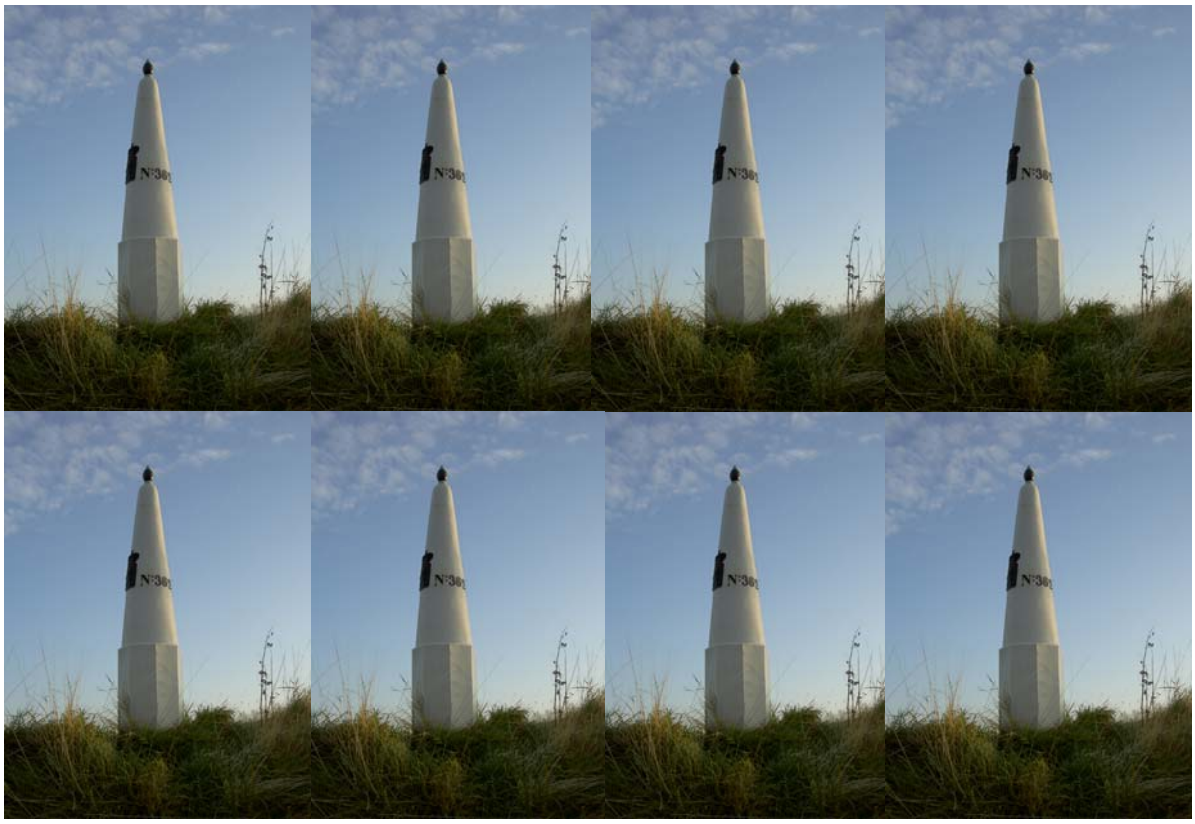
Referring abroad

Enablers and barriers of cross-border care



Master thesis
Health economics, policy & law
Erasmus Universiteit

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December 2007

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Master Thesis

Health Economics, Policy & Law
Rotterdam: Erasmus Universiteit

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14 December 2007

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Summary

Cross-border health care is an issue of growing importance in the European Union. It offers health care services and products to patients in other countries than the country which covers their residency or insurance. Through rulings of the European Court of Justice, the possibilities for patients to receive cross-border care have been clarified. Although data on patient mobility within the EU is limited, the extent of cross-border health care is estimated to be around 1% of total health care expenditure in the EU. The numbers of patients seeking cross-border care can vary enormously per border and the direction can be either unidirectional or bidirectional depending on the border. Though cross-border care is unlikely to become a dominant activity in any country's health care system, there is scope for increased patient mobility. ZorgSaam hospitals believes that there is greater scope for cross-border care and therefore wishes to attract Belgian patients. One of the ways through which patients seek cross-border care, is through their GP. The role of GPs is important in two ways: as referrers they can channel patients, and as the professionals that patients usually trust most and being the first contact point, GPs can influence patients' choices about where to be treated. This has lead to the following main research question of this study:

How can ZorgSaam increase referrals from Belgian GPs?

In order to be able to answer this question, the concept of cross-border care has first been looked into. The conceptual model that followed from this consists the interlinked elements of the institutional factors, processes, contextual factors and actors on various levels (European, national, regional). This model helped develop the research method used.

This method consisted of semi-structured interviews held with GPs in the border region (most of whom had Dutch patients and therefore had some experience with ZorgSaam) and interviews with representatives of two leading mutualities. GPs were asked about their referral decision making. Both groups were asked about possible enablers and barriers of cross-border care and their attitude towards it.

From the results it can be concluded that, GPs and representatives of the mutualities have a positive attitude towards cross-border care as long as it is of benefit to the patients. The GPs do not perceive any real advantages for Belgian patients to cross the border to seek care in a ZorgSaam hospital, other than the extra choice it provides for patients. However, there is adequate hospital care available in Belgium. The GPs have therefore never referred their patients to ZorgSaam.

The results have also given some insight into the other barriers and enablers of cross-border care. The enabling factors are the cultural and linguistic similarities and the short distance to a ZorgSaam hospital from Belgium. However, as the GPs remarked: "*It is not so much the distance to Terneuzen that is the problem; it is rather the idea that you are going abroad that is the problem*". That going abroad is the problem, is made evident by other barriers found. The unfamiliarity with the Dutch health care system, differences in organisation within Dutch hospitals and ICT applications and the unfamiliarity with Dutch specialists too are reasons for Belgian GPs not to refer their patients to ZorgSaam. Many of the barriers found are similar to those factors that determine whereto GPs generally refer their patients. Therefore ZorgSaam will need to compete with Belgian hospitals on these factors.

For ZorgSaam to be able to increase the referrals from Belgian GPs it will be necessary that they improve the relationship between GPs and ZorgSaam specialists. Provide information to GPs (and patients) concerning the possibilities and procedures of cross-border care, and what patients can expect from ZorgSaam. It has also been suggested that ZorgSaam not only puts effort in attracting Belgian patients, but also those Dutch patients that are now more orientated towards Belgian health care services.

Management summary

Objective

Cross-border health care, is of growing importance and through rulings of the European Court of Justice, the possibilities for patients to receive cross-border care have been clarified. Though cross-border care is not or is unlikely to become a great phenomena, there is scope for increased patient mobility. ZorgSaam hospitals believes that there is greater scope for cross-border care and therefore wishes to attract Belgian patients.

One of the ways through which patients seek cross-border care, is through their GP. The role of GPs is important in two ways: as referrers they can channel patients, and as the professionals that patients usually trust most and being the first contact point, GPs can influence patients' choices about where to be treated. This has lead to the following main research question of this study: *How can ZorgSaam increase referrals from Belgian GPs?*

Recommendations

Based on this study, the following recommendations can be made:

- ZorgSaam should improve the relationship between Belgian GPs and specialist
    - Inviting Belgian GPs to functions specifically aimed at them that are held at convenient hours. This will allow Belgian GPs to get acquainted with ZorgSaam specialists
    - Encouraging ZorgSaam specialists to present at refresher courses organised by Belgian GP associations. This too will allow Belgian GPs to get acquainted with ZorgSaam specialists
    - Enabling GPs to have direct contact with ZorgSaam specialists by handing out a phone list with direct contact numbers. This will ease the working relationship between GPs and specialists
    - Creating an understanding of the differences in the organisation of hospitals, making it easier for Belgian GPs and ZorgSaam specialists to work together
- Providing Belgian GPs with information concerning cross-border care: when can patients seek cross-border care, how should they go about it, what is the procedure, what can patients and GPs expect
- ICT solutions reducing the administrative burden put on GPs when they refer patients to ZorgSaam
- Not only aiming to attract Belgian patients, but also aiming to attract Dutch patients who are now more Belgium orientated. Thus showing Belgian GPs that ZorgSaam can also provide adequate care to Belgian patients

Motivation

Interviews were held with Belgian GPs in the border region with Zeeuws-Flanders. These interviews have covered the perceived enablers and barriers to receiving health care in the Netherlands and the practical barriers they have encountered when having referred patients to the Netherlands. Interviews were also held with representatives of two leading mutualities to get a better insight in the barriers and enablers of cross-border care and differences between the health care systems of Belgium and the Netherlands. Analysis of the data was qualitative in nature.

The results have shown that both GPs as well as the representatives of the mutualities are generally favourable towards cross-border care, as long as it benefits the patient. Various barriers have been mentioned by the both the Belgian GPs as well as the representatives of the mutualities. These barriers are concerned with the several elements of cross-border care discussed in the theoretical framework of this study. They include the lack of knowledge concerning the possibilities and procedures of cross-border care, differences between systems and the organisation within hospitals, cultural differences and distance. By taking away these barriers, ZorgSaam could increase the referrals from Belgian GPs. However, not all barriers can be influenced by actions of ZorgSaam.

Contents

Chapter 1. Introduction

1.1 Motive

Cross-border health care, the ability of nationals from one European Union member State to access health services in another member state, is an issue of growing importance in the European Union. It offers health care services and products to patients in other countries than the country which covers their residency or insurance. Rising costs coupled with problems of resource allocation and the occurrence of waiting lists in some countries has lead to governments and public to seek health care services in other member states than their own (Rich & Merrick, 2006). On the supply side, cross-border markets offer the opportunity of economies of scale and increases in efficiency and quality, while on the demand side it offers patients more and a broader choice in health care services and products (Paulus, Fecher, van der Made, Evers & Boonen, 1999; Maarse, 2001)

Up until 2002, cross-border care was still a strictly regulated domestic process. A series of rulings of the European Court of Justice (eg. Decker, Kohll, Müller and Fauré) have linked the right to health care with the right to the freedom of moving goods and services between member states as stated in the Treaty of Europe. This has resulted in the development of a new legal right: the right of nationals from one European member state to access health care in another (Rich & Merrick, 2006).

Although data on patient mobility within the EU is limited, the extent of cross-border health care is not thought to be huge. It is estimated that around 1% of total health care expenditure in the EU can be contributed to cross-border health care. The numbers of patients seeking cross-border care can vary enormously per border (from only a few to thousands) and also the direction can be one-way or both ways depending on the border (Glinos & Baeten, 2006). This has lead to some countries exporting patients, while others are importing patients (Busse, Wörz, Foubister, Mossialos & Berman, 2006). Whilst patient mobility has increased, this has not increased excessively (Rich & Merrick, 2006). According to a study done by Hermesse (1999) the demand seems to be concentrated in border regions and in high technology health care. Besides this, it also seems to be limited to those individuals that have sufficient information concerning cross-border health care. Botten, Grepperurd & Nerland (2003) therefore estimate that less than 10% of patients will be eligible for cross-border care. Even though at present there is not a lot of cross-border care, nor will it ever become a dominant activity in any country's health care system, there is scope for greater patient mobility due to a continuing imbalance between supply and demand (Rich & Merrick, 2006).

ZorgSaam, a group of Dutch health service providers including hospital services in Terneuzen (basic specialist care) and Oostburg (out-patient clinic and short stay care) and Hulst (out-patient clinic), too believe that there is scope for greater patient mobility and would like to broaden its client base and attract patients from Belgium. Since the hospital facilities of ZorgSaam are all situated within 10 kilometres of the Belgian border, wishing to attract Belgian patients seems natural. Especially when considering the absence of a language barrier between the Netherlands and Flemish speaking Belgium, a fluid border with respect to history, culture and a feeling of belonging (Baeten & Glinos, 2006). This would seem to offer opportunities for ZorgSaam to increase the number of Belgian patients.

At present, the general patient flow between Belgium and the Netherlands is predominantly a one-way flow of patients from the Netherlands to Belgium (Glinos & Baeten, 2006). In 2002 around 0.5% of total hospital admissions in Belgium were of non-Belgian patients of whom 60% came from the Netherlands (Glinos, Boffin & Baeten, 2005). According to hospital figures of 2005 (van Sabben, personal communication, 2007), ZorgSaam treated just 63

Belgian patients in the day care clinic, 241 Belgian patients in the out-patient clinic, and admitted 60 Belgian patients.

Because of the lack of certain types of specialist medical care in Zeeuws-Flanders and because of the close proximity to hospitals in Belgium, there has been cooperation as early as 1978 between Dutch health insurers and Belgian hospitals in the border area (Brouwer, van Doorselaer & Hermans, 2001). This, unidirectional, so-called Zeeuws-Vlaanderen regeling (Zeeuws-Flanders arrangement) allows the Zeeuws-Flemish to get the required top clinical medical care in certain Belgian institutions. ZorgSaam hospitals too has a history of cooperation with a Belgian institution, UZ Ghent, but then with regards to treatment of patients, patient pathways, education and research (ZorgSaam, 2006)

1.2 Research Questions

What is made clear above, is that as of yet there is hardly a patient flow from Belgium to the Netherlands. This raises some questions. A first question that can be asked is: how can ZorgSaam attract Belgian patients? However, this question will need some specification as it is very broad. A study done by Nederpelt (2007) concerning the patient satisfaction of Belgian patients treated in ZorgSaam gives an idea of how to specify very broad question mentioned above.

According to the majority of Belgian patients treated in ZorgSaam, ZorgSaam was either recommended to them by friends and family or they were referred to ZorgSaam by their GPs (Nederpelt, 2007). The role of GPs (and other referrers) is particularly important to cross-border care in two ways: as referrers they can channel patients, and as the professionals that patients usually trust most and being the first contact point, GPs can influence patients' choices about where to be treated (Glinos, Baeten, Boffin, 2006). Especially in the case of cross-border care, patients will be faced with a lot of unfamiliarity. GPs are in a position to take away some of this unfamiliarity of their patients. This allows us to specify the main research question and gives the following result:

How can ZorgSaam increase referrals from Belgian GPs?

To be able to answer this question, other questions need to be answered first. First of all an insight should be gotten into GPs' referral decision making, which gives us the following sub-questions:

1. On what factors are the referral decisions of GPs based?
2. What are the reasons for Belgian GPs to refer or not to refer their patients to one of the ZorgSaam hospitals?

Secondly, insight should be gotten in how GPs perceive cross-border care and what barriers and enablers could either hinder of stimulate cross-border care. However, as was mentioned above, there is hardly a patient flow from Belgium to the Netherlands, therefore it can be expected that Belgian GPs have little knowledge concerning cross-border care and might therefore be unable to identify enablers and barriers of cross-border care. It will be necessary to question other actors also. An obvious choice is the mutualities, who are involved with cross-border care in the sense that they either cover the costs of cross-border care or reimburse patients.

3. How do GPs and mutualities perceive the possibility for patients to receive cross-border care?
4. What are the barriers and enablers of cross-border care according to Belgian GPs and mutualities?
5. What are the practical consequences associated with cross-border care according to the GPs and mutualities?

Before being able to answer these questions, a literature study will be done to determine the properties of cross-border care thereby exposing barriers and enablers of cross-border care. This theoretical framework will be discussed in chapter 2. In chapter 3 the research method will be described. In the following chapter (chapter 4) the results of this study will be presented, after which in the conclusion, chapter 5, the research questions will be answered. This thesis will end with a discussion (chapter 6).

Chapter 2. Theoretical Framework

In this chapter the theoretical framework will be given. The theoretical framework of this thesis is structured in line with the conceptual framework of patient mobility and cross-border care. By discussing the various elements of the conceptual framework, enablers and barriers of cross-border care can be identified.

Cross-border care: conceptual framework

To get a better understanding of the concepts of cross-border health care and patient mobility, an explanation of these concepts will be given. Baeten & Glinos (2006) have defined patient mobility as being a general term that describes any kind of movement that involves patients moving beyond their area of residence or catchments area to access health care services. This definition encompasses a phenomenon composed of many interrelated concepts that is very complex. How these concepts interrelate can be made clear with the use of a model based on the policy analysis model by Walt & Gilson (1994) in which a large role has been given to contextual factors, substantive content and the different actors involved and their beliefs and values.

Another reason for making use of this model is also based on the fact that the implementation of a policy is "a process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends" (Barrett and Fudge, 1981: pp. 4). Implementation of a policy can therefore not simply be regarded as a simple and mechanical transfer of policy intent into practise. ZorgSaam may have the intent to attract Belgian patients and thus stimulate cross-border care, but ZorgSaam will be dependent on others (insurers and referrers among others) to be able to actually attract these patients.

Rosenmöller, Baeten, Mckee, Mossialos & Jorens (n.d.) have adapted the policy analysis model to suit the concept of cross-border care, which in turn has been adapted to suit this thesis. Within the *institutional framework*, the concept of cross-border care will be discussed in a European context. The rulings of the European Court of Justice (ECJ) especially have made a big impact on the development of cross-border care and have taken away many barriers thereby strengthening the rights of patients to seek health care services abroad.

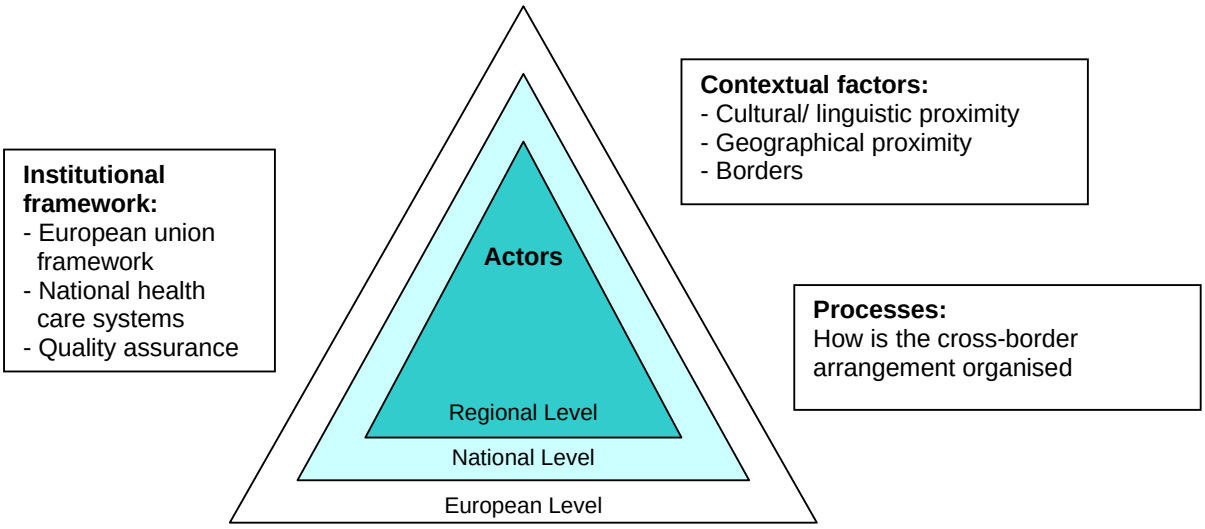

Figure 1: Conceptual framework of cross-border care (adapted from: Baeten, 2006)

Besides this, a description of the health care systems of Belgium and the Netherlands will be of importance, because it gives insight into how health care is organised in both countries

and may give an indication of possible barriers that patients could encounter when seeking cross-border care. The element of *processes* is concerned with the organisation of cross-border care and will clarify how European legislation is put into practise. The *contextual framework* is concerned with the influence of the rigidity and fluidity of borders on cross-border care and how the border between Belgium and Zeeuws-Flanders may or may not pose barriers to cross-border care. The last element of our model, *actors*, particularly shows how the various elements of the model are interrelated. This element shows how various actors view cross-border care and what the deciding factors are whether to support, stimulate, make use of cross-border care or oppose it. Thus identifying enablers and barriers of cross-border care. This model can be seen in figure 1.

