

**HEALTH CARE
WITHOUT FRONTIERS?
The development of a
European market in
health services?**

Lyndsay Mountford

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About the author

Lyndsay Mountford is a freelance health economist working in Luxembourg. She is the author of the recent European Parliament Report: *European Union Health Policy on the Eve of the Millennium*.

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1 INTRODUCTION AND SUMMARY

In April 1998, the European Court of Justice (ECJ) made two rulings which many member states of the European Union (EU) regarded as a momentous development in the application of European law to the field of health care. Mr Kohll, a Luxembourger, had taken his daughter (a minor) to Germany for orthodontic treatment and wanted a Luxembourg insurance fund (Caisse de Maladie) to reimburse that proportion of the cost of the treatment to which he would have been entitled in Luxembourg. Mr Decker wanted his Caisse de Maladie to reimburse, at Luxembourg rates of entitlement, the cost of a pair of spectacles purchased in Belgium. In each case, the Luxembourg insurance fund responsible for the claims had refused to reimburse the claimants on the grounds that, under existing European regulations governing the coordination of member states' social security schemes, they should have obtained prior authorisation before seeking treatment outside Luxembourg. In both cases, however, the ECJ upheld the claimants' cases under existing Treaty provisions governing the free movement of goods and services.

To many member states these rulings represented an unprecedented attack on their right to organise their health and social security systems in their own way under *subsidiarity*, a right itself enshrined in Treaty provisions. Thus Article 129 of the Maastricht Treaty, whilst giving the EU a limited competence in health promotion, explicitly ruled out the extension of this competence to health care organisation and delivery, as does the new Article 152 of the Treaty of Amsterdam.

Against this, there is also a growing body of evidence that the health care sector is extensively affected by EU legislation in areas governing the free movement of products and professionals¹. Until the Kohll and Decker rulings, these applications had been limited to the *production* of health care services. The best known instances have been the rules of public procurement (building of hospitals, purchase of equipment), the mutual recognition of medical qualifications, the free movement of medical professionals and the licensing of pharmaceuticals. The Kohll and Decker rulings were innovative in extending single market principles to the *delivery* of health services to patients.

The immediate concerns of member states concentrated on the possibility of an explosion of cross-border activity by patients seeking

8 unauthorised care abroad. This scenario gave rise to a number of specific anxieties, in particular the fear that Europe-wide trade in health care delivery would have the potential to weaken member states' ability to set financial limits on health care expenditures by:

- weakening the gatekeeping function;
- reducing the effectiveness of waiting as a rationing device;
- constraining the ability of member states to exclude particular services from offer.

In practice, a dramatic explosion of cross-border trade, bringing with it serious financial implications for social security budgets, seems very unlikely to happen, for a number of reasons. One important factor is that cross-border flows in the EU, though apparently increasing over time earlier in the decade (the available data provide a very poor basis on which to base categorical assertions), appear to be falling in absolute terms and are still only a tiny proportion of total health care expenditures at 0.3%-0.5% on average each year. These flows largely reflect the pre-Kohll and Decker situation in which cross-border flows were constrained by pre-authorisation procedures. Nonetheless, even in the border regions of the EU, where natural barriers to cross-border trade in health care services are lower, and where explicit attempts have been made to promote cross-border cooperation between medical services for the benefit of patients, total patient flows remain very small. Both the pre- and post-Kohll and Decker experiences of patients travelling across borders for health care show that more can be done to lower barriers to trade. Even so, it seems likely that natural barriers such as language differences and travel costs will continue to constrain cross-border trade, except perhaps in the most specialised fields of medical care.

A second issue is that the ECJ has so far ruled out the extension of single market principles to hospital care, a line which it continues to take in preliminary opinions on cases now pending before it. Given the speed with which procedures traditionally carried out during inpatient stays are now becoming available on an outpatient or day case basis, ambulatory procedures could become increasingly significant as a proportion of total health care spending. At present, however, data collection at an EU level does not allow us to track any such 'cost creep' attributable to the changing composition of ambulatory care.

The third issue, with which both the ECJ and member states continue to struggle, is the partly legal and partly administrative problem of how to apply the ECJ judgements to their own particular health care systems. The ECJ Kohll and Decker rulings were in respect of the Luxembourg system of restitution insurance. Under this system, patients receive and pay for medical services directly from licensed practitioners and are then reimbursed the costs of their treatment from the insurance fund to which they are affiliated. This system is also adopted by Belgium and France. The other main type of insurance-based social security system is a benefits-in-kind system such as that maintained by The Netherlands, for example. Under this, affiliation to a health insurance fund provides a patient with access to the services of contracted medical professionals without direct payment for services. Several further cases have been referred to the ECJ by Dutch Courts expressly for the purpose of determining whether the Kohll and Decker rulings apply to the Dutch system of financing health care. The opinion of the Advocate General in one of these cases suggests that The Netherlands system of health care delivery (unlike the Luxembourg system) does not constitute a 'service' under the terms of the Treaties, since no direct payment or reimbursement of money is involved. If upheld by the ECJ, this view would lead to a two-track system under which patients under some health care financing systems would have a right to movement across national boundaries not afforded to patients in other systems. As yet untested is the possible legal and administrative application of Kohll and Decker principles to tax-based, benefits in kind systems, which now make up majority practice among EU member states.

It seems improbable that such an inconsistency could be countenanced at a political level. It is likely that increasing efforts will now be made to agree a political solution, brokered by the European Commission, rather than one which is determined by the legal judgements of the ECJ. The emerging evidence is that this political solution will be more closely based on, and designed with reference to, an assessment of the costs and benefits of an increase in cross-border health care delivery, drawing on proactive attempts to encourage cross-border health care in the so-called Euregios (border regions) of the EU.

The purpose of this paper is to set out the background to the development of regulations governing cross-border health care in the EU; to explore the possible implications of the Kohll and Decker rulings (and of subsequent ECJ cases) with particular reference to the experience of cross-border health care in the EU; and to set out some more speculative thoughts on how an internal EU market in health care delivery is likely to develop in the future.

The paper is the result of two stages of informal investigation. Initial desk study gave rise to a seminar paper, now incorporated into the text below. This reviewed the development of regulations governing cross-border flows of patients within the EU; summarised such analyses of these flows as are contained in the very small literature base; set out the reasoning behind the April 1998 ECJ rulings; and finally gathered together some of the preliminary reactions of representatives of member states' health ministries. The last element drew on the records of two international meetings held in late 1998^{2,3}. The extant analyses of cross-border flows are based on data which are now somewhat old and of dubious quality, suggesting that an important prerequisite for policy development in this area is the development and utilisation of a much more effective database than currently exists. Nonetheless, three case studies are described in some detail: a study of cross-border flows between France and Italy⁴; an analysis of cross-border flows in the Euregio Meuse-Rhine⁵, part of the Interregional programme of the EU which is directed at strengthening cooperation across borders within the so-called Euregios, namely the border regions of EU member states; and a survey of frontier workers' attitudes to cross-border care between France and Belgium⁶.

A second short phase of informal research was defined by an interim seminar held by the Office of Health Economics in October 1999. The possible impact of the Kohll and Decker rulings depends on whether and to what extent patients will move freely across borders for their health care in the future. In part this will depend on new rulings of the ECJ which could extend further the limited scope for cross-border transactions established by the Kohll and Decker cases. The seminar also agreed that, subject to these rulings, a range of drivers and incentives might impact on patient flows and that these should be

considered in relation to all the key stakeholders in the process:

- **payers:** how insurance funds and government payers are reacting to Kohll and Decker and whether they see these rulings as a threat or an opportunity;
- **providers:** what incentives do providers have as a result of the rulings to set up facilities to attract patients across borders. Is there evidence of this happening?
- **patients:** the literature already encompasses a number of hypotheses about what factors will predict patient flows, a qualitative summary of which is set out below, particularly with reference to the Euregio Meuse-Rhine study. The findings of a study of migrant workers on the borders of France and Belgium also provide some insight into what motivates patients to move across borders for health care⁶. In addition to this literature-based evidence, there was also anecdotal evidence that groups representing patient interests might be active in promoting cross-border health care.

In order to explore these questions further, the second part of the exercise encompassed interviews with a number of representatives from provider and payer organisations, as well as discussions with other commentators concerned with a pan-European view of future health service delivery and planning. These interviews concentrated in particular on the most recent phase of several ongoing Euregio health cooperation projects involving The Netherlands, Belgium and Germany. These projects were identified by the OHE seminar as potentially crucial for the future development of regional European health care markets, and as important test beds for exploring the impact of cross-country trading in health services. Interviews were conducted with a number of people involved in the Euregio Meuse-Rhine, Euregio Scheldemond and Euregio Rhine-Waal health care projects, all of whom were considering how best to implement the Kohll and Decker rulings. It did not prove possible to locate any patient interest groups focused on this issue. Some anecdotal evidence about the entrepreneurial behaviour of some doctors became available.

The paper is structured in the following way. Chapter 2 sets out the background to the development of the coordination regulations governing patient mobility in the EU. Chapter 3 contains an analysis

12 of the Kohll and Decker judgements, showing how these appeared to overturn the existing regulations, and contains a brief summary of further cases and their possible implications for the liberalisation of cross-border trade in health care. There are two central issues concerning the scope of the judgements: whether and how they apply to all member states' health systems; and whether they apply to hospital services. As will be seen, the former question is still much in doubt, although a succession of opinions so far have been consistent in ruling hospital care out of the scope of the ECJ's judgements. Chapter 4 draws together the reactions of many member states in the immediate wake of the Kohll and Decker rulings. Chapter 5 provides an overview of the extent and composition of cross-border flows pre-Kohll and Decker. Chapter 6 draws on case study material in the literature to exemplify and analyse some of the determinants of cross-border patient flows, and some of the issues to which they give rise in a post-Kohll and Decker world. The fieldwork suggests that an internal EU market in health services is most likely to develop, albeit very slowly, as an interaction of the response of market drivers to the liberalisation of trade, within a growing supra-national regulatory framework. A final concluding chapter considers some possible impacts of the main market drivers and how these might come to be monitored and managed at a political level within existing Treaty competences of the EU.

2 BACKGROUND: THE DEVELOPMENT OF REGULATIONS GOVERNING CROSS-BORDER CARE IN THE EU

Regulations providing for the preservation and coordination of national social security rights across EU member states predate the establishment of the European Community and were associated with a transition from permanent migration within Europe (which tended to characterise 19th century labour flows) to shorter periods of mobility and eventually the development of a commuting workforce in border regions. Originally, such regulatory provisions consisted of bilateral agreements between states, the earliest dating back to a health agreement of 1910 between Belgium and France. Another early example was a similar bilateral agreement between Germany and Belgium in 1925.

These agreements arose from a need to ensure that the mobility of the labour force was not impeded by loss of social security rights. This became particularly important for frontier workers. Since such workers are likely to be covered for health care in their place of work, it was necessary to ensure that they also had rights to health care in their place of residence. European Community cross-border social provision began in the original six signatory countries (Belgium, France, Italy, Luxembourg, The Netherlands and West Germany) of the European Coal and Steel Community (ECSC) which was established in 1952. Article 69, paragraph 4 of the ECSC Treaty stated that:

‘They (the member states) will prohibit any discrimination in the remuneration and working conditions between national workers and immigrant workers, without prejudice to special measures affecting frontier workers; in particular, they will make efforts among themselves to achieve any arrangements which would remain necessary so that the provisions relating to social security do not create an obstacle to the movement of the workforce.’

The Treaty of Rome of March 1957 instituted the European Economic Community (EEC) based on the fourfold principle of the free movement of goods, capital, services and persons. Article 48 of this Treaty states that *‘the free movement of workers shall be guaranteed...[this] entails the abolition of any discrimination based on nationality between workers in Member States as regards employment,*

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remuneration and other working conditions.' This article laid the first rule of European social law. The EEC Treaty defined the rights of migrant workers moving within the Community as based on the principles of *equal treatment*, *aggregation of insurance periods*, and *export of benefits*. Thus Article 51 of that Treaty stated:

'The Council shall, acting unanimously on a proposal from the Commission, adopt such measures in the field of social security as are necessary to provide freedom of movement for workers; to this end, it shall make arrangements to secure migrant workers and their dependants:

- *aggregation, for the purpose of acquiring and retaining the right to benefit and of calculating the amount of benefit, of all periods taken into account under the laws of the several countries*
- *payment of benefits to persons resident in the territories of member states.*

Equal treatment: from the time a national of a member state has the right to a benefit from another member state, that person is covered by the administration of this second state under the same conditions as its own nationals. Any discrimination based on nationality is prohibited, even if the interested party resides on the territory of another member state. The person is simply considered equivalent to a national of the state where he is entitled to a benefit.

Aggregation of the insurance periods: this means that acquisition of the right to benefits and the calculation of their amounts takes into account all periods of insurance, employment or residence in all member states where they were realised. This aggregation process, without which freedom of movement would be seriously impeded, requires that every social security institution of a member state should take full account of the periods of insurance realised in every member state, as if they were periods realised in accordance with the legislation that it applies itself (ruling of the ECJ in the case of *Caisse primaire d'assurance maladie d'Eure-et-Loire/RECQ* of 19 January 1978). The application of this principle involves close relations being established between the national social security bodies.

Exporting benefits: this forces any member state to settle benefits to their insurance holders, even if they reside in another member state.

Prior to this, during the inter-war period, Belgian and French legislators had been innovative in constructing a set of principles as a basis for regulating the provision of health care services in kind across borders. The formal agreement between France and Belgium established the principle that the cost of health care provided in the place of temporary or permanent residence should be borne by the social security system of the treated person. This principle was applied later on in all European social security agreements, and was eventually incorporated into EEC Regulations 3 and 4 of 1958, which installed a coordination system of social security rights at a European level in implementation of Article 51 of the EEC Treaty. This heralded the first of four stages of assimilation of treaty provisions into regulations governing the European coordination of health care protection schemes.

This first stage created the institutional organ – the Administrative Commission – which controls the application of regulations, negotiation of agreements between member states, and the basic accounting functions relating to invoices and receipts of payments for cross-border care. Regulations 3 and 4 ensure the acquisition of the right to health insurance benefits by different groups of employed workers:

- workers and/or members of their family temporarily resident on the territory of another member state;
- workers and/or members of their family transferring their residence from one member state to another;
- pensioners and/or members of their family in the country of residence as well as in the country of temporary residence;
- the members of a worker's family who reside in the territory of a member state other than that of the place of work of the insured party.

