

# Integrated care across borders: possibilities and complexities

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## Abstract

The main purpose of this practice paper is to describe and analyse the possibilities and complexities of integrated health care across borders. First, we portray an ideal scenario for this type of care with a case of patients suffering from rheumatoid arthritis and living in the Dutch-Belgian frontier area. It shows how cross border care enhances continuity of care/tailor-made care and the other way around. Secondly, based on different literature sources, we describe actual regulations on health care across borders. We show that these regulations can be a major hindrance to integrated care. This raises questions on the scope and content of policies directed at both cross border and integrated care.

## Keywords

integrated care, cross border care, institutional context, European Union regulation

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## Introduction

Within the European Community, we notice an increasing number of cross border health and social care arrangements. A number of these are settled within the so-called Euregions. Euregions encompass trans-national co-operative arrangements on issues that vary from health care to transport and from environment to social security. Cross border arrangements between the Netherlands and Belgium or Germany are well-known examples.

Cross border arrangements with regard to health and social care enable specialities in one country, for instance, to be made accessible for patients coming from the other side of the border. Usually, they relate to facilities not available in the immediate vicinity in one of the participating countries, such as open-heart surgery and trauma care. As such, they offer patients the opportunity to receive more or different health care services and products in countries other than the nation in which they are living or are insured. This enlarges the possibilities to obtain tailor-made care.

Tailor-made or chained care is an important characteristic of integrated care. Integrated care is often

defined as the methods and strategies for linking and co-ordinating the various aspects of care delivered by different care systems, such as the work of general practitioners, primary and speciality care, preventive and curative services, acute and long-term care as well as physical and mental health services (mission statement *International Journal of Integrated Care*). Irrespective of the type of integrated care, the main purpose of each arrangement is to link or tailor supply structures (in terms of the type, time and number of services and products delivered) to specific features of care demand. The demand orientation of integrated care explains why this is also often referred to as tailor-made care [1].

By enlarging the possibilities to obtain tailor-made care, cross border care may stimulate integrated care. Instead of having to set up an integrated care arrangement in the host country of the patient, cross border care offers the opportunity to have access to tailor-made health care arrangements, services and products abroad. Experiences so far show that most integrated care arrangements, however, concern the integration of several echelons of care on a national level. On the other hand, the ruling of the European Court of Justice, entitled Decker and Kohll (see

below), created a legal ground to facilitate and enhance cross border care and offers more opportunities for integrated care across borders.

In this paper, we further explore the possibilities of integrated cross border care from the viewpoint of patients and discuss complexities due to legislation and regulations and sometimes conflicting interests of the actors involved. Both possibilities and complexities of integrated care across borders are illustrated by way of a case. We follow Mrs Lieve Janssen who suffers from rheumatoid arthritis and who lives in a small Belgian town near the Dutch border. Generally, patients with rheumatoid arthritis need many different health care services and products. As such, these patients have a complex care demand and most likely have to make an appeal on different care providers. This implies that health care delivery has to be coordinated among care providers. In other words, activities have to be geared to one another and thus have to be integrated [1]. In her need for tailor-made care, Mrs Janssen is regularly referred to health care providers in the Netherlands.

In this article, we will first present our case and sketch the ideal scenario for integrated cross border care for the patient. Next, we will discuss the context (national and European Union regulation) within which this type of care takes place. Finally, we will return to Mrs Lieve Janssen and look at all the obstacles she encounters in her struggle to obtain integrated care across borders.

## **This is ... Mrs Lieve Janssen**

Mrs Lieve Janssen is a 49-year-old woman living in a small Belgian town only 15 km from the Dutch border. She is married and has two children. She has been working as a cook in a school-kitchen for more than 14 years. Three months ago, she started complaining of increasing pain and stiffness in the small joints of her hands and feet and noticed that her joints were swollen. Since two weeks, she cannot perform her job anymore. Her general practitioner suspects her to have rheumatoid arthritis. He prescribes an anti-inflammatory drug and refers her to a rheumatologist in the same town. The rheumatologist is working in a nearby Dutch hospital but once a week he has an outpatient clinic in the Belgian town, which is only 27 km from his hospital. He confirms the diagnosis rheumatoid arthritis and prescribes methotrexate, a disease modifying anti-rheumatic drug. In addition, the rheumatologist refers her to the patient education group in the Dutch hospital. These groups offer multidisciplinary care for patients who have recently been diagnosed to suffer from rheumatoid arthritis. During

the sessions, patients receive information on the disease and its course, explanation on importance and possible side effects of drugs and instructions on joint-sparing techniques. During the sessions, appliances and aids can be provided as well. In addition, contact with an occupational physician, who evaluates the situation at the work place, is possible if indicated.