2.1 Institutional framework

In this chapter (chapter 2.1) the institutional framework will be discussed. In chapter 2.1.1 cross-border care will be put into a European context. From this chapter it will be clear what the Impact is of rulings of European Court Justice and what barriers of cross-border care have been addressed (chapter 2.1.2). In the following chapter (chapter 2.1.3) the health care systems of the Netherlands and Belgium will be discussed. The differences between these two systems will help identify possible enablers and barriers of cross-border care (chapter 2.1.4). The last element of the institutional framework concerns quality and the continuity of care (chapter 2.1.5). The final part of this chapter shows possible barriers due to problems in the continuity of care (chapter 2.1.6).

2.1.1 Cross-border care in a European context

Whilst there is a an increasing mobility of patients within the European Union, cross-border health care services still encounter problems due to incompatible rules between the various member states and a lacking of a clear framework for co-operation between the member states (Sylvest & Beale, 2007). It is the European Court of Justice (ECJ) that has shaped an emergent European Union health policy because of the absence of a comprehensive legal framework on a European level. Essentially though, the entitlements of patients to seek cross-border care are still determined by national law (Harvey & McHale, 2004).

Recent judgements from the ECJ have lead to a greater ease of flow of patients across borders. These judgements are based on two distinct rights; the right to access healthcare which is anchored in EU legal traditions such as the charter of fundamental rights and is supported by the governments of the member states; and the right to freedom of movement (of people, goods, services and capital) within the context of the European Economic Community (Rich & Merrick, 2006).

To get a better understanding of health care in a European context, we will go into the basic legal provisions and some of the ECJ rulings that are of interest to this study.

The Treaties

The twenty-five EU member states are increasingly ceding more sovereign rights to the European Union, which has enabled the EU to enact laws and regulations with similar effects as the national laws and regulations of the individual member states. Theses so-called community laws, supersede the national laws when they are in conflict. The legal framework of the European Union is based on the treaties and regulations that have been ratified by the member states (Harvey & McHale, 2004).

The 1957 Treaty of Rome has established four fundamental freedoms, which are: the freedom of movement, the freedom of people, the freedom of goods and services and the freedom of capital. The Treaty of the Establishment of the European Community (EC treaty) has provided the legal basis for every citizen of the European Union to move freely and to settle on the territory of the member states (article 18). Another article of interest within the EC treaty is article 49, which, in theory, stipulates that national boundaries do not exist when it comes to the seeking of health care in another member state, in so far as that people have the freedom to move and live anywhere within the European Union. The right to the freedom of movement and the free access to goods and services, then, have formed the legal basis for the Kohll and Decker cases which will be discussed later in this chapter.

Regulation 1408/71

The provision of health care services is an important aspect of the social policy found within the EU that also contains pensions, education and employment (Sieveking, 2006). To prevent that the free movement of people within the European Union can be deterred due to individuals loosing their rights to social protection outside of their home member state, a European regulation 1408/71 was drawn up which was meant to coordinate the social security systems based on article 42 of the EC treaty. With regard to health care, this regulation has as a basic principle that the home state (or relevant institution within that state) is responsible for the payment of obtained health care services. Entitlement to certain health care services is equivalent to what is legally available in the home member state and what is covered in the benefits package (Österle, 2007).

This regulation is not meant to create perfect patient mobility between the member states, but rather it is meant to guarantee the rights of patients whilst they are staying in another member state. Based on article 42, the regulation arranges the rights of reimbursement of health care services that EU citizens obtain in a member state other than the member state in which they are insured. This regulation applies to dentistry, ambulatory and hospital services and to drugs. Different arrangements have been made for those receiving care whilst temporarily abroad and those seeking planned care abroad according to the rules laid out in article 22 of regulation 1408/71 (See chapter 2.2.1).

Other relevant directives and frameworks

Besides the above mentioned treaties and regulations, there are other directives and frameworks which facilitate cross-border care. An example of this is that the mobility of health care professionals between member states is eased with European rules regarding mutual recognition of professional qualifications. Directive 95/46/EC (European Parliament, 1995) on the protection of individuals with regards to the processing of personal data addresses the issues concerning data protection and the sharing of confidential data between Member States. A last example is the e-health action plan that has been developed for using information and communication technologies with the aim of improving access, quality and effectiveness of health care services across the European Union (Clarke, Magannis & Shiels, 2006)

European Court of Justice rulings

Kohll & Decker: Rules on treatment abroad

It was in 1998 through the landmark cases of *Decker* and *Kohll* (Case C-120/95; Case C-158/96) before the ECJ, that cross-border health care became subject to the oversight of the European Union treaties and regulations. *Decker* had bought a pair of spectacles in Belgium on a prescription from a Luxembourg ophthalmologist and sought to get this reimbursed by his Luxembourg health insurer. He was denied reimbursement, on the grounds that he should have obtained prior authorisation. *Kohll*, again a Luxembourg national, also sought reimbursement of medical services obtained in another member state without prior authorisation. In this case it was concerning dental services obtained in Germany. Kohll was refused on the grounds that it was not urgent and that appropriate treatment could be found in Luxembourg.

The ECJ concluded that when the reimbursement of costs of medical services obtained in another member state is conditional upon prior authorisation of the insurer, this unlawfully hampers the free movement of goods and services within the EU; it constituted a violation of Article 49 of the treaty. This means, for instance, that when domestic policies of member states restrict cross-border care they are in violation of European Community law.

Exceptions, however, can be made on the basis of article 46 of the treaty to the extent that national rules serve "the objective of maintaining balanced medical and hospital services open to all" (Case C-158/96, paragraph 50).

These court rulings triggered extensive discussions about their precise meanings and implications. In the cases of Geraets-Smits/ Peerboom and Vanbraekel the court was asked to clarify the scope and meanings of their previous rulings.

Vanbraekel and Geraets-Smits/ Peerboom: Hospital care – prior authorisation as an obstacle to free movement of medical services

Vanbraekel (Case C-368/98), a Belgian national, wanted to obtain reimbursement from her sickness fund for services received in a hospital in France. When following the reasoning of article 36 of regulation (EEC) No 1408/71, a patient that incurs medical expenses, should be able to recover these expenses in accordance with the tariffs applicable to the home member state. A full refund is only applicable when the service is carried out on behalf of the home member state, which implies that the home member states sets the terms of reimbursement. In the Vanbraekel case, the benefits offered by the French legislation were lower than those offered by the Belgian legislation for the same treatment given in Belgium. This leads to the question whether the rule of regulation (EEC) No 1408/71 entitled beneficiaries to recover the higher benefits offered by their home state, or whether the benefits were limited to those offered by the host state. The court found that if a patient has a lower level of cover when receiving health care in the host member state, the patient would be deterred from using those health care services. This constitutes a barrier to the free movement principles. As a consequence, the own insurer should grant additional coverage that covers the difference.

In the cases of Geraets-Smits and Peerboom (C-157/99) the requirement of prior authorisation was challenged under the treaty rules on services (article 50). At that time, the Netherlands had a social security scheme under which patients were offered health care services for free by those providers that were contracted by the social security service. Authorisation for treatment given by providers not contracted was only given if two conditions were met; the treatment for which authorisation was sought is accepted by the professional community as being 'normal' and the treatment had to be necessary in terms of both time and quality. The court regarded the requirement of authorisation to be a barrier to the principles of free movement as it may deter patients from seeking health care services in other member states. However, according to the court the requirement of prior authorisation is justified in 'overriding circumstances' relating to the control of costs and maintenance of high quality hospital services within a member state. Hospital services fall within the framework of the planning of health services in terms of hospital infrastructure, geographical dispersion and services offered and it is in the interest of the general public to allow for the requirement of prior authorisation when wishing to obtain hospital services in another member state. The court went on to say that authorisation may only be refused when treatment which is the same or similarly effective can be obtained without undue delay in the home state with which the insurer has made agreements.

In both cases, the court affirmed that medical activities fall within the scope of article 60 of the treaty (now article 50) and that no distinction need be made between intramural and extramural care. In theses cases, the court reaffirmed the ruling already made in *Kohll* that the national rules are considered being social security rules cannot be considered as exemptions of articles of the current articles 49 and 50 of the treaty.

Müller- Fauré / van Riet: Non hospital care – the removal of the requirement of prior authorisation

The Müller – Fauré and van Riet *(C-385-99; ECR I- 4509)* cases confirmed and refined the previous judgements. Müller – Fauré received dental treatment in Germany without having asked for authorisation beforehand. Van Riet received both hospital and non-hospital services in Belgium after having been refused authorisation. Both sought reimbursement from their respective sickness funds. The court reaffirmed its earlier rulings concerning prior authorisation. From this it becomes clear that the court does not make a distinction between systems operating with a refund system (i.e. in *Kohll*) and systems based on benefits in kind

(i.e. In *Müller – Fauré)*. Besides this, the court redefined the concept of undue delay stating that account should be taken with a patient's medical condition and history, account should also be taken with the degree of pain a patient experiences and the degree of disability which may affect a patient's ability to work.

Ferlini: Host MS may not charge different tariffs depending on the status of the patient
The case of Ferlini (C-411/98) concerned a foreigner married to an EU official who worked and resided in Luxembourg and gave birth in a hospital in Luxembourg. The hospital sent an invoice, which was drawn up on the basis of the scales of hospital fees applicable to those who were not members of the Luxembourg insurance scheme. The charge for her hospitalisation on this invoice amounted to 71.4% more than a native of Luxembourg covered by a Luxembourg insurance scheme would be required to pay. That this was the case was not disputed. The question put to the court was whether these scales were allowed.

The Court ruled that the price for hospitalisation should be the same for all and that it should matter whether they pay for services through public or private insurance or out of pocket payments. The court prohibits any discrimination based on nationality.

Keller: responsible institution bound by decisions of physicians made in host member state
Mrs Keller *(C-145/03)*, a German national, lived in Spain and was a member of the Spanish social security system (Insalud). During a family visit in Germany, Mrs Keller was admitted to a regional hospital and was diagnosed with malignant tumours that could cause death immediately. To get the required medical attention, Mrs Keller applied for an E112 form, which she received based on the seriousness of the disease. Her physicians in Germany were of the opinion that she needed a type of medically proven surgery that was only available in a private clinic in Zurich (Switzerland). Mrs. Keller paid for the treatment out of pocket and requested reimbursement from Insalud. Insalud repeatedly refused, based on the grounds that, though serious, the nature of the disease meant that it did not fulfil the requirements of it being an emergency case in a life threatening situation that justifies receiving medical care in a private clinic outside the EU community without giving Insalud the opportunity to ascertain the possible treatment options and offer them.

The question that was put toward the ECJ was whether the issuing of the forms E11 and E112 meant that the responsible institution (in this case Insalud) is bound by the diagnosis made by registered physician in the host member state that necessitates immediate surgery, even if this means that patients are transported to a third country. The ECJ remarked that even if treatment is given outside the EU community, that this does not necessarily mean that regulation 1408/71 is not applicable. Regarding the actual case, the ECJ ruled that when either the E111 or E112 form has been issued and thus that the insurer has given the insured permission to seek medical services abroad, the insurer is bound by the decisions made by the physicians in the host member state. This ruling is based on the idea that regulation 1408/71 aims to divide the responsibilities between the responsible institution and the institution of the host member state. Furthermore, it is based on the mutual acknowledgment of physicians.

Watts: Medical expenses incurred in another Member State
The ECJ addressed the case of Yvonne Watts *(C-372/04)*, a British national, who needed urgent hip surgery. When she was told that she would have to wait one year to undergo the surgery In the UK, Ms Watts requested an E 112 form from the Primary Care Trust in the UK so she could seek health care abroad. Her request was refused on the ground that the delay was within the "UK government National Health Service Plan targets" and was therefore not considered as an undue delay, which would have been a ground for receiving health care abroad. Notwithstanding this, Ms Watts went to France to undergo surgery and asked the NHS to reimburse the costs, which they refused on the ground of lack of medical necessity.

The ECJ ruled that the NHS must refund hospital treatments provided in another member state when patients have to wait longer than medically acceptable. Besides this, the ECJ also ruled the waiting time must not exceed a delay that is deemed clinically acceptable,

in light of medical condition of the patient, course of illness, nature of disability and the degree of pain. The court concluded that the 'waiting time' must be flexible and dynamically, which means that if a patient's health should deteriorate then the waiting time should be adjusted accordingly. Furthermore, the Court concluded that when a patient seeks treatment in another member state, this falls within the scope of the provision on the freedom to provide services. This freedom of service provision is inhibited by the requirement of prior authorisation. However at the same time, the Court also considered that this requirement is both reasonable and necessary in the light of overriding circumstances.

Stamatelaki: Reimbursement of the cost of treatment in private hospitals
In the case of Stamatelaki (C444/05), a Greek national, sought health care in a private hospital in the UK. His home social security institution denied Stamatelakis reimbursement of incurred costs on the ground that Greek law stipulates that treatments received in private hospitals abroad are only reimbursed where it relates to children less than 14 years of age. After his death, relatives of Stamatelakis brought action before the Greek courts, which in turn asked the ECJ) whether Greek legislation was consistent with Treaty principles concerning the freedom to provide services.

The ECJ reiterated the fact that Member States must comply with Community law, in particular where the principle of freedom to provide services is concerned. This principle prohibits Member States from introducing obstructions on the exercise of that freedom in the healthcare sector, which according to the court has been introduced in Greek legislation. The absolute nature of the prohibition is not proportionate and does not serve public health interests, according to the court. However, some prior authorisation schemes do comply with community law. Furthermore, the court ruled that no distinction should be made between care provided in a public or private setting. The service provided to the patient should be considered, regardless of the provider.

2.1.2 Conclusion: How the EU enables patients to seek Cross-border care

In the preceding chapters the legal bases of the right to receive health care in other member states and the subsequent ECJ rulings have been discussed. It can be concluded that the current legal position of patients seeking health care in another Member State is based on Regulation 1408/71, which coordinates national social security systems and Article 49 EC, which stipulates that national boundaries do not exist when it comes to the seeking of health care in another member state. A lot of barriers to cross-border care have thus been removed and patients have been enabled to seek cross-border care more easily.

The court rulings have gone beyond what some member states anticipated (Mossialos & Palm, 2003) and has demonstrated a tension between member states' autonomy in controlling their health care systems and the European Union's objective of creating a single European market (Sylvest & Beale, 2007). Especially when considering that the health care systems of the member states of the European Union were designed as territorially closed systems that were meant to serve both economic efficiency and social justice objectives (Rosenmöller, et al, n.d.). Health care systems in the European Union are characterised by a system based on collective responsibility, universal coverage and social solidarity and endorse access to health care service for the entire population irrespective of financial status. In practise, national governments have confined their health care activities to their own country and as a result statutory health insurance has traditionally been limited to providers within national boundaries (Mossialos & Palm, 2003).

Although the court does not question the exclusive competences of the member states in providing health care services, it does not give member states full control of it either. According to the court, member states should respect the economic principles of community law, but they are entitled to propose barriers to free movement of hospital services only conditionally and when absolutely necessary for reasons of public interest (den Exter, 2005).

While in the past cross-border care was seen as an unnecessary burden on national health care systems and should primarily be used in cases of emergency, today cross-border care is seen in a more favourable light. The majority of governments and policy makers now see cross-border care as a right or service that requires cooperation between the member states through networking, resource and information sharing (Rich & Merrick, 2006).

Even though a single European Union health care market is in its developing stage and many controversial issues (i.e. mobility of health care professionals and inequity) still need to be addressed (Rich & Merrick, 2006), the following can be concluded from the courts rulings;

The *Kohll* and *Decker cases* have given patients the opportunity to be reimbursed for the health care services abroad and have eased the flow of cross-border health care. When combining the cases of Decker and *Kohll* with the cases of *Smits-Peerboom* and *Vanbraekel*, the concept of health care as a fundamental right has been strengthened, not only within the EU, but also within member states themselves (Rich & Merrick, 2006). In the *Watts* case the requirement of prior authorisation is still found to be acceptable in overriding circumstance. The rulings in these cases means that Belgian patients who wish to receive medical treatment in a ZorgSaam hospital can do so when they have asked for prior authorisation from their mutuality, which is administered under the E112 scheme. However, since there is overcapacity in Belgium, it cannot be expected that that authorisation will be given often.

After authorisation, the patient will receive benefits in kind or will have his health care expenses reimbursed. Whether the health care provider in the host member state is private or public, does not matter for reimbursement according to the ruling in the *Stamtelaki* case. Meaning that Belgian patients will have no trouble being reimbursed for care received in ZorgSaam, a private hospital (like all in the Netherlands). Benefits in kind are to be reimbursed at the rate of the host state, but only for those benefits in kind that are in the basic benefits package of the home state. Cash benefits are to be provided at the rates of the home state. If the patient paid out of pocket, then the home Member State must reimburse the patient. However, it is not clear whether this principle applies to planned care, although according to Hervey (2007) it probably does not.

From the *Ferlini* case, it follows that there can be no discrimination in tariffs between patients. This has several consequences. First of all, it means that Belgian patients who receive medical care in a ZorgSaam hospital need not fear that they can be faced with tariffs that are higher than those charged to Dutch patients. This could especially be important when patients wish to be reimbursed for hospital care they received and when considering the 15/25 kilometre arrangement (See chapter 2.2.2), because patients will only be reimbursed up to Belgian tariffs. If the tariffs for Belgian patients in the ZorgSaam are (much) higher than for Dutch insured, the patient could then be faced with high costs that he must pay out of pocket. This could then pose a barrier to cross-border care. Secondly, the *Ferlini* case reduces the risk that Belgian patients will be given priority over Dutch patients if the mutualities were willing to pay more than the official tariffs. Thereby, reducing the possibility of any upward pressure on tariffs and waiting times in the receiving country (Baeten, McKee, Rosenmöller, 2006).

The *Keller* case has made clear that the responsible institution is bound by the decisions made by the physicians in the host member state. This means that when Belgian patients receive medical care in a ZorgSaam hospital, the mutuality will have to reimburse the treatment (when covered) that the physician prescribes. This could most certainly be an important decision for a regional hospital that only offers basic specialist care like ZorgSaam, because if a ZorgSaam specialist believes that a patient should be referred elsewhere to receive the specialist care they do not offer, then the patient is not required to get his medical dossier reviewed by the competent institution. If this were the case, this could hinder cross-border care to ZorgSaam.

2.1.3 Health care systems of Belgium and the Netherlands

The health care market is not one that is based on a framework of free market competition due to market imperfections (i.e. heterogeneous product and information asymmetry), but is regulated by government. The way in which the health care market is regulated, differs between countries as it is influenced by historical, cultural and other developments. Each country will therefore have its own health care system, degree of decentralisation and insurance schemes.

While in some countries the way the health care market is regulated may stimulate the movement of patients across borders, in other countries it may hold it back. (Paulus, et al., 2000). Determining factors include, among others, whether or not private insurance schemes are present, the presence of certain referral systems, reimbursement systems, out of pocket systems and waiting lists. Private insurance covering cross-border care will stimulate it and so too will lower out of pocket payments and the absence of a referral system in the host country. More autonomy offered to providers and insurers will also offer more degrees of freedom in utilising cross-border health care.

A model that can be used when describing health care systems, is the health systems model that was developed in connection with the world health report of 2000 (Murray & Frenk; WHO, 2000). This model assumes that health care systems perform four functions (stewardship, financing, service delivery, creating resources) to reach three objectives: a healthy population, responding to expectations and fair distribution of burden of the funding of the health care system.

The function of stewardship involves three aspects: setting, implementing and monitoring rules for all actors in the health care system (Murray & Frenk, 2000). This function therefore ensures that a level playing field for all actors is created. The function of service delivery refers to the combination of inputs into a production process that takes place in a certain organisational setting and that leads to the delivery of a certain set of interventions (Murray & Frenk, 2000). For instance, the extent to which provider organisations can be viewed separately or as belonging to networks with different levels of complexity (primary, secondary and tertiary care) determine whether there is a gate-keeping function for first-contact providers. Financing is the process by which revenues are collected from primary (i.e. households and firms) and secondary (i.e. government) sources to form fund pools before being allocated to provider activities (Murray & Frenk, 2000). There are several ways in which these funds can be mobilised among the various sources, such as compulsory or voluntary insurance, out of pocket payments, co-payments and taxes. The choice of how to mobilise funds is likely to affect a health care system's performance. Another important aspect is choosing what, how and from who to purchase.