A second stage started in 1963 with EEC Regulations 36/63 and 73/63. These made provision for frontier workers and seasonal workers respectively. Regulation 36/63 granted frontier workers – those who work and are insured on one side of the border, but live on the other side – double access to health care, both in their home state and in their working state, provided that they returned at least once a week to their country of residence. EEC Regulation 73/63 introduced an important innovation by authorising employed workers of a member

state to seek health care on the territory of another member state without transferring their residence as such to that country, subject to the employed workers receiving prior authorisation from their insurance organisation. They would be entitled to the reimbursement of the benefits in kind, in accordance with the legislation applied by the social security institution of the provider country. Case law of the ECJ, in particular the UNGER ruling of 19 March 1964, extended the concept of 'worker' to any worker who moves into another member state for whatever reason, even if it is not related to his profession, for a period of less than one year, subject to holding an E111 form which proves his membership of a social security scheme in his country of origin. Consequently, any worker who was an EU national and a member of a social security scheme, should enjoy guaranteed social benefits in the member states, at any moment and wherever he might be within the EU.

In the third stage, all existing EEC coordination regulations were absorbed in 1971 into one new instrument, Regulation 1408/71, which governed all cross-border flows until the 1998 Kohll and Decker rulings. Regulation 1408/71 was innovative in defining the concept of the frontier worker, namely 'any employed or self-employed person who pursues his occupation in the territory of a member state and resides in the territory of another member state to which he returns as a rule daily, or at least once a week'. The rights which formerly only applied to the border regions now applied to the whole territory. In summary Article 34 of the Regulation implemented a system for reimbursing benefits in kind, which allowed the recipients of benefits to gain reimbursement upon returning to their country of insurance.

In a fourth and final phase in 1981, the personal scope of the coordination rules was extended to self-employed workers and their family members by EEC Regulation 1380/81.

The European coordination regulations allow three main types of cross-border care, as follows.

Migrant workers (E106)

As a special category, frontier workers benefit from a double access to health care, that is both in the state of residence and in the state of

work at the same time. To initiate this right in the state of residence (assuming that workers are insured in their state of work) an E106 form is issued. In the case of frontier workers between France and Belgium, this double access has been extended by bilateral agreement to family members.

Temporary stay (E111)

The regulations provide mechanisms for individuals to access health care abroad in emergency situations so as to encourage mobility between member states. Originally this was meant for migrant workers from southern member states to allow them to return to their home land during vacation periods with insurance coverage for health care. Gradually, it applied to the international tourist mobility which developed from the 1960s onwards. It also applies to short-term business and professional mobility. To initiate the right to health care in these situations, the form E111 is used. A condition for this type of care is that the person's state of health necessitates immediate care (Regulation 1408/71, Article 22, 1a).

Pre-authorised care (E112)

Conceptually, flows for pre-authorised care are quite different from E106 care (aimed at promoting labour mobility within the EU) and E111 care (intended to facilitate tourism). Free patient mobility and the opportunity for patients to demand health care abroad, regardless of professional mobility or temporary stay, has not been an objective as such of European coordination policy. Throughout the efforts for economic integration, it has also been clear that the social security systems of the member states differ too much to be harmonised. However, the regulations contain some provisions which tend in that direction. In cases where patients obtain prior authorisation from their competent institution, people falling under the scope of the coordination regulations may obtain medical treatment in another member state which will be paid for, at tariffs prevailing in the providing state, by the competent institutions in the state of insurance (Regulation 1408/71, Article 22, 1 b and c). Form E112 proves that the authorisation has been given by the competent institution.

18 **The regulation of E112 pre-authorised care**

The authorisation policy of the competent health protection institutions remains largely a prerogative of the national member states. Criteria tend to be established by panels of doctors whose views can vary considerably as to the admissibility and application of the European regulations. The regulation only stipulates in which cases authorisation cannot be refused, namely:

‘when the treatment is covered by the legislation of the residence state but cannot be given within the time normally necessary for obtaining the treatment, taking account of the current state of health of the patient and the expected course of the disease’ (Article 22(2)(2)).

When implementing the EU regulations, some countries, of which the UK is one, have no additional legislation. In the UK, the Department of Health (acting in this case for England, Scotland and Wales – Northern Ireland and Gibraltar have separate arrangements) has issued guidelines to health authorities explaining citizens’ rights to referral elsewhere. To obtain medical treatment in another EU member state, the patient must gain the approval of a National Health Service consultant (specialist doctor) together with a letter of recommendation for treatment abroad. This request must then be agreed by the local health authority which meets the costs of the treatment in another country. The Department of Health issues the E112 on receipt of this agreement. There is no formal right of appeal in the UK, although the patient may apply to the Department of Health for further consideration in the event of an unfavourable decision at local level. In Luxembourg, approval for treatment is given by the medical panel of the local insurer and sometimes a second opinion of a consultant physician is required. Patients have a right of appeal based on Luxembourg’s own Social Insurance Act. Luxembourg and Spain are examples of countries which grant permission to go abroad under wider circumstances than those prescribed in the EU regulations, including cases of extended waiting periods and for treatments unavailable locally.

Somewhat contrary to the spirit of the regulatory framework, one of the factors which prompts patients to seek care abroad is precisely

its non-availability in the domestic system. Indeed, it is worth noting that the actual wording of Article 22(2)(2) is the result of an amendment brought about by EEC Regulation 2791/81, following the judgements of the ECJ in the *Pierik* case. The previous version obliged member states to grant the E112 form *'when the treatment in question cannot be given to the interested party in the territory of the member state in which he lives'*.

Arguably one of the new cases before the ECJ (Smits-Peerbooms, discussed below) could result in a reversion to the former state where the ECJ recognises a right to all available medical provision, even if that treatment is not covered by the health insurance system in the home state. The range of services which are technologically and medically possible is continually expanding. The services which different member states make available to their citizens at any moment can be expected to differ. With cross-border provision of health care, the range of services potentially available to citizens in one country could ultimately be determined not by the decisions of national health policymakers, but by a combination of decisions reached in EU countries.

In a number of member states the judiciary has assumed an active role in adjudicating between patients' rights to health care – based on arguments of medical necessity, medical urgency and patient freedom to choose a provider – and the social constraints engendered by limited resources and the need to contain costs. This judicial regulation has extended to patients' access to health care in another member state. In these cases, the courts have tended to adjudicate the interests of patients in obtaining care which might otherwise not be available and the interests of payers in circumscribing packages of care.

For example, there are a number of well-documented cases in The Netherlands. One important decision concerned the right of a patient to be reimbursed for a by-pass operation carried out in London⁷. The patient's sickness fund had refused to reimburse the patient for the operation. The Central Appeals Board ruled that urgent treatment could not be refused simply because it was to be provided abroad. Key criteria were the clinical necessity for the procedure and its availability in The Netherlands. In this case, it was determined that the treatment could have been obtained in Amsterdam and the patient could

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have been treated within the time period requested. There was, therefore, no clinical justification for the operation to have taken place in London, and the view of the sickness fund was upheld.

Another case involving a by-pass operation in London for a Dutch national insured in The Netherlands, determined that the three month waiting time guideline specified by the Dutch National Health Council should not be considered a legally binding maximum⁸. The Court held, instead, that the clinically acceptable maximum waiting time should be determined by reference to the needs of individual patients and set on a patient by patient basis. In this case too, the decision of the sickness fund not to reimburse the patient was upheld.

More recently, civil and administrative courts in The Netherlands have had to deal with cases involving heart transplant operations. One concerned a privately-insured patient and the other a publicly-insured patient. Both patients were refused authorisation by their respective insurers for a heart transplant in a Belgian hospital. In the case of the privately-insured patient, a Dutch hospital had turned him down for a transplant on the grounds that the clinical team saw no possibility of a successful outcome. The transplant team in Belgium judged differently. A Dutch civil court concluded on grounds of *reasonableness* and *fairness*, that the patient was entitled to reimbursement of costs, since a second opinion on his condition was not available in The Netherlands⁹.

The publicly-insured heart transplant patient suffered a different outcome, since in his case the Regional Court of Breda, an administrative court, ruled that the Dutch heart transplant team was obliged under the Dutch Sickness Fund Act (WTZ) to follow the national heart transplant protocol, i.e. that the protocol formed an integral part of the specification of the entitlement for the heart transplant benefit¹⁰. This demonstrated that in The Netherlands the right to be reimbursed for foreign care depends crucially on what kind of insurance a patient has and under which jurisdiction, civil or administrative, the case falls.

Subsequently, in a separate case which also drew on arguments of reasonableness and fairness, the Dutch Appeals Commissioner overruled a private insurer's refusal to reimburse an eye operation in a German university hospital which was considered to have more expe-

rience with the treatment in question than Dutch hospitals. The insurer argued unsuccessfully that the insurance policy did not allow payment for treatment in a hospital which had been selected exclusively on the basis of the quality of care it offered¹¹.

In Italy, the courts have also played a prominent role in adjudicating patients' rights to cross-border health care. Until 1989 it was relatively easy for Italian patients to obtain authorisation for care abroad, both for E112 care and for care delivered by non-EU providers. The rights of Italian patients to health care are established not just in statutes, but by Article 32 of the Italian Constitution. In addition, the poor reputation in some quarters of the Italian National Health Service, the Servizio Sanitario Nazionale (SSN), and the fact that funding for care obtained abroad was borne entirely by the Italian Ministry of Health, combined to produce a high demand for such care and a relaxed authorisation procedure.

In 1989 an Italian Ministry of Health Decree established referral committees made up of specialist doctors to carry out the authorisation process. Use of recognised foreign centres of excellence could be authorised in cases where the care prescribed was not available in an adequate form in Italy. Circular no. 33 of 12 December 1989 applied these regulations to European Community care, stating, 'It is recognised, in fact, that until the national hospital system is reorganised and can guarantee for all specialty services standards of care and speed of delivery comparable with those in other member countries of the Community, the exceptional instrument of transfer abroad for care cannot be limited in situations where there are objective deficiencies in the national hospital system.' Italian Ministry of Health Decree, 24 January 1990 (since revised) laid down a list of services for which E112 authorisation could be granted by the regional referral committees. A maximum waiting period was specified for each service. E112 authorisations halved between 1989 and 1997.

The rulings of Italian courts on access to foreign health care providers have tended to endorse payers' attempts to limit use of foreign care:

- the Regional Administrative Court of Tuscany refused an appeal by a patient for reimbursement of the cost of treatment at a cardio-

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thoracic centre in Monaco, on the grounds that the patient could obtain the necessary care in an Italian hospital¹². A similar decision was issued by the Regional Administrative Court of Piedmont which attached considerable importance to the fact that it was the referral committee of medical specialists denying the authorisation¹³;

- the Regional Administrative Court of Sicily turned down an appeal by a patient for reimbursement for surgery for a detached retina (a treatment not included in the list of services eligible for E112 authorisation)¹⁴.

However, the Italian courts have not always upheld the referral committees. In one case, the Regional Administrative Court of Tuscany upheld the right of a patient to reimbursement for a heart valve implant using the so called Ross-implantation method¹⁵. This was affirmed by doctors to be clinically more effective for this patient than standard methods, but was unavailable in Italy and so procured in Monaco. In another case, an administrative court ordered future costs of a US-based treatment for a brain-damaged child to be reimbursed, or the therapy to be provided by the SSN, notwithstanding an earlier declaration by the Region of Tuscany that the treatment in question was clinically ineffective, a view which the Court considered to be out of date¹⁶.

3 THE KOHLL AND DECKER JUDGEMENTS

The implementation of EC Regulation 1408/71 in Luxembourg national law was challenged in 1995 by two Luxembourg nationals who argued before the ECJ that the prior authorisation procedure violated EU rules on free trade. Mr Kohll argued that the authorisation procedure restricted him from purchasing services in other EU member states and therefore contravened articles 59 and 60 of the EC Treaty. Mr Decker argued that the prior authorisation procedure restricted the free movement of goods within the EU and so violated Article 30 of the EC Treaty.

The judgements of the European Court of Justice

The ECJ considered the cases under three headings:

- ***The applicability to the field of social security of the economic rules on free movement of goods and services***

Hitherto member states had argued that social security and health should be fields subject to the subsidiarity conditions of the Maastricht and Amsterdam Treaties and hence should remain a strictly national competence. The prevailing principle underlying the development of social security regulations was one of coordination rather than convergence.

- ***The validity of EC Regulation 1408/71***

The authorisation procedure contained in EC Regulation 1408/71 had been carefully implemented into Luxembourg national law by the Social Insurance Code and the statutes of the Union des Caisses de Maladies des Salariés. These national rules stated that authorisation could not be refused if foreign treatment were recommended by both the patient's doctor and a medical advisor or if the treatment required was not available in the Grand Duchy. The last provision could be interpreted as going beyond the requirements contained in the EU Regulation.

- ***The application of the EU rules on the free movement of goods and services to the facts of the cases***

Judgements on the Kohll and Decker cases were delivered in April

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1998 amidst considerable national interest among member states. The ECJ, fully aware of the possible implications of its judgements, took the unusual step of issuing a press release concurrently with its verdicts.

As regards the applicability of economic rules to the fields of health and social security, the ECJ concluded that member states have a great deal of freedom in the organisation of their social security systems, for example to determine the conditions for affiliation to a scheme and the entitlement to benefits. The ECJ concluded, however, that this discretion could not be used to breach EC law. The Advocate General states in his opinion:

'The Court's consistent view is that 'Community law does not detract from the powers of the member states to organise their social security systems' by no means implies that the social security sector constitutes an island beyond the reach of Community law and that, as a consequence, all national rules relating to social security fall outside its scope'.

The ECJ further argued that although in this case national rules (those of Luxembourg) complied with EC Regulation 1408/71, this Regulation, constituting secondary EU law, could not take legal precedence over primary EU law, namely the EU Treaty itself. The ECJ did not declare Regulation 1408/71 invalid, but argued that it did not provide an exhaustive list of the means by which someone could obtain medical goods and services in another member state. It argued that the Regulation should be seen as merely one possible means by which a citizen of one member state might obtain medical goods and services in another member state.

