321	retired cross-border worker, costs refundable by competent country	340	444	469	549	374	2,176
701	cross-border worker, special category for refunding of costs	215	314	236	2	0	767
309	emergency healthcare, costs refundable by competent country	264	94	6	0	0	364
607	temporary stay, costs not refundable by competent country	113	92	100	45	27	377
605	employee, costs not refundable by competent country	113	117	80	20	5	335
617	pensioner, costs not refundable by competent country	53	82	45	24	14	218
TOTAL		24,594	31,018	30,925	27,812	21,530	135,879

B. Day care

		Numbers of patient stays			
SIS2	**categories of patients**	**2006**	**2007**	**2008**	**TOTAL**
301	cross-border worker, costs refundable by competent country	15,307	16,054	14,975	46,336
307	temporary stay, costs refundable by competent country	7,429	9,151	7,799	24,379
317	pensioner, costs refundable by competent country	5,454	5,879	5,446	16,779
305	employee, costs refundable by competent country	1,205	1,316	1,371	3,892
321	retired cross-border worker, costs refundable by competent country	565	551	432	1,548
302	cross-border worker, costs refundable by competent country, disability insurance	218	191	186	595
701	cross-border worker, special category for refunding of costs	323	3	0	326
319	family members of employees, costs refundable by competent country	73	76	74	223
605	employee, costs not refundable by competent country	96	44	17	157
607	temporary stay, costs not refundable by competent country	62	59	33	154
TOTAL		30,925	33,514	30,441	94,880

The SIS2 code 307 is used for a French tourist who visits Belgium and is in need for an emergency medical intervention or treatment. This treatment will be granted by means of the European Health Insurance Card (EHIC).

Code 309 as SIS2 is used for a medical intervention or treatment granted to expats or students who did not change their domicile. An example is a French expat who resides in Belgium and has the need for an immediate medical intervention. This notion of 'immediate' is not necessary to be able to obtain the treatment or intervention.

It became clear that patient stays within the context of an international convention are not only those patients coming to Belgium for elective interventions, but also includes patient stays within the context of emergency care (SIS2= 307), pensioners (SIS2= 317), employees (SIS2= 305), cross-border workers (SIS2= 301) etc.

The group of foreign patients in Belgium is larger than only those coming for elective surgery by means of a prior authorization, based on a E112 or S2 document, of patients coming within the context of ZOAST, INTERREG and IZOM agreements.

4.3.3. Integrated overview for inpatient care for year 2008

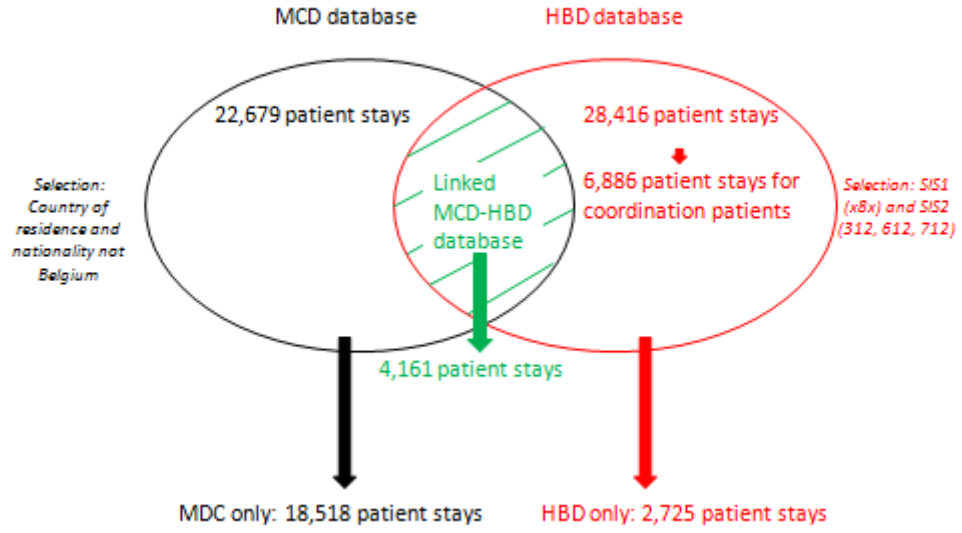
As an example, the volumes of foreign patient stays, based on the different data sources will be discussed by means of figure 4.12. Only data for inpatient care for year 2008 is discussed.

Based on the selection criteria used within the MCD database (country of residence and nationality not Belgium to select foreign patient stays), 22,679 patient stays were selected (cfr. Table 4.9). Based on the HBD database, 28,416 stays were selected when based on the criterion 'international convention' (based on SIS1= x8x, table 4.14). When using the SIS2 codes for coordination patients (SIS2= 312, 612, 712) on top of the selection based on SIS1 'international convention' 6,886 stays were selected (table 4.15). within the linked MCD-HBD database (based on the 22,679 stays within MCD and 6,886 stays within HBD database), 4,161 foreign patient stays were selected (table 4.17). This volume of 4,161 stays represent 60 % of the stays selected within the HBD database based on SIS1 and SIS2, and represents only 18 % of the foreign patient stays selected within the MCD database when using the selection criterion foreign country of residence and foreign nationality.

There are still 18,518 stays (or 82 % of the 22,679 stays) within the MCD database that were selected based on a foreign nationality and a foreign country of residence for which no data in the HBD database is available. We can assume that this volume represents direct billing and contracting patient stays, or foreign patients (with a foreign nationality and foreign country of residence) who are insured in Belgium.

On the side of the HBD database, there are 2,725 stays (or 40 % of 6,886 stays) that were selected based on the criterion 'international convention' (SIS1=x8x) and 'authorization for healthcare treatment abroad' (SIS2= 312, 612, 712). This volume of 40 % represents linkage problems between the MCD database and HBD database [123].

Figure 4.8: Overview of foreign patient flows based on different databases



4.4. Results of the hospital reports

In this part, the foreign patient flows are visualized in the participating hospitals. In the second part, a comparison is made between the data provided by the hospital and the data from the national MCD and HBD databases.

Six Belgian hospitals (three contracted type and three border type) participated in the case studies. Excel sheets from four hospitals (two border type and two contracted type hospitals) were complete. One hospital provided enough information to visualize the foreign patient flows, but did not provide enough detailed information on the different types of foreign patient to allow a comparison of the data provided by the hospital and the

The hospitals defined a foreign patient as a patient with a foreign country of residence or with a foreign status of insurance. The hospitals' billing and administrative data were the basis for the identification of foreign patient flows.

4.4.1. Characteristics of hospitals included in the survey

Five hospitals accepted to participate to the survey and to provide data.

Table 4.15 : Characteristics of the hospitals which participated to the survey

Hospital	A	B	C	D	E
Size	medium-sized hospital (with more than 500 beds)	medium-sized hospital (with more than 500 beds)	medium-sized hospital (with more than 400 beds)	medium-sized hospital (with more than 400 beds)	medium-sized hospital (with more than 200 beds
Location	Flanders	Flanders	Flanders	Brussels	Brussels
Type	contract	Border	border	contract	contract
			No data received on outpatient	No data received on outpatient	

4.4.2. *Evolution of the share of foreign patients in the case study hospitals*

The flows of foreign patient stays in the different hospitals in figures 4.13-4.17 are based on the data provided by the hospital, and are described only for hospital A.

As one can see, the outpatient care constitute the largest part (more than 7 % in 2010 of all outpatient care was delivered to foreign patients) of foreign patients in hospital A. Inpatient care for foreign patients constitute in 2010 5.5 % of the total inpatient care in the hospital, and for day care, the volume of foreign patients is limited to less than 1 % of total day care stays in the hospital. Total numbers of foreign patients do not exceed 4 % of total admissions in hospital A.

Figure 4.9: Evolution of the share of foreign patients in hospital A.

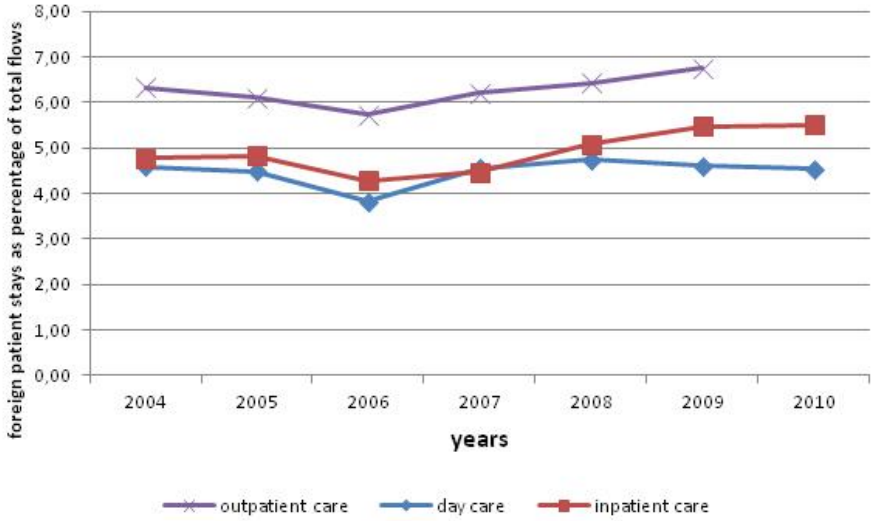


Figure 4.10: Evolution of the share of foreign patients in hospital B.

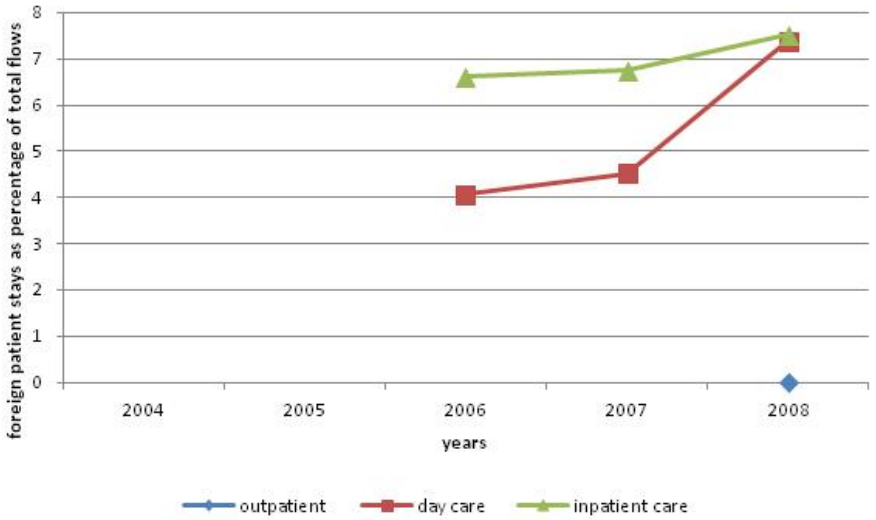


Figure 4.11: Evolution of the share of foreign patients in hospital C.

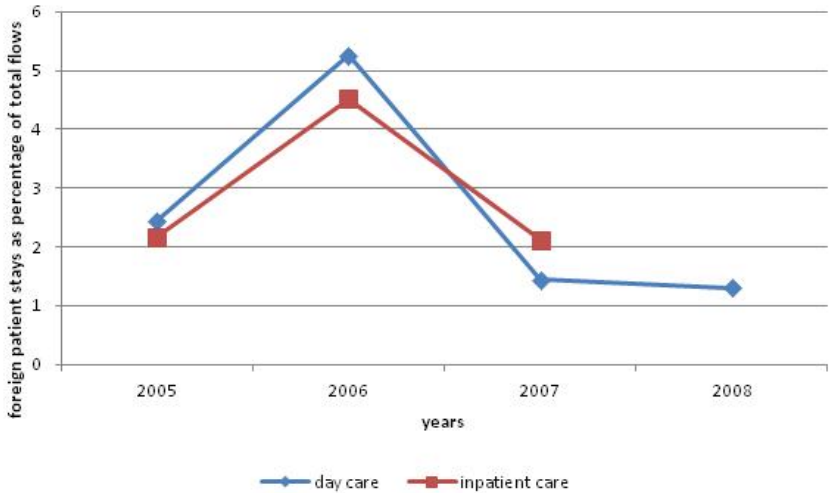


Figure 4.12: Evolution of the share of foreign patients in hospital D.

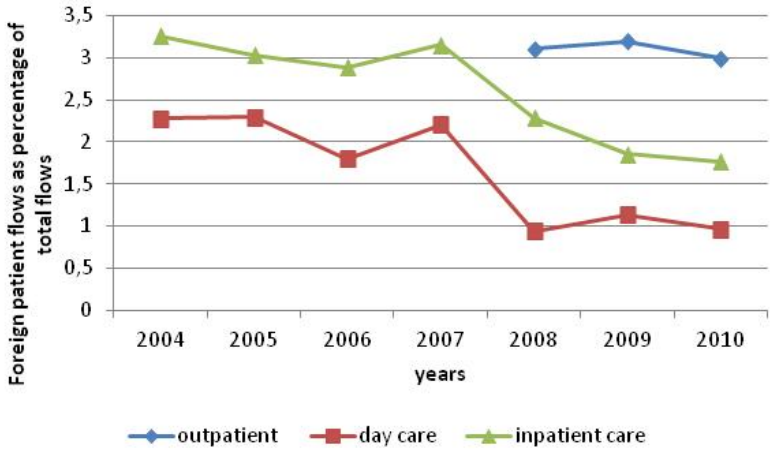
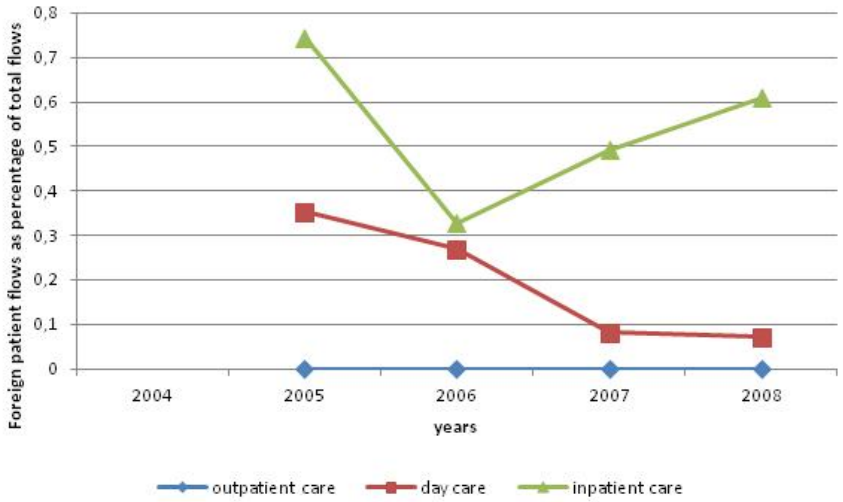


Figure 4.13: Evolution of the share of foreign patients in hospital E.



4.4.3. Differences in tariffs charged

We will only present those categories for which hospitals charged a different price.

Only four hospitals provided us information on the tariffs they charge.

A comparison of the tariffs charged in the different case study hospitals, for the fictive example of the hip arthroplasty (A) and for the menisectomy (B) has been performed (detailed table in appendix, main results described below).

Hospital A does not charge a different price if the patient is a Belgian or foreign patient, even not if the foreign patient is a patient from outside the EEA who comes on its own initiative, both for the hip prosthesis and the menisectomy.

Hospital B however charges the same price for a foreign patient who comes with a prior authorization document E112/S2 as for a foreign non-EEA patient who comes on its own initiative, both for inpatient care. In hospital B, patients with a prior authorization document E112/S2 have to recover the costs made in the hospital, themselves with their foreign healthcare insurer. The hospital also charges a higher tariff charged by the treating doctor and a higher lump sum for laboratory testing to EEA-E112/S2 and non-EEA patients for inpatient care for EEA-E112/S2 and non-EEA patients in comparison with a Belgian patient. Hospital B, the supplements for a stay in a private room for day care procedures are also higher for EEA-E112/S2 and non-EEA patients than for Belgian patients.

Hospital C charges the same prices for Belgian and foreign EEA patients with a prior authorization document E112/S2. For non-EEA patients, a higher price (due to higher co-payments for cost of hospital stay) is charged to the patient for inpatient care. For day care procedures, the same supplements are charged to Belgian, EEA and non-EEA patients. Only for non-EEA patients, a higher lump sum day care is charged.

Hospital D charged a higher price to non-EEA patients for inpatient care, due to a higher co-payment for the cost of the hospital stay. No higher supplements are charged to EEA-E112/S2 or non-EEA patients.

4.4.4. Comparison of case mix between different foreign patient flows

We asked the participating hospitals also to provide us information on pathologies and treatments of the different categories of foreign patients, by using the APR-DRG codes or the nomenclature codes Only for two hospitals is a comparison possible between the treatments/procedures for patients with a prior authorization document E112/S2 and patient coming to Belgium by means of a contract concluded between the hospital and a foreign healthcare insurer. Unfortunately, no definite conclusion can be drawn for these two case studies. All detailed results are presented in appendix.

4.5. Comparison of the results of the macro analysis and hospital reports

A comparison is made between the data provided by the case study hospitals and the data available within the national databases. This comparison is useful to evaluate if the national databases are able to provide a factual picture of the foreign patient flows in Belgian hospitals, and to identify the other categories of foreign patients besides patients coming to Belgium within the context of the EU Coordination Regulations and cross-border cooperation agreements. Other important flows are direct billing and contract patients.

Because of privacy reasons, the codes for the different hospitals are changed in this part in comparison to 4.3.1.2.

4.5.1. Hospital A

Hospital A was not able to provide detailed data for years 2004 and 2005 (table 4.28). Hospital A realized in 2006 290, in 2007 325 and in 2008 570 foreign patient stays based on the national databases MCD and HBD. The volumes of foreign patient stays, identified by the hospital, were for years 2006 and 2007 higher than the volumes that were identified based on the national databases, but for 2008, the volumes based on the national databases were higher. The volumes of patient stays from patients within the EEA identified by the hospital are higher than the volumes that could be identified based on the national databases, as well for the volumes of patient stays of patients from inside the EEA who came with a prior authorization. Contract and direct billing patient stays are not identifiable based on the national databases, and therefore data of the individual hospital are necessary. Within the national databases, for 119 patient stays for inpatient care MCD data were not linked to HBD data (for 2007: 69 and for 2006: 71 patient stays). The hospital identified in 2008 1 patient stay by means of contracted care with a foreign healthcare insurer. The remainder category of this hospital included for 2008 for inpatient care 86 patient stays (identified by the hospital). This category might include direct billing patients. In this hospital, the direct billing patient stays constitute a much larger group of stays than contracted care patient stays, because this hospital has concluded some contracts with foreign healthcare insurers in more recent years, so these patient flows are not yet identifiable in the national databases.