This framework of the WHO (2000) will be used describe the health care systems of Belgium and the Netherlands.

Belgian health care system

Stewardship

As in many other European countries, the Belgian health care system is based on the principles of equal access and the freedom of choice, which makes it an integral part of the social security system (Corens, 2007).The Belgian health care system is a cross between a Bismarckian- type of compulsory national health insurance with a broad benefits package and a Beveridge-type of system with universal coverage (Callens & Peers, 2003).

Health insurance is predominantly organised through private, not for profit sickness funds, the so-called mutualities (Corens, 2007). All individuals entitled to health insurance must join or register with a sickness fund. Belgian citizens have a free choice between the six sickness funds or a regional service of the public Auxiliary Fund for Sickness and Disability Insurance. These sickness funds developed historically along political and religious lines.

The two largest sickness funds, the Christian and Socialist mutualities, together insure approximately 75% of the Belgian population (Schokkaert & van der Voorde, 2005).

The basic benefits package in Belgium differs between employed and independents (i.e. tradesmen). For instance, independents are only obligatory to insure themselves for major risks (Kemenade & de Lint, 2005). The content of the basics benefits package is decided on through a complex process of negotiations within the RIZIV/INAMI (National institute for health insurance) (Schoakkaert & van der Voorde, 2005). The result of the negotiations, is a yearly fee schedule for each type of health care service provided (including hospital care.), which is called the nomenclature. In all these negotiations, the mutualities can be seen as the representatives for patients (Schokkaert & van der Voorde, 2005).

This compulsory health insurance is combined with a system of private health care delivery, which is based on independent medical practice, on free choice for patients of physician and on fee for service payments (Corens, 2007). This voluntary insurance also covers items not covered in the compulsory health insurances, such as supplements that have to be paid when taking a single occupancy room in a hospital, orthodontics and non-traditional therapies such as acupuncture (Schokkaert & van der Voorde, 2005). Approximately 65% of the Belgian population has additional voluntary health insurance (Callens & Peers, 2002).

Financing

The Belgian health care system is financed through a combination of insurance (54,5%), income based taxes (32%) and out of pocket payments (13,5%) (Kemenade & de Lint, 2005). The insurance cover that is offered by the municipalities and the social contribution rates levied are the same for all the municipalities (Schokkaert & van der Voorde, 2005).

In order to increase the efficiency of the system and keep costs down, stakeholders are now required to assume a growing financial responsibility, with mechanisms that are now based on case-mix and share of risk, instead of the old mechanisms based on simple reimbursement of costs and medical treatment (Callens & Peers, 2003; Crainich & Closon, 1999).

There are two systems of payment. The first is a reimbursement system, for which the patient pays the full costs of services and then obtains a refund for part of the expense from the sickness fund on submission of the bill, which covers ambulatory care. The second is a third-party payer system, for which the sickness fund directly pays the provider while the patient only pays the coinsurance or co-payment, which covers inpatient care and pharmaceuticals.

Not all health care costs that patients incur are covered by their health insurance. Therefore, patients in Belgium participate in health care financing via co-payments, for which the patient pays a certain fixed amount of the cost of a service, with the third-party payer covering the balance of the amount. It has been estimated that patients are subject to between 13,5% and 17% of total health care costs out of pocket (Kemenade & de Lint, 2005; van Camp & Ourti, 2005; Closon, et al., 1999). For instance, Co-payments for inpatient care amount to €40 for the first day and €13 for each additional day plus additional co-payments for, for instance, drugs (€1 per day) and lab tests (€7 per stay) (Missoc, 2006). The second way in which patients participate in health care financing is via co-insurance, for which the patient pays a certain fixed proportion of the cost of a service and the third-party payer covers the remaining proportion. For instance, there is an annual out-of-pocket maximum between €450 to €2500 depending on income. According to van Camp & Ourti (2003) costs that are covered by the insured themselves are relatively high by international standards.

Health care delivery system/ creating resources

Delivery of health care is mainly private and is based on the so-called ‘liberal medicine’. This includes an independent, medical practice, free choice of physician and fee-for-service payments (Crainich & Closon, 1999). Besides this, access to any level of care can be accessed by patients directly. Whereas in many countries GPs can be seen as filters for secondary care and tertiary care (i.e. hospital care), they do not provide this role in Belgium.

Although, the position of GPs has been strengthened and patients now pay lower co-payments when they are registered with a GP (Gonzalez, 2004). Moreover, the co-payments for those patients who seek specialist care directly, without first having seen a GP, have increased (Schokkaert & van der Voorde, 2003). Nevertheless, since there is no referral system in Belgium, specialists and hospitals often form the first point of contact between patients and the health care system. Belgian patients can choose the physician with whom they have first contact, can switch physician whenever they should wish to do so and get a second opinion or consult more than one physician at the same time. This also means that people are free to choose which hospitals they attend and that at the same time public hospitals are obliged to accept each patient. However, in practise most patients are referred to hospital by their GP's or by private specialists.

The right to free choice of physician is heavily defended by the very powerful stakeholder group of specialists, but it does lead to patients shopping around for care and leads to over consumption of medical care and thus has also been responsible for increases in health care expenditure. This, together with the fee-for-service payment element (described above), explains why the average number of physician contacts per person in Belgium is relatively high at 7.1 outpatient contacts per person in 2004, compared to an average of 6.3 in the then 15 Member States belonging to the European Union (Eurostat, 2005).

The health care market is a highly competitive one, because there have hardly been restrictions on entry to medical schools. Due to a lack of control over the supply side of the health care market, the number of health care professionals has increased continuously since the 1970s (Crainich & Closon, 1999). In fact, Belgium is facing with an oversupply of physicians, dentists and physiotherapists.

Because financing is mainly fee-for-service (see below) and based on the number of patients, hospitals have a clear incentive to attract as many patients as possible. This means that hospitals compete on the type of services they offer. Hospitals therefore attract renowned specialists and purchase expensive apparatus as a means of competing (Glinos, et al., 2005). As a consequence though, Belgium does not have problems concerning waiting lists that other European countries such as The Netherlands and the United Kingdom have (had). In certain cases waiting lists may exist, but this is rather due to externalities (i.e. lack of donors in case of transplants), rather than to a shortage in capacity.

Most physicians (like GP's and specialists) are paid on a fee-for-service basis (Corens, 2007). Specialised primary care is supplied at the specialists' practise or at a hospital out-patient department. In the latter case, specialists have contractual agreements with the hospitals and hospitals retain part of the specialist's fees in return for the use of its facilities.

Hospitals are funded via public funding in the form of taxes and receive a prospective budget (increasingly) based on diagnosis-related groups (DRGs). In addition they are funded by user payments (75% of costs). The costs of the medical services are directly integrated into the system of health insurance and are thus covered by the sickness funds (Schokkaert & van der Voorde, 2005). Excluding some exceptions, remuneration is predominantly fee-for-service.

Within hospitals, a distinction is made between medical and non-medical services (Schokkaert & van der Voorde, 2005). Medical and medico technical services not only refer to consultations, laboratories, medical imaging and technical procedures, but also to paramedical activities (physiotherapy). The costs associated with medical services are remunerated via a fee-for-service system to the service provider. The non-medical services refer to accommodation expenses (nursing units), emergency admission (accident and emergency services), and nursing activities in the surgical department.

The Dutch health care system

Stewardship
The Dutch health care system can mostly be characterized as a Bismarck-type system that is contribution based and managed by social partners, but it also has some characteristics of a Beveridge system with the compulsory national basic benefits package. The Dutch health care system is organized for a greater part by private institutions. For instance, health care institutions such as hospitals are usually not state owned. Secondly the health care system is financed by private health insurers. Thirdly individual providers have autonomy over medical decision making and organizational decision making (Putter, van Hout & Ribeiro, 2006). However, the national government is responsible for planning, affordability, solidarity and the quality of the health care system without actually able to achieve this itself.

As in all other countries, the health care market in the Netherlands is also a regulated one. The last three decades have seen an increasing growth of state intervention within the health care system, by the introduction of financial and planning legislation, by the formulation of a large number of policy measures and by the launching of many policy plans (Boot & Knapen, 2005). Since the late 1980s the Dutch health care system has slowly become more of a regulated market (Boot & Knapen, 2005). Within this regulated market emphasis was put on the idea of competition, which would stimulate health care providers and insurers to be more efficient and customer directed and to make patients more aware of their health care consumption (CPB, 2003).

Financing
The Dutch health care system is financed through a combination of insurance premiums that are the same for every Dutch citizen and taxes for uninsurable risks that is income based (AWBZ premium). Since 2005 the Netherlands has a new health insurance system characterized by a compulsory national health insurance. Every Dutch citizen is required to register with one of the private health insurers and is required to be insured for at least the basic benefits package, but they can take out additional insurance (Hamilton, 2003).

What is included in the basic benefits package is decided on by the minister of health. Health insurance companies are not allowed to reject those who wish to have the basic benefits package. The objective of this new health insurance system was to provide Dutch citizens with more choice. Dutch citizens now have free choice of insurer and of health care provider. Health insurers now have a countervailing power, which means that they will aim to contract health care providers in a competitive market, thus enabling them to compete on price, quality and the extent of care. Hospitals will need to compete on the afore mentioned aspects in order to be contracted (RVZ, 2003).

Depending on the policy, insured can claim the costs of health care with their health care insurer (reimbursement) or can receive benefits in kind from those providers with which their insurer has a contract. Patients are not faced with co-payments, but rather with a no-claims discount (which in 2008 will be replaced by a compulsory deductible). Health insurers are free to decide which providers to contract. Even though the insurance premiums are gathered collectively, they are managed by private health insurers (Putters, et al., 2006).

Health care delivery system/creating resources
In the Netherlands, the health care delivery system can be found on several levels or so-called echelons. These echelons represent different sectors of the health care delivery system which have similar functions (Boot & Knapen, 2005). A patient cannot make use of health care services of the second echelon (specialized care) when he has not yet passed the first echelon (non-specialized care). In the Netherlands GP's therefore are often seen as having a gate keeping function.

Until the 1980s the funding arrangements for hospital care in the Netherlands was open-ended and hospitals received a fixed amount for i.e. hospitals days and numbers of operations. Because this arrangement induced output maximisation by providers, a prospective hospital budgeting system was introduced by the government (Putters, et al., 2006). This led to growing waiting lists for hospital care in the 1990s. Great effort has been put into reducing these waiting lists and norms for waiting lists have been set (so-called Treeknorms) that are acceptable (Polder, Takken, Meerding, Kommer & Stokx, 2002). According to these norms, 80% of the demand for health care must be met within a certain number of weeks (i.e. out-patient clinic = 4 weeks, day care = 6 weeks, in-patient clinic= 8 weeks). An inventory of waiting lists done by the NVZ Ziekenhuizen (Dutch hospital branch organisation) in 2006 show that on average the waiting lists are on or below the Treeknorms (Leemhuis-Stout, 2006), but that this differs per type of specialist care and per institution.

2.1.4 Conclusion: How differences in health care systems can enable or pose barriers to cross-border care

It is of importance to have an understanding of the structure of the health care systems on both sides of the border when discussion cross-border care. Differences in the two health care systems could result in barriers to cross-border care.

In both countries, there is extensive government regulation of many aspects of the finance and delivery of health care, but it is not the government that is the main provider of services, nor is it responsible for health insurance (van Doorselaer & Schut, 2000). When looking at the Belgian and Dutch system it is clear that health care is paid for in a greater part by the health care insurers. Whilst health insurance in Belgium is mainly financed through taxes, in the Netherlands it is mainly financed through premiums paid for by the insured. Another global similarity is that in both countries there is compulsory health insurance that covers nearly the entire population. Besides this, citizens can have additional health insurance. Both systems are characterized by free choice in health insurer and provider. Although, In the Netherlands the GP's has a gate keeping function and patients cannot seek hospital services without a referral. There are some differences with regards to the compulsory benefits package offered in Belgium and in the Netherlands. Whereby in the Netherlands the benefits package only includes medical expenses, in Belgium there is a link with social benefits in cases of illness and being incapacitated for work (Ros & Smits, 2005).

The availability of health care services is higher in Belgium, which is probably due to the fee-for-services payments and the prospective budgeting of the Belgian hospitals (Evers, Paulus & Boonen, 2001). Belgium has a much higher capacity of acute hospital beds and a higher rate of other outpatient services such as GPs, medical specialists, dentists, and certain equipment. The Netherlands do have a higher overall bed capacity. This could be explained a relatively high amount of chronic care facilities such as rehabilitation centres and nursing homes (Maarse, Nieboer & Paulus, 2001). Whilst the availability of health care services is higher in Belgium, the availability of certain facilities aimed at continuity of care available in the Netherlands are not available in Belgium (i.e. nurse practitioners and physical exercise facilities). It is believed that the relatively high emphasis on care as opposed to on cure in the Netherlands has resulted in these facilities (Evers, et al., 2001).

Overall, the Netherlands has struggled with waiting lists due to a shortage in capacity, which Belgium has not. In fact Belgium has an overcapacity in health care services. This too has affected the way in which health care providers work. It has been mentioned that in Belgium physicians have a more service-directed attitude due to the strong competition between health care providers, which is less so in the Netherlands (van der Wijst & Ruijten, 2004). Van Tits & Gemmel (1995) mentioned that surgeons in Belgium have the tendency to operate more quickly and that they have higher expectations of the successfulness of the operations compared with their Dutch counterparts.

Another difference in the delivery of services between Belgium and the Netherlands is that in the Netherlands, patients need to be referred to hospitals by the GP or another health care provider due to the echelons, while in Belgium patients have free choice in first contact and do not need to get a referral note. This also leads to a difference in the role of the GP in the two countries. The GP in the Netherlands has a more central role with greater responsibilities, which the GP in Belgium does not have (van Tits & Gemmel, 1995).

The above-mentioned differences have resulted in there being varying incentives for cross-border care. The problems that the Netherlands has had with waiting lists and the over-capacity of health care services in Belgium can be expected to stimulate cross-border care from the Dutch patients' point of view. For Belgian patients, the larger availability of paramedical services in the Netherlands could be a reason for them to seek health care services in the Netherlands.

On the other hand, financial considerations are increasingly important to patients, especially those suffering from a chronic disease (Evers, et al., 2001). This provides an incentive for Belgian patients to seek cross-border care in the Netherlands, since they are faced with relatively high out-of-pocket payments in Belgium (Paulus, et al., 2000).

Besides this, that Belgium does not have a referral system could also stimulate cross-border care (Paulus, et al., 2000). Patients could then more easily cross the border to seek care without having seen a GP or other physician first. Because, the mutualities have been given more financial responsibility, this too could in stimulate cross-border care (Callens & peers, 2003; Paulus, et al., 2000).

2.1.5 Quality of care: co-ordination

Ensuring quality of health care is a very important aspect when discussing cross-border care. The EU Commission (2006) declared that the provision of high-quality health care is an issue of deserving priority, because health is a prerequisite for a good quality of life. Whilst a member state is able to guarantee the level of quality of health care services domestically through i.e. educational requirements of health care providers and the setting up of quality and safety standards, a member state has no control over health care services abroad where other standards may apply (van der Mei, 2002). There can be considerable variation in the approaches that member states have taken to ensure quality of care. For instance there is great diversity in the extent to which activities are compulsory or voluntary and in the extent to which information systems have been designed to support quality assurance activities. However, there are some universal approaches such as those related to safety and pharmaceuticals.

According to Bertinato, et al. (2005) there are three steps that must be taken to be able to ensure the quality of cross-border care. The first step is to ensure the quality of care at the national level. The second step is assessing the quality of cross-border care.

Step 1: Quality at the national level
When looking at a member state's overall health system, this would include ensuring quality of pharmaceuticals (registration and licensing, which are based on frameworks established at EU level), technology (health technology assessment) and the individual health professionals (training and continuing education). At a clinical level the quality of care can be ensured by including methods that enhance the processes and outcomes of care (quality assurance systems, guidelines, monitoring systems such as quality indicators or patient surveys). Besides these methods, health care institutions can adopt other methods such as peer reviews and visitation programmes.

Steps 2 and 3: Quality of cross-border care: continuity of care and after care
According to Bertinato, et al. (2005) patients can be assured that the key elements of a high-quality system are in place in European countries. The question is whether this is also the case with issues such as doctor-patient relationships and the continuity of care?

The first issue, doctor-patient relationships, deals with aspects such as the knowledge that patients have of physicians abroad and how to select them, the sharing of a common language and whether the selected physician has access to the necessary medical records (Trembley, 2003). The second issue, continuity of care, is believed by many (scientists, unions, health care professionals) to be crucial to successful and safe treatment (Health and consumer protection directorate-general, 2006). For instance, it is important that sufficient information of a patient's medical history is available when patients have obtained care in another Member State, as they will often still need care in their home member state. Continuity of care can then be seen a series of connected patient-care actions, not only within a health care institution, but also among multiple institutions. It requires coordination across time, settings, providers, and patients (Anderson & Helms, 1995). For patients it is of important that the aftercare they receive in the home member state fits with the treatment they have had so far (Bertinato, et al., 2005).

For continuity of care to be of good quality, it is of importance that procedures are in place that communicate the necessary information that is needed for health care providers in the state to give the proper and necessary care. Especially in those instances where there is need for specific follow-up treatment. Information must also be made available to providers in the host member state, such as prior conditions before care is given (Bertinato, et al., 2005). It is no surprise then, that the EU commission proposed a patient data exchange system (Health and consumer protection directorate-general, 2006). However, the privacy and security of this data must be ensured (Trembley, 2003).

Not only the communication between the two involved member states is of importance, but also whether the necessary health care, medical devices and medication can be received when a patient receives after care in the home member state (Bertinato, et al., 2005). As the European commission (Health and consumer protection directorate-general, 2006) pointed out, European-wide prescriptions would help ensure the continuity of care when patients seek medication that was prescribed abroad in the home member state.

The question that still remains is, when there is continuity of care that crosses borders, where does the overall responsibility lie and who has clinical oversight? Although healthcare is clearly intended to benefit patients, sometimes patients suffer harm through errors or omissions in healthcare. In their study on stakeholder perspectives, Glinos, et al. (2005) found that stakeholders were unfamiliar with the way in which other parties work and what they did, which lead to uncertainty in the responsibilities that each party should have. It has been argued by many (i.e. national governments) that the overall responsibility for the treatment should be with the member state of treatment. However, purchasers of health care have argued the necessity for them of being able to check the quality and safety of health care given abroad, as they pay for the treatment and will have to deal with possible follow-up costs in the case of adverse events (Health and consumer protection directorate-general, 2006; Glinos & Baeten, 2004).

Giving the responsibility and clinical oversight to the relevant authority in the member state in which the patient is treated may seem to solve all problems; however in practise it is not so simple. The *MRSAnet* and *Euregio Maas-Rhein* found a lack of common quality and safety standards in the area of infectious diseases (Health and consumer protection directorate-general, 2006). Whilst MRSA was almost eliminated in Dutch clinics due to an aggressive 'search and destroy' strategy, the prevalence rates of MRSA were much higher in Germany. This leads to a situation in which it is possible that patients and personnel crossing the border to the Netherlands can infect the hospital population there and this poses a barrier to cross-border care. Especially since the Netherlands cannot impose a similar 'search and destroy' strategy in Germany.

2.1.6 Conclusion: How continuity of care can enable or pose barriers to cross-border care

As has been mentioned before, cross-border care between the Netherlands and Belgium is predominantly a one-way flow of patients from the Netherlands to Belgium. There might not be solid evidence of how the continuity of care is arranged for Belgian patients who have obtained health care services in the Netherlands, but there is evidence of how continuity of care is arranged for Dutch patients who obtained health care services in Belgium. According to Engels (2003), due to a lack of clarity, of communication and of coordination there is no guarantee that there is adequate continuity of care. Discontinuity of the care process was also attributed to differences in professional culture and lack of knowledge of the cross-border health care system, resulting in reluctance on the part of Dutch physicians towards cross-border care. Engels (2003) concludes that despite that Dutch insurers offer their members the possibility to be treated in Belgium, the stages of cross-border care are not yet connected enough to speak of a so-called “borderless care chain”. This could mean that the same is true for cross-border care given in the other direction. The above shows that it is possible that the continuity of care, or rather the discontinuity of care, could pose a barrier to cross-border care.