The rules governing the free movement of goods and the free provision of services can be divided into a two-stage test. The first stage determines whether there have been any restrictions on the free movement of goods and services across internal borders of the EU. In both these cases it was easy to establish that a more restrictive view was being taken of the acquisition of goods and services in some member states (Belgium and Germany) than would apply in another (Luxembourg).

Once some restriction is identified then the second stage asks whether there is any reason which might justify this restriction. Under

EU law, violation of free movement can be justified in two possible ways. One involves justification on the basis of Articles 36 or 56 of the EU Treaty. These articles provide a list of grounds under which violations of the free movement of goods and services will be tolerated. They include the health of humans and animals, but do not include any economic justifications. They are applicable where there is deemed to be direct discrimination against a foreign good or service.

The second method of justifying infringements of the free movement of goods and services is through the *rule of reason*. This allows member states to advance a wider selection of justifications for breaching the Treaty articles on free movement. These justifications are based on the wider idea of the general good and can permit financial considerations to be advanced in justification. The rule of reason can only be invoked where there is judged to be indistinctly applicable discrimination, that is, rules which seem to apply to foreign and domestic goods and services alike, but in reality have a greater negative impact on foreign traders or service providers. The ECJ did not classify the obstruction to the free movement of goods and services in the Kohll or Decker cases, but the Advocate General held the opinion that the Luxembourg measures were indistinctly applicable and so permitted arguments for discrimination based on the rule of reason.

The Luxembourg government proposed two justifications for the discrimination. It insisted that prior authorisation was necessary to ensure the financial balance of the social security system. Second, it argued that it was needed in order to protect the public health of the population since there would be no way to ensure the quality of the goods and services provided by orthodontists and opticians in other member states.

The ECJ dismissed the first argument on the grounds that since both Messrs Kohll and Decker had sought reimbursement at prevailing Luxembourg tariffs the local Caisse de Maladie would not have to pay out more as a consequence of the foreign nature of the transactions than if the goods and services in question had been obtained in Luxembourg.

The second point was also dismissed by the ECJ, which argued that the measures introduced to harmonise the training requirements for most medical professions during the 1970s, culminating in the

mutual recognition of diplomas, provided an assurance of a minimum level of skill and qualifications from health care providers right across Europe. (The ECJ has since been strongly criticised for this assertion).

However, the ECJ noted in the case of Mr Kohll that the requirement to maintain a balanced medical and hospital service open to all might provide a justification for discrimination in the future, although it did not do so in this particular case. The Advocate General also referred to the concept of a ‘hospital infrastructure’, noting that services provided in the context of a ‘hospital infrastructure’ were distinctive because the location and number of hospitals is determined by forward planning and the costs of a person’s stay in a hospital cannot be separated from the costs of running the hospital as a whole. He concluded that if people were to receive treatment in hospital abroad the cost of maintaining an under-utilised hospital at home might well throw off balance the financing of the social security health care system. This could endanger the continued existence of hospital facilities for people who did not wish to travel. This opinion, which has since been reiterated in the Smits-Peerbooms opinions of the Advocate-General, clearly placed a very significant restriction on the implications of the rulings for cross-border flows. The issue is explored later in the paper.

Immediate implications of the ECJ rulings

The ECJ rulings on the Kohll and Decker cases have given rise to a dual system of obtaining health care from another member state:

- under EC Regulation 1408/71, providing for the issue of, for instance, forms E111 and E112, an insured person may receive treatment abroad for which s/he will be reimbursed in accordance with the scale of charges in the country in which s/he receives treatment;
- the new (Kohll and Decker) option whereby the insured person obtains treatment abroad and subsequently requests reimbursement in accordance with the scale of charges in the country in which s/he is resident.

In addition, the rulings have left considerable ambiguity about the specific areas of health care provision to which the Kohll and Decker case law applies. One issue is that Articles 30, 59 and 60 of the EU Treaty, which govern the free movement of goods and services, may

not apply where this free movement would compromise the maintenance of a care capacity or medical competence in a national territory which is essential for public health. This ruling will only be further tested, however, when further cases now pending are dealt with by the ECJ. A second issue, as described in more detail below, is that the majority of member states who do not operate the Luxembourg-type system of restitution insurance, have been left in doubt about whether and how the Kohll and Decker rulings apply to their particular systems of social security provision.

Further ECJ cases

- *Ferlini C-411/98*

Mr Ferlini was a civil servant of the EU and was insured under his employer's insurance. His wife delivered a baby in a Luxembourg hospital. Luxembourg hospitals have a different set of tariffs for foreign patients than for nationals. This is not allowed under EU competition law. The hospital is arguing that it is not an enterprise for the purposes of this legislation. The ECJ has now decided in the claimant's favour, thereby ruling out the two-tier pricing system.

- *Vanbraekel C-368/98*

This case concerns the hospital care of a Belgian national treated in France. The Belgian Mutualité (insurance fund) had refused to authorise the treatment, but the national court allowed the patient to go. The question to be determined, and the particular interest of this case, is whose tariffs will be reimbursed? The Vanbraekel family is actually claiming that Belgian tariffs (which are higher than French tariffs) should be applied, and the case points to a situation in which patients might in future adopt whichever access to foreign care is likely to provide them with higher levels of reimbursement. (Nine member states intervened in this case, an exceptionally high number.)

- *Smits and Peerbooms C-157/99*

These cases concern two Dutch citizens. Mrs Smits-Geraets sought reimbursement from the Dutch insurance fund VGZ for treatment for Parkinson's disease received in the Elena Clinic in Kassel, Germany.

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This clinic specialised in ‘specific and multidisciplinary’ treatment of Parkinson’s disease. Patients are admitted for between three and six weeks. Reimbursement was refused on grounds that adequate treatment of Parkinson’s disease was available in The Netherlands and that there was no medical necessity for seeking specific clinical treatment in the Elena Clinic. Mrs Smits-Geraets responded by arguing that the clinical quality of care in the German clinic was superior to the ‘fragmented approach’ offered in The Netherlands. Two senior neurologists differed in their views on the clinical arguments for seeking care abroad.

Mr Peerbooms went into a coma as a result of a car accident in December 1996. His consultant neurologist requested on his behalf reimbursement of the cost of treatment in the University Clinic in Innsbruck, Austria, where he received a special intensive neuro-stimulation therapy. This therapy is available in The Netherlands only on an experimental basis and the patient would not have qualified for it under the restrictions currently in force which reserve the treatment for patients less than 25 years of age. This request was refused on the grounds that appropriate care could be obtained from a Dutch provider assigned to Mr Peerbooms’ sickness fund. Dutch medical opinion was of the view that the treatment of comatose patients in Innsbruck was of no additional value over and above the facilities on offer in The Netherlands. However, Mr Peerbooms, who was admitted to Innsbruck in a vegetative state, did recover full consciousness following the treatment there.

The Advocate General has expressed his opinion to the ECJ in the Smits/Peerbooms cases. The opinion argues that health services of the benefits-in-kind type offered by the Dutch health care system do not constitute a service under the terms of the Treaty relating to the free movement of services. In addition, the Advocate General has reiterated the opinion that the maintenance of a secure, domestic hospital infrastructure should rule out the application of the free movement principles to hospital care.

- *Müller-Fauré and Van Riet C-385/99*

Mrs Müller-Fauré, a Dutch insured national, deliberately request-

ed dental care during her holiday in Germany, allegedly because she was not satisfied with the care provided by Dutch dentists. She was refused reimbursement by her health insurance on the grounds that the treatment administered was not urgent. This case is perhaps most important because of an increasing perception among member states that provisions for emergency care (E111) are in practice being blurred, and are being used to fund non-emergency health care provision.

Mrs Van Riet, also a Dutch national, obtained an arthroscopy at a Belgian hospital in order to avoid long waiting lists in The Netherlands. She requested authorisation after the intervention, but was refused it on the grounds that sufficient and adequate care could have been given to her in The Netherlands.

4 THE APPLICABILITY OF THE KOHLL AND DECKER RULINGS TO MEMBER STATES' HEALTH SYSTEMS

The Kohll and Decker judgements produced a variety of responses from representatives of member states' health or social security ministries. A selection of 'round the table' comments, derived from two international gatherings is reproduced below to give a flavour of member states' reactions. One meeting was an international symposium held in Luxembourg in November 1998, sponsored jointly by the Association Internationale de la Mutualité (AIM), the Ministry of Social Security of the Grand Duchy of Luxembourg and the European Institute of Social Security (EISS). The second was a preparatory meeting for the German EU Presidency held in Bonn in November 1998. It has not always been possible to identify from the published records of these meetings the position of Greece, Ireland, Portugal and Sweden. Furthermore, the precise source of the comments reproduced below under country headings is not always clear. Indeed, within member states different stakeholders will have different views. Main preoccupations seem to be the following, however:

- do the judgements apply to all of the very different systems of health care financing which can be found in the EU?
- if yes, what administrative processes are involved and what would need to change?
- what are the strategic implications for health services planning and financial control?

A typology of financing systems

It may be helpful to rehearse some of the fundamental difficulties which member states have encountered when relating the Kohll and Decker judgements to their own particular situation. The various health care systems of the EU member states can be classified in different ways. Following the OECD classification, it is possible to discern six major sub-systems which comprise three sources of finance:

- out-of-pocket payments;
- voluntary (or private) insurance premiums;
- compulsory (or public) contributions in the form of insurance

payments or taxation funding; and three methods by which third parties can arrange for health care benefits to be provided:

- reimbursement of patients for medical bills (indemnity insurance) with no connection between insurers and providers;
- direct contracts with (often independent) providers to provide benefits in kind, usually with work-related payment systems;
- ownership and management of providers in an integrated model, generally lacking work-related payment systems.

EU health care systems are sometimes referred to either as Bismarckian, where they involve social insurance/third party payers providing reimbursement insurance (e.g. Luxembourg, France, Belgium) or benefits in kind (Germany, The Netherlands); or as Beveridge systems which are based predominantly on taxation. In practice, most systems combine, in different proportions, elements of all six sub-systems listed above.

The Kohll and Decker case rulings of the ECJ were based on the Luxembourg system of reimbursement insurance under which patients apply to their particular *caisse de maladie* for reimbursement, or part reimbursement, of fees which they have already paid to a medical practitioner or institution. It is less straightforward to see how this might apply to a benefits-in-kind insurance system in which a patient affiliated to an insurance fund obtains benefits directly from a provider with payment for the service being made between third party payer and provider. In this case there is no system for direct reimbursement to patients. In some health care systems there is additional direct government funding, which implies a divergence between the full resource costs of treatment and the tariffs established against fee for service items. In yet other cases, funding may be by means of block contracts, implying that tariff structures are incomplete. The development of the discussion below includes a commentary on how The Netherlands, an insurance-based benefits-in-kind system, is tackling these problems.

An important additional factor concerns the role of the gatekeeping physician. In the Luxembourg system, although a referral process exists, the patient may initiate a demand for care at any level of the system. This is also generally true of Belgium and Germany. In other

countries, such as The Netherlands and the UK, patients may only access secondary and tertiary levels of health services through a gate-keeping physician. Hence the patient's ability to shop abroad for care may be dependent on the ability of a gatekeeping physician to assist (or block) this process, depending on how exactly member states set up systems for patients to access care. This issue is pertinent to the question: what will be the future drivers of demand for cross-border trading in health care?

Member states' reactions to Kohll and Decker

Austria

Under the Austrian health insurance system, the insured can choose between benefits in kind and the reimbursement of costs (of up to 80% of the contract cost). The Austrian health insurance funds do not seem to anticipate any additional effect from the Kohll and Decker rulings. Indeed, they see the 20% discount from payment as providing an incentive for domestic consumption. (One very specific problem in Austria has been Hungarian dentures offered at very low prices, which Austrian courts have already ruled are comparable to domestic dentures in quality).

Belgium

In response to the Kohll and Decker rulings, the Belgian Ministry of Health produced a circular enabling it to respond to specific situations that have immediately arisen in practice. It contains four principles:

- services that have been dispensed without prior authorisation in any of the 14 other EU member states may be reimbursed in Belgium at the rates of the Belgian health care insurance system, inasmuch as the legal conditions stipulated for reimbursement in Belgium are met;
- services must have been supplied outside of any hospital stay and should not relate to medicines. The latter have been excluded pending investigation into how to deal with different forms of presentation and dosage and information given to patients;
- the cost of the services concerned should not exceed a total of

€500 per trip, an amount which figures in Articles 17.7 and 34.4 of Regulation 574/72;

- the sum to be reimbursed should not exceed the amount of the costs actually incurred.

The Belgian Ministry of Health considers that ‘health care without borders’ should be implemented through systems and processes which have been developed and agreed at European level, rather than bilaterally. Belgium notes that the Kohll and Decker rulings add a sixth set of pricing rules to those which it already manages: E112; E111; E111 price fixing when the insurance holder does not have his E111 form; pricing based on the relevant member state when the party in question has consented; different rules for pensioners on temporary stays abroad; Kohll and Decker.

Further Belgian concerns are about how to support the patient as consumer and to reduce the extra risks this new status may entail, particularly risks associated with the administrative complexities of billing for care which has not been authorised in advance.

On balance, however, the Belgian Ministry of Health does not fear large-scale movements of patients beyond national borders, identifying cultural and linguistic barriers as the main impediment to mobility. Cross-border flows currently account for a small proportion of total budget. Reimbursements to Belgians for care received abroad currently amount to a little under 1% of the national health care budget. Taking out specific situations, namely people living near the borders and nationals resident abroad, reduces the percentage to 0.2%.

With respect to medical infrastructure, Belgium has been concerned less about the possibility of losing patients abroad, and more about gaining patients who might add to waiting lists and even displace its own nationals on these lists. Belgium queried the assumption of the EJC that homogeneous quality of services automatically derives from the reciprocal recognition of the qualifications of care providers. About 50,000 foreigners already come to receive treatment in Belgium annually, accounting for costs and income of approximately 1.2bn Belgian francs.

Denmark

Denmark has noted the Kohll and Decker judgements but is unclear

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whether they apply to the system of public provision of benefits in kind which operates in Denmark. There would be greater cause for concern if the ECJ were to offer further case law which explicitly included a benefits-in-kind social security system.

Finland

Finland has a taxation-based health system offering benefits in kind to all citizens. Until now patients seeking treatment abroad without obtaining prior authorisation have not had the costs incurred reimbursed. Since this arrangement contradicts the ECJ judgements, an amendment is planned under which these patients would be eligible to a partial reimbursement of expenses.