Table 4.16: Comparison of hospital data with national databases for hospital A

		number of foreign patient stays									
		2004		2005		2006		2007		2008	
		hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD
inpatient care	total number of EEA	NA	120	34	83	193	112	188	116	216	160
	EEA - prior authorization	NA	14	NA	3	124	16	120	16	129	25
	EEA - contracts	NA	81	NA	54	0	71	0	69	1	119
	EEA - remainder category	NA		NA		69		68		86	
day care	total number of EEA	NA	NA	130	NA	281	175	326	208	296	407
	EEA - prior authorization	NA	NA	NA	NA	142	9	153	22	141	11
	EEA - contracts	NA	NA	NA	NA	0	147	0	166	1	382
	EEA - remainder category	NA		NA		139		173		154	
non EEA	inpatient care	NA	3	0	2	0	0	1	0	0	0
	day care	NA	NA	2	NA	3	3	0	1	1	3
TOTAL						477	290	515	325	513	570

NA: not available

4.5.2. Hospital B

Table 4.29 provides an overview of the comparison of the volumes of foreign patient stays between the national databases and the data provided by the hospital.

Hospital B could not provide us more detailed information on the different categories of foreign patient stays for day care for years 2004-2007. The volumes of foreign patient stays for inpatient care are approximately steady based on the national databases. The volume of contracted patient stays for inpatient care appeared to increase over time until 2007, and then a decrease is noticed, due to a change in the billing system of the hospital. The total volume of foreign patient stays is also characterized by a decline of foreign patient stays from 2007 to 2008, when based on the data of the hospital. This decline is less distinct when the national databases are used.

The volumes of foreign patient stays by means of a prior authorization show a large difference according to the data source that is used. Based on the national databases, 2, 14 and 16 patient stays are identified for inpatient care for years 2006, 2007 and 2008 respectively. However, when we use the data of the hospital, 353, 323 and 289 patient stays by means of a prior authorization are identified. It is possible that some contracted patient stays were executed into practice by means of a simplified authorization procedure, and are thus categorized as patient stays by means of a prior authorization instead of contracted stays or stays for which no linked MCD and HBD is available. It might also be possible that some direct billing patient stays are categorized as patient stays with a prior authorization, when for example these patients has some kind of authorization document from their healthcare insurer. The hospital identified a large number of patient stays within the remainder category. These stays might include direct billing patients. When we might assume that some patient stays for inpatient care are categorized as stays by means of a prior authorization, but are in practice stays by means of a contract with a foreign healthcare insurer, or are stays of direct billing patients, the volume of these stays (contract + remainder category) approaches more the volume of stays that is identifiable based on the national databases for these categories.

In comparison to hospital A received hospital B more patients from outside the EEA.

In hospital B, it seems that direct billing patients are more omnipresent than contracted patients, when assuming that the greater part of the remainder category presents direct billing patients.

Table 4.17: Comparison of hospital data with national databases for hospital B

		number of foreign patient stays									
		2004		2005		2006		2007		2008	
		hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD
inpatient care	total number of EEA	950	909	884	875	857	833	844	819	713	810
	EEA - prior authorization	468	437	428	337	353	2	323	14	289	16
	EEA - contracts	28	256	89	244	95	732	98	680	33	740
	EEA - remainder category	454		367		409		423		391	
day care	total number of EEA	687	NA	746	NA	565	526	673	690	386	887
	EEA - prior authorization	NA	NA	NA	NA	NA	58	NA	3	57	5
	EEA - contracts	NA	NA	NA	NA	NA	393	NA	601	11	862
	EEA - remainder category	NA		NA		NA		NA		318	
non EEA	inpatient care	177	206	178	191	152	183	275	338	112	160
	day care	112	NA	106	NA	116	134	185	226	39	183
TOTAL						1.690	1.676	1.977	2.073	1.250	2.040

NA: not available

4.5.3. Hospital C

Table 4.18 provides an overview of the comparison of the volumes of foreign patient stays between the national databases and the data provided by the hospital.

Hospital C could not provide us more detailed information on the different categories of foreign patient stays for day care for years 2004-2005. The total volume of foreign patient stays increases over time when using the national databases as well as the data provided by the hospital. The volumes of contracted patient stays largely increases over time, both for inpatient and day care. For inpatient care, the volumes of direct billing patients decreases over time, whereas for day care, these volumes of direct billing patient is increasing. For years 2006 and 2007, the number of patient stays by means of a prior authorization identified by the hospital are larger than the volumes identified based on the national databases. This might be due to the fact that some contracted patient stays occur by the appliance of simplified authorization procedures, and perhaps are therefore classified as stays by means of a prior authorization instead of a contracted stay. The remainder category for inpatient care decreases over time, but increases over time for day care. This decreasing trend for inpatient care for the remainder (direct billing) patient stays might be due to the fact that this hospital concluded more contracts with foreign healthcare insurers over time. The volumes of patient stays from outside the EEA are not so large as in hospital B and are roughly stable.

In this hospital (in contrast to hospital A and B) contracted care is more important than direct billing patients.

Table 4.18: Comparison of hospital data with national databases for hospital C

		number of foreign patient stays									
		2004		2005		2006		2007		2008	
		hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD
inpatient care	total number of EEA	NA	1.466	NA	1.553	1.538	1.783	1.718	1.955	1.918	2.579
	EEA - prior authorization	NA	626	NA	441	646	594	687	613	364	89
	EEA - contracts	NA	758	NA	1.034	644	1.146	832	1.297	1.447	2.416
	EEA - remainder category	NA		NA		248		199		107	
day care	total number of EEA	NA	NA	NA	NA	744	682	1.023	1.001	1.676	1.903
	EEA - prior authorization	NA	NA	NA	NA	282	57	249	103	244	24
	EEA - contracts	NA	NA	NA	NA	189	621	439	856	827	1.866
	EEA - remainder category	NA		NA		273		335		605	
non EEA	inpatient care	NA	25	NA	14	4	19	8	15	5	11
	day care	NA	NA	NA	NA	14	11	6	9	7	10
TOTAL						2.300	2.495	2.755	2.980	3.606	4.503

NA: not available

4.5.4. Hospital D

Table 4.19 provides an overview of the comparison of the volumes of foreign patient in hospital D. The volume of foreign patient stays increases over time in hospital D. This is partly due to the increasing volume of contracted (inpatient and day) care. Over five years, these volumes has almost doubled for inpatient and day care. This is also reflected in the decreasing volumes of patient stays within the remainder category. This remainder category consists of patient stays of patients who came to hospital D for a treatment which was not covered in the contract concluded between the hospital and the foreign healthcare insurer. The volumes of foreign patient stays by means of a prior authorization document for inpatient care, identified in the national databases, are larger than the volumes identified by the hospital for these patient stays. This might be due to the fact that some contracted patient stays occur by the appliance of simplified authorization procedures, and perhaps are therefore classified as stays by means of a prior authorization instead of a contracted stay. For day care, the opposite is true for years 2006 and 2007: in the national databases, less patient stays with a prior authorization were identified than the hospital indicated.

In this hospital (as in hospital C and in contrast to hospital A and B) contracted care is more important than direct billing patients.

The volumes of patient stays from outside the EEA are not so large as in hospital B and are roughly stable.

Table 4.19: Comparison of hospital data with national databases for hospital D

		number of foreign patient stays									
		2004		2005		2006		2007		2008	
		hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD	hospital X	MCD-HBD
inpatient care	total number of EEA	1.499	1.341	1.532	1.350	1.340	1.282	1.429	1.384	1.603	1.854
	EEA - prior authorization	98	92	108	104	130	251	119	454	119	542
	EEA - contracts	794	1.156	770	1.131	769	904	1.054	814	1.285	1.225
	EEA - remainder category	616		657		448		262		206	
day care	total number of EEA	1.925	NA	2.072	NA	1.805	1.767	2.158	2.240	2.277	3.209
	EEA - prior authorization	46	NA	35	NA	81	62	77	46	151	260
	EEA - contracts	962	NA	1.107	NA	1.140	1.675	1.644	2.150	1.796	2.917
	EEA - remainder category	923		932		587		443		334	
non EEA	inpatient care	9	10	3	5	7	7	6	7	4	5
	day care	6	NA	2	NA	3	2	6	4	4	12
TOTAL		3.439		3.609		3.155	3.058	3.599	3.635	3.888	5.080

NA: not available

4.5.5. *Comparison of the data of all case study hospitals for year 2008 with national databases*

Table 4.20 gives a comparison of case study hospitals A, B, C and D for year 2008.

In hospital C and D, patient stays of the contracting type are more important than direct billing patient stays, when assumed that the remainder category consists largely of direct billing patients. Hospital B, as opposite to hospitals A, C and D, treats more patients from outside the EEA.

The volumes of foreign patient stays for inpatient care from patients from inside the EEA, are the largest in hospital C. Hospital A treats the lowest volume of foreign patients. The volumes of inpatient care, identified based on the national databases approach the real volumes of patient stays (based on the hospital data) in hospital A and the least in hospital C.

The volumes of foreign patient stays within the context of a contract concluded with a foreign healthcare insurer are the largest in hospital D and the smallest in hospital A. The ability to identify these contracted patient stays within the national databases is limited as there does not (yet) exist a specific code (such as there exist for coordination patient stays by combining SIS1 and SIS2 codes). The volumes of contracted patient stays can thus only be estimated based on the volumes of stays for which there does not exist linked MCD-HBD data in the national databases, as we assume that contracted patient stays are included within the MCD database but not in the HBD database.

Table 4.20: Comparison of the data of all case study hospitals data with national databases

		number of foreign patient stays - 2008							
		hospital A		hospital B		hospital C		hospital D	
		data hospital	MCD-HBD	data hospital	MCD-HBD	data hospital	MCD-HBD	data hospital	MCD-HBD
inpatient care	total number of EEA	216	160	713	810	1.918	2.579	1.603	1.854
	EEA - prior authorization	129	25	289	16	364	89	119	542
	EEA - contracts	1	119	33	740	1.447	2.416	1.285	1.225
	EEA - remainder category	86		391		107		206	
day care	total number of EEA	296	407	386	887	1.676	1.903	2.277	3.209
	EEA - prior authorization	141	11	57	5	244	24	151	260
	EEA - contracts	1	382	11	862	827	1.866	1.796	2.917
	EEA - remainder category	154		318		605		334	
non EEA	inpatient care	0	0	112	160	5	11	4	5
	day care	1	3	39	183	7	10	4	12
TOTAL		513	570	1.250	2.040	3.606	4.503	3.888	5.080

Key points

- **A rough estimation of the overall volume of elective foreign patients is based on the MCD, by counting all hospitalizations from foreign patients not residing in Belgium. This leads to a small but increasing share of foreign patients in Belgian hospitals: for classic hospitalizations from 0.85% in 2004 to 1.29% in 2008, and for day care from 1.14% in 2006 to 2.76% in 2008. These numbers suffer from several possible biases: a possible underreporting in the MCD, and on the other hand a too broad selection (including foreigners actually living in Belgium but with official residence abroad, emergency admissions during vacation period, etc…).**
- **The majority of these patients resides in neighboring countries: Nederland (60 % of classic hosp , 46 % of day care hosp) and France (14% of classic hosp, 24% of day care hosp). A quarter of classic hospitalizations related to the musculoskeletal system (back procedure, hip prosthesis, etc..) and 12% to circulatory system (PCI).**
- **The insurability status of the patients, a variable added in the MCD in 2008, is not yet reliable enough to allow a distinction between the three groups of foreign patients.**
- **It is thus not possible to identify the three types of foreign patients in the administrative databases. Only coordination patients (those coming with a prior authorization document E112/S2) can be specifically identified from the hospital billing database (HDB), but due to poor linkage with MCD, pathology and severity of coordination patients is not available for all of those. Based on the group for which data was available, data show that the case mix of foreign patients coming to Belgium with a prior authorization document E112/S2 is less severe than the case mix of Belgian patients**
- **Contracted care is becoming more important in recent years**
- **Due to the fact that only coordination patients are identifiable within the hospital billing database (because of their social insurance status codes), only conclusions on this category of foreign patient stays were made. Based on the available data, no analysis could be made of the severity-of-illness levels of direct billing and contracted care patients compared to Belgian patients.**
- **The volumes of inpatient care, identified based on the national databases approach the real volumes of patient stays in some, but not in all of the case study hospitals**

5. PATIENT MOBILITY AND FINANCING OF BELGIAN HOSPITALS

This chapter outlines the impact of patient mobility on Belgian hospital financing from a legal point of view.

The chapter starts with a short reiteration of the key principles of Belgian hospital financing relevant within the scope of this research project. We will then focus on the Patient Mobility Act of 4 June 2007 which intended to create a separate financing framework for foreign patients staying in Belgian hospitals. This analysis will follow a *chronological* order. First an overview is given of the reasons underlying this legislative initiative, describing the financial risks of Belgian hospitals when they are confronted with a substantial number of foreign patients using the different patient mobility routes identified above. This is followed by a critical analysis of the financing system introduced by the *original* Patient Mobility Act in order to remedy to the described problems, after which the important modifications brought to the original system by the Health Act of 19 May 2010 will be discussed. The chapter concludes with a closer look at the relation between patient mobility and hospital doctors.

5.1. Key elements of Belgian hospital financing for classic hospital stays

Belgium has a *dual way* of hospital financing, maintaining a dichotomy between financing of costs related to medical interventions, covered by fees of the hospital doctors, and costs related to the hospital stay itself, covered by a closed and prospective *Budget of Financial Means (BFM)*. This split-up, which makes the financing image (already) quite complex, finds it origin in the concern of hospital doctors to maintain their financial autonomy (the majority of them are hired on an independent basis). Nevertheless, the two systems are interconnected, as hospital doctors are legally obliged to transfer a part of the collected fees to the hospital to finance a part of the cost related to the hospital stay, which may not be entirely covered by the fixed BFM.

The Belgian hospital financing system does not know a form of pathology-based financing, based on one integrated price for *all* costs related to a treatment of a certain pathology (medical costs, nursing costs, capital costs, general administrative costs, …) like e.g. the Dutch DBC-system. An overview of different systems of hospital financing is described elsewhere [124, 125].

5.1.1. *Financing medical interventions of hospital doctors: general aspects*

The fee charged by the hospital doctor is considered to cover *all* costs directly or indirectly linked to the delivery of medical interventions (use of medical, nursing and administrative personnel, purchase; repair and maintenance of medical equipment; use of hospital premises; use of medicine,…) *'which are not covered through the Budget of Financial Means'*.[ccxxxi] Medical costs are thus paid through a separate way of hospital financing and refer to medical interventions as such, whereas the BFM is deemed to cover the *working costs* related to the hospitalization of the patient (cf. *infra*).[ccxxxii]

The *collection* of fees for medical services provided to hospitalized patients is however centralized at the hospital level.[ccxxxiii] The hospital will subsequently pay the collected fee to the concerned physician, while withholding an amount in order to cover the costs linked to the medical interventions made, and that are not covered by the BFM.[ccxxxiv]

This contribution (which can be expressed as a real amount or a percentage rate) is determined in the *general agreement* concluded between the hospital and its physician.[ccxxxv]

The actual fee charged to a hospitalized patient depends on whether the hospital doctor has acceded to the tariff conventions agreed upon within the framework of the statutory Health and Disability Insurance (HDI).[ccxxxvi]

'Conventioned' doctors are obliged to apply conventional tariffs to all HDI-patients lying in a non-private hospital rooms (common or two-patient hospital room).[ccxxxvii] If the HDI-patient is staying in private hospital room, it is possible to charge a freely determined fee supplement on top of the conventional tariffs *on condition* it does not exceed a maximum tariff level stipulated in the hospital doctor's general arrangement with the hospital.[ccxxxviii]

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ccxxxi Art. 154 Coordinated Act of 10 July 2008 concerning the hospitals and other care institutions[105], further indicated as 'Hospital Act'. One has to remark however that not all hospital doctors are paid fee for service. Art. 146 Hospital Act foresees also other remuneration schemes for which a hospital can opt: remuneration on the basis of the division a 'pool' of fees charged for the whole hospital or hospital service; remuneration on the basis of a contractual or statutory percentage of the same pool or the payment of a salary (labor contract).

ccxxxii Art. 100 Hospital Act.

ccxxxiii Art. 147 Hospital Act.

ccxxxiv Art. 155 §3 Hospital Act.

ccxxxv Art. 144 §3, 4° jo. art. 155 §3 Hospital Act.

ccxxxvi See art. 50 Coordinated Act of 14 July 1994 concerning the statutory sickness and invalidity insurance[71].

ccxxxvii Art. 152 §1 Hospital Act.

ccxxxviii Art. 152 §1 and §6 Hospital Act .

Under certain circumstances, a stay in a private hospital room may not give rise to the charging of fee supplements[ccxxxix]:

- If this is required by the health condition of the patient or is necessary because of the technical requirements of the medical examination, treatment or supervision;
- If this is due to the unavailability of unoccupied non-private hospital rooms;
- For the length of stay at intensive or emergency care, unless the patient has explicitly requested it;
- For children accompanied by a parent, unless explicitly requested.

The maximum supplement level also applies for every conventioned doctor when treating a non-HDI patient.[ccxl] As such, the physician in this case only has a limited freedom to set his fee.[ccxli]

'Non-conventioned' hospital doctors are in principle free to determine their fees, whether patients are lying in a private hospital room or not, on condition this does not exceed the maximum tariff level negotiated in his general agreement with the hospital. As an exception to this general principle, conventional tariffs must be applied in case of:

- Certain types of patients with a low socio-economic profile or a chronic disease[ccxlii];
- In case of an 'involuntary' stay in a private hospital room (see above)[ccxliii].

The hospital has the duty to inform its patients about the convention status of its doctors.[ccxliv] If not, also doctors who did not adhere will only allow to charge maximal convention tariffs.[ccxlv]

Finally, one has to point out that the financing of fees for medico-technical services provided to hospitalized HDI-patients has been partially detached from the classic fee-for-service mechanism. Due to the automation of these services and their exponential increase, these services are now to a large extent financed in a more structural way by charging every patient a lump-sum fee per patient-day and/or admission, irrespective of the number of performed tests. The amount of these lump-sums varies from hospital to hospital and is determined according to complex calculation rules.[ccxlvi]

5.1.2. *Financing of the basis of the Budget of Financial Means*

The financing of costs related to the hospital stay is based on *closed-envelope* budget technique. The idea behind financing through closed budgets lies in the fact that hospitals are made more responsible for the expenses they make (compared to earlier financing methods based on a retrospective payment method covering the real amount of hospital costs). In addition, one wanted to come to a *just* division of limited means.