2.2 Processes

In the previous on the institutional framework of cross-border care was given. This chapter explained the rights of patients in a European context, but did not explain the actual arrangements through which patients can receive cross-border care. This will be explained in this chapter (chapter 2.2 of) on the process element cross-border care. In chapter 2.2.1 a description of the different types of arrangements of cross-border care will be given. Chapter 2.2.2 will show how Belgium has translated the European rules concerning cross-border care into their national legislation.

2.2.1 Different types of arrangements

There are several ways in which patients can seek cross-border care. There is an array of access procedures, patient pathways and payment methods, which can divided into three broad groups: arrangements through regulation 1408/71, institutionally arranged care, self managed care (Rosenmöller, Baeten, McKee, Mossialos & Jorens, n.d).

Arrangements through regulation 1408/71

The first group consists of the arrangements through regulation 1408/71 (see figure 2). This regulation covers provisions for those falling ill abroad and those wishing to receive treatment in another country. When seeking cross-border care following the lines of article 22 of regulation 1408/71 a distinction is made between necessary care whilst abroad temporarily and planned care. The receiving of planned medical treatments in another member state is subject to more strict rules, since these treatments can only be obtained when the own health insurer has given authorisation.

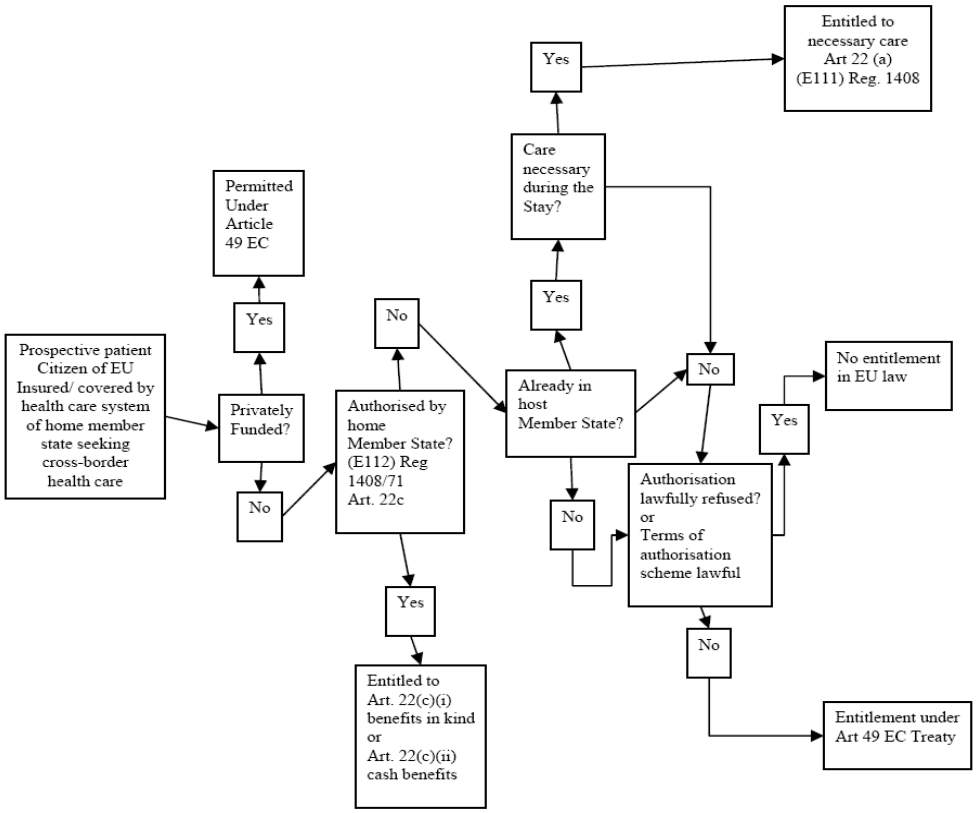

Figure 2: Entitlements of EU citizen patients seeking cross-border health care (Hervey, 2007).

Member states have a wide discretion in determining whether or not to grant prior authorisation, however authorisation must be granted when the treatment is part of the benefits package and when there is undue delay in receiving the treatment in the own member state (see article 22 of regulation 140871). According to Rich & Merrick (2006) the use of "a period normally necessary" in article 22 has still given insurers wide discretion as this term was left to broad interpretation. Authorisation is granted on the basis of a number of forms. These include the forms (e.g. E106 and E121) for those patients that live in another member state than the one in which they are insured. The European Insurance Card (EHIC) is meant for those patients receiving emergency care whilst temporarily in another member state and which all individuals with healthcare insurance coverage within member states are eligible to receive (RIZIV, 2000b). The aim of this card is to take away barriers in patient mobility by reducing the number of forms and formalities. In a second phase this card will substitute all other forms relating to temporary stays. Authorisation for planned care is based on form E112, which too will eventually be replaced by the insurance card.

Institutionally arranged care

The second group of arrangements is that of institutionally arranged care of which the majority are based on contracts between a health care purchaser in the home member state and providers in the host member state or between providers on both sides of the border (Busse, et al. 2006). Contrary to the arrangements based on regulation 1408/71, the content, price, quality are defined through the contract negotiations and not through the legal framework of the health care system of the host member state (Rosenmöller, et al., n.d.). The duration of the contracts can differ between arrangements with some being permanent and other temporary.

Institutionally arranged cross-border arrangements can roughly be grouped under four headings that reflect different rationales, involving different actors and reflect different groups of patients (Busse, et al., 2006). First of all there are emergency coordination arrangements that involve the shared use of emergency and ambulance services. The rationale behind these arrangements is that for certain groups of people living in border regions, a neighbouring country's emergency services is easier accessible. Secondly, there are arrangements among providers, which involves the planning of provision in such a way as to take into account the availability of resources close by (even when these are across the border) and thus reduce the chance of wastefully duplicating resources (Busse, et al.). Thirdly, there are arrangements between insurers/health care purchasers, which reduces the presence of organisational hurdles (i.e. waiting lists) and increase the ability for purchasers and providers to behave in a market-like manner (Busse, et al.). It also allows insurers to control the cross-border flow of patients and the resulting costs and allows for a more structured flow of patients rather than the ad-hoc nature of the E112 forms (Glinos, et al., 2005). The Zeeuws-Flanders arrangement is an example of this type of arrangement. Last of all are the administrative arrangements designed to facilitate cross-border care without actually being involved in the providing and purchasing (Busse, et al.).

Self managed care

The third group of arrangements is that of self-managed care. Patients can seek cross-border care on their own initiative. They will have to find the information on cross-border care options and organise the care appointments themselves (Glinos & Baeten, 2006). The treatment costs and possibly travel expenses could be paid out of pocket, through health insurance or travel insurance. This last arrangement puts patients in a vulnerable position

with regards to the quality and content of health care they receive and the tariffs (Rosenmöller, et al., n.d.). This is because there is hardly any supervision by health care purchasers and public authorities.

2.2.2 Conclusion: How Belgian patients are enabled to receive cross-border care

As it stands now, those insured via the Belgian social security scheme can receive health care in another member state according to the rules laid out in regulation 1408/71 and in the Social Provisions Act of 1999 (Directie-generaal Sociaal Beleid, 2005; Palm, Nickless, Lewalle & Coheur, 2000). This act stipulated that the RIZIV/INAMI's Insurance Committee and the competent foreign institutions are given the authority to promote free movement of insured persons in the border regions by laying down cooperation rules (Palm, et al., 2000).

The application process for planned medical services in another Member State has been arranged in the so-called circular (omzendbrief) 2006/117, which replaced circular 2005/48 (RIZIV, 2006a). In this circular the terms and conditions were listed on which the mutualities could base their decisions on whether or not to allow their insured to seek medical services in another Member State. It stipulated that patients could not get authorisation via the E112 scheme when the treatment was available in Belgium and could be gotten without undue delay and when it is not covered by their insurance. If this were the case, then the particulars of the foreign care must be given: physician, institution and treatment, duration etc. When these criteria are met and treatment can therefore be offered under better medical conditions that are essential according to the advising physician of the mutualities, patients will receive authorisation (Directie-generaal Sociaal Beleid, 2005).

In response to the *Kohll* and *Decker* cases the regulations of circular 2006/117 also stipulates that if patients have received health care services in another member state without prior authorisation, that they should be reimbursed (RIZIV, 2006a). This is subject to certain conditions; the received health care services should be covered by insurance; they do not include hospitalisation and that the reimbursement would be based on Belgian tariffs. This is authorised since EU legislation states that patients should be reimbursed up to at least the level of reimbursement provided by their own system (See Vanbraekel (Case C-368/98) in chapter 2.1.1).

Circular 2006/ 117 (RIZIV, 2006a) has made cross-border even more attainable by stipulating that those living in the border regions (within 15km of the border) can automatically receive health care services in the bordering Member State as long as the actual service takes place within 25 kilometres of the border. Patients will still need an E112 form, but will receive this without the involvement of the advising physician of the mutuality. Treatments for which this applies are for example dialysis, hospitalisation, radiotherapy and radiology. An overview of the various arrangements is given in appendix 1.

The Belgian arrangements go beyond EU legislation, as it now enables those living near the border to seek hospital treatment without prior authorisation. This arrangement will be beneficial for ZorgSaam hospitals in the sense that is eases access to health care services, however if tariffs are higher than those in Belgium, patients could end up paying the difference.

2.3 Contextual factors

In this chapter (chapter 2.3) the contextual factors will be discussed. This element covers the geographical and cultural factors that might affect cross-border care (chapter 2.3.1). Chapter 2.3.2 shows how the geographical and cultural factors might affect cross-border care along the Belgian-Dutch border.

2.3.1 Borders: geographical and cultural proximity

Patient mobility can take place within one country across regional borders, but it can also take place between countries (cross-border patient mobility). In this case cross-border care is referred to as the delivery of care in a member state (the so-called host member state) other than the member state (home member state) in which the patient has insurance coverage.
A distinction should be made between countries sharing a common frontier or between countries that do not, because when the countries share a frontier, the frontier is not just that: a border. It is often also a border between regions and local communities on both sides of that frontier (Baeten & Glinos, 2006).

The degree of fluidity of the border is a very important aspect to as in some cases there is a lot of cross-border activity (fluid border), while in others there is hardly any (rigid border) (Bassi, Denert, Garel & Ortiz, 2001). Patient mobility is more likely to develop in cross-border regions where the border is a fluid one and in those regions where there is a lot of regional cooperation (Glinos & Baeten, 2006). The degree of fluidity depends on aspects such as culture, language, traditions and habits, which, when similar on both sides of a border, may ease cross-border activities. As Vandemeir (1999) said 'people living close to frontiers cross from one side of the border to another, sometimes without even realising it, as they have erased this concept'.

Another important aspect when considering cross-border care has to do with the availability of health care services on each side of the border. In those border regions where there is little need for certain services (i.e. thinly populated areas), cross-border arrangements could ensure that the local population still has access to these services (Baeten, 2000).

2.3.2. Conclusion: How the Belgian- Dutch border enables cross-border care

The border between Belgium and the Netherlands can be considered a fluid border (Glinos & Baeten, 2006). Geographically speaking, the border between Belgium and the Netherlands is not one determined by any natural phenomenon, such as a mountain range or a river; rather it runs across fields. Not only is the border geographically speaking fluid, but also language wise. There is no language barrier as residents of northern Belgium speak Dutch (Flemish) and therefore those living on either side of the border share a common language. There are also hardly any cultural barriers, because the border often runs through local communities that share the same history and cultural attributes. It has also been mentioned that because Zeeuws-Flanders is cut of from the rest of the country, the Zeeuws-Flemish have more common ground with the Flemish (Glinos & Baeten, 2006).

There is a big difference in the number of health providers located in the Netherlands and Belgium (Zorgloket, 2000). On the Dutch side of the border in Zeeuws-Flanders, hospital care is provided by ZorgSaam. In Belgium there are many more hospitals institutions, including regional hospitals in Knokke-Heist, Damme-Sijssele, Eeklo, Ghent, Sint-Niklaas and Antwerp and teaching hospitals in Bruges, Ghent and Antwerp (See appendix 2). The fact that there are many more hospital institutions in Belgium, means that there are plenty of

alternatives for Belgian patients to choose from in their own country. Besides this, ZorgSaam merely offers basic specialist services, while on the Belgian side of the border there are several teaching hospitals. ZorgSaam is therefore unlikely in the position to offer types of care unavailable in Belgium. This poses barriers to the flow of patients from Belgium to the Netherlands.

2.4 Actors

In this chapter the element concerning the actors of the conceptual framework will be discussed. The attitudes that these actors have will be discussed, but only insofar that they are of interest to this thesis. In chapter 2.4.1 the view on cross-border care from the perspective of Member States and that of Insurers will be given. This will be followed by the view of the health care providers and thus the referrers. Because looking at cross-border care from a patient's perspective is also of importance to referrers, the patient perspective will be discussed in chapter 2.4.3. In the last chapter, chapter 2.4.4 the afore mentioned perspective is translated to a more Belgian/Dutch perspective.

2.4.1 Member states and Insurers

From a national government's perspective there are several enabling factors that make them wish to stimulate cross-border health care. When considering mutual exchanges of patients across borders, cross-border care can be beneficial to both countries. Botten, et al. (2003) reason that the principles of absolute and comparative advantages in economic theory of international trade prove this. The central idea is that all countries can benefit if they all focus on those activities (i.e. health care activities) that they perform relatively better. As long as health care providers in the various countries perform in a different way with respect to health production costs, specialisation and the division of labour will benefit these countries. Besides, the provision of an additional patient option may have a disciplinary effect on providers, inducing them to economise on costs and keep charges down (Botten, et al., 2003). However, care must be taken to assure the quality of health care. Competition should therefore not only be on price, but also on quality.

Botten, et al. (2003) also mention that treatment abroad results in an increases in the overall number of patients treated and can lead to a reduction in waiting lists in the domestic member state. However cross-border care could lead to crowding out of domestic patients in the host member state especially when there is a one-way patient flow. This has lead to governments being reluctant to support cross-border care, because they not only decide on the services and products that are made available, but also on the amount of these services and products that are made available (van der Mei, 2002). For instance, there should be a certain number of general practitioners in order to be able to offer adequate care or there should be enough hospital beds to meet needs of the population. Both under capacity (resulting in, for instance, waiting lists) and over capacity (unnecessary waste of human resources and capital) should be avoided. To be able to avoid this, member states need to be able to plan health care services and that could be made impossible when allowing citizens to seek care abroad without limitations. The crowding-out problem mentioned above will be less of a problem when there is a mutual exchange of patients across borders. Even though treatment of foreign patients will occupy national health resources, it is offset by the export of own patients.

A third enabling factor that Botten, et al. (2003) mention, are possible cost savings. A purchaser (mutuality) who selects those health care providers (both abroad and domestic) with the most affordable tariffs will save resources. As a consequence, patients can be treated at lower costs, which also mean that an increased number of patients can be treated out of the same budget. However, the transaction costs must not exceed the savings and that treatments costs reflect true treatment costs or no gain is reached (Botten, et al., 2003). On the other hand, there is the possibility that health care services sought in other member states may be more expensive, thus putting a financial strain on the health insurers (van der Mei, 2002).

Allowing citizens to seek health care services in other member states could mean that citizens might wish to obtain services and products that are not available at home, which are not covered by their insurance benefits package or which are more expensive than at home.

The consequence of this is that a member state will loose part of its autonomy in deciding the types of treatment and products to be made available to its citizens at certain prices (van der Mei, 2002).

2.4.2 Health care providers

There are several reasons as to why health care providers, such as hospitals, would wish to stimulate cross-border care and attract patients from abroad. The first reason is that providers could greatly increase their client base when attracting patients from across the border (Baeten, 2000). This is especially the case for those health care services for which there is overcapacity in the host member state. Also for those treatments that are more lucrative, extra effort could be put into attracting patients from abroad (Brouwer, 1999).

Another reason is that the quality of care could be increased when providers cooperate with providers abroad. Those treatments that were not available in the institutions, could now be made available when the providers cooperate. This could mean that providers can further specialise and that economies of scale could be created (Brouwer, 1999).

However, there are also reasons as to why providers are reluctant to stimulate cross-border activity. Smeets, Bruinsma & Straetmans (2002) found that domestic providers could be reluctant to refer their patients to providers across the border, because they would rather see the insurer's money invested in the home health care system. Domestic providers may also complain about unfair competition when the tariffs abroad are lower than those at home (Baeten, McKee & Rosenmöller, 2006).

Providers might also perceive patient mobility as a threat to the care they provide and the responsibility that they have towards their patients and might therefore wish to stem the flow of patients to other member states (or regions). For instance, a study concerning the continuity of care of Dutch patients who were treated in Belgium identified several bottlenecks in the communication between caregivers on both sides of the border. Discontinuity of the care process was attributed to differences in professional culture and lack of knowledge of the cross-border health care system, resulting in reluctance on the part of Dutch physicians towards cross-border care (Engels, 2003).

Evidence from Norway showed that a high share of the public providers not only discouraged cross-border care, but in some cases even tried to obstruct it (Botten, et al., 2003). Glinos & Baeten (2006) mention that the reluctance of referrers could have a negative effect on patient mobility. Referrers play a crucial role in guiding patients in their choice of whether (and where) to receive care abroad (Baeten, 2000). They therefore need to be involved actively and positively in cross-border cooperation. Because patients rely on the advice given by referrers, some of the information needs of referrers will be similar to those of patients (Baeten, et al. 2006).

Information needs that GPs could have include those factors that determine whereto they refer their patients. Generally speaking (so not necessarily in the case of cross-border care), referrers predominantly base their decision to refer a patient to a specific hospital institution on medical considerations; whether appropriate care is available (Aaras, Fylkesnes & Forde, 1998; Earwicker & Whynes, 1998) and the general standard of clinical care (Mahon, Whithouse, Wilkin & Nocon, 1993). Earwicker & Whynes (1998) also mentioned that trust and familiarity with the specialist and their skills were mentioned by GP as factors determining whereto to refer their patients. Patient preferences, however, can also be a consideration (Aaras, et al.; Mahon, et al.). Likewise, the distance to the hospitals (Aaras, et al.; Mahon, et al.;). Waiting time was also mentioned to be an important factor (Mahon, et al.). However GPs did mention that waiting time information was invariably out-of date and inaccurate (Earwicker & Whynes, 1998). Costs were only considered by a minority to be of any influence on their referral decisions.

It stands to reason that when a foreign hospital institution can compare favourably with domestic institutions on these factors, that this will stimulate cross-border care.

2.4.3 Patients

Generally speaking there are two types of patients that seek cross-border health care (Baeten & Glinos, 2006); those that are abroad at the time when they have need of health care services (tourists, long-term residents); those that seek cross-border care either because seeking health care services abroad is more convenient or because they are dissatisfied with health care services in their home state. Only the second type of patient will be actively making a decision to seek cross-border care. The factors on which that decision is based, will help identify possible enablers and barriers of cross-border care.

Before describing what factors influence the decision of patients whether or not to seek cross-border care, it is important to make one assumption. This assumption is that patients wish to be treated as close to home as possible and preferably make use of health care services in a system they are familiar with, but that under some circumstances they are willing and sometimes even preferring to be treated abroad (Glinos & Baeten, 2006). What factors actually seem to influence their decision making is uncertain, but what is clear is that the final decision will be based on both objective (medical and non-medical factors) as well as subjective factors (Brouwer, van Exel, Hermans & Stoop, 2002). Patients seem to compare the domestic health care service with that of a foreign system and based on this will decide whether or not to seek cross-border care (Glinos & Baeten, 2006).

Distance to care
That patients prefer to travel short distances to seek health care partly explains why cross-border care is found predominantly in cross-border regions. However, long-distance travelling may become acceptable when transportation is well organised – either via publicly funded programmes sending patients abroad or via privately funded package deals including transportation and accommodation whilst abroad. Besides distance, the infrastructure must also be adequate (van Tits & Gemmel, 1995).