France

French Ministry officials have noted the need to interpret the scope of the judgements as potentially covering health care products in the widest sense (e.g. medicines, appliances, prostheses) and all the medical and paramedical services provided by health care professionals. France notes that all member states will be required to take measures, whether or not their national social security legislation provides for a reimbursement mechanism for products and care purchased by patients outside the territory in which they live. It even calls for the health market to develop, but under the supervision of Parliament, rather than through further case law of the ECJ.

The main French concern is the impact of Kohll and Decker on cost containment measures, including medical guidelines, service coding, rules governing prescriptions and a policy of contracts between the social security funds and health care practitioners. These contracts are linked to the rules governing reimbursement by social security schemes of the cost of services for insured persons. A mechanism for care schemes and networks has been gradually put in place. France's view is that these priority setting measures cannot be applied to practitioners outside the country.

There are also controls on expenditures at the macro level which unauthorised flows of patients might serve to contravene.

Like Belgium, French ministry officials believe that quality con-

trols will have to go well beyond the recognition of professional qualifications, to establish minimum rules or equivalent standards relating to the monitoring of comparable medical practices.

Germany

The Kohll and Decker judgements created a considerable stir in Germany when they were announced in April 1998. The Federal Ministry of Health felt that the freedom of goods and services provision of the EU Treaty could not automatically apply to social security schemes, where it has already been accepted that convergence of arrangements is impracticable. Clearly, ECJ case law is pushing EU member states towards some coordination of social security systems. The question is, how far can and should this coordination go? Concern about this tension was at the heart of the German response.

There were several particular questions. Do the ECJ decisions apply to benefits in kind? Unlike The Netherlands (see below), Germany thought not. Do the ECJ judgements apply to hospital care, outpatient medical and dental care, medicines and aids? The Federal Ministry felt that further ECJ case law was needed to clarify this.

Finally, there was a general concern about the need to maintain financial control over health care and some anxiety about how far the rulings would undermine the mechanisms for this control.

Italy

Italy shares the view that the judgements should not automatically be extended to benefits-in-kind payments systems, which it thinks would cause problems with quality assurance, minimum standards, and a heavy burden of administration, particularly over billing. Italy has argued that if there is more cross-border health care in future, health systems will be 'thrown off-balance'.

Luxembourg

Luxembourg finances health care through restitution insurance in which patients choose and pay for medical services and are then reimbursed a proportion of their payments. Given the already open nature of Luxembourg's health system, it was not surprising that Luxembourg

should have been one of the contestants before the ECJ. Luxembourg had implemented EC Regulation 1408/71 in national statutes and had also previously implemented a cross-border agreement with Belgium which entitled Belgian frontier workers to receive treatment in their country of residence while applying for reimbursement in accordance with the charges of the country of employment, (namely Luxembourg).

Though very small, Luxembourg is the wealthiest country per capita in Europe, with one of the most expensive health systems. It relies to an extent on external health care infrastructure and expertise. Questions of priority setting and strategic capacity would not seem to be at the forefront of its concerns, and it may seem surprising, therefore, that Ministry of Social Security officials have been relatively unenthusiastic about the Kohll and Decker rulings. The main reason for this, however, is the anticipation of administrative difficulties in implementing Kohll and Decker, based on the previous experience of administering a cross-border agreement with Belgium. Eventually this was replaced by a charging scheme in accordance with the legislation of the country in which the treatment is given. Officials have commented: 'To the satisfaction of nearly everybody, Luxembourg has given up what was a complicated scheme in our bilateral relations with Belgium. The case law of the Court has reintroduced this scheme for us through the back door'.

Administrative problems identified by Luxembourg concern in particular the need to identify and categorise correctly a service purchased abroad so as to apply national charges. A secondary issue of concern was an increased possibility of fraud and the possible administrative burden of checking and validating invoices. They have raised the question of authorised providers, including the need of patients to ensure that doctors are registered under the state health scheme in other member states. A more general concern is the increased burden of information on patients to ensure that unfamiliar services procured abroad are in accordance with their requirements. The question of information for patients is dealt with in more detail below.

The Netherlands

The Netherlands has not only been the most relaxed member state in

its response to Kohll and Decker, but has actively sought to implement cross-border health care agreements in line with the ECJ's rulings.

The Netherlands has an insurance-based health care system providing benefits in kind. In the early months after Kohll and Decker, the Dutch organisation of health insurers, the Sickness Funds Council, and the Minister of Public Health agreed that the Dutch system of social health insurance is compatible with the ECJ judgements, although some adjustments to Dutch legislation were made.

The Kohll and Decker judgements, based on the Luxembourg regulations, involve restitution insurance: the insured is reimbursed all or part of his costs. Under the Dutch social health insurance system, the insurance provides benefits in kind, via contracts which the sickness fund makes with independently established care providers. The insured can choose from among the care providers which have been contracted by their sickness fund. Dutch legislation does not preclude the purchase of care from beyond its borders in other member states of the EU. However, this has happened only occasionally before. Consequently, in the extension of the Dutch system under Kohll and Decker, patients will be allowed to obtain care in another member state as long as the care provider has contracted with the sickness fund of the insured person concerned.

A significant proportion of the Dutch population is privately insured. The Netherlands has statutorily required private health insurers to provide a so-called standard package, alongside any other insurance packages they may offer, which is open to certain groups of insured. The exclusion of care obtained in another member state has been removed by amendment to existing statutes (the WTZ Act).

Spain

Spanish Ministry of Social Security officials have professed some dismay at the ECJ judgements and have argued that they do not establish the free movement of patients, but of services and goods. Whether this distinction is important or useful seems doubtful.

Other points which they have made are:

- private insurance companies are also directly involved since national territorial restrictions on private insurance policies can be

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- considered unlawful according to EU legislation;
- it is difficult to foresee what problems might arise if flows are of significant magnitude;
 - there is a fiscal issue if flows are large enough, since there is a net tax flow out of the resident, and to the foreign, country in respect of taxes on goods and services purchased abroad;
 - external flows, if not predictable or controllable, undermine volume assumptions necessary to support the whole pricing system;
 - since the Kohll and Decker rulings are based on the existence of a reimbursement system, they do not seem to be applicable to countries like Spain which have a taxation-based health financing system offering benefits in kind;
 - within the Spanish health service, there is no free competition among health care providers within the framework of social security, whereas competition will be created by external flows. Thus, if a Spanish insured cannot resort to Spanish private health care services, it should not be possible to resort to French private services either.

United Kingdom

The Department of Health has made two general comments. It felt that the free market principles underlying the ECJ's decisions should not be applied indiscriminately to health systems, and that the balance between subsidiarity and free market principles should be struck through political mechanisms rather than through the case law of the ECJ. In addition, the Department noted that the health financing arrangements in Luxembourg are quite unlike those in the UK. The latter is based on a tax-financed, generally residence-based system providing benefits in kind through state-owned institutions. A number of specific points emerged:

- the UK has no system which allows patients to purchase health care from outside the National Health Service and to be reimbursed from the state at national tariffs. Under subsidiarity, member states are free not to opt for a reimbursement system and, therefore, any requirement to introduce one would seem to be in conflict with subsidiarity;

- in specific instances, the UK has arrangements so similar to a reimbursement system that perhaps these could be adapted. For example, the UK has a system of vouchers for spectacles which exempts certain groups of the population from part or all of the cost of purchasing spectacles;
- as regards, orthodontic services, the Department of Health has argued that UK dentists working in the NHS are not providing a service for remuneration as defined in Article 60 of the EC Treaty. The UK concluded from the ECJ decisions that hospital care was not included in the reasoning of the Court, noting that even within the national system UK patients have little freedom of choice in practice.

The UK also intended to scrutinise legislation governing state health care purchases from the private sector, to ensure that there exist no legal obstacles to this care being purchased outside the UK.

5 PATTERNS OF CROSS-BORDER FLOWS IN THE EU

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A central concern of EU member states is that liberalisation of cross-border trade in health services by the ECJ rulings will lead to an unprecedented increase in patient flows and costs, and will thereby weaken existing systems of rationing and financial control. Very little is known about the possible extent of latent demand for cross-border health care, but this chapter summarises existing EU data on cross-border flows for medical treatment. The following chapter introduces the Euregio projects, where explicit attempts have been made in border regions to lower barriers to cross-border delivery of health care, and demonstrates that to date cross-border flows have been a tiny proportion of total expenditures, even in the border regions where natural barriers to trade are lower. The paper goes on to consider what incentives exist to payers, providers and patients to push this trading margin out further under the increased liberalisation which the Kohll and Decker decisions, and subsequent ECJ rulings, may offer.

Some theoretical considerations

Drawing on George France's analysis of cross-border flows of Italian patients as analogous to international trade in services, it may be helpful to begin by defining and conceptualising possible future cross-border trade in health services within a somewhat broader framework¹⁷. Services, which are estimated to account for about 20% of total international trade, are inherently non-storable, since their production and consumption tends to occur simultaneously. They may or may not require physical proximity to be traded. Following these ideas, Sapir and Winter¹⁸ have developed a typology of international trade in services as follows:

- **Type 1:** neither users nor providers move (e.g. financial or professional services transmitted by telecommunication);
- **Type 2:** users move to providers (e.g. tourism);
- **Type 3:** providers move to users (e.g. engineering services);
- **Type 4:** providers establish branches in the country of the users (e.g. advertising or retail distribution).

Type 1 comes the closest to the trade in goods. Type 4 represents a

flow of capital, i.e. foreign direct investment. The categories 1-4 are not necessarily mutually exclusive.

Services may be particularly subject to problems of information asymmetry. Goods are for the most part 'search goods' in that quality can be established before they are consumed. Many services, however, are 'experience goods' where quality can be assessed only after consumption, and some are 'credence goods' where it remains extremely difficult to assess quality even after consumption. In the latter two cases, the reputation of providers is particularly important.

The Decker judgement of the ECJ concerned the purchase of spectacles. On the subject of cross-border trade in medical devices and equipment, the literature is almost completely silent, and analyses of historical cross-border trading do not distinguish these goods from other health care services. Other than for medicines, devices and equipment, and like many other services, health care is non-storable, is produced and consumed simultaneously, and generally requires direct contact between the user and provider. Usually, for reasons of efficiency, users move to providers (Type 2). Thus, cross-border service flow Type 1 is currently rare in health care, although technological developments in long distance diagnostics and remote-controlled micro-surgery mean that this type of telemedicine transaction is already technologically feasible. Type 3 transactions would be characterised by professionals carrying their skills across borders and perhaps using local health facilities as a temporary base. This is certainly permitted in the EU, although no-one knows to what extent it happens. Type 4 transactions occur when foreign investors create medical facilities in a country. Type 2 transactions encompass all the current types of cross-border patient flow in the EU, but are perhaps best exemplified by E112 care, where patients actively choose a foreign, in preference to a domestic, provider.

The question then arises, how large is cross-border trade in health care services likely to become in terms of the various kinds of Type 2 flows, and what will the implications be for cross-border health care expenditures? Where predictions of future patterns of health care trading are concerned, Type 2 flows need further breakdown into component parts. As described above, health care may typically involve not

just the purchase of a service, but the acquisition of a good, in the form of a medical device (Mr Decker) or pharmaceutical product. It may involve merely a visit (ambulatory care) or an inpatient stay. It seems likely that the future demand for and supply of these different types of service will develop in different ways in response to different factors.

Historic patterns of cross-border flows

The principal source of data for systematic analysis of cross-border flows in the EU is the financial data collated by the Administrative Commission for the purpose of settling claims between member states for cross-border health care. Generally, the providing state applies for full cost reimbursement by means of the E125 form. This is a claim for payment of actual expenditures, namely the reimbursement of health care benefits in accordance with the sickness/maternity insurance tariffs of the country of stay.

For some types of health care obtained abroad a flat rate claim is sought through the use of an E127 form. Usually this is the case for family members of workers residing in another member state and pensioners now resident in a member state which grants them a pension. This is the payment of a lump sum, calculated on the basis of information given in the bookkeeping of the institution which has provided the benefits (the Administrative Commission assesses the grounds used to calculate the lump sums and fixes their amount). Member states can alter the rules of billing by bilateral agreement, or can waive claims for health care provided on their territory or apply claim compensation. Denmark, Spain, the UK and Ireland have in most cases opted for flat rate accounting for the health care provided or have even renounced any claim (incidentally making it more difficult to estimate the real patient flows for these countries).

The most systematic analysis of the financial data is contained in a 1991 study undertaken for the then Directorate General V of the European Commission by the Association Internationale de Mutualité (AIM), subsequently partially updated in a 1997 publication (Hermesse et al.)¹⁹ and most recently in a second report by AIM²⁰. The total cost of claims, distinguished by E125 and E127, is shown in

Table 1. For the 12 EU member states at the time of the original study, the total financial transfers amounted to €460 million in 1989. This figure had grown to €1,103 million in 1993, which has been estimated as still only 0.13% of the total health care expenditures of the EU and less than €4 per inhabitant.

Table 1 Claims for reimbursement of cross-border health care 1989-1998

| | 1989* | | 1993* | | 1997** | | 1998** | |
|-------------------------|-----------|-------|-----------|-------|-----------|-------|-----------|-------|
| | € million | % | € million | % | € million | % | € million | % |
| Full cost claims (E125) | 352.2 | 76.5 | 756.5 | 68.6 | 598.3 | 67.0 | 613.3 | 81.0 |
| Flat rate claims (E127) | 108.2 | 23.5 | 346.2 | 31.4 | 295.6 | 33.0 | 144.3 | 19.0 |
| Total | 460.5 | 100.0 | 1,102.7 | 100.0 | 893.9 | 100.0 | 757.6 | 100.0 |

*Sources:**Reports of the Administrative Commission for social security of migrant workers, 1990 and 1994

**AIM Report, May 2000

Table 2 sets out the global claims and debts by member state for the two years for which this breakdown is available. The 1989 figures show a concentration of claims among the original signatories of the Treaty of Rome, namely Belgium, France, Germany, Italy, Luxembourg and The Netherlands, largely based on full cost (E125) claims. The 'global' figures for 1993 suggest that newer members, namely the UK (1973) and Spain (1986), had increased their share. These newer member states mostly base their claims on flat rate contributions.