Every year a global national budget is fixed by the Ministry of Public Health, which is subsequently divided among the Belgian hospitals

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ccxxxix Art. 152 §1 Hospital Act.

ccxl Art. 152 §3 Hospital Act jo. art. 50 §6 HDI-Act 14 July 1994.

ccxli Cf. art. 15 Royal Decree nr. 78 of 10 November 1967 concerning the execution of healthcare professions[126].

ccxlii Art. 152 §5 Hospital Act and its executive Royal Decree of 29 September 2002 in execution of art. 138 Hospital Act [127].

ccxliii Art. 152 §2 Hospital Act. This equal treatment of conventioned and non-conventioned hospital doctors as well as the difference of treatment between patients lying in a private and a non-private hospital room (where the latter can be charged higher fees) are both reasonably justified within the light of the art. 10 and 11 of the Belgian Constitution (Const. Court nr. 2000/36 of 21 December 2000[128]; Const. Court 29 nr. 2009/170 October 2009[129]).

ccxliv Art. 153 Hospital Act.

ccxlv Art. 50 §3bis HDI-Act. See also Const. Court nr. 78/2008 of 15 May 2008[130]

ccxlvi Clinical Biology (laboratory testing): See art. 57-58 HDI-Act and the Royal Decree of 12 November 2008 implementing art. 57, § 2, of the statutory health and disability insurance act, coordinated on 14 July 1994, concerning the calculation rules for the clinical biology lump-sums paid per patient day[131]; Medical imaging (radiology): See art. 69 HDI-Act en Royal Decree 10 March 2009 in execution of art. 69 §1 of the statutory health and disability insurance act, coordinated on 14 July 1994, determining the rules for the calculation of the lump-sum fees for medical imaging paid per admission by hospitalized patients [132].

following the rules set by the Royal Decree of 25 April 2002[ccxlvii] concerning the assessment and payment of the budget of financial means of the hospitals.[ccxlviii] The 'Budget of Financial Means' (BFM) apportioned to every hospital is of a *fixed* and *prospective* nature and is considered to cover all costs related to a patient stay in a non private hospital room including all costs of nursing care.[ccxlix] One has to remark that next to this 'general' BFM, hospitals also receive a number of separate budgets to finance certain hospital services (heavy burns, palliative care, chronic diseases).[ccl] In principle the composition of these separate budgets follows the logic of the general BFM, unless provided otherwise.[ccli]

As an exception to the broad definition of costs covered by the BFM, the Hospital Act lists a number of costs which are explicitly excluded[cclii]:

- fees for diagnosis and medical treatment provided by general and specialized hospital doctors (see above 6.1.1) and certain types of care provided by a number of allied health professionals (e.g. physiotherapist, midwife);
- the costs of pharmaceutical products and specialties[ccliii];
- costs of medical imaging and clinical biology (see above 6.1.1);
- costs of implants, devices and certain medical aids that are not included in the BFM.

Legal controversy exists whether this list of excluded costs must be considered to be *limitative* in nature.[ccliv]

5.1.2.1. Determination of the BFM

Budget components: overview

The (general) Budget of Financial Means is composed out of 16 distinct budget components which are grouped under three major budget parts A, B and C.[cclv] Each budget component relates to a specific type of hospital cost (see below) [cclvi] and is fixed according to a specific calculation method.[cclvii]

ccxlvii Royal Decree 25 April 2002 governing the determination and payment of the budget of financial means of the hospitals. [133]

ccxlviii Art. 95 Hospital Act.

ccxlix Art. 100 (1) Hospital Act. As such, art. 104 Hospital Act explicitly prohibits hospitals to ask patients for a financial contribution to cover costs of care which the BFM already covers on a fixed basis (and thus are included in the average patient-day price determined on the basis of the BFM).

ccl Art. 96 Hospital Act jo. 5 §1 Royal Decree 25 April 2002.

ccli Art. 5 §2 Royal Decree 25 April 2002.

cclii See art. 102 Hospital Act.

ccliii Costs of pharmaceutical specialties are financed through a fixed fee per hospital stay, payable by every patient. See art. 37 §3 HDI-Act and the Royal Decree of 16 May 2006 in execution of art. 37 §3 statutory sickness and invalidity insurance Act, coordinated on 14 July 1994, concerning the determination of a lump-sum granted to hospitals for reimbursable pharmaceutical specialties. [134]

ccliv As such is argued that despite the initially broad scope of costs covered the BFM ('all costs related to stay in common hospital room'), art. 100 Hospital Act also determines that mentioned costs are specified by the Royal Decree (leaving art. 102 Hospital Act to be a non limitative list of costs not mentioned by the Royal Decree of 25 april 2002) . Pro: Court of Appeal Antwerp 30 March 2009[135]; Tribunal of first instance Antwerp 9 April 2009 [136]; Contra: Court of Appeal Ghent 13 January 2008[137]; Court of Appeal Ghent 16 April 2008[138]; See also Court of Cassation 24 January 2005 [139]and Court of Cassation 15 September 2008[140].See further on this question: DIJKHOFFZ, 2009-10. [141]

cclv Art. 7 Royal Decree 25 April 2002.

cclvi Art. 8- 23 royal Decree 25 April 2002.

cclvii Art. 24-85 Royal Decree 25 April 2002.

Table 5.1: Overview of the composition of the BFM *(art. 7 Royal Decree 25 April 2002)*

Budget part A: covers *capital and investment costs*, subdivided in three sub budget parts A1, A2 and A3
Budget part B: covers the *operational costs* of the hospital, and is composed of nine sub-budget parts
B1: communal services (maintenance, administration, transport, heating, catering,…)
B2: clinical services (cost of nursing personnel).
B3: working costs of medical-technical services (MRI, PET, radiotherapy)
B4: costs following from certain legal obligations (hygiene, quality, data registration)
B5: hospital pharmacy
B6: extra-wage charges for medical technical personnel (supplementary social advantages)
B7: scientific research, development of new technologies
B8: specific costs related to patients with a weak socio-economic profile
B9: implementation costs of collective agreements concluded with the nursing personnel
Budget part C: covers additional financial charges (pre-financing of investment costs, , recovery payments due to overspending budget, budget reduction due to charging of supplements for one patient hospital rooms), and is composed of four sub-budget parts C1, C2, C3 and C4

For the matter of this research, it is important to take a closer look at the calculation method of the most important part of the BFM, namely budget component B2 covering the costs of nursing personnel.

Calculation of the B2-part of the BFM

The B2-budget is composed out of two major parts: a basic part based on 'justified beds' and a supplementary part based on activity and care profile.[cclviii] Both are calculated by means of a point scoring system [cclix] using the *Minimal Hospital Data (MHD)* hospitals have to register at the dismissal of every patient, irrespective whether this hospital stay is financed through the BFM or not.[cclx] The MHD fall apart into three different types of data:

- Administrative Data
- Minimal Clinical Data (MCD): provide information on the diagnosis and treatment given to the patient
- Minimal Nursing Data (MND): provide information on the type and amount of nursing care provided per patient day

The HDD have to be registered for six month-periods.[cclxi] Five months after this period (serving data validation and control by the hospital), the HDD must be transferred to the Federal Public Service (FPS) Public Health.[cclxii]

First step: determining number of basic B2-points

The calculation of the basic part of the B2-budget starts from the MCD registered with the FPS Public Health during the three last known years of service. These data are used to divide hospital stays into 355 basic APR-DRG's (*All Patient Refined-Diagnostic Related Groups)*. A further subdivision is then made based on the degree of severity of illness (minor, moderate, major, extreme) and age (<75 y., >75 y., geriatric patients).

Per 'specific' DRG a national average length of stay is determined. From a financing point of view, this national average length of stay is considered to be the **'justified' length of stay** per DRG. Except in case or real short of long stays, hospitals will receive *guaranteed* financing for the whole

cclviii Art. 36 Royal Decree 25 April 2002.

cclix Art. 45-46 and Annex III attached to the Royal Decree 25 April 2002.

cclx See Royal Decree 27 April 2007 determining the rules by which certain hospital data must be communicated to the Minister of Public Health. [142]

cclxi Art. 5 Royal Decree 27 April 2007.

cclxii Art. 6 Royal Decree 27 April 2007.

justified length of stay. In case the actual length of stay is less than the justified one, the hospital can keep the surplus.

The number of justified lengths of stay (i.e. the number of registered hospital stays shorter or equal to the national 'justified' length of stay per DRG) serves to calculate a number of **justified patient days** for each individual hospital based on its case mix of the last known MCD-registration year.

The total number of justified patient days is subsequently assigned to the different nursing departments of the hospital and converted into a number of **justified beds** per department. This is done by dividing the number of justified patient days by the normative capacity utilization ratio of the service[cclxiii], and multiplying the result by 365.

Once the number of justified beds is determined, budgetary points are granted using the minimal nursing staff ratios that have been set in the past for the various types of nursing departments (expressed in FTE=full time equivalent).[cclxiv] For every FTE per justified bed a specific basic point is granted.[cclxv]

Second step: determining the number of supplementary B2-points

On top of the basic B2-points, every hospital is granted a number of supplementary B2-points. Here one could distinguish between general supplementary points and certain categorical supplementary points related to specific types of nursing care.

General supplementary points

Each hospital earns supplementary financial points according to its relative position among all hospitals on the basis of both their nursing profile (according to the hospital's registered MND) and their profile based on medical interventions (using the HDI-nomenclature data). In conformity with this ranking, hospitals are subsequently divided in deciles and points are allocated.[cclxvi] The number of supplementary points per justified bed varies from 0 points for the lowest decile to 0.34 for the highest decile for surgery and internal medicine (C & D-beds) or 0.38 points for pediatrics (E-beds).[cclxvii]

Operating rooms

Additional points are added for the financing of *operating room personnel*. A global financing envelope is determined which takes the form of a number of budgetary OR-points. These are dispersed over all hospitals in proportion to their number of 'justified' operating rooms.[cclxviii] To calculate this number the legislator has established an average 'standard time' for 2200 different types of surgeries.[cclxix] This standard time does not correspond to the duration of the surgery, but is considered to reflect the total use of nursing personnel during the operation.

This standard time is raised with:

- a certain percentage to indicate the time spent to prepare and clean-up the operating room;
- an 'adjustment' coefficient in order to include surgical interventions performed on non-HDI patients.[cclxx]

In order to get the total amount of justified operating rooms, the total amount of 'adapted' standard time for all surgeries performed is divided by (1520 x 3), where 1520 stands for the financed time per operating room and 3 for the financed number of nurses per operating room. Per justified operating room, the hospital earns 7,5 supplementary points.

Services of intensive care

cclxiii The normative capacity utilisation ratios set by the government are 70% for paediatric and maternity services, 80% for surgery, internal medicine, tuberculosis treatment, infectious diseases and regular hospitalisation, and 90% for geriatric services.

cclxiv See art. 45 in fine Royal Decree 25 April 2002. This is for example 0.4 FTE per justified bed for surgery and internal medicine and 2 FTE for intensive care.

cclxv Art. 46 §2 1° a) Royal Decree 25 April 2002.

cclxvi Art. 46 §2 2° Royal Decree 25 April 2002.

cclxvii See GERKENS and MERKUR, 2010 [143], p. 106.

cclxviii See art. 46 §3 2° a) Royal Decree 25 April 2002.

cclxix See Annex IX attached to Royal Decree 25 April 2002.

cclxx This percentage varies from 33% (short operations) to 25% (ordinary operations) and 20% (lengthy operations).

It was already clarified above that hospitals receive a number of supplementary B2-points for every justified C, D and E-bed based on activity-indicators as the HDI-nomenclature and the hospitals care-profile. On top of this general surplus, hospitals gain an additional number of supplementary points for the part of these beds that have been classified as *intensive care beds*.[cclxxi]

These additional points for intensive-care beds are determined based on three indicators:

- Number of CPR procedures done in the C, D and E-division of the hospital (selected list based on HDI-nomenclature data). On the basis hereof hospitals are ranked into deciles and points are awarded. 20% will be taken into account;
- Care profile determined on the basis of Minimal Nursing Data. On the basis hereof hospitals are ranked into deciles and points awarded. 40% will be taken into account[cclxxii];
- National percentage of intensive days determined per APR-DRG (on the basis of MCD) (40%)[cclxxiii].

On the basis hereof hospitals are ranked into deciles and points are awarded. 40% of them will be taken into account.

To g the eventual number of supplementary points, one must multiply the total number of points gathered from the three calculations above with the number of justified C, D and E-beds, and subsequently divide it by 4.

Third step: determining the financial value per B2-point

The financial value of all these points is calculated by dividing the national prospective B2-budget by the totalized number of (basic and supplementary) B2-points of every hospital concerned.[cclxxiv] Subsequently, a final B2 budget calculation is done for each hospital by multiplying the financial value per point with the amount of B2-points the hospital has gathered.[cclxxv]

5.1.2.2. Payment of the BFM (Situation before Patient Mobility Act of 4 June 2007)

The BFM is split-up in a fixed and a variable part.[cclxxvi] The fixed part is composed of the budgetcomponents A1, A2, A3, B3, B4, B5, B6, B7, B8, B9, C1, C2, C3 as well as 80% of the B1 and B2 components.[cclxxvii] The remaining 20% of B1 and B2 is considered to be the variable part of the BFM, and as such can be exceeded (contrary to the fixed BFM-part). [cclxxviii]

For the payment of both the fixed and the variable part of the BFM one has to distinguish between two types of patients:

- Patients insured by the Belgian statutory health and disability insurance (HDI)
- Patients not insured by the Belgian statutory health and disability insurance (non-HDI)

Therefore both the fixed and variable part are subsequently split up into a HDI-part and a non-HDI part on the basis of the number of HDI and non HDI patient-days registered by the hospital during the last known year of registration.[cclxxix]

Hospital stays of patients covered by a Belgian health insurance fund are financed out of the fixed and variable HDI-parts of the BFM.

The fixed HDI-part is paid out in *twelfths* by the national federations of the different health insurance funds[cclxxx] in proportion to their share of the

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cclxxi See art. 46§2 2° c) Royal Decree 25 April 2002.

cclxxii See annex VII attached to the Royal Decree 25 April 2002.

cclxxiii See annex VIII attached to Royal Decree 25 April 2002.

cclxxiv Art. 45 §5-6 Royal Decree 25 August 2002.

cclxxv Art. 45 §7 Royal Decree 25 August 2002.

cclxxvi Art. 95 Hospital Act and art. 4 Royal Decree 25 April 2002.

cclxxvii Art. 86 §1 Royal Decree 25 April 2002.

cclxxviii Art. 86 §2 Royal Decree 25 April 2002.

cclxxix Art. 86 §3 Royal Decree 25 April 2002.

cclxxx Art. 99 §1 of the Royal Decree of 25 April 2002 list them as follows: The National Federation of Christian sickness Funds, the National Federation of Socialist Sickness Funds, the National Federation of Liberal Sickness Funds, the National Federation of Independent Sickness Funds, The

insured patients treated at the concerned hospital during the last known year of service.[cclxxxi] This stable, monthly income prevents that hospitals would suffer from activity fluctuations throughout the year.

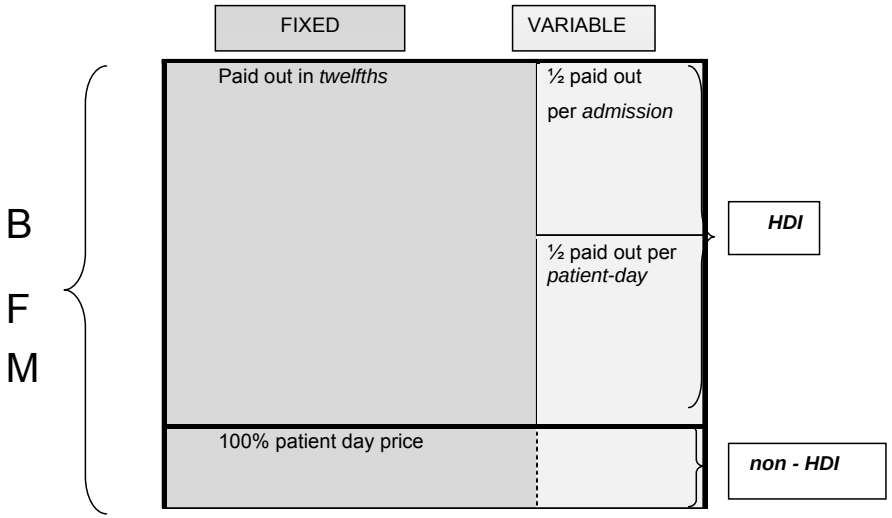
At the other hand, the link with hospital activity remains for the payment of the variable HDI-part. Two different prices are determined here: a price per admission and price per patient-day. One receives the price per admission by dividing 50% of the variable HDI-part by the number of admissions that were realized during the year of service that served as a basis for the calculation of the 'justified activities' of the hospital concerned.[cclxxxii] The price per patient-day is calculated in a similar way by dividing the other half of the variable HDI-part by the number of patient-days during that same year.[cclxxxiii]

One must notice that the payment of the HDI-part of the BFM is not entirely financed out of the means of the statutory health insurance, but only for 77%. The other 23% is at the expense of the FPS Public Health. This state subsidy is transferred to the NIHDI, from where it is distributed over the different sickness funds responsible for the payment of the HDI-part of the hospital's BFM.[cclxxxiv]

Patients not covered by the Belgian sickness insurance will be charged an average patient day price or '100% per diem rate'. This average price is the result of the sum of the fixed and the variable non-HDI part of the BFM that is subsequently divided by the number of non-HDI patient days realized during the last known year of service.cclxxxv

For some non-HDI patients the same state subsidy of 23% will be granted. This will be the case for patients covered by the Public Centers for Social Welfare (OCMW/CPAS), the Overseas Social Security Office (DOSZ/OSSOM), the National Institute for war invalids, war-veterans and war victims (IV-NIOOO/IV-INIG) and the Relief and Provident fund for seafarers (HVKZ/CSPM).

Figure 5.1: Composition and payment of the general Budget of Financial Means (situation prior to Patient Mobility Act of 4 June 2007)



5.1.2.3. Room Supplements

On top of the price determined on the basis of the BFM, the hospital also has the possibility to charge the patient certain *room supplements.* As from the 1st of January 2010, this will only be admitted for a stay in a private hospital room (i.e. single bed room), on condition that at least half of the total number of hospital beds is made available for patients who want to be

National Federation of Neutral Sickness Funds, the Auxiliary Fund for Sickness and Invalidity Insurance and the Sickness fund of the National Belgian Railways (NMBS/SNCB).

cclxxxi Art. 99 §2 a) Royal Decree 25 August 2002.

cclxxxii Art. 99 §2 b) Royal Decree 25 August 2002.

cclxxxiii Ibid.

cclxxxiv Art. 110-111 Hospital Act and Royal Decree 26 June 2002 executing art. 101 of the Hospital Act of 7 August 1987. [144]

cclxxxv See art. 100 Royal Decree 25 August 2002.

hospitalized without supplements (i.e. in non-private rooms with two or more hospital beds).[cclxxxvi]

No supplements for a stay in a private hospital room may be charged under the following circumstances[cclxxxvii]:

- If this is required by the health condition of the patient or is necessary because of the technical requirements of the medical examination, treatment or supervision;
- If this is due to the unavailability of unoccupied non-private hospital rooms;
- For the length of stay at intensive or emergency care, unless the patient has explicitly requested it;
- For children accompanied by a parent. Every hospital is in principle free to determine the amount of room supplements, though the public authority retains the right to fix a maximum supplement level. Unlimited charging of room supplements is also counteracted by the BFM. As such, budget component C3 foresees in a *reduction* of the BFM with a fixed amount to compensate this extra charging[cclxxxviii], as the FPS is of the opinion that as it is financing all nursing personnel (also for care provided in one-patient rooms) part of the charged room supplements should flow back to the Treasury.[cclxxxix]

[cclxxxvi] Art. 97 §1 Hospital Act, as modified by the Program Act of 23 December 2009[145].