Perception of quality
When patients are dissatisfied with the quality of health care services in their home member state, they will be more likely to seek health care services in a member state which they perceive to offer better quality care (Glinos & Baeten, 2006). However, when a possible host member state is perceived to offer lower quality health care services, patients will be disinclined to cross the border to that member state.

Availability: Speed of delivery
When considering the concept of availability, two different dimensions can be distinguished. The first dimension concerns the availability of certain types of care (Glinos & Baeten, 2006). When unavailable, patients will go elsewhere to acquire these services. The second dimension considers the quantity of the health care services that are available. Insufficient capacity that leads to waiting times and waiting lists are reasons for patients to seek health care services in another member state (Glinos & Baeten, 2006).

Price for the patient
Prices and co-payments in the home member state can be a reason for patients seeking cross-border health care when this presents important savings for the patient (Glinos & Baeten, 2006). An important consideration is whether the treatment abroad will be reimbursed by the patient's health insurer or whether he will be confronted with large amounts of co-payments (Hermans & Brouwer, 2003). Especially for patients coming from a member state with out-of-pocket payments, there is a strong incentive to find the cheapest treatment (Glinos & Baeten, 2006). However, real price comparisons of health care between member states is very difficult, due to differences in content, quality and the way that health care services are financed (Rhodes, Wiley, Tomas, Casas & Leidl, 1997). Another consideration is whether the accommodation and transportation costs when receiving treatment abroad is covered by the health insurer.

Familiarity with the health care system abroad
When patients are not familiar with the health care system of the host member state and the treatment methods used there, they will be less inclined to go abroad to receive health care (Glinos & Baeten, 2006). Information on the health care system in another member state (i.e. information on the treatment methods, reimbursement, and pre and after care) is therefore crucial (Baeten, 2000).

2.4.4 Conclusion: Enablers and Barriers according to Dutch and Belgian actors

The preceding chapters have dealt with the perceptions of member states and insurers, health care providers and patients concerning cross-border care has thereby identified possible enabling factors and barriers. The enabling factors and barriers that play a role in the situation of ZorgSaam wishing to attract Belgian patients will now be discussed.

As has mentioned before, there is an overcapacity of health care services in Belgium. This poses a barrier to cross-border care when this constitutes an outflow of patients (to for instance the Netherlands) and could mean a reluctance of the Belgian government to promote cross-border care. Belgian GPs did not refer patients to ZorgSaam, because more than adequate hospital care is available in Belgium (van Tits & Gemmel, 1995). Therefore there is a lack of demand for cross-border care. Especially considering that in Zeeuws-Flanders only basic specialist care is available. Also the fact that the Netherlands has been known to have had problems with waiting lists could inhibit Belgian referrers and patients from viewing the Netherlands as an alternative provider of health care services.

Quality of care is also a factor that is of importance to member states, insurers, referrers and patients. According to Glinos, et al. (2005) the Dutch often perceive the Belgian health care services as being more advanced in terms of using high-tech medical facilities and delivering very high quality care. Van Tits & Gemmel (1995) found that earlier negative perceptions that Belgian GPs had of the quality of health care in the Netherlands poses a barrier to cross-border care.

The costs of cross-border health care are taken into consideration by the insurers who need to cover these costs and patients who might be required to pay certain co-payments or cover the amount the insurer does not reimburse. The fact that Van Tits & Gemmel (1995) found that referrers were unsure whether treatment in the Netherlands would be covered by the Belgian mutualities is already a barrier to cross-border care. In their study on stakeholder perspectives, Glinos, et al., (2005) found that according to Dutch insurers Belgian hospital tariffs tend to be 10% cheaper compared with Dutch tariffs. This constitutes a motivation for Dutch health insurers to send patients to Belgium for treatment and therefore might also obstruct patients from seeking care in the Netherlands.

The ZorgSaam hospitals all lie within 10 kilometres of the Dutch border and there can be seen as an alternative hospital for Belgian patients. However, the busy provincial roads and the bridge across the Ghent Terneuzen channel could inhibit cross-border care. The question that still remains is whether there are good public transport links to the ZorgSaam hospitals from Belgium.

The fact that the border is fluid, both geographically speaking as well as culturally, constitutes an enabling factor for cross-border care from the patient's point of view. Also the fact that 43 of the 103 specialists working in ZorgSaam are Belgian (van Sabben, personal communication, 2007) would be an enabling factor, because it takes away some of the unfamiliarity of cross-border care. However, van Tits & Gemmel (1995) did find that Belgian GPs were unfamiliar with the Dutch health care system. This could lead to reluctance on the part of Belgian referrers to refer their patients to ZorgSaam, as they will be unable to properly advise their patients.

The study on cooperation in the Euregio Scheldemond by van Tits & Gemmel (1995) was done in 1995. The question is whether these results are still valid today, twelve years later. It could well be that some of the barriers are now no longer there.

Chapter 3. Method

In this chapter the research design of this study will be discussed. In chapter 3.1 a description is given of the subjects on whom this study is focused. The research design is described in chapter 3.2., followed by the procedure, which is described in chapter 3.3. In the last chapter, chapter 3.4, the method of analysis is described.

3.1 Subjects

The target population of our study consists of Belgian GPs working close to the Belgian border with Zeeuws-Flanders (Stretching from Knokke to the west to Antwerp to the east). The aim of this study is to see how ZorgSaam can attract Belgian patients through their GPs. It is for this reason that the target population consists of those GPs most likely to refer their patients to one of the ZorgSaam hospitals. Since Hermesse (1999) found that patients seeking cross-border care predominantly live in border areas, coupled with the 15/25 kilometre arrangement in Belgium, the decision was made to contact in the border region.

Although it would be interesting to see whether the 15/25 arrangement significantly increase the number of patients seeking cross-border care, this study did not look beyond this border. ZorgSaam is merely a regional hospital that does not offer top-clinical care and it is unlikely that referrers further from the border will refer their patients to ZorgSaam. Another, more practical, reason is that because the research method used is a face-to-face interview, including GPs from all over Belgium would be too time consuming and expensive.

Initially it was hoped to focus this study on those referrers who have already referred patients to a ZorgSaam hospital and compare their responses to referrers who have not done so, it was not possible to identify them beforehand. Two methods were used to find the sample for this research project. Use was made of a list of CZ insurers, which consists of GPs to which Dutch insured are subscribed. Because these GPs have Dutch patients, they are more likely to know of differences between the Belgian and Dutch health care systems and may therefore be better able to identify barriers to cross-border care. Besides this, GPs in certain towns in the Belgian border region were found via the Belgian yellow pages. This would ensure that GPs along the whole Belgian border with Zeeuws-Flanders could be approached.

Besides the interview with GPs, interviews were held with representatives of the international department of two mutualities: The Christelijke Mutualiteit (CM) and the Mutualité Libres/Onafhankelijke Ziekenfondsen (MLOZ). CM represents more than 42% of the Belgian population (75% in Flanders) for the basics benefits package and just fewer than 47% of the independents. The MLOZ represents just over 16% and 25% of the Belgian population and independents (MLOZ, 2006).

3.2 Research design

To answer the research questions mentioned in chapter 1, interviews have been held with two groups. Firstly, interviews have been conducted among Belgian GPs in the border region with Zeeuws-Flanders. These interviews have covered the perceived enablers and barriers to receiving health care in the Netherlands and the practical barriers they have encountered when having referred patients to the Netherlands. Secondly, interviews with two leading mutualities have been held to get a better insight in the barriers and enablers of cross-border care and differences between the health care systems of Belgium and the Netherlands. Both interviews will too give the respondents' view of cross-border care. Analysis of the data is qualitative in nature.

Research method

When doing a study, a choice can be made between quantitative methods and qualitative methods. While quantitative methods have the aim of reaching generalised answers to research questions, qualitative methods develop concepts which help to get a better understanding of social phenomena and puts emphasis on meanings, experiences and views of the respondents (Patton, 2002). Since this study aims to identify barriers and enablers and the views that the respondents have of cross-border, a qualitative research method will give the most fitting results.

There are several ways in conducting qualitative research, including: observations, interviews and focus groups. The qualitative design method that will be used in this study depends on the goals of the study (Patton, 2002). This study can be characterised as a fundamental study with the aim of getting an understanding of the reasons for Belgian physicians to refer their patients to one of the ZorgSaam hospitals and to find out the perceived barriers to cross-border care.

For this study, the chosen method is the face to face interview technique. The main reason is that interviews allow the researcher to probe and ask follow-up questions when necessary. This is not possible with those techniques in which the questions are fixed like those in questionnaires (Mcnamara, 1999). A disadvantage of an interview is that they are time consuming. Interviews commonly take between 30 minutes and several hours (DiCicco-Bloom & Crabtree, 2006). However this disadvantage is offset with the amount of data that can be gathered. Even though interviews are time consuming, interview response rates among professionals were found to significantly higher than mail questionnaires, though the difference was small (Cartwright, 1978). However, trends have shown that since 1978 response rates have decreased, with interviews leading the list (Johnson, n.d.). He estimated a response rate of around 60% for interviews.

There are several types of interviews, such as structured, semi-structured and unstructured interviews (DiCicco-Bloom & Crabtree, 2006). In this study the semi-structured interview technique will be used. This type of interview is generally organised around a set of predetermined open-ended questions, with other questions emerging from the dialogue between interviewer and interviewee. The pre-determined open-ended questions will be listed in an interview guide and will be based on the theoretical study of this thesis. The interview guide can be seen as a brief list of memory prompts of the areas to be covered in the interviews. Questions may not follow on exactly in the way they are outlined in the interview guide (Bryman & Bell, 2003). The semi-structured interview is intended to ensure that the same general lines of inquiry are pursued with each person interviewed. This provides more focus than with unstructured interviews, but still allows a degree of freedom and adaptability in getting the sought after information (Patton, 2002).

Interview guide

The interviews began with a short introduction and explanation of the aim of the study. It was also explained that the study would be anonymous and that the recording of the interview would be used to analyse the results and would ensure that their actual comments would be used.

The first questions asked concerned the factors that determine the choice to refer patients to a particular hospital/specialist. Respondents were then asked whether or not they had ever referred patients to the Netherlands/ZorgSaam hospitals and why or why not. These questions served as a kind of introduction into the topic at hand. These questions could easily be answered by the respondents and as it made them identify important factors when referring patients to a hospital, they could then more easily think of possible enablers and barriers when referring to a hospital abroad. Especially since it was expected that the

majority would have had no experience with cross-border care, starting with questions concerning cross-border care would most likely illicit many *'I don't knows'*.

After these introductory questions, respondents were asked about cross-border care. This included questions about how they feel about cross-border care and of its advantages or disadvantages. They were also asked to identify barriers and enablers. Both unaided responses and aided responses were asked. The respondents were asked about the various topics aspects of cross-border care that can be found in the theoretical chapter (chapter 2.) of this thesis; institutional framework, contextual factors, processes and actors. The last question that was generally asked was what action the respondents believed ZorgSaam should take to attract more Belgian patients.

The interviews were held in Dutch and whenever possible Belgian terms were used (i.e. mutualiteit instead of ziekenfonds). Care was taken not to use the term ZorgSaam, because in the last decade the name of the hospital of Terneuzen has changed several times and it is therefore wise to simply use the term Terneuzen to avoid any confusion. In the results we will therefore too only mention the names of the towns and cities where the hospital institutions are located, thus giving Terneuzen, Gent, Dame-Sijssele, etc.

3.3 Procedure

An advance letter was sent out to GP's living in the border area to announce the study and asked GPs whether they were willing to partake in the study (see appendix 3.). Hembroff, Rusz, Rafferty, McGee & Ehrlich (2005) found that advance letters can improve response rates significantly. To further increase the response rate, the GPs partaking in the study have been offered an incentive or rather a token of appreciation. The difference in response rates between an incentive or not is even greater when the burden of the interview is high (Singer, Van Hoewyk, Gebler, Raghunathan, & McGonagle, 1999). Considering that Belgian GPs work hard and long hours and that the interviews took place in the weeks that GPs were administering flue shots the offering of an incentive seemed prudent.

A total of 57 advance letters were sent out. A week after the letters were sent out, each GP was phoned and asked to partake in the study after which an appointment was made. The study was further explained as well as the procedure; that the interviews take between 30 minutes and an hour and that the researcher would come to them. These phone calls were made to further persuade GPs to partake, rather than waiting for a response from them after the initial request in the advance letter. These phone calls were conducted during one week at various times to ensure that as many GPs as possible were contacted. A few GPs were also called back at a later time, because an appointment could not be fixed when they were first contacted. All appointments were made between the 12th of October and the 26th of October 2007 at the rooms of the GP being interviewed.

The representatives of the mutualities were phoned. During this phone call, the aim of the study was explained and they were asked to partake in this study.

3.4 Analysis of the interview data

To be able to answer the research questions, thorough analysis of the interview data was required. All interviews were recorded and transcribed for analysis. The overall analytical approach adopted largely follows the conventions of thematic analysis, whereby the researcher produces a list of codes that represent themes identified in the interview data (Aronson, 1994). The themes can come from both direct quotes as well as paraphrasing commonly held beliefs concerning cross-border care. After having identified the various

themes, it is necessary to identify all data that relates to these already classified patterns. Everything that the respondents remarked upon that fits with a specific pattern was identified and then placed with the corresponding pattern. The next step was to combine and catalogue the related patterns into sub-themes. Themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). The last step was to build a valid argument for choosing the themes. These arguments have been based on the theoretical framework of this study. By referring back to the theoretical framework, the researcher has gained information that is enabled to make inferences from the interview data (Aronson, 1994).

Chapter 4. Results

In this chapter the results of the interviews will be presented. In chapters 4.1 a description of the actual sample is given. Chapter 4.2 is concerned with the referral decision making of the respondents and will cover general referrals as well as why to or not to refer to a ZorgSaam hospital. Chapters 4.3 through 4.6 shows what the respondents know of the elements of the conceptual model of cross-border care. In these chapters the remarks of the respondents working for the mutualities are given also.

4.1 Respondents

Of the 57 GPs that were initially contacted to take part in this study, a total of 23 GPs agreed to partake in this study. 27 GPs did not want to take part in this study. The majority of these did not want to take part due to a lack of time or because as a general rule they never take part in studies. 4 did not want to take part in this study because they believed that there would never be a patient flow from Belgium to the Netherlands. They therefore found this study of little consequence. Even after assuring them of the value of these views they did not wish partake in the study. The remaining 9 GPs could not be reached even after 3 call-backs at various times. The GPs came from various towns spread out over the border region with Zeeuws-Flanders. Table 1 shows where the respondents have their practise, in what region the towns can be found and the distance of the practise to Terneuzen. This group of respondents (the GPs) will be referred to as Respondent group A in the rest of this chapter.

Table 1. overview of where respondents have their practise

Town	Number of respondents	Distance to Terneuzen*	Town	Number of respondents	Distance to Terneuzen*
Moerkerke-Damme	2	55	Watervliet	1	24
Maldegem	5	46	Wachtbeke	1	22
Sint-Laureins	1	32	Zelzate	2	19
Bassevelde	1	20	Belsele	1	46
Boekhoute	1	15	de Klinge	1	28
Assenede	2	20	Kieldrecht	2	33
St-Jan-Eremo	1	28	Stekene	2	41

* Distances in kilometres, rounded off

The second groups of respondents consists of the two representatives from the mutualities CM and the MLOZ. This group of respondents will be referred to as respondent group B.

4.2 Referral decision making

4.2.1 Deciding factors when referring patients

When referring their patients to a hospital, the respondents of group A mentioned several factors. The respondents primarily base their decisions on medical considerations i.e. is the required care available and is it of good quality. This choice is greatly influenced by whether or not they know the particular specialist. As the respondents mentioned *"it is not so much referring a patient to a particular hospital, but rather to a particular specialist".* According to the respondents, a good relationship is of importance for several reasons; knowledge of their skills, trust, teamwork, and communication. The knowledge of a specialist's skills enables

GPs to determine which specialist is most likely able to treat the patient (i.e. experience in a certain type of operation) and it also gives GPs an idea of the level of quality that can be expected from a specialist. This level of quality is paramount *"As a GP you want to make sure that the patient receives the best possible treatment*". This is not so much a question of knowing (of) a specialist, but also trusting the specialist. A relationship with a specialist based on trust is also of importance, as it makes it easier for the GP to get a patient referred to a hospital, because specialists will not second guess this decision. As respondents mentioned *"when I refer a patient, the specialist knows that I have done so for good reason"*. Trust also eases the communication between GPs and specialists. Respondents mentioned that if they had questions regarding a patient they need only call a specialist to get an answer. Specialists knew that the GP would not waste his time. This is, for instance, greatly facilitated by a special list distributed to GPs with the direct contact numbers of specialist working in the hospital of Damme-Sijssele. The teamwork between GP and specialist is also of importance, because sometimes they do need to work together (communicate well). Therefore they must have a good understanding.

Besides medical considerations, and the relationship with the specialist, other factors are also of importance. Most often mentioned was the distance to the hospital. A hospital must not be too far away and should be easily reachable (with own transport, but also with public transport). Patient preferences are also taken into consideration by the respondents. According the respondents patient preferences are determined by the experiences of friends and family, distance, hotel facilities of the hospital. However, it is not very often that patients have particular preference.

The respondents of respondent group A were asked to mention to which hospitals they mostly referred to. In appendix 4 the places where GPs mostly refer to are given.

4.2.2 Referring to ZorgSaam

When asked whether they have referred Belgian patients to the Netherlands, the majority of the respondents of group A answered negatively. One respondent had referred a patient to the eye clinic in Oostburg. A second had referred a patient to Terneuzen, because it was more practical for that patient to go to there. Some respondents did mention that they had had Belgian patients who were admitted to Terneuzen after having been involved in an accident in Zeeuws-Flanders.

11 respondents had Belgian patients (living in the Netherlands) who were insured via both the Belgian social security system and the Dutch social security system. These patients were referred to Belgian hospitals without exception. The majority of the respondents, however, did have experience with referring their Dutch patients to Terneuzen. Of the 23 respondents interviewed, 17 had Dutch patients who were insured via the Dutch social security system.

When the respondents were asked why they had never referred their Belgian patients to the Netherlands, their initial response was that they "had never really thought about it" and therefore did not view Terneuzen as a possibility. After some follow-up questions, the respondents did mention waiting lists in the Netherlands, the lack of top clinical care in Zeeuws-Flanders and the abundance of hospital care in Belgium as reasons not to refer their patients to Terneuzen. The respondents generally thought of cross-border care in the Euregio Scheldemond in terms of a patient flow from the Netherlands to Belgium. They were aware of the contracts between OZ and certain Belgian hospitals allowing Dutch patients to seek certain types of medical care in Belgium.

The initial response of one respondent was that he made sure that his Belgian patients were referred to a Belgium hospital and his Dutch patients to a Dutch hospital, because of the extra administrative burden when doing otherwise. Another respondent (from de Klinge) mentioned that even though Terneuzen was closer by than St-Niklaas, one of the reasons

that he did not refer his patients to Terneuzen was that it was not easily accessible with public transport.

4.3 Institutional framework

European regulations

The respondents of respondent group A have no idea of how cross-border care has been arranged on a European level. Their only remarks on this topic were that they believe that "something" is done on a European level, but what this something is, respondents could not say. They did know that emergency care could be received without problems in other countries.

Health care systems and organisation of hospitals

The respondents of group A and B mentioned several differences in the way that health care services are organised in Belgium and in the Netherlands. These differences can mostly be found on an organisational level.

The first difference that the respondents of group A mentioned was overcapacity of health care services in Belgium and waiting lists in the Netherlands. According to the respondents, these waiting lists would be unacceptable to Belgian patients who are used to being given care immediately. When asked, respondents affirmed that these waiting lists would be reason for Belgian GPs not to refer their patients to the Netherlands. When asked how long they though waiting lists to be, respondents most often thought in terms of months rather than weeks. They did acknowledge that the length of waiting lists will differ between specialities. Their ideas concerning the length of waiting lists were generally based on experience of their Dutch patients seeking hospital care in Terneuzen, but also based on their Dutch patients who specifically sought hospital care in Belgium because of the waiting lists in the Netherlands. The respondents generally believe that one of the reasons that there are waiting lists in the Netherlands is the "9 to 5 mentality" of Dutch specialists.