In 1993, 58% of the total claim was accounted for by France (49% in 1989). Italy was the highest debtor with 43% of the total debt in 1993 (up from 37% in 1989). Closer analysis of the French claim suggests that trade with neighbouring countries predominates, accounting for up to 90% of the claim in 1993. Trade with Italy is particular-

Table 2 Global claims and debts 1989 and 1993

| | Global claim (in € million) | | | | Global debt (in € million) | | | | % of total EU population 1993 |
|-------------|--------------------------------|------|--------|------|-------------------------------|------|--------|------|--|
| | 1989 | | 1993 | | 1989 | | 1993 | | |
| | Amount | % | Amount | % | Amount | % | Amount | % | |
| Belgium | 65.8 | 14.3 | 79.8 | 7.2 | 36.0 | 7.8 | 90.0 | 8.1 | 2.9 |
| Germany | 60.0 | 13.0 | 66.3 | 6.0 | 110.0 | 23.8 | 147.8 | 13.4 | 23.2 |
| Denmark | 0.8 | 0.2 | 0.8 | 0.0 | 0.0 | 0.0 | 0.8 | 0.0 | 1.5 |
| Spain | 5.6 | 1.2 | 110.3 | 10.0 | 12.8 | 2.7 | 58.0 | 5.2 | 11.3 |
| Ireland | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 0.1 | 2.3 | 0.2 | 1.0 |
| France | 226.1 | 49.1 | 635.0 | 57.6 | 44.5 | 9.6 | 107.5 | 9.7 | 16.6 |
| Greece | 3.7 | 0.8 | 5.9 | 0.5 | 9.6 | 2.0 | 26.0 | 2.3 | 3.0 |
| Italy | 62.1 | 13.5 | 61.0 | 5.5 | 169.3 | 36.7 | 476.0 | 43.1 | 16.4 |
| Luxembourg | 4.2 | 0.9 | 8.4 | 0.7 | 21.9 | 4.7 | 59.2 | 5.3 | 0.1 |
| Netherlands | 21.5 | 4.6 | 9.2 | 0.8 | 28.9 | 6.2 | 4.0 | 0.3 | 4.4 |
| Portugal | 3.8 | 0.8 | 7.2 | 0.6 | 8.1 | 1.7 | 37.2 | 3.4 | 2.8 |
| UK | 7.0 | 1.5 | 118.7 | 10.7 | 18.8 | 4.0 | 93.8 | 8.5 | 16.7 |
| Total | 460 | 100 | 1,103 | 100 | 460 | 100 | 1,103 | 100 | 100* |

Note: *Total does not add to 100% due to rounding error

Sources: Reports of the Administrative Commission for social security of migrant works, 1990 and 1994

ly significant. Luxembourg is a special case for two reasons. Its very small size does not justify a comprehensive medical infrastructure, and the presence of large numbers of other EU nationals among the population means that authorisation for health care abroad is relatively easily granted.

Hermesse et al. attempted to break down the composition of the global flows: the E125 form contains information on type of access, type of care and age of beneficiary. The study took a sample of 13,550 E125 forms, representing 2.5% of the total for seven countries for 1988. These were Germany, Belgium, France, Luxembourg, The Netherlands, Portugal and Denmark. They analysed the forms according to the type of claim distinguishable on the claim forms.

Whilst accounting for a minority of numbers of claims (14% of

the total number of forms) pre-authorised (E112) care accounted for 60% of the total cost of cross-border care. Temporary stay (E111) care accounted for 25% and frontier workers (E106) for 16% of total expenditures respectively. The relative financial importance of pre-authorised care is explained by an average cost per form four to five times higher for E112 care than for E111 care.

Hospitalisation accounted for 68% of the financial flow, compared with 18% for ambulatory medical care and 14% other services, including pharmaceuticals. In terms of numbers of claims these categories accounted for 9%, 40% and 51% respectively.

France dominated as the destination country for pre-authorised care, having 78% of the total financial value of claims. These flows are concentrated on Marseilles, Lyons and Paris, all large clinical centres of excellence. The next largest recipients of pre-authorised flows – Belgium, The Netherlands and Germany – follow a long way behind with 11%, 6% and 4% of total claim value respectively.

Analysis of debts provided some insight into the pre-authorisation procedures of member states. Italy appeared to make most use of the E112 form with 74% of debt, accounted for particularly by patients from the northern Italian provinces who travel to France for treatment. Italy and Luxembourg together accounted for over 95% of the French claim and 63% of the Belgian claim.

Analysis of cross-border flows suggested that the age-group 21 to 65 years was most active in pre-authorised care, accounting for 69% of the value of claims and 77% of numbers of forms. The population aged over 65 scarcely used pre-authorised cross-border care according to this analysis, accounting for only 9% of both claim value and number of forms.

The relatively low share of Mediterranean countries in the total claim for immediate (E111) care has also been singled out for particular comment, since EU tourism in these countries ought to predict a higher incidence of claims for temporary stay care. One possible explanation for this is the use of complementary private travel insurance, which provides a package of benefits, of which reimbursement of health care costs is one part. The growing importance of cross-border social security payments for retired people has also been noted.

6 CASE STUDIES OF CROSS-BORDER FLOWS

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A few articles in the literature analyse cross-border flows for individual member states or within a particular region. In addition, formal evaluations are becoming available of some of the collaborative cross-border health care projects in the border regions of the EU. Although the totality of flows has until now been small within the EU, cross-border flows may be significant enough for certain pathologies or regions to warrant explicit attention in regional health care planning and funding. Scrutiny of individual member states therefore provides an opportunity to consider in more detail the characteristics of patient flows, determinants of demand, the influence of payers and providers and the possible limitations on the future growth of cross-border health care. In addition, some of the case studies point to the strategic planning issues which might arise in future given a significant growth in these flows, and to those areas where increased regulation of cross-border trade may be called for.

The current chapter summarises key findings of studies which have investigated cross-border health care flows between Italy and other countries; three collaborative, cross-border EU health care projects; and some of the factors influencing cross-border flows of French and Belgian patients. The available case studies focus in particular on cross-border health care in hospital services. Hospital services are important: as shown above, hospitalisation has been estimated to represent nearly 70% of the current financial flows, compared to ambulatory medical care (18%) and other services, including pharmaceuticals (14%). However, this remains an area of cross-border health care trading to which the ECJ has so far ruled out application of free market principles.

Cross-border flows of Italian patients within the EU²¹

Given its position as the most important importer of health care services (exporter of patients) in the EU, what has been happening in Italy, and why, is of particular interest. A presumption which occurs quite frequently in the literature is that some of the factors which influence patient flows between regions within a member state may also impinge on cross-border behaviour. In addition to international

cross-border flows between Italy and (in particular) France, there is significant interregional movement of patients within Italy itself which is potentially of interest. In 1992, for the Servizio Sanitario Nazionale (SSN) as a whole, approximately 600,000 transactions for hospital care were recorded which involved movement of patients across regional borders. This represented 6% of all hospital admissions in Italy in that year. With the exception of Piedmont, Valle d'Aosta and Trentino-Alto Adige, all the northern and central regions are net exporters of hospital care services (importers of patients) and all the southern regions are net importers of care. In 1991, 268,000 southern patients (8.0% of the total admissions for the area) travelled out of the area for care. 23,000 children, or 10% of southern children hospitalised (35% for Calabria), were treated in extra-regional hospitals.

The main reason given by southern patients for the decision to move considerable distances is dissatisfaction with the quality of care obtainable in their home or nearby regions. Patients perceive that there are problems with the quality of facilities, the absence of specialisation or with therapy already received. They report being advised to go outside the area by their doctors²². A measure of the poor reputation of southern hospitals is that children travelling north for care frequently have relatively simple problems which are easily treatable in the home region on an outpatient basis. There is some evidence that patients' rights are less well respected in southern regions than elsewhere²³, and this is seen as a particularly important factor in the willingness of patients to travel long distances for paediatric care.

Even so, it is unlikely that the poor reputation of southern health services is wholly merited. Diagnoses in the out-of-region hospitals have been shown to confirm the original ones. Moreover, the facilities in southern regions are adequate for many services for which patients move²⁴. The most obvious area in which this is not true is oncology, given that there are fewer radiotherapy facilities in the south.

A potentially very important factor governing interregional flows is that patients have been relatively unconstrained. The SSN allows considerable freedom of choice to patients and whilst the use of providers outside the local health authority or region of residence has had to be authorized, approval has been automatic, and frequently retrospective.

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Virtually the full power of prescription has lain with the patient's doctor. The non-availability of a particular service in a particular geographical area has been viewed as a valid motive for an SSN patient to be authorised to go to another region. Regions exporting these patients did not pay for this directly and central grants were eventually adjusted to take account of mobility. These adjustments have been notional, and done well after the transactions have taken place, so regions importing care had no clear idea of the real costs involved. Patients could also obtain help with transport costs.

In 1987, eight of the 20 Italian regions explained almost 80% of movement of patients to foreign countries²⁵. The Valle D'Aosta, a small northern region bordering France, accounted for the highest proportion of these, with 32.6 transactions per 10,000 inhabitants, whilst Piedmont and Liguria, also bordering France, and Sicily in the south, also recorded significant flows.

Movement outside Italy is for relatively serious pathologies, including oncology (38% of all transactions), nephrology (15%), orthopaedics (10%), cardioangiology and cardiosurgery (10%) and ophthalmology (8%). As for interregional flows, patients report being influenced by: reputed low quality of Italian services; long waiting times; inadequate nursing support; difficult relations with doctors; and problems in obtaining information on domestic care options and the care being received. They are apparently influenced by the clinical reputation of French centres and the overall way in which patients are treated, which seems to feature significantly in the choice. Recipient hospitals in France have facilitated this movement by recruiting Italian-speaking staff, providing explanatory brochures and administrative forms in Italian and offering accommodation for patients and visitors at special rates. They do, therefore, compare favourably, even with north Italian oncology centres in regions which are relatively well equipped such as Lombardy, Piedmont and Liguria. A notable difference between north and south Italy, however, is that patients from the northern and central regions tend to use foreign providers more for follow-up care after medical treatment in Italy, whereas the southern patients tend to move abroad for treatment immediately after diagnosis.

Patients travelling outside Italy probably incur considerable out-of-pocket expenditure: the extent of their financial commitment varies per region. In a sample of Italian patients using the Gustave Roussy Institute in Paris, about half were only partially reimbursed or received no assistance at all²⁶.

Several studies have confirmed the importance of Italian doctors as instruments of referral to overseas facilities²⁷. One found that for 18% of the patients interviewed, their doctor had specified both the foreign facility and the name of the foreign specialist to contact²⁸. Another study found that doctors were a principal source of information for patients on foreign care options²⁹ and yet another that 62% of Italian GPs (primary care doctors) believed that the condition of the SSN justified the use of foreign care³⁰. These views were 'institutionalised' in the ease with which E112 authorisation was granted, essentially leaving the decision on location of care to the discretion of patients and doctors. Regions had little financial incentive to refuse E112 authorization since the medical costs generated were paid by the Ministry of Health out of its own budget and directly to the other national authorities.

After 1989 this situation changed and the central Italian authorities sought to curtail patients' freedom to seek health care abroad. Authorization thereafter depended on the results of a search within the domestic system for the care required. A list of pathologies has been drawn up for which authorization for care abroad could be given. This specifies the maximum waiting times for care to be provided in Italy, after which patients are entitled to go abroad. National legislation has established regional 'referral committees' for each of the listed pathologies, which determine whether patients can obtain the necessary care within 'a reasonable time' from a domestic provider. The committees also determine where the patient can best obtain care abroad. Authorisations for hospital care abroad rose until 1991, but then dropped sharply.

Changes have also been made in the financing arrangements for E112 transactions. From January 1997, the Italian Ministry of Health has continued to settle with other national authorities directly, but has then deducted these expenditures from the regions' central grants. It seems possible that there will as a result be a further decline in the

demand for foreign care by Italian patients, and that in future flows will become even more concentrated in therapies where foreign providers enjoy a clear-cut comparative advantage, particularly for oncology (France) and transplants (France and Belgium).

An attitude survey of French and Belgian frontier workers³¹

Reference has already been made to bilateral arrangements between Belgium and France to extend to workers' families the right of access to health care in both country of residence and country of work that frontier workers themselves already had. A study has also been carried out to explore the attitudes of a group of workers resident in Belgium and working in France, who are affiliated to one of the federations of the Christian or Socialist Mutualities, and workers resident in France and working in Belgium who are affiliated to one of the 'Caisses Primaires d'Assurance Maladie' in the frontier area. Whereas patterns of demand for cross-border care can be described by claims data and hospital use statistics, the data say little about motives for cross-border flows. The study was carried out from the users' perspective, to explore how and what type of services are used, why and under what circumstances, and what factors impede or motivate cross-border use of health care services.

The study involved 690 Belgian (i.e. resident in Belgium, working in France) workers and 436 French (i.e. resident in France, working in Belgium) workers, who were asked to complete a questionnaire during the autumn and winter of 1994-95. The response rates were 53% and 41% respectively. About one-fifth of both groups of frontier workers did not know that they had access to health care on both sides of the border, and only about half of each group knew that the entitlement extended to their families. Despite this, the majority saw their double entitlement to health care as an important advantage, although the Belgian workers were significantly more likely to see it as an advantage than their French counterparts. The latter might be explained by the high proportion (three-fifths) of 'Belgian' frontier workers who had French or dual nationality.

There was evidence of misunderstandings about the process of reimbursement. Health care costs are reimbursed in the country where

the care is provided, whereas the majority of both sets of workers believed that payment for care was made by only one of the two countries. Both groups reported some problems with reimbursement, of which the most common problem was 'expenses not being covered'. Almost half of both groups had private insurance to complement the other forms of health protection.

The major source of primary medical care for both groups is the country where they live. However, more Belgian workers than French consulted a primary care physician in their country of work. Consultations with GPs in 'work' countries are lower for workers' families, although about 20% of Belgian workers' families use GPs in the work country, suggesting that they deliberately choose to cross the border for care.

The questionnaire sought information on other types of care obtained across the border. Table 3 shows the pattern of cross-border use for six categories of care, namely: ambulatory care; purchase of drugs; paramedical care; specialised care, hospital care and maternity care. There was generally higher consumption of cross-border care by the Belgian workers than the French. The same patterns were evident in the use of cross-border care for family services shown in Table 4. Overall use by frontier workers' families was lower than by the frontier workers themselves, and was again higher for the Belgians than for the French.