[cclxxxvii] Art. 97 §2 Hospital Act.

[cclxxxviii] Art. 83 §1 Royal Decree 25 April 2002. If the real amount of room supplements charged lies below the amount fixed in budget-component C3, the latter can be revised on the explicit demand of the hospital director. In this case, the revised reduction of the BFM may not exceed 80% of the amount of supplements charged during the year for which the revision has been demanded (art. 83 §2 Royal Decree 25 April 2002).

[cclxxxix] DURANT, 2010, 107. [146]

5.1.3. Financing of day-care hospital stays

5.1.3.1. Day-care

Since 1987, financing of day-care is regulated through *tariff agreements* negotiated between hospitals and sickness-funds at the level of the NIHDI.[ccxc] These agreements determine a number of *lump-sums*, hospital specific or not, which are linked to a number of nomenclature codes. Whenever the hospital provides a service relating to one of these codes, the corresponding lump sum can be charged.

The current Agreement of 24 June 2011[ccxci] (valid until 30 June 2013) foresees in the following lump sums:

- A hospital specific mini lump sum, equal to 1/2 of the B2-part of the patient-day price (100% per diem rate), calculated on the basis of the BFM, chargeable for:
  - Urgent admissions
  - Intravenous therapy for therapeutic reasons
- A hospital specific maxi lump-sum, equal to the B2 part of the patient-day price (100% per diem rate), chargeable for:
  - General anesthesia
  - Administering chemotherapeutic agents (A-medication)
- Day hospital lump-sums: seven groups of lumps sums, bundling a a selection of nomenclature codes. The lump sum payments vary between 140 and 247 EUR
- Lump sum “chronic pain”: 3 lump sum payments with corresponding
- (new) nomenclature codes and payments varying between €72 and €196.
- Lump sum “plaster room”: a fixed amount of €26.10
- Lump sum hemodialysis

According to art. 1 of the Agreement, this financing framework remains limited to day-care services offered to beneficiaries of the Belgian statutory health insurance. It is not clear however how the financing of general day care offered to non-HDI patients is regulated. Most probably, the abovementioned lump-sums are applied per analogy.

5.1.3.2. Day surgery centre

Since the 1st July 2002, the day surgery centre is financed through the hospital’s BFM. The general costs are included in budget part B1 and costs specific to the day-surgery centre and its activity in the operating room are included in budget part B2. For the latter, a number of justified beds is calculated based on the justified activities of the day surgery centre.[ccxcii] This concerns two types of stay:

- Stays registered in day care (through the MHD-registration) for which at least one surgical nomenclature code from a specified list (*List A*) was recorded
- Unjustified *in*patient stays for which a nomenclature code from a specified list (*List B*) was recorded
- Unjustified inpatient stays must meet all of the following criteria:
  - It involves one of 32 selected APR-DRG’s
  - It concerns an inpatient stay
  - It concerns a scheduled admission
  - The length of stay is maximum three days
  - The stay has a severity of illness rate of I (minor)
  - The patient did not die during the stay
  - The stay has a risk of mortality of I (low)
  - The patient is under 75 years of age

The total number of justified stays in a surgical day hospital is the sum of all stays in surgical day centre and all unjustified inpatient hospitalizations. Each justified stay receives a justified length of stay of 0.81 days. This will be the basis for calculating the number of justified beds for the surgical day

ccxc See art. 42 HDI-Act.

ccxci National Agreement Hospitals-Insurance Institutions, 24 June 2011. [147]

ccxcii See Annex III attached to the Royal Decree of 25 April 2002.

clinic (see higher). This number of justified beds is taken up as C-beds in the B2 calculation of the BFM.

5.1.4. Financing capital costs

In Belgium the regional authorities (Communities) financially intervene for the costs of new hospital buildings and the purchase of the first medical equipment and instruments. This subsidy was originally limited to a maximum of 60%[ccxciii], were the other 40% is debited through budget component A1 of the BFM.[ccxciv] However, if it concerns hospital infrastructure which is considered of having 'priority', a percentage division of 90% federal means (through the BFM) and 10% regional capital subsidies is maintained.[ccxcv] For both financial interventions, it is necessary that the regional authorities approve a building calendar indicating the proceedings of the planned construction works.[ccxcvi]

The financial intervention of the Communities for the construction of new hospital buildings or the extension of existing infrastructure is however limited by a maximal building cost level and a maximal building surface level determined for every hospital individually.[ccxcvii] If building plans exceed these levels, the subsidy will only be granted if the hospital bears the cost surplus.

Key points

- **Medical costs are financed through the fees charged by healthcare professionals working in the hospital. Whatever the remuneration scheme, hospital doctors contribute part of their income to the hospital to help finance their activities in the hospital. Conventioned doctors have to respect conventional tariffs, unless supplements are legally possible. Unconventioned doctors determine their fees freely, in respect of the maximum tariff set in the hospitals' general agreement**
- **Financing of non-medical costs is done through a closed and prospective budget of financial means determined on the basis of the APR-DRG related 'justified activity' of the hospital. The BFM is composed out of a fixed and variable part and a HDI and non-HDI part**
- **The payment of the fixed HDI-part of the BFM is done in twelfths by the Belgian sickness funds. On the basis of the the variable HDI-part both a price per day and a price per admission are calculated chargeable to the patients sickness fund. On the basis of the non-HDI part of the BFM a 100% per diem rate is calculated chargeable to the patient himself.**
- **In certain legally defined occasions it is possible for the hospital to charge an room supplement on top of the prices determined on the basis of the BFM**

ccxciii Art. 63 Hospital Act and art. 3 §1Royal Decree 13 December 1966 determining the subsidy percentage for the construction, reconditioning, equipment and instruments of hospitals and the conditions under which these are granted[148].

ccxciv See art. 9 and 24-29 Royal Decree 25 April 2002.

ccxcv Art. 3 §1bis Royal Decree 13 December 1966. Are considered to be 'priority' investments: 1) investments necessary to fulfil new hospital recognition norms, 2) investments leading up to a rationalization of the healthcare offer (internal reorganization, interhospital collaboration) (, 3) investments in day-care and 4) investments aiming at the improvement of accessibility and patient comfort.

ccxcvi Art. 64 Hospital Act and Royal Decree 4 May 1999 determining the general criteria to fix and approve the calendar referred to in art. 46bis, par. 1Hospital Act of 7 August 1987 for the public authorities meant in art. 128, 130 and 135 of the Constitution[149].

ccxcvii See Ministerial Decree 11 May 2007 determining the maximum cost taken into account to subsidize the construction, extension or reconditioning of a hospital or a hospital service[150].

5.2. Patient mobility and hospital financing: the Patient Mobility Act of 4 June 2007

5.2.1. *Tension between patient mobility and closed budget financing*

Already in 2003, at the occasion of the conclusion of the bilateral framework agreement with the British NHS, several members of parliament expressed their doubt on the compatibility of the system of hospital financing with a potentially increasing inflow of foreign patients in Belgian hospitals, as they were confronted with the emergence of new, simplified patient mobility routes such as cross-border contracting between Belgian hospitals and foreign healthcare insurers.[ccxcviii] In its advice of 12 February 2004[ccxcix] also the National Board of Hospital Institutions (NBHI) pointed at several financial risks of hospitalizing a large number of foreign patients and suggested to create a separate financing framework outside of the BFM that would allow hospitals to charge a price that would at least cover the real costs of hospitalization. At that time however art. 104ter of the old Hospital Act of 7 August 1987[ccc] , as inserted by the Act of 14 January 2002, explicitly prohibited hospitals to charge non-HDI patients another than the average patient day price. This was done in order to prevent a system of hospital care at divergent speeds, where less lucrative domestic patients would meet problems to access healthcare due to an inflow of wealthy foreign patients.

In 2007 the Belgian legislator took action to tackle some of the financing problems caused by the treatment of foreign patients in Belgian hospitals. The suggested solutions, eventually introduced by the Law of 4 June 2007 on the improvement of patient mobility[ccci], were heavily inspired by a white paper of the Belgian Employers Federation favoring the internationalization of the Belgian medical sector[cccii] and a Parliamentary resolution of 1 June 2006 on the mobility of patients within the European Union.[ccciii]

Looking at the parliamentary preparations, one could discern three main problems related to patient mobility that led the initiators of the Law of 4 June 2007 to undertake legal action.

5.2.1.1. *First problem: patient mobility as impediment to an (equal) growth of the overall hospital sector*

An increasing inflow of foreign patients would detriment the development of the Belgian hospital sector as a whole if these patients were kept included in a hospital financing system based on the annual granting of a *closed* and *prospective* Budget of Financial Means (BFM).[ccciv] This is substantiated by referring to the calculation method of budget component B2 (see above), which covers the costs of the 'clinical services' (nursing, care staff and medical products). It constitutes by far the most important part of the overall BFM.[cccv]

For certain hospitals oriented on patient mobility an increased inflow of foreign patients could mean a substantial raise of justified patient days (possibly up to the maximum limit of 112% of the recognized beds[cccvi]). This leads to an increase of budgetary points, and consequently the assignment of a larger B2-budget.

This positive financial effect for the hospital concerned will however be only of short-duration and moreover detrimental to the rest of the hospital

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ccxcviii CRIV 50 COM 975, 5-25[151]

ccxcix Advice NBHI of 12 February 2004[65]

ccc Actual art. 116 §1 Hospital Act.

ccci Act of 4 June 2007 modifying the legislation with a view to improve patient mobility[152], further indicated as the 'Patient Mobility Act'.

cccii VBO-FEB, 2006. [153]

ccciii Chambre of Representatives, nr. 51/2538/003. [154]

ccciv Bill modifying legislation in order to improve patient mobility, Chamber of Representatives, 51/2966, 5-6. [155]

cccv CORENS, 2007, 76. [156]

cccvi The number of justified beds above the limit of 112% of recognized beds will only be financed for 50%. (Annex III attached to Royal Decree 25 April 2002).This financial sanction is meant to refrain hospitals from unlimited expanding their activity (treat more patients to elevate justified activities), averse from any planning criteria. As such they cannot (illimitedly) add extra, unrecognized beds to increase profit. See SERMEUS, 2006, 66. [109]

sector, in particular to those hospitals that are less oriented on exporting healthcare. This is mainly due to the closed nature of the BFM, both at national and at hospital level. At national level, an activity increase due to an inflow of foreign patients for one hospital will result into the assignment of a lower BFM to other hospitals receiving less foreign patients. At hospital level, overriding the fixed part of the BFM due to an activity increase could result in recovery payments.

Both risks will be explained more in detail below.

Assignment of lower budget to other Belgian hospitals less prone to patient mobility

At the national level, exporting healthcare will result in a higher total number of budgetary points used to divide the global B2-budget over all Belgian hospitals. Consequently, *the financial value per point will lower.* Because of the closed nature of the global budget, this results in a smaller BFM for hospitals treating few or no foreign patients.

This conclusion stems from the logic of the system. The exact negative financial impact is however almost incalculable, as in practice one will notice that the financial value per point keeps on rising due to the tendency of hospitals to reduce the lengths of hospital stay to stay below the national average or 'justified' length of stay. This is financially beneficial, as financing up to the justified length of stay will be guaranteed, while the hospital is liberating capacity. This however causes also the justified length of stay to reduce, which will result in less justified patient days and consequently less budgetary points.

Financial risks of overrunning HDI-part of BFM

Treatment of large numbers of foreign patients authorized by a social security coordination instrument (e.g. in case of cross-border cooperation agreements using a simplified S2-authorization procedure) bears financial risks for the whole hospital sector. At the end of the period for which the BFM has been accorded, a comparison is made at national level between the sum of the prospective variable HDI-budget parts accorded to the hospitals and the actual expenses per admission and per patient day made by the statutory health insurance funds.[cccvii] If one finds that the global variable HDI-budget has been overrun, this negative difference will be spread over the whole hospital sector during a later period.[cccviii] More concretely, every hospital will see both the fixed and variable part of his BFM proportionally reduced based on the relative size of its budget compared to the rest of the sector.[cccix]

Up till today however, the public administration has not yet taken the necessary executive measures to implement this sanction mechanism in practice, leaving the described financial risk only to exist at the theoretical level. This means that hospitals who are receiving an increasing number of foreign patients *assimilated* to Belgian social insured (such as patients coming under a cross-border cooperation agreement functioning on a coordination logic) have a financial advantage here.

One further has to remark that *both the fixed and variable part* of the expenses made by the Belgian health insurance funds for hospital stays of foreign patients authorized under a social security coordination instrument are *recovered* from the foreign healthcare insurer who issued the authorization document.[cccx] This recovered capital however does *not* flow back to the global Budget of Financial Means. Because of its closed nature, no readjustment of the initial budget is possible, despite the increasing volume of patients coming from abroad.

[cccvii] Art. 117 Hospital Act.

[cccviii] Art. 2.1 Royal Decree 11 June 2003 executing art. 104quater of the coordinated Hospital Act of 7 August 1987. [157] One has to remark that the legislator was of the opinion that the financial sanction of art. 117 Hospital Act would only be applied scarcely, as the ever decreasing lengths of hospital stay would compensate for an increasing amount of admissions.

[cccix] Art. 2.4 Royal Decree 28 September 2003.

[cccx] See Royal Decree 11 June 2003 executing art. 136 §1 third paragraph, art. 136 §5 and art. 136, second paragraph of the statutory sickness and invalidity insurance Act, coordinated on 14 July 1994, in concern to the amounts that the health insurance funds have to pay out in twelfths. [158] As such the expense made per admission and per patient day (variable HDI-part) as the expense made through the budgetary twelfths (fixed HDI-part of the BFM, in which the coordination patients are deemed to be included) is reconverted into a normal patient-day price (as for non-HDI patients) which is subsequently recovered from the foreign healthcare insurer.

Financial risks of overrunning non-HDI part of BFM

The initial positive financial effect of treating foreign patients outside the context of social security coordination does not detract the hospital from the fact that it is still operating within the boundaries of a prospective non-HDI budget divided into a fixed and a variable part.[cccxi] After the financial year has ended, a revision will be made of the *actual amount* of non-HDI patient day prices the hospital has received, having regard to the actual number of non-HDI patient days realized during the period for which the BFM has been accorded.[cccxii] If it turns out that the fixed non-HDI part of the BFM has been overrun, the surplus will be debited from the BFM of the next year. As a consequence, a large part of the original financial benefit will be lost.

5.2.1.2. Second problem: cost ineffective character of the Belgian patient-day price

A second problem regarding patient mobility lies in the fact that Belgian legislation obliged hospitals to charge foreign patients the normal patient-day price in case of hospitalization.[cccxiii] This is an *average* price which is the result of dividing the overall BFM by the number of patient-days registered during the last known year of service. As such it does *not reflect the real costs of hospitalization*. Hospital financing in Belgium is not pathology-based but relies on logic of compensation. By charging a unique average price for all hospital stays, patients with simple, less complex pathologies will pay for *all* hospital services even though they do not make use of them.[cccxiv] As such they also contribute to the financing of hospital stays which require more complex and intensive care, but for whom the average patient-day price does not cover the complete cost of hospitalization.

This balance becomes disturbed when hospitals are confronted with an increasing inflow of patients from abroad. If the majority of these foreign patients suffer with heavier pathologies which generally require more specialized and/or surgical treatment, a risk of underfinancing could emerge.

This negative effect is enhanced by the actual way of calculating supplementary B2-points and the actual financing-system for operating rooms and intensive care departments.

Calculation of general supplementary B2-points

As the general supplementary points are partially calculated by means of HDI-nomenclature data (used as indicator to measure medical activity), this also means that none of the foreign non-HDI-patients are included. As such, certainly hospitals with a structured inflow of foreign patients trough cross-border contracts certainly have a financial disadvantage here.

Financing of operating rooms

Problematic here is that non-HDI patients are not included when determining the number of justified operating rooms. In practice the standard times needed for the calculation are determined on the basis of the *HDI-nomenclature* code of the type of surgery. As a consequence, no data are available to take into account foreign patients that come to have elective surgery outside of a social security coordination context. This is slightly counteracted by the fact that the total amount of 'adapted' standard time will be elevated with a sort of 'adjustment' coefficient representing the percentage of patient days for non-HDI patients realized for the surgery department during the last known year of service.[cccxv] As such, for all non-HDI patients only an *average* standard time is used (calculated on the

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cccxi Art. 86 §3 Royal Decree 25 April 2002.

cccxii See art. 92.4 Royal Decree 25 April 2002. One remembers that the patient day price for non-HDI patients equals the sum of the fixed and variable non-HDI part of the BFM, divided by the number of non-HDI patient days realised during the last known year of service (art. 100 Royal Decree 25 April 2002).

cccxiii Bill modifying legislation in order to improve patient mobility, Chamber of Representatives, 2966/1, 6. [155]

cccxiv SERMEUS, 2006, 67. [109]

cccxv This equals the ratio between the total number of patient days realized for the surgery department divided by the number of HDI-patient days realized for the same department (art. 46 §3 2° a) 1 Royal Decree 25 April 2002).

basis of the original total of 'adapted' standard time) which could lead to underfinancing in case of lengthy operations.[cccxvi]

Another problem is the total number of OR-points that equals 11,3% of the total number of basic and supplementary B2 points calculated on the basis of justified beds (cf. *supra*).[cccxvii] During the past years however, the number of justified beds steadily got reduced because of the shortening length of hospital stays. As a consequence, also less budgetary OR-points can be dispersed, despite the rising number of surgical interventions.[cccxviii] Certainly for hospitals having a large inflow of foreign patients for surgical interventions, this could bring financial losses.

Financing of intensive beds

As said above, the cost covering character of the average patient day price calculated on the basis of the BFM could diminish in case the hospital's case mix is altered by admitting a (large) inflow of patients from abroad, certainly if these patients would in general show a heavier pathology profile. In this case the extra-financing points for intensive beds (for which non-HDI patients will only account for 80% in the indicators used) will more than likely not cover up the additional financial cost caused by an increase of intensive nursing care.

5.2.1.3. Third problem: only partial inclusion of capital costs in patient-day price

A third problem are the costs made for building, purchasing and maintaining hospital infrastructure and material. Since the patient-day price is calculated on the basis of the BFM, this means that foreign patients only contribute for 40% to the financing of the hospital infrastructure they are making use of. Since the other 60% is financed through regional subsidies (see above 6.1.4), foreign patients are enjoying a financial benefit paid for by the Belgian taxpayer.