Another clear distinction between the Dutch and Belgian healthcare system that the both groups of respondents mentioned, are the echelons of which the Dutch system is made up of. This cannot be found in Belgium and patients are therefore free to choose which physician to contact first and they can change physician whenever they wish to. The respondents did acknowledge that their position as GP is a little different from that of the Dutch GP (who is a gatekeeper). Nevertheless, they are still the managers and keepers of the global medical dossier of their patients. The fact that the global medical dossier is being promoted and that patients can receive discounts on their co-payments when having been referred to hospital by their GP has not lead to a significant increase in the number of patients enrolled with GPs according to both groups of respondents. The respondents do not believe that the number of patients that go to the GP as first contact has increased significantly.

When asked whether this difference in the Dutch and Belgian systems is likely to influence cross-border care, a minority of respondents responded positively. These respondents believed that since Dutch patients need referral notes, this would likely also be the case for Belgian patients seeking hospital care (or other types of secondary or tertiary care) in the Netherlands. Respondents of group B, mentioned that Belgian patients do not need this referral note.

Belgian specialists are forced to work in a very competitive market, because there are no echelons in service delivery and patients can see whichever physician they wish to and change physician whenever they wish to. As a consequence, the health care service delivery

is very patient orientated. The respondents believe that a Belgian specialist will spend more time listening and explaining things to a patient than a Dutch specialist (Respondents do believe that Dutch specialists do listen and explain adequately).

The competitive nature of the Belgian health care market in part gives reason for specialists in Belgium to have consultations in the evenings when their patients are free from work (It must also be noted that in Belgium, patients often do not get sick leave). If a specialist is unavailable, the patient can easily go to another specialist who is available. The fact that specialists in the Netherlands do not have consultations in the evening hours could certainly hinder cross-border care according to the respondents.

Another, though more minor, result of the tough competitive market coupled with fee for service system is that many tests are being done unnecessarily in Belgium (according to both respondent groups). The respondents of group A believe that in the Netherlands, tests are done very conscientiously. They have said that this, from a medical point of view, is a favourable aspect of the Dutch health care system. However, though they do acknowledge that unnecessary testing increases health care costs, they do believe that Belgian patients have come to accept being tested thoroughly. As they said: “if a patient believes that not enough is being done (i.e. tests), the patient will simply go elsewhere”. According to both groups of respondents, Belgian patients could be seen as a little spoilt and with high expectations.

The respondents of group A have also described the organisation in Belgian hospitals as being chaotic, while in the Netherlands it is very organised with clear patient pathways and protocols. The upside of the chaotic organisation in Belgium is that hospitals and specialists are more flexible than in the Netherlands. This enables the specialists and hospitals to find solutions to problems more easily. The downside, however, is that it is often not clear to the patients (and his GP) to know what is happening or going to happen. Due to clearly defined patient pathways and protocols this is clearer in the Netherlands thereby relieving the patients (and his GP) of a lot of stress and anxiety.

Another difference in the organisation of hospitals in Belgium and the Netherlands is that the care chain is a lot shorter than in the Netherlands. In Belgium patients can, when possible, go through the necessary tests on the same day as their consultation with the specialist. The respondents of group A believe that in the Netherlands, a patient will first have to see a specialist, after which an appointment will be made for tests a few weeks later. The patient can expect to hear the results of these tests another couple of weeks later. Respondents believe that this difference in organisation stems from the more patient orientated nature of the Belgian health care system, where much effort is put in making a patient’s hospital experience as pleasant as possible.

The majority of respondents of group A have had negative experiences with having their Dutch patients admitted in Terneuzen (in emergencies). Whilst in Belgium, it is simply a matter of making a call to get a patient admitted. The respondents have found that this to be more complicated when getting a patient admitted in Terneuzen. First of all it may take some time for them to be able to contact the specialist, especially in the evenings. Secondly, the respondents feel they have to defend their decision to actually get the patient admitted. This negatively influences the relationship that the respondents have with the hospital and the specialists in Terneuzen.

Another problem associated with emergency care, is the fact that ambulance are not allowed to cross the border. One respondent even mentioned having to transport a Dutch patient in his car to the Dutch border where an ambulance was waiting to transport the patient to Terneuzen. According to the respondents this certainly hinders cross-border care.
According to respondents B, steps were taken to get some border cooperation where ambulances were concerned. This failed, because of differences between the Dutch and Belgian ambulance services; in the Netherlands, ambulances are better equipped and have nurses or physicians on board, while Belgium has two types of ambulances, of which only the MUG has similar equipment; Dutch ambulances are unwilling to cross the border, because the Belgian tariffs for ambulances services are lower than those in the Netherlands. According to Respondents of group B the fact that there is a cross-border arrangement

concerning ambulance services in the Euregio Meuse-Rhine is a fluke and it is therefore unlikely that these types of arrangements will become commonplace.

With ICT systems such as MediBRIDGE and MediRing in Belgium, reports from labs, hospitals and specialists are automatically integrated. This keeps the GP well informed of the latest developments and greatly increases the speed with which the GPs have the results of tests. Usually GPs can expect the results the same day and can then inform their patients straight away. Terneuzen does not work with this system and as a result there could be a delay in the receiving of these reports. As some respondents of group A remarked: “this leaves patients in anxiety longer than necessary”. Besides this, as reports are usually faxed from Terneuzen to the GP in Belgium, GPs will then have to enter the findings into the patient dossiers themselves. This is very time consuming and considering that GPs in Belgium work long hours, this is unacceptable to them. According to respondents of group B, the difficulties due to different technologies/programmes in the various countries are being tackled with the Netcard project. This will in future enable the various countries to exchange information without problems. However many issues (I.e.) privacy) still need to be addressed.

Not only the respondents of group A have administrative concerns about cross-border care, but also the respondents of group B believe that the current administrative process could hinder cross-border care. A dossier will have to be made and it will be necessary for a Belgian physician (be it a GP or specialist) to send in the medical dossier to the responsible mutuality. This involves taking extra steps that normally do not have to be taken. This will be a burden to both patients and GPs.

Quality

The respondents of both groups perceived Dutch hospital care to be of similar quality as that of Belgian hospitals. Those of group A that did perceive the quality of Dutch hospital care to be of lower quality than Belgian hospital care, mainly based this idea on the existence of waiting list in the Netherlands (so something must be “wrong”), rather than on actual differences in quality of the medical care given. As one respondent remarked: “a patients is already dead before he can get treatment in the Netherlands”.

Because Terneuzen only offers basic specialist care, respondents of group A did feel that sending a patient to Terneuzen could pose problems when it turns out that the patient needs care that is not available in Terneuzen (i.e. when situation more severe than initially thought). Respondents believe that it is preferable to send their Belgian patients to a Belgium regional hospital, rather than to Terneuzen. In a Belgian regional hospital the patient may face the same problem, but because the patient will not have to have gone through the whole process of getting authorisation to seek medical care, it is to be preferred.

Respondents of group A did not perceive any problems with continuity of care in the case of cross-border care. They believed that as long as the patient medical dossier are kept up-to-date and can be made available to the physician that needs it, there should be no problem. Some did mention that specialists in the Netherlands should be made aware of how, for instance, home care is arranged in Belgium. When asked if continuity of care posed a problem, the respondents of group B responded that it was possible. They said that where the overall responsibility lies is yet to be determined. Nor is it certain what steps should be taken when medical faults have been made.

4.4 Processes

The respondents of group A were ignorant of the arrangements that make cross-border care possible. A minority of the respondents did mention the possibility of getting emergency care abroad via the E111 forms (The EHIC card was not mentioned). When asked what they

knew of the possibilities for Belgian patients to obtain health care services abroad, the majority of the respondents believed that the municipalities would be very reticent to allow their insured to seek cross-border care. Many respondents also believed that the costs incurred by patients would not be reimbursed or reimbursed with difficulty by the mutuality. Other respondents did not associate any problems concerning costs and the reimbursement of these costs.

Only a few respondents had heard of the E112 forms when specifically asked about them. Their knowledge concerning the E112 form stems from their Dutch patients who had made use of these when obtaining health care services in Belgium. These respondents had not thought of these forms as a means for Belgian patients to seek cross-border care. When asked whether they had heard of the 15/25 kilometre ruling, only two respondents responded positively.

During the interviews the various arrangements were explained to the respondents of group A. Respondents then believed that this provides some possibilities for their Belgian patients to seek cross-border care. The respondents of group A believed that mutualities would be reluctant to give authorisation for patients to seek cross-border care. However, if the mutualities gave patients authorisation to seek cross-border care, they did not perceive any problems. The respondents of Group B acknowledged that the mutualities would not easily give authorisation. This is due to the fact that the Belgian legislator has interpreted the rights given to patients by the EU in a purely medical sense, without taken the patient's situation into account. This means that a hospital in the Netherlands might be more easily reached and closer by, would not be reason for a mutuality to give authorisation. According to one of the respondents of group B, mutualities believe that this interpretation by the Belgian legislator is too strict.

Respondents generally believed that the fact that patients would have to actually get the forms pose a barrier. The fact that the reimbursement of costs would be according to the Belgian tariffs could also be a barrier (according to both the respondents and respondents of the mutualities). However, because the majority of the respondents believe that there is hardly any difference in the costs of health care services in the Netherlands and Belgium, this problem is not a large one. Due to the many other barriers still present, respondents did not believe that the arrangements alone would induce them to refer their patients to Terneuzen.

4.5 Contextual framework

Cultural and Geographical proximity

Without exception, the respondents of both groups have said that there are hardly any cultural differences between the inhabitants of Zeeuws-Flanders and East- and West-Flanders. They went on to say that the inhabitants of the border regions are hardly aware of there being borders and cross them without difficulty to i.e. go shopping or dine out. However, when it comes to health care services, those living in the border areas of Belgium would not think of crossing the border in order to get access to it. Respondents remarked that there is a general resistance to seeking health care services in the Netherlands, as there is an abundance of good quality hospital facilities in Belgium and there is therefore no need to cross the border. Another aspect that the respondents mentioned is the waiting lists in the Netherlands which do not give Dutch hospital care a good reputation.

When asked whether Belgian patients could have problems with being treated by specialists in Terneuzen, the respondents of group A remarked that this is unlikely to be so. First of all, many specialists working in Terneuzen are Belgian. Secondly, since the Zeeuws-Flemish are very similar to the Flemish (It was also remarked that they were "even more so than the Walloons"), patients could not have any problems with being treated by a Zeeuws-

Flemish specialist. Although some respondents did remark that this could be different when being treated by a specialist from “above the rivers”. Who, according to some respondents, might be too direct in their communication towards patients, which Belgian patients are not accustomed to.

According to the majority of the respondents of group A, Terneuzen is geographically speaking near enough for patients living in the border region of Belgium with Zeeuws-Flanders to travel to for hospital care (see Table. 1). However, since there is an abundance of hospitals on the Belgian side of the border, Terneuzen is most often not the nearest regional hospital.

Only for those patients from the surrounding area of Zelzate, Terneuzen is geographically speaking more easily accessible when compared with the other nearest hospital location of Ghent. For those patients living in the surrounding area of De klinge, Terneuzen is approximately at a similar distance as is St Niklaas (other nearest hospital facility). However, according to the respondents from this area public transport links are not as good to Terneuzen as they are to St-Niklaas. St-Niklaas is therefore geographically speaking the better option. Whilst Hulst is only a very short distance away, the respondents still refer to St Niklaas because, though further away, it does offer all basic specialities, while Hulst is only an outpatient clinic. A similar situation, as described above, applies to those patients living in the surrounding areas of, Assenede and Boekhoute and Watervliet. Whilst Terneuzen is relatively near, the hospital facilities in Eeklo and Damme-Sijssele are more easily reached. According to respondents from West-Flanders, the distance to Terneuzen is too far and not easily reached and therefore does not induce GPs in this area to refer their patients to Terneuzen for routine problems. The distance to Oostburg is acceptable, but because of there being more than adequate hospital services in West-Flanders (especially considering that Oostburg has limited facilities), Terneuzen and Oostburg are, geographically speaking, unlikely to be an option. Only if Terneuzen could offer certain services that are unavailable in Belgium, would the respondents then refer their patients to Terneuzen.

Even though all respondents remarked that the distance to Terneuzen is acceptable, “It is not so much the distance to Terneuzen that is the problem; it is rather the idea that you are going abroad that is the problem”.

4. 6 Actors

When asked what their attitude was towards cross-border care, the respondents of group A generally answered that they “did not have any problems with it”. If cross-border care could benefit their patients in any way, then they felt that it should be stimulated. However, they did have one concern: the fear of loosing contact with their patients. They were afraid that once a patient was referred to a hospital in the Netherlands, that they would not see the patients again, because patients could be referred by one specialist to another without intervention by the GP. GPs mentioned that in Belgium patients would not be referred from one specialist to another, when the GP has acted as first contact.

The respondents of group B were rather more in favour of cross-border care. Though they did believe that very few patients would ever make use of the possibilities of cross-border care.

Respondents were then asked to mention possible advantages and disadvantages of cross-border care. The respondents of group A generally did not perceive any real advantages, since Zeeuws-Flanders cannot offer any health care services that are not readily available in the Belgian border region. They believe that there is therefore little demand for cross-border care. Others did say that even though cross-border care could not offer any extra types of health care services, it could offer extra choice for patients.

An advantage that was stressed by the respondents of the mutualities was the possibility of regionalisation of the capacity of health care services. This could prove very

advantageous, as it could increase efficiency and quality. When the respondents of group A were asked if they too saw advantages of regionalisation of the capacity, they agreed.

According to all the respondents, the current situation still providers barriers to cross-border care. Generally, the respondents of group A felt that as few barriers as possible should be placed on cross-border care when it is beneficial to their patients. The respondents of group B had conflicting views, while one of these respondents believed that cross-border care should not be held back and that should be made easier for patients to seek cross-border care, the other respondent of group B did not agree with this and believed that certain barriers should be kept in place. The reason for this was that otherwise control of the outflow-of patients could be lost. Without any barriers to cross-border care, patients could receive treatment that could of questionable quality. This respondent did mention that this was not a fear if patients go to the Netherlands to receive treatment, but this could be the case in other countries.

Chapter 5. Conclusion

In this chapter the conclusions of this study will be given. The main research question of the study is as follows:

How can ZorgSaam increase referrals from Belgian GPs?

This question can be answered with the help of a five some sub-questions that deal with referral decision making in general and with cross-border care.

1. *On what factors are the referral decisions of GPs based?*
2. *What are the reasons for Belgian GPs to refer or not to refer their patients to one of the ZorgSaam hospitals?*
3. *How do GPs and mutualities perceive the possibility for patients to receive cross-border care?*
4. *What are the barriers and enablers of cross-border care according to Belgian GPs and mutualities?*
5. *What are the practical consequences associated with cross-border care according to the GPs and mutualities?*

In chapter 5.1 the factors that determine whereto GPs refers will be given. This will be followed by the reasons that Belgian GPs do not refer their Belgian patients to ZorgSaam (chapter 5.2). In chapter 5.3 the general attitude of GPs towards cross-border care will be given, after which the barriers to cross-border care will be discussed in chapter 5.4.
In the final chapter (chapter, 5.5) the main research question will be answered.

5.1 Referral decision making

The decision to refer a patient to a particular hospital was found to be based predominantly on medical considerations and relationship with the specialist. This result does not differ considerably from what has been found in the literature, as these factors were also mentioned by Aaras, et al. (1998), Mahon, et al. (1993) and Earwicker & Whynes (1998). However, because quality is not easily determined, it is the relationship with the specialist that is most important. This is not surprising, since GPs and specialists need to work together and rely on each other.

Besides these two factors, other factors mentioned by the GPs in this study were found to be of importance, including patients' preferences and distance to hospitals. These factors too were found in the literature (Aaras, et al.; Mahon, et al.). The GPs did add that 'distance' should not be seen merely in terms of the number of kilometres, but also in how easily it is reached by patients (i.e. roads, public transport). Though distance is important, quality of care and the relationship with specialist are even more important and when not good enough, will be reasons for GPs to refer their patients elsewhere.

5.2 Referring to ZorgSaam

From the results it is clear that Belgian GPs do not refer their Belgian patients to ZorgSaam. However they do refer their Dutch patients to ZorgSaam. They said that they did not refer their Belgian patients to ZorgSaam, because they did not think of ZorgSaam as an alternative to choose from. This is not surprising since there is an adequate number of hospital facilities available in Belgium that are just as far away or even nearer. The GPs also never thought of referring their Belgian patients to ZorgSaam, because of the perceived waiting lists in the Netherlands. That they mention these is also not surprising, since many of their Dutch patients specifically sought health care services in Belgium to avoid the waiting

lists in the Netherlands. The respondents therefore generally thought of cross-border care in terms of a patient flow from the Netherlands to Belgium.

5.3 Attitude towards cross-border care

The GPs were not opposed to cross-border care; rather they supported it if it could be beneficial to their patients. Cross-border care could be beneficial if it offered services that were otherwise unavailable, if it meant receiving these services more quickly and if these services were of better quality. This corresponds with the various factors that determine a patient's decision whether or not to seek cross-border care as mentioned by Glinos & Baeten (2006). However, GPs generally perceived few benefits for their patients in this instance. Though they did mention more choice for the patient (like Paulus, et al., 1999), it should be noted that as it is, Belgian patients already have several alternatives to choose from.

The representatives of the mutualities had a more favourable attitude towards cross-border care. This was mainly due to the possibilities that regionalisation of the capacity of available health care services could offer. They, like Brouwer (1999), believe that treatments that were previously unavailable, could now be made available when providers on both sides of the border cooperate. Besides it could create extra competition and therefore improve quality (Botten, et al., 2003; Paulus, et al., 1999). The mutualities did not mention the possible cost savings of cross-border care mentioned by Botten, et al. (2003), because this is unlikely to have a big impact in cross-border care between Belgium and the Netherlands. Surprisingly, they did not mention the loss of autonomy in deciding the types and tariffs of treatment and products mentioned by van der Mei (2002). One of the representatives did mention the possible loss of control, also mentioned by Glinos, et al. (2005) if patients could seek cross-border care without their being any barriers. Therefore he did believe that some barriers are crucial.

5.4 Barriers and enablers of Cross-border care according to GPs and the mutualities

As has been shown in chapter 2.1.1 patients have been given the right to seek cross-border care, albeit under certain conditions (i.e. authorisation is needed for hospital care in order for the costs to be covered). In this study it was found that GPs had no idea of the various arrangements that allowed patients to seek cross-border. This in itself is a barrier to cross-border care and is made evident by the fact that GPs had never really thought about referring patients to ZorgSaam. Once they were made aware of the possibilities for patients to seek cross-border and when patients would be covered by their mutualities, they did see some possibilities for cross-border care. This confirms the barrier that exists if referrers are unsure whether treatment in the Netherlands is covered by the Belgian mutualities (van Tits & Gemmel,1995).

The fact though that patients will then need to take steps to get the necessary permission poses barriers according to the GPs. The 15/25 kilometre arrangement may make this easier, because this arrangement allows patients to receive hospital care abroad without having their medical file examined by an advising physician of their mutuality (though they do still need to use the E112 form) (RIZIV, 2006). However, the fact that this arrangement is conditional upon place of residence could pose problems. When exactly would a patient reside more than 15 kilometres from the Border? It is also important that patients actually hands in the E112 form to the hospital or the specialist, because otherwise the reimbursement of costs will merely be up to Belgian tariffs. Since it was estimated that Dutch hospital tariffs are 10% higher than the Belgian hospital tariffs, patients could end up covering part of the costs themselves (Glinos, et al., 2005). Although Rhodes, et al. (1997) does say that it is difficult to actually compare tariffs.

That Belgium patients are required to pay co-payments could be reason for those patients to go to the Netherlands to seek care according to Glinos & Baeten (2006). However the GPs believe that these co-payments do not amount to much and will not be enough reason for Belgian patients to cross the border to avoid them. Especially not considering the barriers mentioned below. Only when all these are taken away, could the co-payments be reason for patients to cross-borders.