A number of reasons were identified for the relatively high use of cross-border care by Belgian workers and their families. Accidents at work represent the principal cause of referrals to ambulatory and hospital services. Quality of care is identified as the main influence on consumption of specialist health care. Differences in prices of medications influence the location of purchase of drugs. Overall, ease of reimbursement by the French health insurance system is seen as important, as is coverage by private health insurance.

On the French side, accidents at work also constituted the principal cause of use of ambulatory, hospital and paramedical services as well as medications.

By far the most important reason given by both groups of workers for not being attracted to cross-border health care was that they were

Table 3 Use of cross-border health care by frontier workers

| | Ambulatory care | | Drugs etc. | | Paramedical care | | Specialised care | | Hospital care | | Maternity care | |
|----------------------|-----------------|-----|------------|-----|------------------|-----|------------------|-----|---------------|-----|----------------|-----|
| | B | F | B | F | B | F | B | F | B | F | B | F |
| | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= |
| | 263 | 118 | 269 | 123 | 238 | 118 | 259 | 118 | 252 | 124 | 218 | 112 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Never | 82 | 93 | 36 | 59 | 75 | 90 | 62 | 81 | 73 | 77 | 87 | 92 |
| Occasionally/usually | 18 | 7 | 64 | 42 | 25 | 10 | 38 | 20 | 27 | 23 | 13 | 8 |

Source: Calnan, Palm, Sohy and Quaghebeur, 'Cross-border use of health care. A survey of frontier workers' knowledge, attitudes and use', European Journal of Public Health Supplement Vol 7 No 3 September 1997

Table 4 Use of cross-border health care by the families of frontier workers

| | Ambulatory care | | Drugs etc. | | Paramedical care | | Specialised care | | Hospital care | | Maternity care | |
|----------------------|-----------------|-----|------------|-----|------------------|-----|------------------|-----|---------------|-----|----------------|-----|
| | B | F | B | F | B | F | B | F | B | F | B | F |
| | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= | n= |
| | 263 | 118 | 269 | 123 | 238 | 118 | 259 | 118 | 252 | 124 | 218 | 112 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Never | 87 | 93 | 49 | 80 | 84 | 94 | 74 | 91 | 75 | 77 | 87 | 95 |
| Occasionally/usually | 13 | 7 | 51 | 20 | 16 | 6 | 26 | 9 | 25 | 23 | 13 | 5 |

Source: Calnan, Palm, Sohy and Quaghebeur, 'Cross-border use of health care. A survey of frontier workers' knowledge, attitudes and use', European Journal of Public Health Supplement Vol 7 No 3 September 1997

more satisfied with the health care facilities in their home country. A second reason given was that they do not get referred for cross-border care by family doctors. French workers suggested that other important reasons for not using cross-border health care were their unfamiliarity with the reimbursement or coverage mechanisms in their (Belgian) place of work and with the medical infrastructure, and linguistic barriers.

Cross-border care in Euregio Meuse-Rhine³²

The Interregional programme of the EU is directed at strengthening cooperation across borders within the so-called Euregios. Within these areas of regional cooperation, health projects have also been set up. One was intended to identify the complementarities and possibilities for cooperation with respect to the supply of hospital care, medical specialties, nursing care, outpatient care and quality assurance in the Euregio Meuse-Rhine. This region covers provinces in Belgium, Germany and The Netherlands, (see Figure 1) and has a total population of 600,000. All the academic hospitals and one general hospital participated. These were located in Liège and Genk (Belgium), Aachen (Germany), and Maastricht (The Netherlands). A study of the project included an analysis of cross-border inpatient hospital care in this region in 1991 and 1992. It drew up a set of factors which might determine these flows and, from these, developed some hypotheses about some of the opportunities for, and obstacles to, cross-border inpatient care in the EU.

Data on cross-border inpatient care were collected from the four hospitals for 1991 and 1992. This was not readily available and had to be extracted from files. Data could be obtained from all hospitals relating to levels of cross-border care on the basis of patients' country of residence. However, only two of the hospitals had data relating to patients' country of insurance. It is the latter which is of particular interest since it implies the financing of care across national boundaries and hence the need for some coordination of social security systems. Furthermore, it is important to note that, as the analysis shows, cross-border workers' (E106) care plays a significant role. Table 5 summarises the cross-border inpatient care.



Table 5 Admissions to project hospitals: total admissions and cross-border care admissions by country of residence

| Providing hospital | Liège, Belgium | | Genk, Belgium | | Maastricht, The Netherlands | | Aachen, Germany | |
|--|-------------------|------|------------------|------|--------------------------------|------|--------------------|------|
| Number of beds | | | | | | | | |
| 1991-1992 | 720 | | 470 | | 690 | | 1,470 | |
| Total admissions | | | | | | | | |
| 1991 | 21,301 | | 21,947 | | 18,295 | | 38,564 | |
| 1992 | 20,829 | | 23,833 | | 20,029 | | 39,989 | |
| Patient's residence | NL | D | NL | D | B | D | B | NL |
| Admissions by country of residence | | | | | | | | |
| 1991 | 5 | 3 | 42 | 0 | 336 | 49 | na | na |
| 1992 | 4 | 0 | 59 | 0 | 340 | na | 423 | 345 |
| Percent admissions by country of residence | | | | | | | | |
| 1991 | 0.02 | 0.01 | 0.19 | 0.00 | 1.78 | 0.26 | na | na |
| 1992 | 0.02 | 0.00 | 0.25 | 0.00 | 1.70 | na | 1.06 | 0.86 |

Notes: B = Belgium; D = Germany; NL = The Netherlands; na = not available

Source: Starmans, Leidl and Rhodes, 'A comparative study on cross-border hospital care in the Euregio Meuse-Rhine', *European Journal of Public Health* 1997; 7 (3)

Supplement: p 38

Flows are very small, but show considerable variation. They were analysed in two ways: first by qualitative analysis of flows per hospital, and second by grouping the levels of flows and considering factors which might predict higher or lower levels.

By hospital

Table 5 shows cross-border admissions to the project hospitals, by country of residence, as a proportion of total admissions. In 1991, for the academic hospital in Maastricht (The Netherlands) 0.26% of admissions were patients living in Germany and 1.78% patients living in Belgium. Among the patients living in Belgium, most came from the Meuse-Rhine region, particularly from Lanaken, a place in which many Dutch nationals live. A majority were cross-border workers, that is, were employed and insured in The Netherlands. If country of insur-

ance, rather than country of residence is used as the definition of cross-border care, only approximately 0.7% of total admissions in 1991, and 0.62% in 1992, could be considered cross-border care. Specialties most used by patients living in Belgium were paediatrics, cardiology, neurosurgery, neurology and urology.

0.86% of total admissions to the academic hospital in Aachen (Germany) in 1992 were patients living in The Netherlands and 1.06% were patients living in Belgium. No information was apparently available on nationality of patient or country of insurance.

The academic hospital at Liège had very few admissions from residents outside Belgium.

The St Jans hospital in Genk (Belgium) had about 0.2% of total admissions from patients living in The Netherlands, most of Dutch nationality. Approximately half of the patients living in The Netherlands were cross-border workers, that is were employed and insured in Belgium, a share which dropped in the second study year. If country of insurance is used as criterion, only 0.07% of admissions in 1991, and 0.18% in 1992 could be considered cross-border care for Dutch nationals both living and insured in The Netherlands. Even these small flows involved little coordination between the different social security systems since almost all the cross-border patients who were insured in The Netherlands were privately, and not publicly, insured.

By rate of hospital admission

Cross-border flows to each hospital were grouped under a three-stage classification as follows: 0.00-0.09% of total hospital admissions, 0.10%-0.99% and +1% of the total and an attempt made to hypothesise factors which might account for the variation in levels.

Liège (Belgium) provides an example of low level cross-border care which may be related to the following factors:

- larger average distance between this hospital and place of residence of insured patients as compared with domestic hospitals;
- differences between the official language of the providers and of insured patients living across the border;
- higher levels of patient charges compared with domestic hospitals;
- more restrictive national regulation for German and Dutch

patients seeking cross-border care in Belgium than for Belgians.

Countervailing factors were identified as: no referral requirements, specialist knowledge of the hospital, shorter waiting lists and fee for service reimbursement of physicians.

Cross-border flows at the intermediate level (0.10%-0.99% of total admissions) consist of patients living in The Netherlands and admitted to Aachen (Germany), patients living in The Netherlands and admitted to St Jans hospital in Genk (Belgium) and patients living in Germany and admitted to the academic hospital in Maastricht (Netherlands). Similar factors to those which might apply to Liège could be at work, except for one difference in each case:

- for the academic hospital in Aachen, the shorter distance between this hospital and the residences of some insured patients living in The Netherlands;
- for St Jans hospital in Genk, the lack of serious differences between the official language of the providers and of patients living in The Netherlands;
- for the academic hospital in Maastricht, the lower level of patient charges implemented in this hospital, as compared with hospitals in Germany.

At the relatively high level of cross-border care there are two groups: patients living in Belgium and admitted to Aachen, and patients living in Belgium and admitted to Maastricht. The following factors may be significant:

- the shorter distances between the hospitals in question and domestic hospitals;
- lack of serious language differences;
- lower level of patient charges implemented in the hospitals in question compared with domestic charges;
- less restrictive national regulations for cross-border care in Belgium as compared to the EU regulations.

In addition, waiting lists in ophthalmology and orthopaedics were a constraint on care in Dutch South-Limburg, but not Belgian Limburg which, it is hypothesised, may account for the small flow of patients from the Netherlands to St Jans Hospital in Genk. (It would have been interesting to see if waiting lists might have contributed to

an explanation of flows in the opposite direction, from Belgium to Maastricht, although there is no information on this in the literature). Evidence from St Jans hospital on insurance type supports the hypothesis that private insurance is likely to be positively related to cross-border care.

The ECJ's Kohll and Decker rulings occurred a year into the latest stage of the Euregio Meuse-Rhine project, which began in April 1997 and was aimed at reducing barriers to cross-border care. Many patients in this large border region live nearer to a provider over the border (for example the hospital in Aachen, Germany, is only five minutes away from Dutch Limburg). In addition, waiting times in The Netherlands were long for some specialties, particularly eye care, orthopaedic surgery and plastic surgery. Under pre-authorisation conditions for granting an E112 in The Netherlands, there would need to be formal confirmation by an insurer that funding would be available for cross-border care, in response to a request by a patient and a formal referral by a GP or medical specialist. Under the reduced authorisation procedures introduced by the latest stage of the Euregio project at the initiation of local Dutch insurers, namely the CZ Groep, all people living in the experimental region will qualify for basic medical care at the provider of their choice, including providers located across the border from where they were insured. The decision protocol for this project was drawn up by the Dutch Board of Health Care Insurers. Very expensive treatments were excluded from the arrangement.

The Netherlands operates a primary care-based gatekeeping system and so patients continue to need a referral by a doctor. Doctors in the region were informed of the project, as were patients insured by the local insurance companies who had initiated the project. The project gave rise to about 75 requests per month for Netherlands-based patients to go abroad for treatment, a total of 1,800 requests over the two years of the project phase. These requests derived from fewer than 600 insured patients or less than 0.3% of people who might be predicted to consult a specialist. Of these about 20% were Germans living in The Netherlands. In addition, many Dutch patients who live near facilities in Germany were acquainted with the German medical system. Language was less of a barrier. Two Dutch doctors had estab-

lished practices in Belgium and were particularly popular with Dutch patients seeking care over the border.

Under internal regulations, each Dutch insurance fund must make contracts with all Dutch providers. One of the insurance funds involved in the Euregio Meuse-Rhine project, CZ Groep, has been setting up contracts with foreign providers using two models. In Germany, they are accessing foreign providers by entering into a formal agreement with the principal German insurance fund, AOK, in the Meuse-Rhine region. Under this agreement, Dutch patients will have access to all those Germany providers with whom AOK themselves contract. This model follows an internal model under which CZ has a formal arrangement with another insurance fund to provide care for the very small numbers of its insured patients in the Amsterdam area. A different model is being adopted in Belgium where CZ wants to set up agreements with all hospitals in the Euregio. In this case it is collaborating with Belgian Christian Mutualités, using their experience to identify key providers. It is targeting in particular those specialities where waiting times are longest in The Netherlands. This provides an immediate solution in the Dutch border regions. A more difficult question is how to cope with possible requests for treatment in more distant parts of the EU. For example, many Dutch people spend part of the year living in Spain where it is already thought that they access non-urgent health care using an E111.

The reluctance of local doctors had been seen as a possible barrier to cross-border trade, with requests for cross-border care being initiated almost exclusively by patients. This remained an issue during the project, for three main reasons:

- under the Dutch system for managing patients, specialist reports are automatically made back to GPs. Referring a patient abroad meant that GPs did not get feedback on treatment and frequently lost sight of the patient's progress;
- even if they did get information back, this was not necessarily in a comprehensible form. For example, medicines might have quite different brand names, or not be available at all in The Netherlands;
- GPs were much better informed about medical care available in The Netherlands than over the border, and preferred to refer to

Dutch university hospitals, particularly for tertiary care.

However, co-operation became progressively better during the course of the project, particularly between German and Dutch doctors, with anecdotal evidence of German specialists initiating some training for Dutch GPs. CZ Insurance Fund was itself responsible for initiating contact between the two sets of doctors. One suggestion for dealing with the problems of cross-border medical records is that the insurance fund could become responsible for its members' patient records.

For patients, the experience of accessing the German medical system is quite time-consuming and potentially quite inhibiting. A patient has to take their E112 to a German sickness fund in order to obtain a Krankenschein, before they are permitted to consult a doctor. Sometimes this has to be done in person, and so two visits are necessary.

Euregio Rhine-Waal³³

The Euregio Rhine-Waal is situated in eastern Holland, in the region where The Netherlands borders Germany (see Figure 1). A Euregio project was conducted between January 1997 and May 1999 to enable German patients (that is, patients living and insured on the German side of the border) to access certain specialities at the University Hospital of Nijmegen in The Netherlands, namely:

- renal transplant;
- open heart surgery;
- neonatal intensive care;
- dermatology;
- radiotherapy;
- trauma care.