One could say the limit of this argument lies in the fact that most Belgian hospitals enjoy a certain overcapacity. When hospitals, by treating foreign patients, are just filling up existing capacity, the detrimental effect of not charging capital costs is less clear than in case hospitals have to *expand* hospital infrastructure to accommodate an increased influx of patients from abroad. In the latter case, one must also point out that the regional Community subsidy is often limited to certain maximum levels, which could cause the hospital to add substantial investments from their own financial reserves.[cccxix]

As from 2007, this Community subsidy is also reduced to max. 10% if capital costs relate to infrastructure costs labeled with 'priority'.[cccxx] As such, priority is given to investments needed to fulfill new recognition criteria and to investments needed because of a 'rationalization of the healthcare offer' (e.g. due to an internal and external reorganization or because of cooperation agreements concluded between hospitals). In this case, the third argument based on capital costs plays less.

On the other hand it has to be mentioned that Belgian hospitals do also benefit from the fact that they can only partially charge capital costs to foreign patients. This allows them to maintain a patient day price which is consistently lower than healthcare providers in neighboring Member States. Especially Dutch hospitals complained about this particular competitive advantage of Belgian contracted hospitals.[cccxxi] Here legal doctrine already pointed that the mentioned regional Community subsidy for capital costs infringes on the European rules on state aid (art. 106-108 TFEU).[cccxxii]

5.2.2. The original Patient Mobility Act of 4 June 2007

With an eye to solve the financial risks explained above, the Patient Mobility Act of 4 June 2007 introduces two new elements:

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cccxvi HELLINGS, 2004. [159]

cccxvii Art. 46 §3 1° Royal Decree 25 April 2002.

cccxviii Advice NBHI of 9 April 2009. [160]

cccxix Here the financial contribution of the hospital doctors (negotiated in the general agreement with the hospital) will often be of crucial importance.

cccxx See art. 3 §1bis Royal Decree 13 December 1966, as modified by the Royal Decree 1 March 2007.

cccxxi BAETEN, GLINOS and BOFFIN, 2005, 66. {Baeten, 2005 #130}

cccxxii LOUCKX, 2007[161]; BAETEN and VERSCHUEREN, 2008, 233-235[162]. More in general on this question: HATZOPOULOS, 2008, 789-90. [163]

- The first innovation was the creation of a **separate financing framework** for foreign patients by modifying some dispositions of the Hospital Act in concern to the determination and payment of the BFM.
- The second innovation concerns the establishment of an **Observatory on Patient mobility** from which the legal assignment can be described as follows:
  - collecting and monitoring data on patient mobility in general and the effect on waiting times in particular,
  - offering expertise and assistance to Belgian hospitals regarding the export of their medical services (price setting, cross-border contracting)
  - playing an advisory role to the Belgian government on the subject of the expansion of hospital infrastructure and staffing ratios as a consequence of the influx of foreign patients.

In what follows we will mainly focus on the first element.

5.2.2.1. Introducing a new financing framework next to the BFM

First modification: narrowing the scope of the BFM

After its modification by the Law of 4 June 2007, art. 95 Hospital Act defines the Budget of Financial Means (BFM) as follows:

"The budget of financial means is determined by the Minister of Health for every hospital separately, based on a global, national budget fixed by Royal Decree negotiated in the council of ministers. The budget of financial means only takes into consideration the hospital treatment that leads to a compensation within the meaning of article 110, with the exclusion of the hospital treatment that is refunded under the terms of the European Regulation on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community (…).

This means that only hospital stays of patients who are socially insured by a Belgian health insurance fund or by certain other institutions mentioned in art. 110. Hospital Act[cccxxiii], would continue to be financed through the BFM.

Art. 95 however explicitly excluded foreign patients residing or staying in Belgium for whom social coverage of healthcare costs is ensured on the basis of European Coordination Regulations 883/2004 and 987/2009. This is most notably the case for the situations covered by art. 17 (residence in Member State other than competent state), 19 (necessary care during a temporary stay outside competent state) and 20 (programmed care outside competent state) of Coordination Regulation 883/2004.

As a consequence, only for the (not explicitly excluded) patient categories mentioned in art. 110 the previous BFM-price setting mechanisms would continue to apply.

For patients who receive healthcare coverage through one of the other institutions mentioned in art. 110 Hospital Act, the newly introduced art. 116 §1 Hospital Act disposes that the King must fix a price per parameter based on the BFM. It provides for the explicit guarantee that this patient category cannot be charged any other price, in spite of any derogatory (contractual) stipulations.

One could reasonably assume that the provisions taken in execution of art. 116 Hospital Act before its modification by the Patient Mobility Act of 4 June 2007 (which had a similar wording) would continue to apply here. As a consequence, the price charged to the patients referred to in this paragraph would equal the sum of the fixed and the variable non-HDI part of the BFM that is subsequently divided by the number of non-HDI patient days realized during the last known year of service.[cccxxiv] The result is actually the classic patient-day price or '100% per diem rate'.

[cccxxiii] Art. 110 Hospital Act mentions the Public Centers for Social Welfare (OCMW/CPAS), the Overseas Social Security Office (DOSZ/OSSOM), the National Institute for war invalids, war-veterans and war victims (IV-NIOOO/IV-INIG) and the Relief and Provident fund for seafarers (HVKZ/CSPM).

[cccxxiv] See art. 100 Royal Decree 25 August 2002.

Second modification: determining a patient-day price on the basis of real costs for patients falling outside of the scope of the BFM

For all other patients, the original Patient Mobility Act of 4 June 2007 introduced a distinct price-setting mechanism. The new art. 116 §2 Hospital Act allowed the King to fix a price per parameter that corresponded to the real costs. Next to the BFM, a parallel financing framework has thus been created, which gives individual hospitals the opportunity to charge certain types of patients a real cost-reflecting and thus possibly higher price for their hospital stay.[cccxxv]

Art 116 §2 Hospital Act would apply on the majority of foreign patients receiving hospital care in Belgium. One can distinguish the following categories:

- Patients falling under the European Coordination Regulation 883/2004, as they are explicitly excluded from the BFM by art. 95 Hospital Act
- EER-nationals coming to Belgium under the free movement of services (art. 56 TFEU)
- Civil servants of the European Union, who are subject to a health insurance scheme proper to the European Communities[cccxxvi]
- Servants of other international organizations or embassies[cccxxvii]
- Non-EU nationals, except in case their situation is regulated by a bilateral or multilateral social security coordination treaty

The scope of application of art. 116 §2 Hospital Act however seems to reach further than the abovementioned categories of foreign patients. Also certain Belgian social insured could be subject to a price that equals the real cost. Here one can refer to:

- Victims of labor accidents

Workers who become victim of a labor accident have right to all medical, surgical, pharmaceutical and hospital care needed due to the accident.[cccxxviii] Depending on the situation, this care will be provided by a recognized medical service of the employer or private insurer himself or by a freely chosen healthcare provider.[cccxxix] Costs of medical care are reimbursed by private insurers or the Labor Accidents Fund[cccxxx] according to the reimbursement rates set by the nomenclature of the statutory health insurance (HDI).[cccxxxi]

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cccxxv Cf. BAETEN, VANHERCKE and COUCHEIR, 2010, 9. [164]

cccxxvi See art. 72 of the Staff Regulations of officials and the conditions of employment of other servants of the European Communities, as determined by Council Regulation(EC, Euratom) 723/2004 of 22 March 2004 [165] and the Joint Rules of the Council of the European Union on health insurance for officials of the European Communities[166]. Auxiliary personnel of the European Communities however may opt to subject to the legislation of the Member State in which they are employed, to the legislation of the Member State to which they were last subject or to the legislation of the Member State whose nationals they are. This right of option must be exercised at the moment the employment contract is concluded. See art. 15 Reg. 883/2004 and art. 17 Reg. 987/2009.

cccxxvii Here one could mention that one of the experts mentioned that hospitals have bad experiences with personnel of foreign embassies for which in a majority of cases hospital bills are left unpaid. Due to their particular international status ('diplomatic immunity'), settling these payment disputes in court is not possible.

cccxxviii Art. 28 Labour Accident Act of 10 April 1971. [167] The Belgian Court of Cassation interprets this provision as a right to all care that restores the victim's physical condition as closely to the one that existed on the moment of the accident: Court of Cassation 27 april 1998[168]; Cour of Cassation 5 April 2004. [169]

cccxxix Art. 29 and 31 Labour Accident Act.

cccxxx The Labour Accident Fund only assumes the role of insurer in case of seafarers. It further acts as a guarantee fund in case an employer (unlawfully) did not subscribe labour accident insurance or when a private insurer fails to fulfill its obligations (art. 56 Labour Accidents Act).

cccxxxi Art. 1, 1st par. Royal Decree 17 October 2000 determining the conditions and tariffs for medical care applicable in case of labour accidents. [170] Medical treatments which are not covered by statutory health insurance are reimbursed up to the amount of the real cost, on condition the private insurer has given his prior authorization. This authorization must be given if the real cost is reasonable and comparable with the cost of similar treatments that are included in the HDI-nomenclature (art; 1, 3rd al. Royal Decree 17 October 2000).

In case the victim needs hospital treatment, costs of hospitalization are covered up to the amount of the 'normal' patient-day price as determined on the basis of the Hospital Act.[cccxxxii] This means that the victim will not be subject to out-of-pocket payments, unlike hospitalized patients covered by the statutory health insurance. Any supplements charged due to the voluntary use of a private hospital room or because of personal facilities (e.g. use of telephone or television) remain at the expense of the victim himself.[cccxxxiii]

Here one has to remark that in practice labour accident insurers often contest the presence of a labor accident or dispute that certain medical issues of the victim follow on from a recognized labour accident. As these disputes often end up in judicial litigation, the statutory health insurance will intervene in the meanwhile to cover healthcare costs (which it will recoup afterwards if the labour tribunal rules in favor of the victim).[cccxxxiv] During this period, he will be considered to be a HDI-patient within the meaning of art. 116 §1 Hospital Act.

- Victims of occupational diseases

Workers who become victim of an occupational disease have right to all medical care needed because of this disease.[cccxxxv] This care is provided by a freely chosen healthcare provider, which may be followed and assisted by a physician appointed by the Occupational Diseases Fund (ODF).[cccxxxvi] When it comes to the coverage of these medical costs, the Belgian legislator here (partially) abandoned the idea of an independent healthcare coverage scheme linked to the presence of a professional risk (cf. labor accidents).[cccxxxvii] If a victim is insured by the statutory health insurance, costs of treatment related to the occupational disease will be compensated by his sickness fund according to the conditions and tariffs of the HDI-nomenclature.[cccxxxviii] [cccxxxix] The ODF however refunds the victim's personal share in order to fulfill the legal objective of guaranteeing healthcare free of charge.[cccxl]

The principle above does not apply however in case of hospitalization. Hospitalization costs will be covered *by the ODF itself* up to the amount of the normal patient-day price as determined according to the Hospital Act.[cccxli]

- Patients who rely purely on private health insurance (e.g. economically inactive persons failing to pay social contributions, whose
- Patients without any social coverage, but whose overall income is too high to be entitled to medical assistance.

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cccxxxii Art. 3 Royal Decree 17 October 2000.

cccxxxiii PUT and VERDEYEN, nr. 1930. [171]

cccxxxiv Art. 136 §2 HDI-Act; MAISETTI, 2009, 7-25. [172]

cccxxxv Art. 31, 5° Act of 3 June 1970 coordinating the different legal provisions on occupational diseases[173], further indicated as 'Occupational Diseases Act'.

cccxxxvi Art. 41, par. 2 Occupational Diseases Act.

cccxxxvii See ROMBOUT and VIAENE, 1987, 182-185. [174]

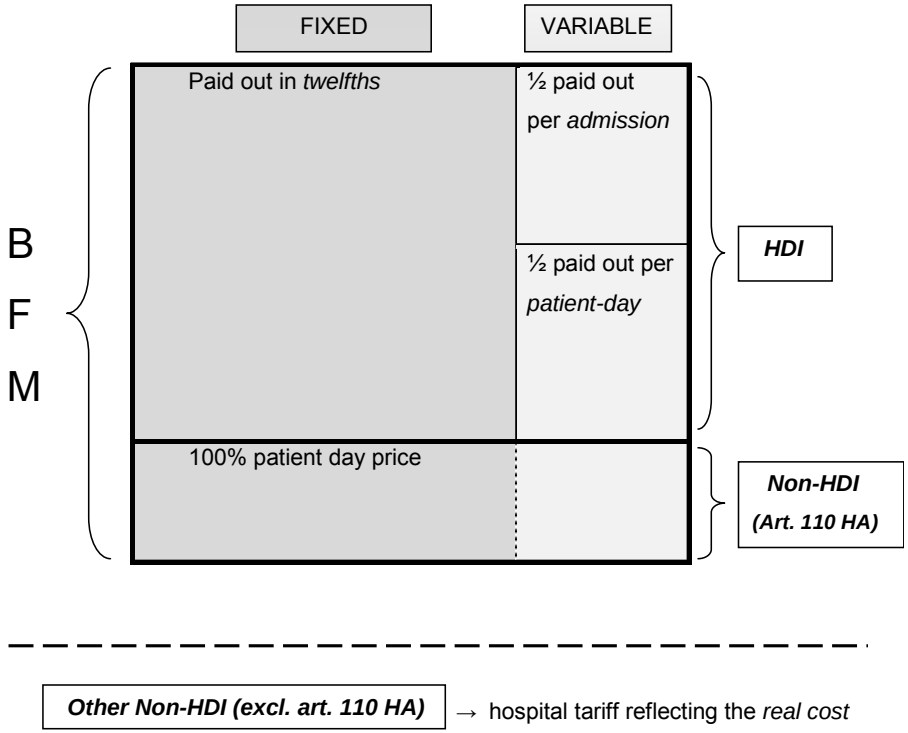
cccxxxviii Art. 1, 1st par. Royal Decree 1965 Modifying the Royal Decree of 18 February 1964, determining the tariffs applicable for medical care in case of compensation for occupational diseases. [175]

cccxxxix In case the victim is not insured by the statutory health insurance, it will be the ODF who takes charge of the medical costs (See Explanative Report attached to Royal Decree nr. 122 of 30 December 1983, which modified art. 41 of the Occupational Diseases Act). This is also the case if the provided medical care is not covered by the statutory health insurance. Here a specific nomenclature defines the conditions and amount of coverage (Art. 41, 1st par. Occupational Diseases Act. and Royal Decree 28 June 1983 determining a specific nomenclature for medical care provided within the scope of the statutory insurance for occupational diseases. [176]

cccxl Art. 41, 1st al. Occupational Diseases Act; DELOOZ and KREIT, 2008, 118. [177]

cccxli Art. 1, 3rd par. Royal Decree 14 April 1965.

Figure 5.2: Composition and payment of Budget of Financial Means after the original Patient Mobility Act of 4 June 2007



5.2.2.2. *Legal and practical issues related to charging a hospital tariff reflecting real costs*

Since the beginning, the 'real cost-principle' introduced by the original Patient Mobility Act of 4 June 2007 has been subject to severe criticism. Also many problems arose in relation to the practical implementation of this new tariff mechanism.[cccxlii] In order to deal with these issues, the entry into force of the Patient Mobility Law has been postponed multiple times[cccxliii]. The necessary Royal Decree needed to implement the new art. 116 §2 Hospital Act has never been taken.

In what follows we give an overview of the main criticisms on the original version.

Financial implications of redefining the BFM

In its Advice of 10 September 2009[cccxliv] the financing division of the National Board of Hospital Institutions pointed out that the exclusion of foreign patients from the Budget of Financial Means that several specific financing measures relying on the existence of the BFM would no longer apply:

- Art. 97 Hospital Act: it would no longer be possible to charge supplements for one-bed hospital rooms, as these are charged 'on top of the BFM'
- Art. 106 Hospital Act: subsidies granted for infrastructure works inscribed on the 'building calendar' of the hospital[cccxlv] are granted through the BFM.

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cccxlii See [178]; Question of senator Stevens to the Minister of Public Health on the implementation of the Patient Mobility Act, 21 January 2010. [179]

cccxliii The original entry into force was foreseen for 1 July 2008 at the very latest. This was postponed to the 1st of July 2009 (Act of 8 June holding diverse provisions[180]) and subsequently to 1st of July 2010 (Act of 10 December of 2009 holding diverse provisions related to healthcare[181]).

cccxliv Advice NBHI of 10 September 2009. [182]

cccxlv Art. 64 Hospital Act.

- Art. 112 Hospital Act: for foreign patients with a weak socio-economic profile would no longer be guaranteed, as these are financed through the BFM (budget part B8)

The NBHI further draws attention to the fact that excluding foreign patients from the hospital's BFM would lead to a reduction of the global BFM budget, which at this moment is also deemed to cover the expenses made for foreign patients. If the latter's hospitalization costs would now be financed through a different mechanism, a reduction of the global budget envelope seems inevitable.

Registration of MCD

As the Patient Mobility Act intended to put up a separate financing framework for foreign patients by explicitly excluding them from the BFM, this does not alter the fact these patients are *still included* in the registration of the Minimal Clinical Data. Art. 4, of the new MHD-Decree of 27 April 2007[cccxlvi] still obliges hospitals to register the Minimal Clinical Data[cccxlvii] for all hospitalizations requiring at least one overnight stay, and which are not included in the BFM. Without modification of the Royal Decree of 25 April 2002 they are included for the calculation of a hospital's number of justified beds. Consequently, hospitals would receive *double compensation* when treating foreign patients: next to an 'immediate' compensation based on real costs, the hospitals would receive a 'postponed' compensation through a BFM assigned on the basis of a case mix including foreign patients. This would constitute an unjustified enrichment, detrimental to other Belgian hospitals treating less foreign patients.

Non-discrimination

Exclusion of foreign patients coming under the European Coordination Regulation 883/2004

As was said above, the modified art. 95 Hospital Act explicitly excluded Regulation patients from the Budget of Financial Means. This implies they no longer have to pay an average price per admission and per patient-day (cf. *supra*), but are subject to a separate financing framework based on a price reflecting the real costs of hospitalization.[cccxlviii]

It is difficult to see how one could justify this difference of treatment with national HDI-patients. Coordination patients (art. 17, 19 and 20 Reg. 883/2004) are entitled to receive 'sickness benefits-in-kind'[cccxlix] from the Member State of residence or stay, in accordance with the legislation it applies, *as though they were insured under the said legislation.* This is interpreted in such a way that Regulation patients have access to treatment in other Member States under conditions *as favorable* as those applying to persons who are socially insured in these Member States.[cccl] As such it is clear that an assimilation has to take place between Regulation patients and patients insured by the statutory health insurance of the Member State of treatment. This is also explicitly what the European legislator had in mind when designing the actual and previous Coordination Regulations. As it is impossible for Member States to export healthcare services to other territories, migrating European citizens

cccxlvi Art. 4, 6° Royal Decree 27 April 2007 now even explicitly includes 'foreign patients' in the personal scope of application of the MHD-registration.

cccxlvii Art. 12 Royal Decree 27 April 2007.

cccxlviii Art. 116 §2 Hospital Act, as inserted by the original Patient Mobility Act of 4 June 2007. One can remark that coordination patients in this case would be obliged to cover hospitalization costs themselves and get them reimbursed afterwards by the institution of the competent state. The third-party payer system where the Belgian statutory health insurance (with the sickness funds as institutions of the state of treatment) directly covers the costs of hospitalization, only applies within the context of the payment of the BFM!

cccxlix The notion of sickness benefits-in-kind is now defined by art. 1 (va) Reg. 883/2004 as 'benefits-in-kind provided for under the legislation of a Member State which are intended to supply, make available, pay directly or reimburse the cost of medical care and products ancillary to that care.'

cccl Case (2001) C—368/98 Vanbraekel{, 2001 #20}, para. 32; Case (2003) C-56/01 Inizan [20].

fulfilling the conditions of Reg. 883/2004 are integrated in the system of the Member State of residence or stay on the behalf of the Member State of social insurance. Afterwards a Regulation of costs between those Member States will then take place.[ccli]

Looking at the above, one cannot do otherwise than conclude that Regulation patients have to be considered as patients covered by the Belgian statutory health insurance, and as such have to be included by the BFM. Art. 95 Hospital Act, as modified by the original Patient Mobility Act, thus had to be amended to avoid an infringement on European legislation.