Assuming that patients can receive authorisation to seek health care at a ZorgSaam institution, there are still many barriers that need to be overcome. One of the greatest barriers to cross-border care concerns the availability of (timely) health care services in Zeeuws-Flanders (and the Netherlands). According to the GPs there is more than adequate number of hospital services available on the Belgian side of the border, both regional hospitals as well as teaching hospitals (Also mentioned by Zorgloket (2000). This already gives GPs and their patients many institutions to choose from. Coupled with the fact that ZorgSaam merely offers basic specialist care, does not give reason for the GPs to refer their patients to ZorgSaam, there is little need for patients to refer their patients based on medical considerations. As has been mentioned, one of the deciding factors for GPs to refer their patients to a specific hospital institution, are medical considerations Aaras, et al. (1998), Mahon, et al. (1993).

Off course, if ZorgSaam could provide these services at a much higher quality or if they could offers services that are unavailable, there would be demand for these services offered by ZorgSaam. Quality being important to both the GPs that partook in this study as well as those in other studies (Aaras, et al.,1998); Mahon, et al.,1993). According to the Belgian GPs the quality of Dutch health care services will be comparable with Belgian services. The GP did not mention the fact that Belgian hospitals attract renowned specialists and purchase expensive apparatus as a means of competing (Glinos, et al., 2005). However, they did acknowledge that Belgian specialist perform more tests than they do in the Netherlands. Since the respondents believe that in the Netherlands, tests are done very conscientiously; this does not mean a lower level of quality.

Another aspect concerning the availability is the timely availability of cross-border care. The Belgian GPs believe that the Netherlands is still struggling with waiting lists (in terms of months rather than weeks). While in the past this may be the case, a report by the NVZ-vereniging van ziekenhuizen has shown that the waiting lists no longer exist (Leemhuis-Stout, 2006). However, this does not mean that patients in the Netherlands will be treated straight away; rather it means that they will be treated within the time frame set by the Treeknorms (Polder, et al., 2002). Considering that patients in Belgium can usually be helped within one or two weeks, these Treeknorms can still be unacceptable to Belgian patients and GPs. Iterating van der Mei (2002), care should be taken, that by attracting patients from Belgium, this will not result in the crowding out of domestic patients and the crossing of the Treeknorms.

Another barrier is that Belgian patients are unfamiliar with Dutch health care services, and this too, according to the GPs, gives reason for Belgian patients to avoid cross-border care. According to Glinos & Baeten (2006) unfamiliarity with a nation's health care system makes patients less inclined to seek health care services. Information on the health care system in another member state (i.e. information on the treatment methods, reimbursement, and pre and after care) is crucial (Baeten, 2000). Considering that the GPs too have limited knowledge of the Dutch health care system poses extra barriers.

One of the differences between the two systems is, that in Belgium there are no echelons in service delivery and patients can see whichever physician they wish to and change physician whenever they want (Crainich & Closon). The GPs believe that if Belgian patients should seek hospital care in the Netherlands, that they will then have to be able to produce a referral note. However, Belgian patients seeking care in the Netherlands who are insured via the Belgian social security system will not need to provide this referral note, since this not a requirement set by the mutuality with which they are insured.

Another difference is that the Belgian health care market is more patient orientated than the Netherlands (van der Wijst & Ruijten, 2004). According to the GPs this translates in the Belgian specialist taking more time to listen to and explain things to patients than his Dutch counterparts. Though explanations are adequate in the Netherlands, this difference in their handling of patients could pose a barrier to cross-border care.

The GPs have said that one of the factors that determine whereto they refer, are the patients preferences. One of the results of this study was that GPs believed that their general attitude towards receiving care in Zeeuws-Flanders is negative. This negative attitude could stem from the afore mentioned availability and quality of services, perceived waiting lists and patient handling. One factor that is certain, has to do with the crossing of borders to receive care in ZorgSaam. GPs confirm the fluid border between Belgium and the Netherlands, an enabler of cross-border care mentioned by Glinos & Baeten (2006). However, this fluid border only stretches to shopping and dining out and not to health care services (in the direction of Belgium to the Netherlands). The fact that there are hardly any cultural and language differences, is an enabling factor and means that once Belgian patients seek cross-border care, they will not encounter any problems due to differences of this nature.

It is not surprising that many of the barriers of cross-border care, involved those factors that determine the referral decision making of GPs. ZorgSaam would have to be able to compete with Belgian hospitals on these factors, if ZorgSaam scores less on these factors than Belgian hospitals, GPs would not refer their patients to ZorgSaam, thus constituting barriers to cross-border care.

The fact that barriers are present is in itself not a bad thing, because, as one of the representative of the mutualities mentioned, barriers are also necessary. Thereby confirming the view point illustrated by van der Mei (2002), that while member states are able to guarantee the level of quality of health care services domestically, they have no control over health care services abroad where other standards may apply. Without any barriers to cross-border care, patients could receive treatment that could of questionable quality. However, this does not apply to care received in the Netherlands (Bertinato, et al., 2005).

5.5 Practical problems associated with cross-border care

The results of this study show that there are certain practical problems associated with cross-border care. These practical problems are those that the GPs have encountered when referring their Dutch patients to ZorgSaam.

One of the problems that GPs have encountered is that the working relationship that they have with specialists in ZorgSaam is not optimal. This is mainly because they are not acquainted with each other and that there are differences in the way that specialists in Belgium and the Netherlands work with GPs. The importance of this relationship has already been mentioned previously and has also been found by Aaras, et al. (1998) and Earwicker & Whynes (1998).

The second practical problem that GPs identified is the ‘5 to 9’ mentality of health care providers the Netherlands. GPs have said that the competitive nature of the Belgian health care system mentioned by Crainich & Closon (1999) could account for health care providers having long working days. They will have consultations in the evenings when Belgian patients are free from work. According to the GPs, many Belgian patients make use of the evening consultations that specialists offer. Not being able to go to an evening consultation in the Netherlands also deters patients to seek cross-border care, according to the GPs.

Administrative problems have also been mentioned. The ICT applications that GPs and ZorgSaam use are incompatible, meaning that it may take longer before GPs get access to, for instance, lab results and also means that they will have to input these results into their

own system themselves. Considering the long working days that GPs already have, having to input the data themselves is a heavy burden. This has lead to one GP making sure that his Dutch patients are treated in the Netherlands and his Belgian patients treated in Belgium.

GPs too say that it is important that ZorgSaam is easily reached by their patients, thereby confirming van Tits & Gemmel (1995) who said that the infrastructure is of importance. In certain areas, though ZorgSaam is closer by than alternative hospital institutions in Belgium, it is not as easily reached by public transport. This too is practical problem and makes Terneuzen seem even more inaccessible.

5.6 Recommendations: Increasing referrals from Belgian GPs

In the previous chapters, enablers, barriers and practical consequences of cross-border care have been given. For ZorgSaam to be able to increase the referrals from Belgian GPs it is important that these barriers are taken away. However, not all barriers can be influenced by actions of ZorgSaam, but some recommendations can be made.

The results have made it clear that the relationship between a GP and a specialist is extremely important in the referral decision making, but also for the teamwork. It is therefore important that ZorgSaam provides the opportunities for GPs to get acquainted with the specialists and that communication between the two is eased. ZorgSaam specialists could give presentations during refresher courses organised by the various Belgian GP associations. This way Belgian GPs could get acquainted with ZorgSaam specialists and ZorgSaam.

The GPs in this study have also said that they would be willing to attend functions that are specifically aimed at them. Many GPs have mentioned that they have been invited by Terneuzen for various functions and meetings (on account of their having Dutch patients) in the past, but as these functions and meeting generally took place when they had consultations, they were unable to attend. ZorgSaam should take this into account when organising functions (aimed at the Belgian GPs).

Another recommendation that could facilitate the relationship between GPs and specialist is a phone list with the direct numbers of specialist. This could be beneficiary to both the Belgian GPs as well as the Dutch GPs. A similar list has already been introduced by the Elisabeth Ziekenhuis in Damme-Sijsele.

Many of the barriers mentioned concerned the lack of knowledge on the part of one or several actors. These barriers could be taken away by providing the necessary information.
First of all, the GPs have little knowledge concerning the possibilities for Belgian patients to seek cross-border care, nor are they aware of the various processes. By providing GPs and patients with information concerning the rights of patients to cross-border care and how to get authorisation, will take away several worries concerning cross-border care.

It is not enough that GPs and patients are made aware of the various possibilities of receiving health care services; they should also be given knowledge of ZorgSaam hospitals and what patients and GPs may expect. This is of importance because unfamiliarity with the way in which other parties work can lead to uncertainty in the responsibilities that each party should have and harm patients (Glinos, et al. 2005). The results have shown that unfamiliarity with the Dutch health cares system (and thus how care is organised) and ZorgSaam is reason for GPs not to refer their patients to ZorgSaam. This type of information is especially important to those GPs that do not have any Dutch patients and know little of how things are organised in ZorgSaam. Giving this type of information is not only important as a means to inform the GPs and their patients, it is also important to clear up some misconceptions concerning for instance the waiting lists and the referral notes.

The lack of knowledge concerning cross-border care not only leads to Belgian GPs being less inclined to refer to ZorgSaam or Belgian patients to seek cross-border services, but also causes problems in other areas. For instance, the GPs mentioned differences in getting patients admitted in Belgium and the Netherlands. While it is not my place to recommend that ZorgSaam changes how this is organised, ZorgSaam could inform its staff on how things are arranged in Belgium, thereby increasing the understanding of the differences between the systems and easing their working relationship.

The GPs mentioned administrative problems due to incompatibility of their ICT applications. Effort should be put on finding a solution for this incompatibly as it could greatly reduce the burden put on GPs when they refer patients to ZorgSaam.

ZorgSaam already has a history of cooperating with UZ Ghent, it could be beneficial to cooperate with other Belgian health care providers to strengthen its position in Belgium. This could lead to Belgian GPs and patients considering ZorgSaam as a possible alternative.

One last recommendation should still be made. Before trying to attract patients from Belgium, ZorgSaam should put more effort in attracting Dutch patients who are now more orientated towards Belgian hospital care. The very fact that some Dutch patients are more orientated towards Belgium does not give out a proper signal and gives Belgian the GPs that care in the Netherlands is inferior to that of Belgium. This too will discourage Belgian GPs to refer their Belgian patients to a ZorgSaam hospital. By attracting the above mentioned Dutch patients would show that that the delivery of health care services in Zeeuws-Flanders functions well.

Chapter 6. Discussion

6.1 Scope of this study

The results of this study can in no way be generalised to the entire GP population in the Belgian border region with Zeeuws-Flanders. This is because the number of respondents that partook in this study is only large enough to give an insight into the perceived barriers and enablers. Even so, this study does provide ZorgSaam with some recommendations that could make referrers more willing to refer their Belgian patients to ZorgSaam. Although, it must be said that considering that does not have any control over factors, such as the abundance of hospital care on the Belgium side of the border, barriers will still remain.

This study will still have some relevance even if ZorgSaam should decide not to follow through in their intent to attract patients from Belgium. The remarks made by the GPs in this study, show some problems that the GPs have had whilst working with ZorgSaam. Considering that quite a few Belgian GPs have Dutch patients, who when in need of hospital care, will primarily be referred to ZorgSaam, it will still be important that the Belgian GPs can have a good working relationship with ZorgSaam. Therefore these recommendations can still be useful.

This study can also be put in a broader context. Through the EU, patients have been given rights to receive cross-border care. Will patients actually cross-borders it will be necessary that those upon whom action depends are considered in the process (Barrett and Fudge, 1981). As has been mentioned in the introduction (chapter 1.1), the role of GPs (and other referrers) are particularly important to cross-border care in two ways: as referrers they can channel patients, and as the professionals that patients usually trust most and being the first contact point, GPs can influence patients' choices about where to be treated (Glinos, Baeten, Boffin, 2006). Though this study merely gives an insight into the barriers that GPs encounter with respects to cross-border care and only involves those GPs in a small geographical area, it is a good starting point to do further research amongst these stakeholders. GPs are able to identify the more practical problems concerning cross-border care that policy makers might otherwise miss as they are further away from the actual cross-border activity

6.2 Problems/limitations of the research method

There are several remarks that could be made concerning the sample of this study. The first remark has to do with the refusal of GPs to partake in this study. One of the reasons that GPs refused to take part in this study, was that they did not believe that a (systematic) patient flow from Belgium to the Netherlands could ever become reality. It could be that these GPs have a more negative view of cross-border care and that they might see more barriers than the respondents.

The second remark that should be made regarding the sample is their lack of experience with cross-border care (in the sense of a patient flow from Belgium to the Netherlands). They were therefore unable to give an account of the barriers that they or their patients may have come across. For instance, the GPs did not see that continuity of care would be a problem. It could be that because of inexperience with cross-border care, they do not see the potential problems that could arise and that have been found by Engels (2003) in the opposite direction. This could mean that certain barriers that do exist have not been mentioned. The barriers that they do mention concerning-cross-border care are their own perceptions. Though these perceptions may not always be in accordance with reality, they are very insightful and do indicate in which areas GPs lack the necessary knowledge concerning cross-border care.

Future research could be aimed at getting an insight in the barriers that GPs who have referred patients have come across. However, due to the fact that the patient flow is a

one-sided one from the Netherlands to Belgium, those GPs will not count many nor can it be expected that they systematically refer their Belgian patients to the Netherlands or more specifically to Zeeuws-Flanders. This may lead to inconclusive results regarding the barriers that GPs encounter.

Even though the respondents might not have had actual experience with cross-border care, they did generally have a good idea of the hospital services that are available in Zeeuws-Flanders and how it is organised, due to the experience that they had with their Dutch patients seeking hospital care in Zeeuws-Flanders. Those GPs without Dutch patients had a limited idea of the types of services available in Zeeuws-Flanders and how care is organised there. The remarks concerning differences between Dutch and Belgian hospitals are therefore valid.

Because the GPs were also selected based on their presence on a list of CZ-insurers and thus having Dutch patients, could also mean that these respondents were typically more negative about the Dutch health care system, than GPs not having any Dutch patients. It could then be that they might view cross-border care in a different light.

Because the representatives of the mutuality work in the international department of their mutualities, it could be said that they are more internationally minded; meaning that their views may differ from those of the mutuality as a whole (as they themselves have admitted). Therefore their remarks made during the interviews, though valuable, might give a too positive view of cross-border care.

When considering the research method, some remarks should be given. One of the inherent problems with interviews is interviewer bias. An attempt has been made to decrease the amount of interviewer bias as much as possible. Respondents were assured of anonymity, so that they felt free to comment. The interviews were recorded, so that the results would less likely to be based on interpretation afterwards. Unfortunately, the recording of an interview with a representative of a mutuality went wrong. Only half of the interview with this representative was recorded properly, and therefore analysis of the other half of the interview was based on the notes taken during the interview. For this reason the results from the representatives of the mutualities were limited. As a result the decision was made to focus this study more on the GPs than initially planned.

6.3 Future research

In this thesis recommendations have been given that ZorgSaam could follow up on in order to attract patients to ZorgSaam through referrals from their GPs. However, it could be worthwhile for ZorgSaam to engage in more research, namely a market research in which ZorgSaam identifies competitors in the border regions. This suggestion is based on certain remarks given in this study. First of all, if ZorgSaam could provide services unavailable in Belgium, then they might be willing to refer their Belgian patients to ZorgSaam. By doing a study into competitors' activities, services that are unavailable or could be of higher quality can be identified. Some of the respondents who had practises near the hospital in Eeklo had said that they preferably did not refer their patients to this hospital, because they believe that the quality of care is less good than that of other alternatives.

Another suggestion for further research could be to see how the Zeeuws-Flemish perceive the health care services offered by ZorgSaam and to what extent they are orientated towards Belgian health care services. As mentioned, most of the GPs that partook in this study had had Dutch patients (seeking care in Belgium), which may give a subjective view of the extent to which the Zeeuws-Flemish are orientated towards Belgian health care services.

Literature

Aaras, I., Fylkesnes, K. & Førde, O.H. (1998) GPs motives for referrals to general hospitals: does access to GP hospital beds make any difference?, *Family practice*, 15(3): pp. 252-258

Anderson, M.A., & Helms, L.B. (1995). Communication between continuing care organizations. *Research in Nursing & Health*, 18: 49-57.

Aronson, J. (1994) A Pragmatic View of Thematic Analysis, *The Qualitative Report*, 2(1). Retrieved from http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html

Baeten, R. (2000) *De gevolgen van de Europese eenmaking voor de organisatie en de verstrekking van de gezondheidszorgen in België*, Brussels: Federale ministerie van volksgezondheid

Baeten, R. (2006) P*atient mobility: framework and typology*. Retrieved on July 27, 2007, from http://www.iese.edu/en/files/6_25206.pdf

Baeten, R., Mckee, M. & Rosenmöller, M. (2006) Conclusion. In Rosenmöller, M., McKee, M. & Baeten, R. (2006) *Patient mobility in the EU: learning from experience*, Geneva: WHO

Bertinato, L., Busse, R., Fahy, N., Legido-Quigley, H., McKee, M., Palm, W., et al. (2005) *Policy brief: Cross-border health care in Europe*, Brussels: WHO European centre for health

Boffin, N. & Baeten, R. (2005) *Dutch patients evaluate contracted care in Belgian hospitals: results of a mail survey*, Report for the project "Europe for patients", Observatoire social européen, Brussels. Retrieved on May 11, 2007, from http://www.ose.be/files/health/.pdf

Botten, G., Grepperurd, S. & Nerland, S.M. (2003) Trading patients: lessons from Scandinavia, *Health policy*, 69: 317-327

Botten G, Nerland SM, Hagen TP. (2002) Sykehuslegenes holdninger til kjøp av helsetjenester i utlandet (Hospital physicians attitudes towards buying health services abroad), *HERO Report 2002:5.*

Brouwer, W., van Exel, J., Hermans, H.E.G.M. & Stoop, A. (2002) Should I stay or should I go? Waiting lists and cross-border care in the Netherlands, *Health policy,* 63: 289-298.

Brouwer, W., van Doorselaer, E.K.A. & Hermans, H.E.G.M. (2001) *Europese invloeden op de wachtlijst: juridische en economische aspecten van Europese invloeden op wachtlijsten in de Nederlandse gezondheidszorg*, Den Haag: Zorgonderzoek Nederland

Bryman, A. & Bell, E. (2003) *Business research methods,* Oxford: Oxford University Press

Busse, R., Wismar, M. & Berman, P.C. (eds.) (2002) *The European union and health services: The Impact of the Single European Market on Member States*. Biomedical and Health Research. Amsterdam: IOS Press

Busse, R., Wörz, M., Foubister, T., Mossialos, E. & Berman, P. (2006) *Mapping health services access: national and cross- border issues*, Retrieved May 4, 2007, from www.ehma.org/_fileupload/File/Projects/HA_Report_01_02_06.pdf

Callens, S. & Peers, J. (2002) *Organisatie van de gezondheidszorg,* Antwerpen: Intersentia

van Camp, G. & van Ourti, T. (2003) *Ongelijkheid in de financiering van medische zorg: progressiviteit en herverdelend effect in België (*SO/01/005, part 3), DWTC: Antwerp/Leuven

Cartwright, A. (1978) Professionals as responders: variations in and effects of response rates to questionnaires, *British Medical Journal*, 2:1419 –21.

Clarke, P., Magannis, E. & Shiels, J. (2006) *Attitudes to the development of cross-border health services: the case of GP out-of-hours services*. Retrieved August 23, 2007 from http://www.crossborder.ie/pubs/BI-01319.pdf

Closon, M.C., Crainich, D. & Swartenbroek, N. (1999) Public health and health policy in Belgium. In: Holland, W. & Mossialos, E. & Permanan, G., *Public health policies in the European union,* Aldershot: Ashgate: publishing

Corens, D. (2007) Belgium: Health systems review, *Health systems in transition*, 9(2)

Crainich, D., & Closon, M.C. (1999) Cost containment and health care reform in Belgium. In: Mossialos, E. Le Grand, J. *Health care and cost containment in the European Union.* Aldershot: Ashgate

DiCocco-Bloom, B. & Crabtree, B.F. (2006) The qualitative research interview, *Medical Education,* 40: 314-322

Directie-generaal Sociaal Beleid (2005) *Beknopt overzicht van de sociale zekerheid in België*, Brussel: Federale Overheidsdienst Sociale Zekerheid. Retrieved September 23, 2007, from http://socialsecurity.fgov.be/NL/nieuws_publicaties/publicaties/overzicht/2005/BEKNOPT-2005.pdf.