The project recognised that cross-border care offered opportunities to German patients in border regions, in particular, access to highly specialised care for which they would have to travel considerably further in their country of residence and insurance. Nijmegen is situated 15km from the border with Germany, whereas Germans in this border area would have to travel up to 100km for similar facilities in Germany. German patients could access both inpatient and ambulatory care in Nijmegen.

At the same time, it was also acknowledged that risks could be

involved. An evaluation, of which the following is a summary, was commissioned by the Dutch insurance fund involved and carried out by the Faculty of Medical Technology Assessment of the Catholic University of Nijmegen (this is so far only available in Dutch). This evaluation report addressed five questions:

1. How many patients from Germany take advantage of the access opened up by the project?
2. What are the consequences, as shown by objective indicators of quality and efficiency, and by the quality of care as seen by patients and carers?
3. What proportion of German patients who are eligible for treatment could be expected to use Dutch facilities annually?
4. What are the resource implications of the additional cross-border flows in the different specialties involved, distinguishing personal, recurrent and infrastructural costs?
5. Did differences in clinical practices, which are acknowledged to exist, inhibit cross-border care, or did cross-border care influence developments in clinical practice? Were any such developments consistent with the adoption of evidence-based best practice?

The evaluation study found that the volume of patients crossing from Germany to use the Nijmegen facilities was very small both in absolute and in relative terms, accounting for less than 1% of estimated potential needs of patients for specialist care in this border region. A notable exception to this was kidney transplantation in 1997, for which patient flows exceeded a pre-set limit on the number of transplants available.

Patients from across the border were concentrated within a 30km radius of Nijmegen. The attitude of referring doctors was important, with some general reluctance among German doctors to refer patients to Nijmegen on account of the income from treatment which would thereby be lost to German medical institutions. One conclusion of the evaluation was that the uni-directional flow (from Germany to The Netherlands) set up by the project, was an inhibiting factor on cross-border trading. Notwithstanding this, the evaluation saw no reason for substantial increases in patient flows to be expected in the future.

Given the volume of patients involved, the University Hospital of

Nijmegen had sufficient capacity to absorb the additional flows. Difficulties could have been anticipated where there existed scarcities in supply such as advanced diagnostic imaging, constraints on operating time and on intensive care capacity. But this turned out not to be a problem. For example, the study found that there were higher numbers of babies who could not be accommodated in neo-natal intensive care during 1998 as compared with 1999, and these figures were lower than 1997. Average waiting times for radiotherapy in fact reduced in 1998 compared with 1997. The expressed satisfaction of patients was high throughout the period, exhibiting no change on previous measurements. In fact, the radiotherapy department had taken special measures to assign doctors to patients whose main function was liaison with referring doctors in Germany. Unsurprisingly, in view of the very small additional patient flows, hospital staff did not experience significant differences in work pressures.

Reimbursement of the costs of cross-border care was based on pre-set tariffs established by the Dutch insurance system. The project investigated how closely these approximated the actual costs of care and found that for all specialties except trauma care, tariffs closely represented real costs. During the project cross-border care accounted for 0.35% of the total yearly budget of the hospital.

The study investigated the influence of cross-border care on the adoption of evidence-based clinical guidelines, and considered whether differences in clinical practices inhibit cross-border care, or whether cross-border care influenced developments in clinical practice. This seemed to depend on the initiative of individual hospital departments. Nijmegen's departments of radiotherapy and trauma were in regular contact with German referring doctors, both during the process of referral and after care. This was less true of the cardiac surgery, neonatal intensive care and renal departments. Referral criteria for radiotherapy were no different as between the two countries, although there were differences in supporting treatment. These were not, however, seen as inhibiting for cross-border care. Indications for neonatal intensive care were the same in both countries but it was unclear how far treatment practices differed. There was, however, an absence of protocols for initiating trauma care and this was seen as an

obstacle to cross-border care between Dutch and German doctors. Germany was still developing guidelines for indications for open-heart surgery and so comparison between both countries was not yet possible. For kidney transplants, protocols for initiating treatment were in accord with international guidelines in both countries. Different parameters for allocating kidneys from available donors did not influence the provision of organs as between German and Dutch patients.

Euregio Scheldemond

The Euregio Scheldemond project was a local initiative and one of 15 projects which had its origin in the EU's Interreg II programme in this region. It is situated on the border between The Netherlands and Belgium in the Flanders region (see Figure 1). The Scheldemond project was initiated by one of the Christian mutualité insurance funds in conjunction with a Dutch insurance fund and with the agreement of the Dutch Ministry of Health and College of Health Insurers. It started formally at end-1997, after two years of prior co-operation. The objective of the project was to improve access to health care across national borders in the region for frontier workers and their families. This region had already been the subject of a special Dutch regulation permitting Dutch patients to go to Belgium for cardiology and neurology, specialties that would otherwise have to be sought in Amsterdam, much further away.

The project has addressed very specific problems. One issue was to comment on the simplification of Regulation 1408/71, which was introduced in April 1999 (see Chapter 2 above).

A second issue, perceived to be an important problem for families in the region, is that family members do not have the same dual access to health care exercised by the frontier worker. Most Dutch frontier workers choose Belgian providers. This is said to be because access to the Belgian specialist services is much easier, since Belgium does not have a gatekeeping function. However, workers' families do not have this choice. Nationality is much less of an issue in Flanders, where the natural border is provided by the River Scheldt rather than by national frontiers.

A third issue is that when the frontier workers become eligible for

a pension, they lose their rights to access both health care systems.

The Euregio Scheldemond project initiated a simplification of the E112 system then in force. A Dutch insurance fund had to give authorisations, which were generally permitted, for Dutch patients to access five hospitals in Belgium, namely in Knokke, Gent (2) and Brugge (2). A principal feature of the project was the dissemination of information to frontier workers, and the establishment around the region of 20 information desks where workers could consult about the exercise of their rights and the problems they encountered accessing the health care system.

As other projects have found, comparison of costs in different countries is very difficult and in Belgium calculation of total costs is particularly problematic. Currently the project has adopted the 'Belgian way of paying'. Belgian hospitals are paid directly, and apparently often on a fee-for-service basis. By contrast, the Dutch system of block contracting gives little information on costs of individual procedures. This project is trying to use major Dutch hospitals, for example Rotterdam, for reference costing purposes. One of the objectives of the costing attempt is to establish whether and when additional costs of cross-border care become critical for the insurer. There are two parts to this. One is the differential cost, which in this case represents a saving to The Netherlands as Belgian costs in the region are lower than Dutch costs. The other part is the possible offsetting effect of higher volumes of treatment.

One of the interesting features of this project concerns the situation of a relatively small hospital on the Dutch side of the border, at Terneuzen. This has tended to lose business to more specialised Belgian hospitals in the project, and there is concern about how it should be utilised in future. It has strategic political importance, having originally been one of three Dutch hospitals in the region during the 1970s, but then becoming one hospital with satellites providing ambulatory care. In order to sustain some hospital infrastructure in Dutch Flanders, Terneuzen will not be allowed to become a satellite of a Belgian hospital. However, cardiac surgery provides a good example of co-operation with one of the Belgian hospitals in Gent since some patients from Terneuzen come to Gent for surgery carried out by

Dutch doctors. Another such example is psychiatric care in Oostburg, where patients who need hospital treatment will be admitted to Brugge. Opportunities exist to set up these hub and spoke collaborations in other specialties too.

There has been no formal response in this project to the Kohll and Decker rulings, but they are seen as an important opportunity to 'Europeanise' health care, beginning with co-operation in the natural regions where language and culture do not divide and where political boundaries are therefore less meaningful. Geographically Belgium has long borders relative to its small size. Most of its hospitals are less than 50km away from any given border. It is seen, therefore, as an important test bed for post-Kohll and Decker developments.

7 FUTURE SCENARIOS AND CONCLUDING THOUGHTS

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The legal and institutional framework for cross-border health care

As has been seen in the preceding discussion, cross-border health care is being driven in two different ways. On the one hand, the ECJ Kohll and Decker decisions have appeared to reduce the legal barriers to cross-border trade in health care services, leaving the initiative for the development of cross-border care with patients, providers and payers. All the current indications are, however, that the extent of the legal relaxation will be limited. Hospital inpatient care, the most expensive component of health care, continues to be excluded from the application of single market principles. In addition, early indications from cases pending also suggest that the ECJ will shy away from rulings which imply the wholesale convergence of social security systems. Furthermore the precise applicability of the rulings to the diverse systems of member states remains extremely unclear. Any attempt to impose a prototype system of health care organisation would, in any case, invoke a strong response from many member states and could be predicted to result in changes to current Treaty provisions.

At the same time, collaborative health care projects have been set up as part of the European Commission's programme of inter-regional cooperation and development in the border regions. These pre-date the Kohll and Decker rulings and are examples of how the existing regulations governing cross-border health care can be adapted for the benefit of patients. The reactions of member states to the Kohll and Decker rulings, and the evaluations of the Euregio projects, raise strategic planning issues, which could be addressed at supra-national level. Informal indications are that the future development of an internal EU market in health care will be managed as a political initiative, and that the institutional home for these developments will be the European Commission, with the ECJ becoming a less important institutional player.

One question which this paper has explored is what the response of market players will be to the Kohll and Decker rulings and what political response this might provoke from member states at EU level. Generally speaking the Kohll and Decker rulings have been treated with varying degrees of hostility and concern by most member states.

A somewhat different view is gaining credence, however. Whilst the concept of a 'free market' is central to the legal framework of the EU, markets are usually regulated by public and private organisations in order to promote their efficient functioning. It has been proposed that more effective regulation of the various markets which comprise the health care sector is a precursor for developing trade in health care services across the EU³⁴ and that the principal role of the EU should be to consider which further interventions, at what level, would promote a beneficial increase in cross-border trade and/or constrain any unwelcome effects of an unfettered growth in trade.

Several recent developments in EU health policy underpin this view of how the development of an EU internal market in health care will in future be handled at an institutional level. The new public health framework document, implementing Article 152 of the Amsterdam Treaty, allows for the development of EU health policy to incorporate the comparative study of EU members states' health care systems, based on EU-level data collection³⁵. This will be implemented by the new Directorate General (DG) Sanco, which has resulted from an amalgamation of the old public health division of the former DG5 into the former DG24, to give the new Health and Consumer Protection Directorate of the European Commission.

In addition, the AIM study recently commissioned by the European Commission DG for Employment and Social Affairs and referred to in Chapter 5 above was invited to consider the implications of the Kohll and Decker rulings, taking into account:

- the responsibility of member states for the organisation and delivery of health services and medical care;
- the Community objectives of contributing to a high level of social protection and health protection;
- the principles of freedom of movement of workers, products and services throughout the EU;
- the possibility of restricting these freedoms on grounds of public health or for overriding reasons in the general interest.

This study has now become available and it comments extensively on what it describes as a 'European reference framework for social and health protection'³⁶.

A further initiative is that member states have set up a High Level Committee on Health, one Working Party of which is now concerned explicitly with the development of the internal EU market in health services. All member states are represented on this Working Party, along with representatives from relevant European Commission DGs, in particular the DG for Employment and Social Affairs and the DG for the Internal Market. The Working Party's future agenda incorporates broad themes in EU health policy, all of which might impinge in some way on the future development and regulation of an internal market in health. One theme concerns the impact of EU Directives on member states' health systems. A number of market-related directives not directly concerned with health (such as the Working Time Directive) may nonetheless have profound implications for health services management and configuration. Other examples include measures to facilitate the free movement of labour between member states and the mutual recognition of qualifications, which led in the UK to the Calman proposals for adjustments to medical training. The impact of EU legislation on member states' health systems is currently the subject of a study by the European Healthcare Management Association under the European Commission's Biomed research programme.

A second agenda item for the Working Party is the possible impact of EU competition policy on health systems, a subject of increasing interest and legal debate. A third is the impact and implications of the Kohll and Decker rulings and a fourth, the experience of the Euregio health projects. The Working Party will in due course make a final report and recommendations to the High Level Committee on Health.

The information base for future policy development

It is already obvious that there are insufficient accessible published data which could be used to guide policy development in this area of European health care affairs and that the development of a robust database is an important precursor for policy analysis. The data required would have at least three components:

- a full, analytical database of cross-border flows, using material regularly collated by the Administrative Commission, and supple-

mented by analyses of information gathered at national level. This might qualify, for example, as an important component of the Public Health Directorate's statistical monitoring programme;

- information drawn from the ongoing evaluations of the Euregio projects, which has been written up but is as yet unpublished and is available only in one or two of the EU languages, especially Dutch. There is an urgent need to place this information fully in the public domain, in languages which all member states can easily access, and to ensure that future evaluations of these cooperative regional projects are based on comparable protocols;
- there is clearly an even wider perspective from which the EU could learn, namely from patterns of international cross-border trade in health care, and the developments of regional health markets in North America, Asia and Africa. These would also merit scrutiny and deserve the attention of the European Commission.

In summary, therefore, any development of an EU-wide market in health services delivery is likely to be the result of a complex interaction of legal decisions, high level policy initiatives and the grass roots response of payers, providers and patients. The following section attempts to draw together some of the main economic themes emerging from the possible responses of the key players, and to signal strategic issues needing a regulatory initiative from the European Commission.

The response of patients

At a micro level, some of the studies of cross-border flows referred to earlier indicate the factors most likely to influence patient use of hospital services across borders. They also imply that considerable cultural barriers will remain, independently of the permissibility of cross-border trading. Factors likely to influence patient flows at the margin include the following:

- *Distance*

An increase in the travel distance between the hospital and the patient's home would, *ceteris paribus*, be expected to lower hospital utilization and reduce cross-border flows. This is to treat distance as a

proxy for the time and other costs involved for patients (and their friends who visit them in hospital). In the Euregio Meuse-Rhine study, if distance were the only predictor of hospital use, patients from only a few locations in Belgium would be admitted to Maastricht; or would be admitted to Aachen from only a few locations in The Netherlands. No patients from either The Netherlands or Germany would be admitted to hospital in Genk, or Liège. German patients would not travel to Maastricht.

- *Specialty-based quality and reputation*

The higher the specialisation and the reputation of hospitals, the higher the likelihood of cross-border flows. There was a wide availability of most specialties in the project hospitals in the Euregio Meuse-Rhine, although some indications of specialist knowledge in Maastricht (cardiology, neurosurgery and paediatrics) and Genk (neurosurgery). Italian patients travel to France predominantly to centres of excellence in tertiary services.