Exclusion of EER-nationals coming under the Treaty

The Patient Mobility Act of 4 June 2007 introduced a different financing framework for the majority of non-HDI patients based on a price reflecting the real cost of treatment. It is however questionable if this difference of treatment with non-HDI patients paying an average patient-day price on the basis of the BFM could not be considered to be a forbidden indirect discrimination on the basis of nationality, considering the *Ferlini* case law of the ECJ (see above - 2.4).

Following *Ferlini* applying different tariffs to foreign patients coming from other Member States could constitute a forbidden discrimination on the basis of nationality and an impediment to the free movement of services. Such a discrimination can however be justified if it is based on a (explicit) Treaty exception or an objective reason of general interest. Looking at the patient mobility case law of the ECJ, only strict justification grounds, such as 'maintaining a high quality, balanced medical and hospital service open to all' or 'securing the financial sustainability of the national healthcare system' were allowed by the Court in the past.

Even if an objective reason of general interest could be proven, it is not sure whether a tariff differentiation system as introduced by the original Patient Mobility Act could be considered to be *proportional* to the found objective.

As foreign patients only partially contribute to the financing of Belgian hospital infrastructure (which will principally depend on regional subsidies financed out of public means and taxes), charging a certain 'capital supplement' could be justified. Yet how to calculate this supplement remains an extremely complex question (as the value of infrastructure evidently decreases over time).

Even if the Belgian legislator would succeed in justifying a tariff differentiation mechanism as introduced by the original Patient Mobility Act under the Treaty, the question remains whether such system would also be in conformity with the non-discrimination principle contained by art. 4 (4) of the Patient Mobility Directive.[cclii] Taken into account its absolute wording, it does not seem possible to derogate from the equal tariff rule it promulgates. In principle healthcare providers should apply the same tariffs on patients coming from other Member States. On the other hand a source of secondary law the Directive cannot overrule exceptions to the fundamental freedoms made by the TFEU itself (see art. 62 TFEU). As such one could reason a certain tariff differentiation could still be introduced if necessary and proportionate to protect public health.[ccliii] Seen the restrictive jurisprudence of the ECJ on this matter however, requiring that such a restriction of the freedom to provide services would be essential for public health or even the survival of the population[ccliv], this hypothesis is highly unlikeable.

[ccli] Art. 36 Reg. 883/2004.

[cclii] Art. 4 (4) Patient Mobility Directive: '*Member States shall ensure that the healthcare providers on their territory apply the same scale of fees for healthcare for patients from other Member States, as for domestic patients in a comparable m situation, or that they charge a price calculated according to objective, non-discriminatory criteria if there is no comparable price for domestic patients.'*

[ccliii] Art. 62 TFEU (referring to art. 52 TFEU). See also consideration 21 of the Patient Mobility Directive.

[ccliv] Case (1998) C-158/96 Raymond Kohll v Union des caisses de maladie[31], para. 51.

Danger of growing waiting lists

Introducing a tariff system reflecting the real costs of hospitalization makes it quite probable hospitals will avert themselves from the domestic healthcare market to aim at the treatment and hospitalization of lucrative foreign patients. Before the modification of hospital financing by the Patient Mobility Act of 4 June 2007, it were mainly hospital doctors who had a real financial interest (*fee for service*) in looking abroad for potential additional patients. For this reason hospitals often intentionally contained too large inflows of foreign patients. With the introduction of the possibility to charge a price corresponding to the actual cost of treatment, without any budgetary restraints, they now also have an immediate financial interest in attracting wealthier patients from around the globe.

If this leads to an inflow of a large amount of foreign patients, there is a risk that domestic patients will be denied a fast access to hospital care. As such, it is probable that for certain (expensive) specialized medical or surgical care, waiting lists will start to grow.

This problem could moreover be enhanced by the fact the Belgian hospital sector in general struggles with a lack of qualified nurses and medical doctors for certain specialisms.

One must point out that also the European legislator was particularly aware of this problem. As such art. 4 (3) Patient Mobility Directive disposes with regard to the principle of non-discrimination on the basis of nationality that '*This shall be without prejudice to the possibility for the Member State of treatment, where it is justified by overriding reasons of general interest, to adopt measures regarding access to treatment aimed at fulfilling its fundamental responsibility to ensure sufficient and permanent access to healthcare within its territory. Such measures shall be limited to what is necessary and proportionate and may not constitute a means of arbitrary discrimination.*' As such, the Member State of treatment retains a possibility to restrict the inflow of foreign patients in case the demand from abroad exceeds the capacities set by national planning criteria (which are normally determined in function of the domestic population of the Member State), without prejudice however to its obligations under Reg. 883/2004.[cccliv]

Moreover it is argued that when hospitals would state that they only attract foreign patients to fill up their *over*capacity, this would still be financially beneficial. In this case it would be possible to charge a real price including a capital cost which has already been covered by regional subsidies (double financing of the same infrastructure).[ccclv]

Possible infringement on European State aid rules

The scope of application of European competition law is based on the concept of 'undertaking', meaning every entity engaged economic activities, irrespective of its legal status and the way it is financed.[ccclvi] An economic activity is at its turn defined as the offering of goods or services on a defined market.

Following the ECJ patient mobility case law, both extramural and intramural healthcare services are to be considered as economic services within the meaning of art. 57 TFEU, irrespective of the way in which these services are remunerated. At least within a healthcare system based on 'médicine libérale' (as is the case for Belgium), healthcare providers have to be considered as undertakings[ccclvii], leading to the conclusion that public healthcare financing, even when assuring the objective of universal coverage, should be in conformity with the European rules on state aid.

Here art. 107 (1) TFEU declares incompatible with the internal market any aid granted by a Member State or by state resources in any form whatsoever which distorts or threatens to distort competition between

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cccliv Cf. Recital 19 Patient Mobility Directive.

ccclv Bill holding diverse provisions in concern to health, Chamber of Representatives, 52/2172/01, 8. [183]

ccclvi Case (1991) C-41/90 Höfner. [184]

ccclvii Case (2000) C-184/98 Pavlov[185]; Case (2001) C-475/99 Ambulanz Glöckner [186]. In concern to Belgian hospitals, this was explicitly confirmed in Decision of the European Commission of 28 October 2009 on aid measure NN 54/2009 (ex CP244/2005)-Belgium. Financing of public hospitals of the IRIS-network situated in the Brussels Capital Region. [187] See also LOUCKX, 2007, 356[188] and CALLENS, FORNACIARI and DEVROE, 2009, 52[189].

undertakings, in so far this has an effect on intra-community trade. As such, four conditions have to be fulfilled to categorize a national measure as state aid:

- Intervention by the State or through state resources, and imputable to the State
- The existence of a benefit for the undertaking
- The selective nature of the measure
- A distortive effect on trade between Member States

According to art. 108 (3) TFEU, Member States are obliged to notify the European Commission (EC) of their intention to grant aid. The EC will assess whether the proposed measure constitutes a form of state aid within the meaning of art. 107 (1) TFEU. If this is the case, the EC will subsequently examine whether the aid measure could be declared compatible with the internal market on the basis of one of the exemptions foreseen in art. 107 (2) and (3) TFEU. Pending a final decision of the commission, Member States are bound to a 'standstill'-obligation.

Any aid granted in violation of the notification or standstill obligation is deemed to be illegal. If this aid is moreover incompatible with the internal market, the EC will –save exceptional circumstances- order the guilty Member State to recover the aid amounts from the beneficiary.

As healthcare providers are undertakings, Member States are bound to assess whether the financial support given to hospitals is legitimate within the light of art. 107 (1) TFEU, irrespective of the fact that the applicable legal framework is predominantly based on concerns of solidarity and universal coverage.[ccclix] If not, they risk to infringe on their 'standstill-obligation', resulting in the recovery of funds provided to hospitals.

Even if public subsidies qualify as state aid under art. 107 TFEU, it nevertheless remains possible to invoke art. 106 (2) TFEU, which foresees in a general derogation from state aid rules for undertakings charged with the operation of a service of general economic interest, if the application of competition law would obstruct them to perform the particular tasks assigned to them. Also in this case, Member States will have to follow a notification and authorisation procedure

It is however not likely that Member States are eager to notify their systems of hospital financing. Next to their time-consuming character, notification procedures give an opportunity to the European Commission to influence the organisation and financing of their national healthcare system. In this case Member States may argue that financing measures do not form state aid, but only form a remunerative *compensation* for executing a *public service obligation*. This approach was validated by the ECJ in its *Altmark-ruling* of 24 July 2003[cccix], but nevertheless subjected to the fulfilment of four cumulative conditions:

- The beneficiary undertaking must be charged with public service obligations (PSO), which must be clearly defined by national legislation or decisions of the public administration;
- The parameters of the amount of compensation are established in an objective an transparent way;
- The compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge, taking into account the relevant receipts and a reasonable profit (*no compensation higher than really necessary*);
- In case a that the public 'contract' to provide a public service obligation is not subject to a public procurement procedure, the amount of compensation must be determined on the basis of the expenses a well-run undertaking would have incurred (*efficiency-criterion*).

If national aid measures meat the abovementioned criteria, they cannot be qualified as state aid within the meaning of art. 107 (1) TFEU. As a consequence, Member States are not subject to notification or approval procedures. Very likely however, the strictly formulated Altmark-conditions will prevent a lot of undertakings executing a PSO to benefit from the compensation approach. Here certainly the efficiency criterion is likely to pose problem, imposing that the level of compensation should take the actual costs incurred by a 'well-run' undertaking as a reference point.

[ccclix] V.D. GRONDEN, 2009, 20. [190]

[cccix] Case (2003) C-280/00 Altmark. [191]

In this regard however, one has to point at the so called SGEI-Decision of the European Commission of 28 November 2005[cccLxi] governing state aid and PSO within the framework of art. 106 (2) TFEU[cccLxii]. This Decision exempts Member States from notifying public service compensation given to a certain number of undertakings entrusted with a service of general economic interest (SGEI), which do not benefit from the Altmark-approach (as one or more of the aforementioned conditions are not met).

Apart from compensatory measures below a certain threshold given to small PSO undertakings, this decision also applies to public financing of *hospitals*, irrespective of the level of compensation. According to the Commission this is justified as '*hospitals (…) entrusted with SGEI missions have special characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in those sectors is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research (…) should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States.*'[cccLxiii]

However, the mentioned exemption of notification for public hospital financing is not unconditional. In order for the Decision to apply, Members states will have to show by means of a three-annual report Member States that the following conditions are fulfilled, which tend to precise the application of the necessity and proportionality-principles embedded in art. 106 (2) TFEU. These conditions in essence regain the Altmark-criteria, however without the efficiency criterion:

Table 5.2: Altmark-criteria

Art. 106 (2) TFEU	Art. 4-6 Decision 2005/284/EC
Necessity	Description of a SGEI by the Member State Formal entrustment of SGEI to undertaking by public authority Preliminary determination of compensation parameters Adoption of provisions to prevent and correct overcompensation
Proportionality	Adjustment of compensation to what is necessary to compensate costs of operation of SGEI Split accounting of SGEI and non-SGEI costs Effective control on overcompensation by public authorities

It is recognized by European jurisprudence that a Member State has a large margin of appreciation both in defining a SGEI, as in determining the compensation of SGEI-costs. Compensation should nevertheless correspond to the real amount of net costs incurred by the operation of the SGEI. As a consequence, compensation should be determined in a transparent and objective way.

In concern to public financing of hospitalisation costs in Belgium, the commission already had the opportunity to briefly touch upon compensation of hospitalisation costs through the budget of financial means (BFM) corresponded to the abovementioned principles.[cccLxiv] As

cccLxi Decision 2005/842/EC of the Commission of 28 November 2005 on the application of art. 86 (2) of the EC Treatyto State aid in the form of public service-compensation granted to certain undertakings entrusted with the operation of services of general economic interest. [192]

cccLxii producing monopoly shall be subject to the rules contained in the Treaties, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union.'

cccLxiii Recital 16 of Decision 2005/842/EC.

cccLxiv Decision of the European Commission of 28 October 2009 on aid measure NN 54/2009 (ex CP244/2005)-Belgium. Financing of public hospitals of the IRIS-network situated in the Brussels Capital Region. The real object of the

such, the Commission remarked that the yearly global budget is divided over Belgian (public and private) hospitals on the basis of compensation parameters clearly defined in the Hospital Act and the Royal Decree of 25 April 2002. Nevertheless this prospectively awarded BFM (from which 22.33% is actually paid out of state subsidies[cccLxv]) does not compensate the real hospitalisation cost. As a consequence, overcompensation will not be not be totally excluded, unless the real hospitalisation costs equal or exceed the average costs used to set the compensation level. The Commission concluded however that the BFM financing system contains sufficient verification mechanisms based on the hospital's annually transferred accounting data to control whether the apportioned closed budget has been exceeded (possibility of recovery measures).

Here one seems to forget however that Belgian hospitals use a cost center accounting system (i.e. accounting system using hospital units as cost centers on which average patient-day prices based on the BFM are booked), which makes it impossible to calculate the real costs of a patient-stay.

In 2008 Belgium had to present its first report on state aid under Decision 2005/284/EC. Herein was explained that the actual system of hospital financing in Belgium does not allow for a precise calculation of the real costs of hospitalisation[cccLxvi]. It was nevertheless defended that it contained enough safeguard and control measures in order to prevent overcompensation in order to be in rule with European state aid rules. One remembers however that not long before the Belgian legislator adopted the Patient Mobility Act which excluded the patient categories not enjoying the state subsidy of art. 110 Hospital Act (among them *all* types of foreign patients) from the BFM and introduced a separate financing framework allowing hospitals to charge these patients a price corresponding to the actual costs of hospitalization. Most evidently, the legal coexistence of these two financing frameworks raises serious doubts on the validity of the argument that hospital financing through the BFM would meet the conditions set by European state aid rules. As such, it is difficult to defend an SGEI-compensation framework based on average costs (despite certain mechanisms to prevent overcompensation), where it would be possible to calculate the actual cost of hospitalisation for patient categories for which no state subsidy is paid. This difficulty contributed to the multiple postponement of the entry into force of the original Patient Mobility Act.[cccLxvii]

5.2.3. Health Act of 19 May 2010

Taking into account the multiple difficulties related to the introduction of a separate financing framework based on real cost of hospitalization, the Belgian legislator was urged to intervene once more, as the Patient Mobility Act would enter into force on the 1st of July 2010 without any implementation measures.

The necessary modifications were done by the Health Act of 19 May 2010, which also introduced a new art. 92/1 Hospital Act that obliges hospitals to communicate all cross-border healthcare contracts to the newly created Observatory on Patient Mobility.[cccLxviii]. They entered into force on 12 June 2010.

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complaint actually did not concern the BFM financing system in general, but certain specific state subsidies given to a number of public OCMW/CPAS-hospitals within the Brussels-Capital Region to compensate certain deficits caused by their legal obligation to give medical and social assistance to every patient (even when having a very weak social and financial status). See on this decision also: FORNACIARI, 2011, 250-253. [193]

cccLxv Art. 110 Hospital Act.

cccLxvi As such, on the basis of the BFM an average patient-day price is calculated which is charged to every patient hospitalized. For HDI-patients however, financing is made less dependent on hospital activity by paying out the fixed HDI-part of the BFM trough monthly twelfths, whereas the variable HDI-part an average price per admission and an average patient day price is calculated. In accounting terms, this also means that hospitals will have only little incentive to correctly assign costs as prices tend to foresee an average remuneration for all hospital cost services.

cccLxvii See Bill holding diverse provisions in concern to health, Chamber of Representatives, 52/2172/01, 8[183];Question for further clarification from Senator STEVENS to the Minister of Public Health on the execution of the Patient Mobility Act, January 2010. [179]

cccLxviii Law of 19 May 2010 containing diverse provisions related to health. [194]

5.2.3.1. *Modification of art. 95 Hospital Act*

Art. 30 of the Health Act of 19 May 2010 *withdrew* art. 2 of the original Patient Mobility Act. This modifying article introduced the new, criticized 95 Hospital Act, excluding coordination patients from the scope of the Budget of Financial Means. What are the consequences of this strange legislative technique, where one found it necessary to lift art. 2 Patient Mobility Act instead of modifying art. 95 Hospital Act? However the official version of art. 95 Hospital Act still excludes coordination patients, on should consider this article to have been implicitly abolished, causing the old version of art. 95 Hospital Act would revive.[ccclxix] As such the BFM is again deemed to cover **all** potential justified activity during the year for which it has been accorded.[ccclxx] This modification implies that after the (failed) attempt of the original Patient Mobility Act one cannot longer speak of a *separate* financing framework for foreign patients.

Strangely enough the reason given for the abrogation of art. Patient Mobility Act did not lay in the open violation of the European Coordination Regulations, but seemed to rely mainly on the concern to give hospitals the possibility to charge supplements on top of the normal patient day price (art. 97 Hospital Act) for all types of patient stays.[ccclxxi]

5.2.3.2. *Modification of art. 116 §2 Hospital Act*

Art. 31 of the Law of 19 May 2010 maintains the distinction between the different types of non-HDI patients on the basis of the State subsidy granted according to art. 110 Hospital Act. The non-HDI patients falling under art. 116 §1 Hospital Act (cf. *supra*) will still be subject to a price per parameter of activity, which in principle equals the normal average patient day price.[ccclxxii]

All other non-HDI patients[ccclxxiii] will from now on be charged a *minimal* price per parameter determined by Royal Decree, amongst others on the basis of the BFM.[ccclxxiv] This phrasing must allow hospitals to charge these patients the normal patient day price (and possible supplements) awaiting the necessary modifications of the Royal Decree of 25 April 2002.[ccclxxv]

On the one hand this means that in the meantime all original financing problems regarding foreign patients related to their inclusion in the BFM will persist. At the other hand, it is probable that also after the required implementation certain issues will continue to pose problems. The non-HDI part of the BFM, now divided over all patients falling under art. 116 Hospital Act, is still composed of a fixed and a variable part. As such, exceeding this fixed part can cause new recovery procedures when the payment of the BFM gets revised afterwards.