Four months later, Mrs Janssen attends a control visit to the rheumatologist. Thanks to the new drugs prescribed, her rheumatoid arthritis is better. She also mentions that the patient education group has been useful. She now attends weekly sessions of a physical exercise group, which are organised within the rehabilitation unit of the hospital in order to maintain joint mobility and condition. She prefers the physical exercise group in the Netherlands to the individual physiotherapy sessions in her own country. She has not resumed work yet, but is following a vocational rehabilitation programme. Indeed, it has become clear that her work as a cook will be physically too heavy. Therefore, the occupational physician, who she consulted during the patient education program, agreed with the director of the school where she is working, that she could change to a part-time secretarial job after vocational rehabilitation.

During the next 5 years, the rheumatoid arthritis follows an uneventful course. For two years, Mrs Janssen has even been followed by the nurse practitioner who attends the practice of the general practitioner once a month. For several months, however, the disease is active and repeated change of therapy does not result in adequate disease control. Moreover, she has increasing difficulties walking because of progressive deformities of her feet. The rheumatologist decides a hospital admission is necessary. In order to guarantee continuity of care, he prefers an admission in the cross border Dutch hospital where he is working. Moreover, for the patient this is the hospital nearest to her home. The aim of the admission is to adapt the anti-rheumatic drugs and to find solutions to the problems with her feet.

During the admission, new anti-rheumatic drugs are started. Because of accompanying stomach complaints, a gastro-protective drug is prescribed. For the progressive deformities of the feet, it is decided that surgery will not be necessary, but in first instance, tailor-made orthopaedic shoes will be made for her. After a hospitalisation of three weeks, Mrs Lieve Janssen feels better and returns home.

A Dutch friend of Mrs Janssen, Mrs Pieters also has been suffering from rheumatoid arthritis for many years and she is followed in the Dutch hospital by the same rheumatologist. She needs a total hip replace-

ment and has been waiting already for several months to be admitted for the surgery. The pain limits her in the performance of her household tasks and causes sleepless nights. Because the waiting lists in Belgium are nearly non-existent, the rheumatologist proposes to make an appointment with a Belgian orthopaedic surgeon in order to be scheduled for surgery in Belgium. Mrs Pieters agrees with this proposal and only two weeks later, she is admitted to a Belgian hospital where she receives successfully a total hip replacement.

## **Institutional contexts**

In our ideal case, both Mrs Janssen and Mrs Pieters can obtain tailor-made care because they can freely pass the Dutch and Belgian borders. However, in reality they will encounter many hindrances when using or purchasing health care in another country. Therefore, we will now present the actual national legal and institutional context of cross border care between The Netherlands and Belgium [2].

### **Health care organisation in Belgium and the Netherlands**

Both Belgium and the Netherlands have a social security system since the first part of the 20th century. In Belgium, health care is financed for the greater part by taxes and additionally by obligatory health insurance for all citizens. Only four to five major health insurance companies, with little mutual competition, exist. For health services that received an official registration (nomenclature), reimbursement exists, but there is usually a substantial out-of-pocket payment. Health care outside Belgium will only be financed (1) in case of illness or accidents during holidays but only after prior authorisation (E111 regulation) or (2) in case a special health service is not available in Belgium (E112). Additionally, for Belgian citizens living close to the border the so-called 15/25 km is relevant, in which health insurers will automatically apply a E112 scheme for those patients who are living within 15 km of the national border and who apply for care in a foreign institution that is no more than 25 km from the frontier [3].

In the Netherlands, health care is mainly financed by obligatory health insurance for all citizens. In contrast to Belgium, many health insurance companies exist which are mutually competing within the limits of national legislation [4]. About two-thirds of the Dutch has public insurance and one-third private. The Health Insurance Act provides for a system of benefit in kind [5]. In this context, the health insurance funds enter

into contracts with health care institutions and individual medical practitioners who are paid directly by the funds without any financial involvement on the part of the patient. In the Netherlands it is also possible for the sickness funds to contract a provider in another country to provide treatment and thus make it possible for a Dutch patient to apply for care in other countries of the European Union. In general, the private insurance companies are more willing to cover cross border care.