- *Waiting times*

In 1991 in the academic hospital in Maastricht there were frequently waiting lists longer than four weeks for nearly all specialties. In the Dutch surrounds of Maastricht there were waiting lists of up to four weeks for ophthalmology and plastic surgery, ENT, orthopaedics, rheumatology, general surgery and urology. In Belgium there was only a waiting list for cardiology in two hospitals.

- *Differential levels of hospital tariffs*

In the case of non-authorised care (following Kohll and Decker) for which country of insurance tariffs would apply, the patient has a direct interest in tariff differentials, to the extent that these become an out-of-pocket expense. Pre-authorised care, for which out-of-country tariffs would be relevant, is prospectively and typically an additional cost to the third party insurer. It is worth noting that different financing systems imply different resource implications for cross-border flows. Tariffs in the The Netherlands include capital costs, which are mostly paid for per day by the governments of Belgium and Germany. Furthermore, the academic hospitals have costs which include teach-

ing and research. The academic hospital in Maastricht had the highest costs per day for publicly insured patients (including capital costs, drug costs and specialist costs) among the hospitals in the Euregio Meuse-Rhine study. The general hospital in Genk had the lowest costs per day, but these excluded cost of specialists, drugs and some of the overhead capital costs.

- *The level of patient copayments*

Other things being equal, higher copayment rates are likely to reduce hospital utilisation. In 1991, patients in Belgium confronted a co-payment of €5.89 per day if admitted to a hospital, a copayment of €0.63 for drugs prescribed in hospital and co-insurance of 25% of the costs of most physician services. At the same time in Germany the copayment rates were €5.16 per day for the first 14 days admitted. Both countries had exemptions for some groups. In The Netherlands, publicly insured patients were not obliged to pay user charges, depending on their insurance contract. Charges for privately insured patients depend on their contract.

Pre-Kohll and Decker regulations require patients to pay user charges according to the rules of the country in which the care is delivered. Thus, cross-border care would have been more attractive to German and Belgian patients seeking care in The Netherlands than for Dutch patients seeking care in either Germany or Belgium. Belgian patients might have an incentive to seek care in Germany because of lower patient charges in the latter.

- *Language barriers*

Unsurprisingly, these have been identified in several studies as a key factor influencing patients' choice of health care provider.

In the light of the evidence presented on the totality of flows, the prospect of large increases in cross-border trade looks like an irrational fear. The ECJ is currently dealing with a handful of 'in principle' cases, and continues to exclude hospital care from EU Treaty provisions. In practice, total cross border flows are tiny. Much E112 care comprises pockets of very specific cultural practices, such as the export of patients

from Italy to France. Even in the Euregio projects, where language and cultural barriers are lower, where double entitlements may already exist and where distances to foreign providers may be shorter than to domestic ones, total flows have still been tiny. Apart from very specific traditional trading practices, patient flows still seem likely to be driven principally by tourism and retirement than by sudden large movements of patients for E112 care.

The response of providers

- *Secondary/tertiary services*

Providers of care are, broadly speaking, either primary care physicians or large institutions (hospitals) – although the relationship of specialists to the primary and secondary sectors varies between different member states. This study found no evidence of explicit entrepreneurial activity by large hospital institutions intended to attract patients from across borders. However, this may prove to be a much more important issue for new members of the EU, though there is great controversy about the likely direction of patient flows between western and eastern Europe. There is evidence of the willingness of institutions, for example some of the large specialist centres in France, to accommodate and ease the way for foreign patients.

- *Primary care*

The case studies suggest that the role of primary care physicians is potentially very important, whether as inhibitors or facilitators of cross-border trade. For example, the pivotal position of doctors in informing, permitting and even promoting cross-border care seems to have been particularly important in Italy. This raises the question, who initiates demand, the patient or the doctor? In some EU member states, such as Germany, The Netherlands and the UK, there is a gate-keeper system such that publicly insured patients need a referral to receive hospital care. This does not apply, however, to other member states, such as Belgium. Referral practices also depend on the remunerative framework within which specialists operate. For example, in Belgium hospital physicians are paid on a fee-for-service basis. In

Germany, hospital physicians are salaried employees and additional payments can only be requested for private patients. In The Netherlands, approximately 90% of medical specialists are self-employed and are paid a mix of capitation and fee-for-service. In Maastricht Hospital, however, specialists are salaried employees.

As has been seen, referral by primary care practitioners across borders also depends on the existence of good administrative processes, in particular provision for the efficient exchange of medical records; on the equivalence of products (such as availability and compatible labelling of pharmaceuticals) across national boundaries; and on familiarity with foreign specialist providers.

Patients tend to prefer doctors of their own language/nationality. Following the Kohll and Decker judgements of the ECJ, there may be an enhanced incentive for doctors to establish practices in border regions to attract the custom of patients, particularly where this is associated with some relaxation of gatekeeping, for example as between The Netherlands and Belgium, and the study found some evidence of this.

Payers

The concept of ‘payer’, though often applied to insurance funds in insurance-based health care systems, applies to all those agencies that operate as purchasers in health care systems, which operate a purchaser-provider split. As can be seen from the discussion above, it is the decisions of insurance funds (to restrict reimbursement for care obtained abroad) which are prompting the flurry of cases now before the ECJ. However, it is also insurance funds which are proving most pro-active and creative in the border regions in establishing mechanisms whereby patients can exploit the opportunities for cross-border care, both under previous EU regulations, and in a post Kohll and Decker era. Thus, insurance funds, at least in the Euregio projects, are proving to be an important innovative and enabling force. They do, however, expect the additional activity engendered by the Kohll and Decker rulings to be relatively small, and see their activities in facilitating cross-border care more as an exercise in quality improvement which, because the option will be exercised by relatively few patients,

is unlikely to prove a threat financially. Furthermore, whilst, for example, the Dutch CZ insurance fund is content to set up restricted contracts with foreign providers in specified regions, it cannot contemplate doing so across all the countries of the EU, in order to accommodate small numbers of patients.

If cross-border care were to develop substantially outside the Euregios, and beyond the current restricted categories of tourism, border workers and pensions, it would require the development of innovative contracting arrangements for benefits-in-kind systems. There is emerging evidence from Germany that private employers with dedicated insurance policies are considering insuring their labour forces on a Europe-wide basis.

The impact of increases in patient flows on the financial stability of member states' health systems

Underpinning the fear of sudden large increases in cross-border flows of patients for E112 care, is a concern about the financial stability of member states' social insurance systems. This was identified by the ECJ as a key concern and has been noted by several member states, particularly central ministry officials from France and Germany, both countries struggling with serious financial pressures in their health systems. The net impact of the Kohll and Decker judgements on member states' financial obligations will be reduced to the extent that any increase in cross-border traffic meets demand that would otherwise be met by the country of insurance, since the tariffs permissible are those that obtain in the competent (i.e. insuring) member state. Such an effect can only occur only where the new provisions for cross-border care permit latent demand to be realised or affect the cost of care provided.

The question turns, therefore, on whether member states' measures of financial control, including implicit or explicit priority-setting, would be undermined in the unlikely event that large increases in non-authorized cross-border patient flows were to materialise, permitted by subsequent ECJ judgements. Financial control on service provision is typically exercised at several levels: the macro, national cash limit; at intermediate level through devolved budgets; and at micro level, through, for example, patient co-payments, gatekeeper

systems and restriction of basic entitlements (the services that can be accessed) or control of timing of access (use of waiting lists).

EU-wide trade in health services delivery could weaken member states' ability to set financial limits in a number of ways. First, it would place pressure on members states to provide an equivalent package of services to all EU citizens. The case of Mrs Smits currently before the ECJ concerns the non-availability of care in the competent member state, in this case The Netherlands. There has also from time to time been pressure, at both national and European levels, to deliver a package of care which is equivalent to what can be obtained elsewhere.

Second, the liberalisation of cross-border trade, particularly if extended to hospital care, would have the capacity to reduce the effectiveness of waiting lists as a rationing device. The boundary between inpatient and ambulatory care is shifting rapidly. The available data are completely unable to support any analysis of past trends, or indications of future demand for, non-hospital care. In addition, there is little evidence on which to base judgements about the extent to which patients will surmount barriers to cross-border health care provision in order to reduce waiting times. On the whole, the literature, and national courts, have tended to concentrate on the rights of patients vis-a-vis the package of services on offer, at home and abroad, rather than on the immediacy of access to existing services. The latter perhaps reflects the continuing lack of explicit, specialty-based waiting time protocols at national level.

Finally, cross-border trade has the capacity to enable patients to avoid the intervention of gatekeeping primary care physicians.

Hospital service and infrastructure planning

When delivering judgement on the case of Mr Kohll, the ECJ noted that the maintenance of a balanced medical and hospital service open to all might be a justification for restricting cross-border trade in medical goods and services. This relates to the indivisibility of large medical infrastructures such as hospitals and the prospective difficulty of maintaining a secure domestic supply of hospital services in border regions if patients move across borders for health care. This comment has come under considerable critical scrutiny, not least from those who

note that what Kohll and Decker did was merely an extension of recent moves by a number of member states to introduce elements of competition and ‘market forces’ into their health services. On the other hand, member states have not necessarily been successful in implementing competitive health systems, since they have to trade off the importance of local access to services with financial and quality considerations.

The Euregio projects demonstrate that flows of patients across borders for hospital care are currently too small to have implications for service planning and delivery. It is extremely unclear, and a point to be addressed in the Euregio Rhine-Waal project, what constitutes a critical level of cross-border trade such that it may begin to impinge on service planning and delivery in the border regions.

However, the demands of delivering integrated cross-border services may argue in favour of a collaborative approach. This theme can be found in some of the recent literature concerned with Kohll and Decker³⁷, and is one proposal of the recent AIM Report to the European Commission³⁸. Possible efficiencies from coordinating service planning in the border regions are:

- to help relieve capacity constraints in hospital infrastructure where services are in effect competing. In such cases, the opportunity for cross-border care is seen as an important service for those patients prepared to seek care abroad rather than wait for domestic supply. In this case the implications are financial rather than infrastructural;
- to rationalise highly specialised medical skills and equipment, particularly in the border regions. The AIM Report³⁹ proposes that member states and insurers might in future purchase evidence-based health care services, particularly in elective care, across political boundaries from EU registered centres of good practice. Similar ideas have been mooted elsewhere⁴⁰.

The Impact of the Kohll and Decker rulings on European health services’ efficiency and quality

Performance indicators for members states’ health systems do, of course, vary dramatically across a range of criteria, ranging from macro indicators such as total funding as a proportion of GDP, the quantity

of medical staff and the quality and quantity of physical estate, through to micro level indicators of efficient utilisation such as length of stay, use of clinical time, and so forth⁴¹. Whilst still a somewhat theoretical discussion in the light of the main conclusion of this paper that cross-border trading is unlikely to increase dramatically in the foreseeable future, nonetheless some commentators are beginning to pose questions about the extent of the convergence which would be necessary to enable cross-border trade to flourish, and the extent to which such convergence would itself be brought about through the liberalisation of trade. Some general themes which have started to emerge are as follows:

- *Quality of care*

The ECJ was dismissive of quality of care arguments on the grounds that clinical training and accreditation requirements had been harmonised across the EU thereby ensuring a minimum common quality of care in all member states. However, a number of member states' government officials have commented on the additional risks, including the increased burden of information, which patients will encounter from trading in health services across national boundaries. These include consumer issues, such as equivalent guarantees for medical devices. (In some member states, spectacles are issued with guarantees. In the UK, provision for replacement is frequently included in household insurance policies).

In practice the ECJ has faced considerable criticism of its dismissal of quality issues⁴². This is because the issue of the human quality of professionals (training, accreditation, etc.) is very different from the quality of services that may be governed (if at all) by treatment protocols. Treatment protocols may reflect the use of cost-effectiveness criteria applied in one member state but not another. Standards (as opposed to clinical quality) of care may also vary from country to country.

A further issue is not the risk to patients per se, but the related question of the extent to which differential quality of care promotes or inhibits cross-border trade in health care delivery, an issue explored above in the analysis of flows of Italian patients to France, and explicitly addressed in the evaluation of the Euregio Rhine-Waal. The arguments are not clear cut. Differential quality promotes trade in the

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Italian case, in a one-way traffic in elective care, but was presented as an impediment to cross-border traffic for emergency care in the Rhine-Waal Euregio. As an issue, however, this will be crucial for possible flows between current EU member states and future new members (see below).

● *Accreditation of institutions*

The clinical competence of medical professionals depends not just on their qualifications but also on their relationship to the clinical infrastructure within which they work. Thus, specialists have very different working relationships in, for example, The Netherlands, where they are required to be accredited to large clinical institutions, and in Germany where they operate single-handedly in the community. In addition, little is known or documented about European-wide standards of accreditation of institutions themselves, and how this is managed within health care systems, whether through contracts with payers, or through professional bodies, or via statutory obligations. These standards may also vary. Although politically very sensitive, growth in cross-border trade would be likely to trigger increasing interest in the accreditation of institutions

Whilst the European Commission does not, under existing Treaty provisions, have a specific competence in health services delivery, the EU does already have an instrument available to it for promoting benchmarks of good practice in the form of the European Investment Bank (EIB) whose lending remit was extended to capital projects in health during the Amsterdam Summit in 1997⁴³. Until now, however, the EIB has operated largely without a European dimension to its financing of EU health care infrastructures, aligning its investments only to national or regional priorities, and appraising projects without any attempt to set European-level benchmarks of cost-effective health services provision⁴⁴.

Implications for EU enlargement

Finally, although it was beyond the scope of this paper to investigate the impact of the Kohll and Decker rulings on pre-accession states, this may turn out to be the most far-reaching issue of all. Cross-bor-

der trade in health care between Italy and France is an interesting example of how patients are prepared to travel where quality differences between domestic and foreign supply are perceived to be large. Anecdotal messages about the eastern European perspective conflict. On the one hand the Kohll and Decker rulings are seen as an important trading opportunity where eastern Europe could perhaps attract income from foreign patients. On the other hand, possible leakages of patients and income from eastern European states to the relatively highly developed facilities of most of the current EU members, is giving rise to concern in pre-accession states about the fiscal implications of increased cross-border trade.

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