Moreover one has to point out again that even if a 'minimal' price is set respecting the requirements of art. 18 and 56 TFEU (objective reason of general interest, necessity, proportionality), the non-discrimination principle from art. 4 (4) of the Patient Mobility Directive will most probably preclude hospitals to charge EU-nationals a price per parameter higher than the one determined for non-HDI patients falling under art. 116 §1 Hospital Act. Information gathered from the concerned public authorities also show that the newly introduced art. 116 §2 Hospital Act was not introduced to allow tariff discrimination for EER patients.[ccclxxvi] For patients coming from third-countries however, this could however be the case (e.g. Saudi oil sheik, Russian billionaire,…)

[ccclxix] Here the administrations informed us that the probable cause of confusion lies in the fact that the now abolished art. 2 Patient Mobility Act still referred to art. 86 of the old Hospital Act of 7 August 1987, which in the meanwhile was coordinated to art. 95 Hospital Act.

[ccclxx] Bill for diverse provisions in concern to health, Chamber of Representatives, nr. 52/2486/02, 9. [114]

[ccclxxi] Bill for diverse provisions in concern to health, Chamber of Representatives, nr. 52/2486/02, 10. [114]

[ccclxxii] Art. 100 Royal Decree 25 April 2002.

[ccclxxiii] One remarks that Regulation patients no longer belong to this category because of the revival of the old art. 95 Hospital Act.

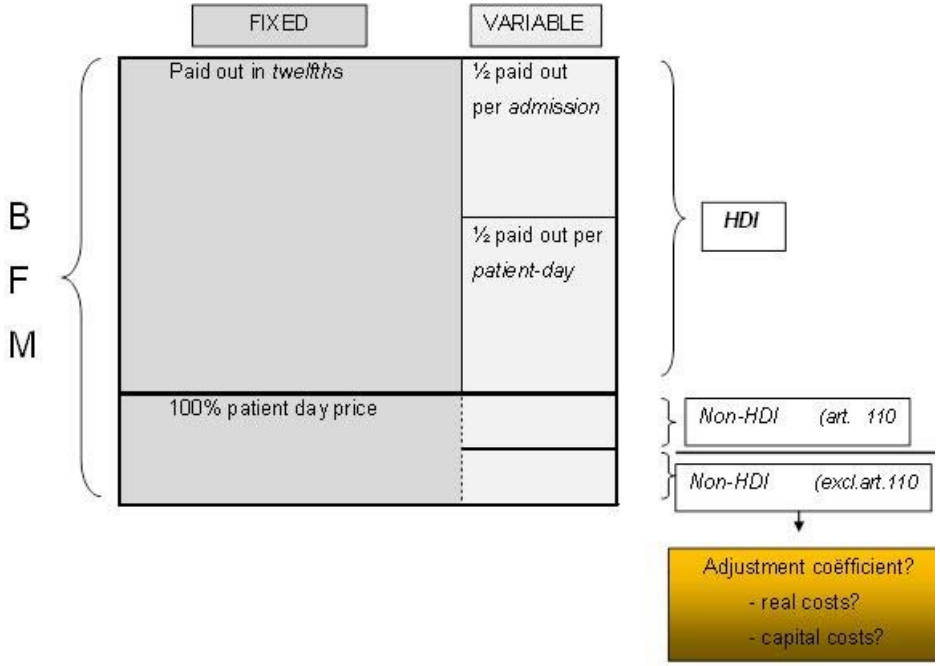
[ccclxxiv] New art. 116 §2 Hospital Act.

[ccclxxv] Bill for diverse provisions in concern to health, Chamber of Representatives, nr. 52/2486/02, 10. [114]

[ccclxxvi] Information NIHDI.

It now remains to be seen how this new 'minimal' price could be designed, as the necessary Royal Decrees have not yet been taken.

Figure 5.3: Possible composition and payment of Budget of Financial Means after Health Act of 10 May 2010



It remains the question if this Royal Decree necessary to implement art. 116 §2 Hospital Act will ever be taken. Here one can point at recent discussion on the manner how hospitals must charge costs of medically assisted procreation to foreign patients. It is well known that a number of Belgian hospitals dispose of a renowned fertility center attracting couples from all over the world to have an in-vitro insemination.

To cover the laboratory costs related to the in-vitro insemination of female gametes, part B4 of the BFM of hospitals with a recognized fertility center foresees in a specific budget on the basis of which a lump-sum is calculated which is deemed to cover all personnel, equipment, material and indirect costs related to IVF-laboratory activities.[cclxxvii] It is however explicitly stipulated that it is forbidden to charge this lump-sum to the concerned patient. Here one may derive this manner of financing will only apply in case of patients covered by the Belgian statutory health insurance (in case of which the lump-sum is immediately invoiced to the health insurance fund of the patient concerned).

Question rose however how hospitals should charge laboratory costs to foreign patients coming for medically assisted procreation. According to a very recent NIHDI circular[cclxxviii] distinction has to be made between two types of foreign patients:

1. For foreign patients assimilated to a Belgian HDI-patient by virtue of an international convention (i.e. coordination patients with an S2 or E112-form) the lump-sum mechanism of art. 74bis Royal Decree 25 April 2002 will apply.
2. For all other (individual) foreign patients coming for MAP (whether they are socially insured in the EEA or outside the EEA) hospitals may charge a price corresponding to the real laboratory cost, however without this price may exceed the tariff charged to Belgian patients in a comparable medical situation. Only if no comparable price exists for a HDI-patient, the hospital may charge a price on the basis of objective, non-discriminatory criteria

With its undiminished application of the non-discrimination principle on the basis of nationality (of art. 4 (4) Patient Mobility Directive?) in a non-EEA context, this circular could be an indication that the Belgian authorities are not eager to implement a price-differentiation mechanism for certain non-EEA nationals within the context of art. 116 §2 Hospital Act.

[cclxxvii] Art. 74bis Royal Decree 25 April 2002.

[cclxxviii] Circular NIHDI ZH 2011/11 of 27 June 2011. [195]

Key points

- **In terms of hospital financing in Belgium, patient mobility brings along several negative financial consequences, both at the level of the hospital sector as at the level of the hospital itself.**
- **Three main problems could be identified: 1) the closed nature of the hospital budget from which the limits are not adapted in function of foreign patient inflows (possibly resulting in posterior budget recuperations); 2) the cost- ineffective character of the average patient-day price if a hospital's case mix is altered by an inflow of foreign patients with a systematically heavier pathology + the fact non-HDI patients are not taken into account for the calculation of several parts of the BFM; 3) the fact that foreign patients only partially contribute to the building of Belgian hospital infrastructure, as these are financed for an important by regional subsidies (paid by the Belgian taxpayer).**
- **The original Patient Mobility Act of 4 June 2007 tended to solve these problems by introducing a separate financing framework next to the BFM for the majority of non-HDI patients (incl. coordination patients) which allowed hospitals to charge a price reflecting the real cost of healthcare provided. Because of many legal and practical problems (a.o. non-discrimination of European patients, danger of growing waiting lists) this new financing mechanism has never entered into force.**
- **Although expenses made by the Belgian health insurance funds for hospital stays of foreign patients authorized under a social security coordination instrument are recovered from the foreign healthcare insurer who issued the authorization document, this recovered capital however does not flow back to the global Budget of Financial Means. Because of its closed nature, no readjustment of the initial budget is made, despite the increasing volume of patients coming from abroad.**
- **After the Health Act of 19 May 2010 all patients are again financed through the BFM , but for certain categories of foreign patients (non- EU) the current average day price only acts as a minimum.**

5.3. Patient mobility and hospital doctors

One part in the financing has not been addressed yet: the fee for medical services paid to hospital doctors. Can we compensate certain financial disadvantages of the actual system of hospital financing by demanding an increased financial contribution of hospital doctors (as negotiated in the general agreement). As most hospital doctors are paid *fee for service.*[cccLxxix] it could be quite beneficial for them to expand their pool of patients across borders.

Would it be possible for hospitals to stipulate a sort of Regulation with their hospital doctors that higher maximum tariffs and higher deduction percentages would apply in case of foreign non-HDI patients? In principle this seems possible based on the system explained above.

However, also here one has to take into mind (at least for EU-nationals) the principle of non-discrimination and the (horizontal) implications of the *Ferlini*-jurisprudence of the ECJ. To the same token one must draw attention to art. 18.1 of the National Convention 2009-2010[cccLxxx] which explicitly provides that doctors who acceded to the convention are not able

cccLxxix Art. 146 Hospital Act provides a limited list of fee-systems that a hospital can apply: 1) fee for service, 2) remuneration based on the division of a 'pool' of fees per service formed for the whole hospital or hospital service, 3) remuneration as a contractual or statutory percentage of the fee per service or 'pool' of fees per service, 4) fixed fee independent of level of activity (sort of salary) or 5) fixed fee with additional percentage based on pool of fees for services. It is possible for the hospital to apply multiple systems (optional right for hospital doctor).

cccLxxx National Convention Doctors-Health Insurance Funds 2009-2010. [196]This has been repeated in art. 9.1 of the National Convention Doctors-Health Insurance Funds 2010-2011 of 13 December 2010 . [197] See also Parliamentary Question of representative VANDEURZEN of 19 May 2008. [198]

to apply higher fees than those stipulated for national social insured in case of European patients coming under the European Coordination Regulation 883/2004 **and** art. 56 TFEU (incl. European civil servants). As such, sickness funds and doctor representatives agreed on the horizontal effect of the principle of non-discrimination on the basis of nationality, which in line with *Ferlini* should also be respected in case of tariff setting done by a group or organization exercising a certain power over individuals and which is in a position to impose certain conditions that could adversely affect the exercise of fundamental freedoms guaranteed by the TFEU.[cccLxxxi]

Info gathered from the NIHDI showed that in 2010 plans were made to inscribe a horizontal non-discrimination-clause with identical meaning in art. 50 HDI-Act. Due to the fall of the Belgian government, and the subsequent parliamentary elections, this plans were postponed *sine die*. It remains however desirable that such a provision would yet be introduced.

However, one should remember that hospital doctors who adhered to the convention will under certain circumstances not be obliged to apply convention tariffs. As such, two important possibilities exist to deviate from this principle:

- If it concerns a 'wealthy' patient, the hospital doctor is able to set his fees freely.[cccLxxxii] This is the case if the patient is part of a family with only one insured, from which the taxable income exceeds €60,804.41, augmented with €2,026.08 for every person at charge. In case of multiple insured, the taxable income per insured person must exceed €40,535.83, augmented with €2,026.08 for every person at charge.
- The question remains how this provision must be applied in practice. Can a doctor request a patients tax declaration, when observing certain external signs of fortune (e.g. luxury vehicle with a foreign license plate)?[cccLxxxiii]
- Possibility to charge supplements in case of 'voluntary' stay in a one-bed hospital room (cf. supra).

Will this provision incite hospital doctors to step out of the NIHDI tariff conventions, in order to have more possibilities to charge higher tariffs to incoming patients (as free setting of fees would revive)?[cccLxxxiv] Next to the possible argument of the application of art. 18 TFEU at the purely horizontal level, one must also point at the non-discrimination principle contained by art. 4 (4) of the Patient Mobility Directive. The second paragraph of this provision states that whenever no scale of fees applies, and healthcare providers are thus *free to set their own prices*, they still have to respect the principle of equal treatment of patients coming from other Member States.

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cccLxxxi Case (2000) C-411/98 Ferlini v Centre hospitalier de Luxembourg[48], par. 50. Here one must remember that doctors who do not express their non-adherence within 30 days following the official publication of the National Convention, will be deemed to be adhered by law (art.50 §3 HDI-Act of 14 July 1994).

cccLxxxii Art. 18.5 National Convention 2009-2010.

cccLxxxiii Critical: HOSTAUX, 2009, 120[199] with reference to parliamentary question of representative STEVENHEYDENS of 15 April 2008. [200]

cccLxxxiv One must note that in case of doctor-specialists a partial adherence to the tariff convention (possibility to apply non-convention tariffs max. four times a week for a maximal period of 4 uninterrupted hours) is not possible for hospitalized patients (art.18.4.2.2 National Convention 2009-2010).

Key points

- **Hospital doctors have a financial interest in expanding their pool of patients across borders as they are paid fee for service.**
- **The most recent National-Conventions concluded between Doctors-Sickness funds explicitly foresee the obligation for conventioned doctors to apply conventional tariffs to European coordination patients, European patients using their free movement of services and European civil servants. Introducing a similar horizontal provision in the HDI-Act would yet be advisable.**
- **Art. 4 (4) of the Patient Mobility Directive obliges also non-conventioned doctors not to discriminate against patients coming from other EU Member States**

6. HOSPITAL FINANCING (LAW) AND ALTERNATIVES TO CHANGE THE HOSPITAL FINANCING SYSTEM

This chapter describes some theoretical alternatives for the current hospital financing system to take account of foreign patients coming to Belgium to receive healthcare.

The status quo and two alternatives will be discussed:

- Keeping the status quo: the financial flow of foreign patients coming to Belgium compensates the Belgian patients going for healthcare treatments abroad.
- Allocation of a separate budget for foreign patients
- Changing the hospital financing system to make it more adapted to foreign patients.

The legal impact of both alternatives is discussed in the second part of this chapter. We conclude with an analysis of the strengths and weaknesses of the status quo and the two alternatives.

6.1. Status quo: the financial flow of foreign patients coming to Belgium is compensated by the financial flow of Belgian patients going abroad for healthcare

6.1.1. Description of the status quo

Every year the budget of financial means (BFM) is determined as a closed budget for the country. The BFM takes into account the financial flows of Belgian patients going abroad for healthcare and foreigners seeking healthcare in Belgium, without corrective actions. Hence, the current financing of hospitals assumes that the financial flow of foreign patients coming to Belgium is compensated by the financial flow of Belgian patients going abroad. Possible fluctuations are seen as random fluctuations without impact on the stability of the system.

Keeping a status quo has some strengths and some weaknesses. A definitive strength is that this choice is keeping the system simple. There is no need for a detailed registration of foreign patients coming in the Belgian

system nor of Belgians going abroad. There is no need to take corrective actions to the system as a whole, e.g. correcting the BFM based on numbers of patients going in or out, or for particular hospitals that treat more foreign patients. This scenario only holds when the financial impact is limited and there is a balance of Belgians going abroad and foreigners coming in. These assumptions might be challenged.

Firstly, it is questionable whether the financial flows are in balance. Belgium is known for treating a high number of foreign patients and for being a net exporter of health services because of its central location in Europe and the relative overcapacity of the healthcare system. Based on the number of cross-border arrangements between insurers and providers or among providers, there is some evidence that Belgium is indeed an incoming country.[125] However, it is not confirmed by data on outstanding claims among countries as documented by the border-crossing money flows under Council Regulations 1408/71 by the Administrative Commission of the European Communities. In 2004, Belgium had more claims from other countries (approx. €112 million) than it had claims on other countries (roughly €67 million). This contradictory finding is not an exception in Europe. Van Ginneken[201] sees the compensation model as the main reason for this unexpected finding. The compensation model leads to severe underreporting of financial flows. Waiver agreements between many countries lead to a situation that the countries do not calculate and therefore do not report utilization and cost data. Also, unpaid claims from previous years may skew the data. Cross-border patient mobility is often not reported as several public payers, both tax-funded NHS-type purchasers (such as in Ireland or Malta) as well as health insurance funds (such as in the Netherlands) maintain cross-border collaborations outside the scope of Council Regulation (EEC) No. 1408/71. Out-of-pocket payments with postponed reimbursement (e.g. the “Kohll/ Decker” procedure) are often not reported in the statistics. And in the reporting, the definition of a foreign patient (based on nationality, residence or country of insurance affiliation) or type of payment (e.g. E111, E112, E121 - pensioners living abroad, E106 - frontier workers) makes it difficult to compare incoming and outgoing financial flows.

Secondly, a compensation model assumes that there are no incentives to treat patients abroad. The Belgian system is designed as a closed budget system for the BFM-part and an open fee-for-service system for the medical treatment. It is clear that there is a financial incentive for the medical specialist to attract and treat foreign patients.

As explained earlier, the BFM part of the budget is a closed system. For the system as a whole, more admissions would lead to lowering the reimbursement rate per justified inpatient day. From the perspective of an individual hospital, this might be different as it competes with other hospitals to get a larger share of the national budget. And more patients, independent of their origin, might be helpful. This incentive is however limited to a maximum of 112%. For the foreign health insurers, there might be an additional incentive. The BFM is calculated in a very complex way taking the case-mix of the patients into account. The way how this budget is paid, differs between HDI-patients and non-HDI patients, including foreign patients. For HDI-patients, the budget is divided in a fixed part that is paid in monthly installments (for about 80%). 20% is due to variable payment per admission and per patient day. For non-HDI-patients, however, the price for an average inpatient day is calculated by dividing the total budget by the total number of justified inpatient days. The price for an average inpatient day is hospital specific and depends on the case-mix of the hospital. This system is quite different from neighbouring countries in which a fixed price per DRG (or similar system) is used. For foreign insurers there might be a double incentive. Firstly, they may contract preferably these patient groups (DRGs) for which the average price is lower than the fixed DRG-price in the country of origin which would give a selection for a higher casemix. Secondly, they may preferably contract these hospitals where the average price per patient day is lower, which means that they are mainly contracting smaller hospitals with a lower casemix. The best buy for a foreign insurer would be a selection of higher casemix patients in an average lower casemix hospital. From a hospital perspective, it is more interesting to contract DRGs for which the average price is higher than the expected cost in the short term. In the long term, casemix differences don't matter as the MCD of the foreign patients is also taking into account for calculating the casemix of the hospital and adjusting the BFM accordingly.

Thirdly, the mechanisms of calculating the BFM and payment for NIH and non-NIH patients do not give an incentive for an accurate recording of

foreign patients in the hospital. Firstly, the added value of accurate recording of MCD for foreign patients is limited. As mentioned in Chapter 2, sometimes non-HDI patient data are included in calculating the BFM and sometimes not. The main reason for inclusion or non-inclusion seems to be their availability, and not their fit-for-purpose.

Secondly, there is no possibility to control for an accurate recording of MCD for foreign patients.

Although the registration of the MCD is mandatory, the only possible way for controlling accurate data registration is in the comparison with the billing data. As contract and direct billing patients are not registered in the billing data, there is no possibility for control.

There might even be a negative incentive. In the payment side, the BFM is divided in two parts. One part is allocated to HDI patients and paid by monthly installments and price per admission and (in)patient day. It is based on the percentage of HDI-patients. The second part is allocated to non-HDI patients and is paid by an average price per inpatient day. When a hospital is not registering MCD for these two groups of foreign patients, the percentage of non-NIH patients will be lower what would lead to higher part one of BFM what would lead to a more secured financing.