Earwicker, S.C. & Whynes, D.K. (1998) General practitioner's referral thresholds and choices referral destination: an experimental study, *Health economics,* 7: 711-722

Engels, E. (2003), Grenzeloos geketend? Deel A. Explorerend onderzoek naar de transnationale zorgketen tussen Nederland en België; 2003.

den Exter, A (2005) Patient mobility in European union: health spas in Ischia, Italy, *Croatian medical journal,* 46(2): 197-200

European Court of Justice (1998a) *Case C-120/95 Nicolas Decker and Caisse de Maladie des Employés Privés.* European Court of Justice. April 28, 1998. Retrieved July 3, 2007 from http://curia.eu.int/en/actu/activites/act98/9811en.htm.

European Court of Justice. (1998b) Case *C-158/96 Raymond Kohll and Union des Caisses de Maladie.* European Court of Justice. April 28,1998. Retrieved July 3, 2007 from http://curia.eu.int/en/actu/activites/act98/9811en.htm.

European Court of Justice (2001) *Case C-157/99 Geraets-Smits/Stichting Ziekenfonds and Peerboom/Stichting CZ Groep Zorgverzekeringen*. European Court of Justice. July 12, 2001, Retrieved July 10, 2007 from http://curia.europa.eu/nl/actu/communiques/cp01/aff/cp0132nl.htm

European Court of Justice (2003a) *Case* C-385/99. Müller-Fauré and Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen. European Court of Justice. May 13, 2003. Retrieved July 10, 2007 from http://curia.europa.eu/nl/actu/activites/act03/0314nl.htm#ToC1

European Court of Justice (2003b) *Case C-385/99. van Riet and Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen.* European Court of Justice. May 13, 2003. Retrieved July 10, 2007 from http://curia.europa.eu/nl/actu/activites/act03/0314nl.htm#ToC1.

European Court of Justice (2005) *Case C-145/03. Heirs Keller and Instituto Nacional de la Seguridad Social (INSS), Instituto Nacional de Gestión Sanitaria (Ingesa), before Instituto Nacional de Salud (Insalud).* European Court of Justice. April 12, 2005. Retrieved July 3, 2007 from http://curia.europa.eu/nl/actu/communiques/cp05/aff/cp050031nl.pdf

European Court of Justice (2006) *Case C-372/04 Yvonne Watts*. European Court of Justice. 16 mei 2006. Retrieved August 1, 2007 from www.curia.europa.eu/nl/actu/communiques/cp06/aff/cp060042nl.pdf

European Court of Justice (2007) Case C-145/03. Stamatelaki and NPDD Organismos Asfaliseos Eleftheron Epangelmation (OAEE). European Court of Justice. April 19, 2007. Retrieved September 12, 2007 from http://curia.europa.eu/nl/actu/communiques/cp07/aff/cp070076nl.pdf

European Parliament (1995) Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data *, Official Journal of the European Communities*, No L. 281: pp. 31.

Evers, S., Paulus, A. & Boonen, A. (2001) Integrated care across borders: possibilities and complexities, *Internation journal of integrated care,* 1(18):

Glinos, I.A. & Baeten, R. (2004) *A literature review of cross-border patient mobility in the European union*, Retrieved May 11, 2007, from http://www.ose.be/files/health/WP12_lit_review_final.pdf

Glinos, I.A., Baeten, R. & Boffin, N. (2006) Cross-border contracted care in Belgian hospitals. In Rosenmöller, M., McKee, M. & Baeten, R. (2006) *Patient mobility in the EU: learning from experience*, Geneva: WHO

Glinos, I. A., Boffin, N. & Baeten, R. (2005), *Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives*, Retrieved May 11, 2007, from http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf

Gonzalez, P (2004) *The "gatekeeping" role of General Practitioners: Does patients' information matter?* Leuven: CORE-Université catholique de Louvain. Retrieved October 1, 2007, from http://www.bu.edu/econ/isp/6th_IOOHC/papers_6th/gonzalez.pdf

Hamilton, G.J. (2003) Private health insurance for all in the Dutch health care system, *Europeanh journal of health law,* 10(1): 53-61

Harvey, T. & McHale, J.V. (2004) *Health law and the European union,* Cambridge: Cambridge University Press

Health and consumer protection directorate-general (2006) *Summary report of the responses to the consultation regarding "community action on health services"* (SEC 2006,1195/4)*,* Brussels: European Commission

Hembroff, L.A., Rusz, D., Rafferty, A., McGee, H. & Ehrlich, N. (2005) The cost-effectiveness of alternative advance mailings in a telephone survey. *Public Opinion Quarterly,* 69: 232–245

Hermans, H.E.G.M. & Brouwer, W. (2003) *Quality Issues on Cross-border Care: A Literature Search*, Rotterdam/Utrecht Report for the High Level Committee of the European Health Management Association (EHMA)

Hermans, H.E.G.M. & Den Exter, A. (1999) Cross-border alliances in health care: international co-operation between health insurers in the euregio meuse-rhine, *Croatian medical journal* , 40(2): 266-272

Hermesse, J. (1999) The opening of frontiers to patients: what economic consequences?, in proceedings of aim international symposium on health care without frontiers within the European Union, Brussels: Association internationale de la mutualité

Hervey, T. & Trubek, L. (2007) *Freedom to provide health care services within the EU: An opportunity for a transformative directive*. Retrived May 7, 2007, from http://eucenter.wisc.edu/Conferences/HealthApr07/HerveyTrubek.pdf

Johnson, D.R. (n.d.) *Adressing the problem of growing non-response rate*. Retrieved September 29, 2007, from http://www.ssri.psu.edu/survey/Nonresponse1.ppt#256,1,Addressing the Growing Problem of Survey Nonresponse

Kemenade, J.W. & de Lint, M.W. (2005) Internationale vergelijking van vijf gezondheidszorg systemen. In Breit, J.G, Elsinga, E., Kasdorp, J.P, Sanders, F.B.M., Vandermeulen, L.J.R., & Wevers, C.J.M. *Handboek Structuur en Financiering Gezondheidszorg* (Band 1), Maarsen: Elzevier gezondheidszorg

Leininger, M. M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. M. Leininger (Ed.), *Qualitative research methods in nursing*. Orlando: Grune & Stratton.

Leemhuis-Stout, J. (2006) Uitkomsten NVZ-onderzoek actuele wachttijden electieve zorg in ziekenhuizen. Retrieved 10 August, 2007, from http://www.nvz-ziekenhuizen.nl/content.jsp?objectid=16790

Lequido-Quigley, H., Glinos, I.A., Baeten, R. & McKee, M. (2007) Patient mobility in the European union, *BMJ,* 334: 1880190

Lenaerts, K. (2006) Communautair recht en gezondheidszorg: De grote lijnen van rechtspraak van het hof van justitie van de Europese gemeenschappen, *Studiën,* I.B. 2006/1-7

Maarse, J.A.M, Nieboer, A. & Paulus, A. (2001) Gezondheidszorg in Nederland en België: een nieuwe vergelijking, *Acta Hospitalia*, 2001(2): 53-67

Maarse, J.A.M. (2001) Europa geen bedreiging voor de Nederlandse gezondheidszorg, *TSG,* 79(1): 55-57

Mahon, A., Whitehouse, C., Wilkin, D. & Nocon, A. (1993) Factors that influence general practitioners' choice of hospital when referring patients for elective surgery, *British journal of General practitioners,* 43(372): 272-276

McKee, M., Mossialos, E. & Baeten, R. eds (2002) *The Impact of EU Law on Health Care Systems*. Brussels: Peter Lang

McNamara, C. (1999) *General Guidelines for conducting Interviews*, Minnesota: LCC

van der Mei (2002) *Free movement of persons within the European Community: Cross-border access to public benefits,* Oxford: Hart

Michels, A. (2007) Theories and core principles of Dutch democracy (No. C-07-01). *European governance papers (EUROGOV)*, Retrieved July 17, 2007, from

http://www.connex-network.org/eurogov/pdf/egp-connex-c-07-01.pdf

Missoc (2006*) Trends in social protection: Comparative tables*. Retrieved August 20, 2007, from http://ec.europa.eu/employment_social/soc-prot/missoc98/english/03/index.htm

MLOZ (2006) *Jaarverslag 2006.* Retrieved October 22, 2007, from http://www.mloz.be/cms/Mloz/jaarverslag%202006.pdf

MLOZ (2007) *Geprogrammeerde medische verzorging in het buitenland*, Brussel: MLOZ

Mossalios, E. & Palm, W. (2003) The European Court of Justice and the free movement of patients in the European Union, *International Social Security Review,* 56(2): pp. 3–29

Murray, C.J. & Frenk, J. (2000) A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*, 78(6): pp. 717-31

Mutual Information System on Social Protection in the EU member states and the EEA. Accessible from: http://ec.europe.eu/employment_social/social_protection/misoc_tables_en.htm

Nederpelt, M. (2007) *Van België naar Nederland: Een onderzoek naar de tevredenheid van Belgische patiënten die zorg in een Nederlands ziekenhuis hebben ontvangen en beweegredenen van Belgische patiënten die de keuze voor zorg in een Nederlands ziekenhuis hebben gemaakt,* Unpublished Bachelor's thesis, Rotterdam, Erasmus Universiteit.

Österlo, A. (2007) Health care across borders: Austria and its new EU neighbours, *Journal of European social policy,* 17(2): pp. 112-124

Paulus, A., Fecher, F., van der Made, J., Evers, S., & Boonen, E. (2000) Cross border care between Belgium and the Netherlands: a health economics and law perspective. *Paper 1st Scientific Euregional Conference (1st SEC), Maastricht 1999.* Retrieved July 29, 2007, from http://www.fdewb.unimaas.nl/eurecom/PDF/Pauluspaper. PDF

Polder, J.J., Takken, J. Meerding, W.J., Kommer, G.J. & Stokx, L.J. (2002) *Kosten van ziekten in Nederland; de zorgeuro ontrafeld*. Bilthoven: RIVM/EUR,.

Poullier, J.P. (1996) Public health strategies in Europe: doing better and feeling worse. In: Detels, R., Holland, W.W., McEwen, J. & Omen, G.S. (eds). *Oxford textbook of public health,* vol.1, pp.275-96

Putters, K., van Hout, E. & Ribeiro, T.C. (2006) *Lokaal verzorgd: verschuivend bestuur en hybridisering in de zorg en dienstverlening,* Tilburg: Universiteit van Tilburg

Rhodes, G., Wiley, M., Tomas, R. Casas, M. & Leidl, R. (1997) Comparing EU hospital efficiency using diagnosis-related-groups, *European journal of public health,* 7(3), pp. 42-50

Rich, F.R. & Merrick, K.R. (2006) Cross border health care in the European union: challenges and opportunities, *journal of contemporary health law and policy,* 23,

RIZIV (2006a) *Toepassing van artikel 22 van Verordening (EEG) nr. 1408/71 na de arresten Kohll en Decker* (Omzendbrief VI nr 2006/117), Brussel: RIZIV

RIZIV (2006b) *Verordeningen (EEG) 1408/71 en 574/72 inzake sociale zekerheid Europese ziekteverzekeringskaart (EZVK)* (Omzendbrief VI nr 2006/224) , Brussel: RIZIV

Ros & Smidt (2005) Grensoverschreidende gezondheidszorg in Euregios. In Breit, J.G, Elsinga, E., Kasdorp, J.P, Sanders, F.B.M., Vandermeulen, L.J.R., & Wevers, C.J.M. *Handboek Structuur en Financiering Gezondheidszorg* (Band 3), Maarsen: Elzevier gezondheidszorg

Rosenmöller, M., Baeten, R., McKee, M., Mossialos, E. & Jorens, Y. (n.d.) Europe for patients: Benefits and challenges of enhanced patient mobility (Draft outline final book), Retrieved May 20, 2007, from *http://www.iese.edu/en/files/6_25268.pdf*

Schokkaert, E. & van de Voorde, C. (2003) *Health care reform in Belgium,* Mimeo: Katholieke Universiteit Leuven

Schokkaert, E. & van de Voorde, C. (2005) Health care reform*, Health care economics,* 14: pp. S25-S39

Sieveking, K. (2007) ECJ rulings in health care services and their effects on the freedom of cross-border patient mobility in the EU, *European journal of migration and law,* 9: pp. 25-51

Singer, E., van Hoewyk, J., Gebler, N., Raghunathan, T. & McGonagle, K. (1999) The Effect of Incentives on Response Rates in Interviewer-Mediated Surveys, *Journal of Official Statistics*. 15: pp. 217-230.

Smeets, M.J.G., Bruinsma, I. & Straetmans, G. (2002) *Contracteren in het buitenland*, Zorverzekeraars Nederland

Sylvest, J. & Baele, A. (2007) The impact of the European court of justice case law on national systems for cross-border health service provision (IP/A?ALL/FWC/2006-105/LOT3/C1/SCI), Report for the European parliament's committee on internal market and consumer protection. Retrieved May 19, 2007, from http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_briefingnote_en.pdf

Trembley, M. (2003) Briefing on cross-border health: Department of health, London. Retrieved September 8, 2007, from http://policyinsider.com/files/European%20Health/cross%20border.pdf

van Tits, M.H.L. & Gemmel, P.a.a.a. (1995) *Haalbaarheidsonderzoek samenwerkings-netwerk ziekenhuizen in de Euregio Scheldemond.* Tilburg/ Gent: IVA-Tilburg.

Vandermeir, M. (1999) "Quelle complémentarité franco-belge?" *Intra-Muros,* pp-33-34.

van der Wijst, L. & Ruijten, L., (2004). Zorg over de grens. *GFK jaargids 2004.*

Zorgloket (2000) Grensbewoners en grensoverschrijdende zorg deel 1, Retrieved August 8, 2007, from http://www.euregiozorgloket.info/content/cms/files/Eindrapport1.pdf

ZorgSaam. 2006. *Samenwerking zorginstellingen: Partnerschap met UZ Gent*. Retrieved September 10, 2007, from http://www.zorgsaam.org/overzorgsaam/samenwerking/zorginstellingen/

Appendices

Appendix 1. Overview for Belgian insured

	With authorisation (E112)	Without authorisation? (Decker and Kohll)	Care with authorisation for those living in border regions	Care without authorisation for those living in border regions
Conditional on place of residence?	No	No	1. max 15 km from the border 2. residing in certain cantons, districts or counties	1. Max 25 km from foreign nursing care 2. Residing in certain cantons, districts or counties 3. Residing in a specified canton
Country of Treatment	EEC + Switzerland	EEC	Max. 25 km from the border	1. Max 25 km from place of residence, no nursing care facility closer by 2. In Luxembourg 3. In France, max 50 km from place of residence
Medical Treatment	Hospitalisation and ambulatory care	Ambulatory care	1. and 2. hospital care and dialysis. 2. specific ambulatory care	1. Hospital and ambulatory care in a nursing facility 2. and 3. 5 specific services
Need of forms?	E112	No	E112	No
Formalities before leaving?	Apply for E112, preferably with medical dossier	Non	Apply for E112, motivation not required	Non
Formalities on the spot?	E112 handed over to health care provider	Paid in full by patient	E112 handed over to health care provider	Paid in full by patient
Reimbursement by Mutuality possible after return?	Yes, but only hospitalisation and according to Belgian tariffs and under Belgian conditions	Yes, but according to Belgian tariffs and under Belgian conditions	Yes, but only hospitalisation and according to Belgian tariffs and under Belgian conditions	Yes, but according to Belgian tariffs and under Belgian conditions

Source: MLOZ, 2007

Appendix 2. Hospitals in border region of Zeeuws-Flanders/ Belgium

Appendix 3. Announcement of study sent to GPs

Datum: 28 February 2008
Referentie: Onderzoek Belgische verwijzers
Betreft: Deelname onderzoek

Mevr. N.J. Kolff
Erasmus Universiteit Rotterdam
Hoyledesingel 36
3054 EL Rotterdam
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Geachte <NAAM>,

Via deze brief vraag ik uw medewerking aan een onderzoek dat binnen ZorgSaam uitgevoerd wordt naar de redenen/aspecten die bepalen of Belgische artsen patiënten wel of niet naar een van de ZorgSaam instellingen te verwijzen. U krijgt deze brief omdat u in de afgelopen jaren patiënten doorverwijzen heeft naar een van de ZorgSaam instellingen.

Sinds 1978 bestaat in de Euregio Scheldemond (Zeeuws-Vlaanderen, Oost-Vlaanderen en West-Vlaanderen) de mogelijkheid voor patiënten om over de grens zorg te ontvangen. De regeling die toen tussen Nederlandse ziektekosten verzekeraars en Belgische ziekenhuizen is getroffen, geldt Nederlandse patiënten die in België kunnen worden behandeld. Sinds die tijd is de mogelijkheid tot grensoverschrijdende zorg binnen de Europese Gemeenschap vergroot. Hoewel de patiëntenstroom nog steeds voornamelijk bestaat uit Nederlandse patiënten die in België zorg ontvangen, is ook het omgekeerde goed mogelijk. ZorgSaam Ziekenhuis, een zorgorganisatie met instellingen in Terneuzen, Oostburg en Hulst, wil in de toekomst meer patiënten aantrekken uit België.

Aangezien een groot aandeel van patiënten die over de grens zorg ontvangt door een arts in eigen land doorverwezen is naar een instelling in het buitenland, richt dit onderzoek zich op u als verwijzend arts. Door een goed beeld te krijgen van de redenen en aspecten die bepalend zijn voor u als verwijzer, alsmede van de barrières en problemen die uw patiënten tegen kunnen komen, kan ZorgSaam de zorgverlening voor de Belgische patiënten verbeteren.

Het onderzoek zal bestaan uit een interview van ongeveer een uur. Tijdens dit interview zal dieper worden ingegaan op mogelijke redenen voor artsen om wel of niet patiënten door te verwijzen naar ZorgSaam. Het onderzoek is dan ook kwalitatief van aard. Dit onderzoek is een afstudeeronderzoek en wordt uitgevoerd door een student in opdracht van de Erasmus Universiteit te Rotterdam, namelijk mevrouw N. Kolff. Uw antwoorden helpen onder andere verbeteringen door te voeren. Er zal binnenkort contact met u opgenomen worden of u deel wenst te nemen aan dit onderzoek.

Dit onderzoek wordt gecoördineerd vanuit een afstudeeronderzoek via de Erasmus Universiteit Rotterdam in samenwerking met Stichting ZorgSaam. De resultaten zullen verwerkt worden door de student,. Als u vragen heeft, kunt u via e-mail contact op nemen op nynkekolff@hotmail.com of telefonisch via 0031 (0)10-4187414. Wij hopen van harte dat u aan het onderzoek wilt meewerken. Uw bijdrage om onze zorgverlening te kunnen verbeteren stellen wij zeer op prijs.

Met vriendelijke groet,

J.S. van der Heide
Raad van Bestuur

Appendix 4. Hospitals to which GPs refer

Place of practise GP	Name of town/city where hospital is situated						
	Knokke	Bruges (Top)	Damme-Sijssele	Eeklo	Ghent (Top)	St-Niklaas	Antwerp (Top)
Moerkerke-Damme	X	X	X				
Maldegem		X	X	X			
Sint-laureins			X	X			
Bassevelde			X	X	X		
Boekhoute			X	X	X		
Assenede			X	X	X		
St-Jan-Eremo		X	X				
Watervliet		X	X				
Wachtbeke					X	X	
Zelzate					X	X	
Belsele					X	X	
de Klinge						X	X
Kieldrecht						X	X
Stekene					X	X	