The three mentioned weaknesses of the compensation system (unrealistic assumption of balance of in and out financial flows, implicit incentives built in the system, no reliable data available) are sustainable when the volumes are low. But there is some growing evidence that these volumes are getting larger. At the same time we have a high variability among Belgian hospitals in admitting foreign patients ranging from less than 1% up to 10% in some hospitals.

Two alternatives were developed. One alternative is to separate the financial flows of foreign patients from the financial flows of Belgian patients. The other alternative is to keep both flows together but to adapt our Belgian financing system to that of neighboring countries what would allow the system to gain more flexibility to treat foreign patients.

6.2. Separating the financial flow of foreign and Belgian patients

6.2.1. Description of the alternative

This alternative includes the separation of the financial flows of foreign patients and these of Belgian patients. In fact, the aim is even broader in separating the financial flow of HDI-patients and non-HDI patients. We will discuss the why and how question.

The 'why' question is very obvious. Our Belgian healthcare system attracts more foreign patients because of its generous capacity, the perspective of good quality and relatively low costs[201]. Because of our closed BFM-budget and the existing compensation measures, hospitals are in general penalized when the number of foreign patients is increasing by an inflation of the financial B2-point. There is no incentive for accurate recording of foreign patients as this would lead to include this patient in the closed BFM-budget. The financial impact of having more foreign patients would be compensated to that hospital, but just many years later. We hypothesize that contract patients and direct billing patients are not systematically recorded in the MCD. There is no incentive and no control.

So if we would take the growing inflow of foreign patients seriously, it would require that the net effect would be budgeted so that there is a real incentive for registering these data correctly. It would require that the volume and casemix of foreign patients is calculated separately to have a net impact of these patients on the BFM.

6.2.2. How to perform that change in the Belgian health system?

Article 96 of the Hospital Act allows to create a separate budget of financial means for several services, departments, functions or care programs. This made it possible to determine a separate budget in Belgium for the rehabilitation services, the services for palliative care, and the burns units. The separate budgets for these services in principle follow the same rules for the establishment of the budget as the general hospitals follows the rules of the general BFM[ccclxxxv], however for most budget parts derogatory calculation rules apply in order to cope with the specific needs of these

[ccclxxxv] Art. 5 §2 Royal Decree 25 April 2002.

services.. The mentioned provision actually does not offer a possibility to introduce a separate BFM for a distinct patient category. A modification of art. 96 would thus be required.

When introducing different budgets in order to separate financial flows of Belgian and foreign patients, one further should take in account certain key principles deriving from European law (which have been extensively described in the previous chapters):

- Assimilation principle: foreign (socially insured) patients entitled to healthcare under the provisions of an international social security convention may not be treated differently than national *HDI-patients*, as this would otherwise infringe on a core principle of healthcare coordination law.
- Principle of non-discrimination on the basis of nationality: the fundamental freedom of free movement of services within the European internal market (art. 56 TFEU/ art.36 EEA-Agreement), as well as the provisions on European Citizenship (art. 18 TFEU) in principle prohibit the introduction of a separate BFM solely for EU/EEA-nationals if this would eventually lead to tariff discrimination with domestic patients. These provisions would however not directly oppose the creation of a distinct budget wherein the aforementioned foreign patient category is included together with domestic patients who find themselves in a comparable situation. This is e.g. the case for Belgian non-HDI patients for whom art. 110 Hospital Act does not foresee in a state subsidy to cover healthcare costs.

Where the introduction of a separate BFM for these patients leads up to a differentiated and possibly higher price, one has to point at the possible risk of indirect discrimination on the basis of nationality, in case a hospital is confronted with a major inflow of (non-coordination) patients from other EEA-Member States.

Here it remains to be seen if the Court of Justice would accept a justification based on a legitimate aim for which the creation of separate hospital budgets constitutes a necessary and proportional measure to achieve it.

Nevertheless one has to point out that art. 4 (4) of the Patient Mobility Directive prohibits in an absolute way that Member States would introduce a legal way for healthcare providers established on their territory to apply a different fee scale to the level of individual patients coming from other EU (EEA)-Member States than is the case for domestic patients in a comparable medical situation. 'Patient' is broadly defined as 'any natural person who seeks to receive or receives healthcare in a Member State'. Because of the absence of any reference to insurance status , introducing different (average) patient-day prices by introducing different hospital budgets for HDI- and non-HDI patients goes against European law.

As a consequence, the Belgian legislator should at all times be aware that hospital financing reforms cannot lead up to price discrimination of individual patients coming from EEA-Member States.

Given the abovementioned principles, budgetary adjustments to patient mobility may thus not be merely based on nationality. Distinguishing between HDI-and (certain) non-HDI patients could be legally sound, on condition price discriminations between these two patient categories are avoided.

The main focus would be to calculate an identifiable budget for non-HDI patients within the framework of the BFM. This correction may be included within the budget (e.g. part B2b or B10) or as two separate BFM budgets. The latter is in line with the current BFM calculations that ends also in two separate budgets for HDI and non-HDI patients. Now that division is made at the very end, before payment. The suggestion is to bring this division upfront in the process. This scenario would require to make an explicit budget for non-HDI patients. This could be done by Royal Decree at the beginning of each year based on historical budgets and the trends in the increase of foreign patient flows that may be expected for the budget year (e.g. based on new contracts, trend analysis).

Secondly, it would require to split all calculations for HDI-patients and non-HDI patients. It would include MCD-registration, calculation of the number of justified days and beds, nursing workload adjustments based on MND, nomenclature data that would apply for NIH-patients only,...). It would require that special algorithms would be developed to calculate the number of justified operation rooms.

6.3. Changing the hospital financing system to make it more adapted to foreign patients

6.3.1. Description of the alternative

Our Belgian hospital financing system is very unique compared to the hospital financing systems of our neighboring countries. A main characteristic of the Belgian system is the use of an overall budget system, taking into account a whole series of criteria and parameters. The final outcome however for the foreign patient is an average price per day per hospital based on the overall casemix of the hospital but independent of the actual treatment of the patient in that hospital. Simply said, when a patient is admitted for a single procedure, the bill doesn't show the cost of that single patient, but the cost of an average patient in that hospital. As a consequence it might be that a treatment in one hospital has a different price than exactly the same treatment in another hospital because of the different patient casemix in these hospitals.

The hospital financing systems in the neighboring countries are more case-based which means that an average price is set per condition (based on DRGs or similar systems) and will be the same (or similar) among hospitals.

Given these differences it is nearly impossible to fit foreign patients into our system. The Belgian hospital accounting system is mainly built around cost centers being departments and units. It allows to calculate losses and profits on the level of the overall hospital and also on the level of every cost centre, but not on the level of an individual patient.

It doesn't allow however to calculate the cost for individual patient passing through the system with its departments and units. The result is that Belgian hospitals don't know what costs they make for an individual patient nor they know what price they get for an individual patient. It certainly wouldn't allow hospitals to calculate losses and profits on the level of an individual patient and to evaluate if the price that they get for the treatment of a foreign patient based on the Belgian "average" prices are covering the costs that the hospital is making for that patient.

Most neighboring countries are using various methods of activity-based costing to determine the actual costs of treatment on the level of patients / admissions. These costs are the basis to calculate a reasonable price of care. The main requirement is a hospital accounting system in which the costs are booked on the level of each patient/admission instead of on the level of cost centers or units.[202, 203, 204]

The main idea of this alternative is to align the Belgian financing system to our neighboring systems in the sense that costs are booked on individual patients and that prices are calculated per condition (DRG-based). It would allow to set a higher price for a more sick patient, of course not only for a foreign but also for a Belgian patient. Many of neighboring countries have these systems in place. The Dutch healthcare system uses the Diagnosis Treatment Combinations (BDC) casemix system for the registration and reimbursement of care provided by hospitals and medical specialists. DBCs are defined as the whole set of activities and interventions of the hospital and medical specialist resulting from the first consultation and diagnosis of the medical specialist in the hospital. In 1995, the Italian National Health Service begun to fund its hospitals on a per case basis, classified according to a DRGs system. In 2000, the German Diagnosis Related Groups (G-DRG) was introduced by the Statutory Health Insurance Reform Act as a new system of reimbursement in Germany. The DRGs in the German system cover medical treatment, nursing care, the provision of pharmaceuticals and therapeutic appliances, as well as board and accommodation, but do not cover capital costs. In the UK, as from 2004, a new reimbursement system for hospital care, the 'Payment by Results' (PbR) was introduced. In this new system, the primary care trusts (local health authorities which are responsible for purchasing nearly all healthcare services on behalf of their local population) still negotiate contracts with healthcare providers to plan the volume of activity for the next year. For each healthcare resource group (HRG) (which is similar to a DRG – and are standard groupings of clinically similar treatments which use common levels of healthcare resources), national tariffs for spells of inpatient and day-case activity are set. A spell is the entire stay of a patient at a particular provider from admission to discharge or death.

All four countries are using a full costing method to calculate actual costs per case. In most countries, a modular approach is used. Cost-related data is arranged according to cost-element groups and cost-centre groups. This makes it possible to calculate the costs per patient and group them later per patient group (DRG). For each country the procedure on how to

allocate indirect and direct costs to cost-centers and further to patients groups is well described. [202, 203, 204]

6.3.2. How to perform that change in the Belgian health system?

The second alternative involves a change of the hospital financing system for all patients and not only for foreign patients. It could increase the transparency of the Belgian healthcare system. The main requirement is to change the hospital accounting system (FINHOSTA) to a patient accounting system in which costs are allocated per patient and not per unit. This change is however of benefit for most hospitals as it would allow a more precise financial management.

6.4. Analysis of strengths and weaknesses of the status quo and two alternatives

Alternative	Strengths	Weaknesses
Compensation of foreign patients in Belgium by Belgian patient flows going abroad	No important changes have to be made concerning the legislation and registration	If the volume of foreign patients increases over time, a status quo is not an equilibrium situation
Actual prices	The costs of the infrastructure can be charged to foreign patients (but also to Belgian patients who are not covered by the compulsory health insurance, like patients who benefit from a treatment at the expense of the social service)	Activity-based costing will be imposed to all Belgian hospitals The legal framework does not allow this scenario because of the principles of free movement of persons and services; because of the principles of equity; and because of the principles of open competition Would undermine the Belgian hospital financing, as there will exist two prices: a 'real' price (for non-HDI patients, including the foreign patients) and an 'average' price (for Belgian and assimilated patients)
Modifications of BMF by means of additional B10 part or modification of part B2	A separate budget of financial means is already calculated for several services (like palliative services etc.), this might be achievable in practice Introduction of a corrective measure for the casemix of non-HDI patients	This scenario implies a modification of the Hospital Act/legislation This corrective measure is also applicable for non-HDI Belgian patients (like patients receiving healthcare on behalf of the social service), and it the casemix of these patients is more severe, the health and disability insurance might be confronted with higher costs. The casemix (of all patients) has to be measured accurately
Separate price for pathology group	If foreign patients come to Belgium for a casemix that is different (and more severe) for Belgian patients, this scenario will introduce a corrective measure	The casemix (of all patients) has to be measured accurately

7. NON-FINANCIAL CONSEQUENCES OF PATIENT MIGRATION: WAITING LISTS AND QUALITY OF CARE

A growing influx of foreign patients may have other effects than the mere financial impact upon the hospital financing system. When it becomes interesting for the provider to treat foreign patients, precedence may be granted to the category of foreign patients, which potentially can result in emerging waiting lists for own nationally insured patients. At this moment, no evidence has been found of this. The fact that it is hard for hospitals to charge the real costs for the treatment of foreign patients may be an explanation. In the study we assumed that the risk of giving precedence to foreign patients at the detriment of national patients may be more present among hospital physicians, as they are still largely paid per treatment. This may not be completely true for conventioned hospital doctors as they as well have to respect the non-discrimination principle. Yet this on its turn implies that inherently there is a risk of deconventioning among hospital doctors.

Apart from the danger of growing waiting list, issues of quality may also raise. Especially in the contracting field, hospitals may become growingly confronted with quality conditions imposed upon them by the foreign insurers (i.e. through healthcare delivery protocols). Hospitals used to cross-border health care contracting mentioned that foreign insurers so far only require that the hospital works on the basis of defined quality norms. These norms are not yet specified in the contract. However, this may change in the future. Insurers may become more strict on this issue and impose certain defined quality norms on treatment delivery, e.g. through detailed care protocols. Hospitals should be prepared to handle these norms, especially when they come into conflict with each other (e.g. with own national provisions and/or with norms from other insurers). Hospitals should not take a receptive attitude here, but rather in a prospective manner prepare a comprehensive policy on quality in the field of healthcare delivery.

A hospital will be stronger in the negotiation of quality protocols if it shows that it has a well thought through policy in place on care delivery, reflecting both national and international standards in the field. It will convince more easily to follow the established hospital criteria, especially when they are evidence based.

In the micro analysis not much information was retrieved regarding waiting lists, policies around waiting lists, nor regarding concrete techniques of measurement of waiting lists. So far hospitals reported not to face waiting lists. Apparently foreign patients mainly fill up existing overcapacity. Nor did we hear of any concrete system in place monitoring potential waiting lists. Another question is whether such kind of system can be installed at the detriment of the foreign patient. From a mere policy point of view it is defendable to break down incoming fluxes of foreign patients when this is at the detriment of the access of own insured patients. We should not forget that hospitals have been entrusted with a public policy task, i.e. guaranteeing the (insured) population an equal access to the health infrastructure. This public task would come at peril when precedence is given to foreign patients.

This consideration is reflected as well in the Patient Mobility Directive. The directive refers to the possibility to prioritise healthcare for the own patients in case a too large quantity of incoming patients would result in waiting lists for the own citizens. In article 4 §3 of the directive we can read that states may “adopt measures regarding access to treatment aimed at fulfilling its fundamental responsibility to ensure sufficient and permanent access to healthcare within its own territory. Such measures shall be limited to what is necessary and proportionate and may not constitute a means of arbitrary discrimination […]”. It shall as well be made publicly available in advance. In a similar line of thought it is mentioned in observation 21:” nothing in this directive should oblige health providers to accept for planned treatment patients from other Member States or to prioritise them to the detriment of other patients, for instance by increasing the waiting time for treatment of other patients. Inflows of patients may create a demand exceeding the capacities existing in a Member State for a given treatment. In such exceptional cases, the Member State should retain the possibility to remedy the situation on the grounds of public health […]”.

To put it differently the influx of foreign patients should not bring at peril the access to healthcare facilities for the own patients. The latter may be prioritised, yet it should be based upon a transparent system which is not

arbitrary discriminating foreign patients and which can be publicly consulted.

How could such a monitoring system look like? So far no such system seems to be in place in the hospitals nor at the national level. It could be a suggestion to have this further investigated in the future on the basis of a comparative research. Do healthcare systems abroad have such systems in place? How do they function? Are they designed to protect the accessibility for the own insured patients from too large quantities of foreign patients?

A first investigation learned that there exists a variety of national approaches towards the monitoring of waiting lists in the field of healthcare. A distinction has to be made with regard to the goal (policy) pursued and the techniques applied. As to the goal, monitoring systems can have as main ambition to measure waiting periods for (given) health treatments in order to monitor accessibility (Denmark; Spain, Hungary); they can also be established with the purpose to reduce existing waiting lists (Ireland; UK) or they may have been established to implement rules that monitor legal consequences of waiting lists (Ireland, UK, Slovenia, Nordic region). The latter kind of approach is typical for states where strict gatekeepers' systems apply. This is especially true in the Nordic region where the gatekeeper system is built around a geographical structure: the patient is then enrolled at the level of the commune at a primary care provider, who can refer the patient for more specialised care to the health infrastructure of the own district/province, eventually leading to a referral to highly specialised care facilities at the central level. Patients who face waiting lists in this system, will get the right to visit another healthcare provider/infrastructure, in the neighbouring community, resp. district or province. In order to give the patient the possibility to move to another provider, maximum periods are established by law.

Apart from the legal approach some health systems simply keep track of waiting lists from a management perspective. The data are then used to monitor the supply of healthcare services (e.g. to increase the number of providers, facilities, equipment, or others, in case one notifies waiting lists for certain treatments). Sometimes the data are made public so that patients are informed on the existence of waiting lists allowing them to make the proper choices as to the selection of the healthcare provider (Hungary, Latvia, Slovenia, Sweden, UK with regard to hospitals). In some systems, the occurrence of waiting lists will allow the authorities to contract private providers to address the shortage of healthcare providers (Ireland, Spain).

The approaches towards the measurement itself are different as well: some systems monitor a large (if not complete) set of treatments; other focus upon certain types of treatment (especially prone to the emergence of waiting lists, due to an undersupply). In Denmark e.g. the main indicator for waiting times is the average waiting time for surgery (elective care/planned interventions). In the near future the system will incorporate as well the access to psychiatry treatments. In Hungary there are 2 types of waiting lists. In cases of non-emergency surgeries the hospitals themselves have to register patients. Hospitals do thus manage the lists themselves yet they must report them to the National Insurance Fund once a month electronically. In some specific cases (mainly transplantations) there are centrally managed waiting lists in the National Blood Transfusion Institute. The registration of waiting lists is then managed by the National Health Insurance Fund. From this database, information on the length of waiting lists/waiting time can be retrieved.

Similarly in Latvia and the UK waiting lists (registry lists) for receiving medical treatment are the prior responsibility of the health-care provider. In Latvia they are then sent to the Health Payment Centre that combines the data and makes them publicly accessible; in the UK data on waiting lists are made available on line by the hospitals themselves. In Sweden the regions and county councils which are responsible for providing public healthcare to citizens, have a common database for reporting waiting times. Data is uploaded into the system from ca 2 300 different administrative systems for both primary and specialised care in all regions/county councils in the country. The data in the database are made public through a website

The Slovenian monitoring system finds its basis in the Patients' Rights Act where reference is made to the obligation of provider-institutions to report data on waiting lists to the National Institute of Public Health. The mentioned rules specify the procedure for putting a patient on a waiting list. They also specify that the regulatory framework applies to all the services that are provided within the public health system. The health services that

are monitored this way are agreed annually by the healthcare authorities. The expected waiting time reported to the National Institute of Public Health is made available to the patients for consultation on the internet. Hospitals also publish the expected waiting times for a more broad set of services on their own web sites.

This is only a first sample of approaches of managing waiting lists. One should not forget that these systems mainly apply in an internal setting, thus monitoring waiting lists created by own patients, not designed with an eye towards the influx of foreign patients and the effects these may have on the national health accessibility. Nevertheless a further study of the „waiting lists monitoring systems“ can shed a light on the techniques and logics applied as well as on the inherent limitations of these systems. Some best practices can be discerned for the development of these systems, taking at the same time into account the different perspective the Belgian system could take (with a focus upon the influx of foreign patients) compared to the applied national monitoring systems (with a mere focus upon the influx of own patients).

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