## **National institutional context**

Traditionally, in the Netherlands there has been a relatively high emphasis on care as opposed to cure-oriented care. Consequently, different facilities aiming at continuity of care are present in this country. In our case, for example, “patient education groups”, “vocational rehabilitation groups”, “physical exercise group facilities” and “nurse practitioners” are available in the Netherlands but not in Belgium. On the other hand, the availability of health services is higher in Belgium, probably due to the fee-for-services payment and the prospective budgeting of the Belgian hospitals [2, 4]. 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 diagnostic imaging machines [4]. Opposed to that the Netherlands have a higher overall bed capacity, which might be explained by the relatively high amount of chronic care such as rehabilitation centres and nursing homes [4].

From the above-mentioned differences, varying incentives for opting for cross border care result. For Dutch citizens the presence of waiting lists in the Netherlands and the high capacity of health care services in Belgium can be expected to stimulate cross border care. For Belgian patients, the larger availability of paramedical services in The Netherlands is a definite incentive to opt for care in the Netherlands. On the other hand, financial considerations are increasingly important to patients with chronic disease. Consequently, a stimulus for Belgian citizens to opt for cross border care in the Netherlands might be the presence of relatively high out-of-pocket payments in Belgium [2]. Finally, we should not forget that the close cultural background and the absence of language barriers between the Flemish and the Dutch are an additional stimulus to cross the borders.

## **European Union regulations**

From our description, so far it follows that both incentives and national regulations for cross border care

clearly differ for both ladies. Consequently, the possibilities for Mrs Janssen and Mrs Pieters to actually obtain tailor-made care across borders vary. In recent years, the European Union (EU) has tried to use instruments such as treaties, regulations and directives in order to make sure that, under certain restrictions, in principle every EU citizen is entitled to medical treatment in another country of the Union.

Until April 1998, the main possibility for patients in EU-countries to receive cross border care has been the authorisation procedure (E112 scheme). It has to be noted that every EU citizen can of course travel abroad for medical treatment if he pays for it himself or if a private insurer is willing to do so.

April 1998 shows a first break with the rules of the E112-procedure. This is related to two rulings of the European Court of Justice (ECJ): Decker and Kohll. Both Decker [6] and Kohll [7] are Luxembourg citizens, with social health care insurance, who applied for care abroad *without* prior authorisation (in the case of Kohll the authorisation was turned down) and because of this received no reimbursement. Decker said that through hindering the purchase of spectacles abroad, the authorisation procedure violated the EC rules on the free movement of goods. Mr Kohll insisted that the authorisation procedure restricted him from purchasing services abroad; in this case, orthodontist care for his daughter.

In both cases, the ECJ stated that the Member States are responsible for the organisation of social security systems. In the absence of harmonisation at the Community level, it is therefore for the legislation of each Member State to determine, first, the conditions concerning the right or duty to be insured with a social security scheme and, second, the conditions for entitlement to benefits. In this, the Member States must nevertheless comply with Community law when exercising those powers. Member States must create possibilities for the freedom of movement of goods and services.

The conclusion of the ECJ in the case of Decker is that Articles 30 and 36 of the Treaty *preclude* national rules under which a social security institution of a Member State refuses to reimburse an insured person on a flat-rate basis the cost of a pair of spectacles with corrective lenses purchased from an optician established in another Member State, on the ground that prior authorisation is required for the purchase of any medical product abroad. In the case of Kohll the final conclusion is that Articles 59 and 60 of the Treaty *preclude* national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost of dental treatment provided by an ortho-

dentist established in another Member State is subject to authorisation by the person's social security institution.

In Decker and Kohll the ECJ in summary concluded that making the reimbursement of medical costs incurred in another Member State entirely dependent upon prior authorisation was a breach of the EC rules on the free provision of goods and services. Although for some the rulings of the ECJ came as a surprise, others [8] have argued that it was likely that the strict application of the prior authorisation procedure could not withstand the judicial scrutiny as it is in conflict with the four freedoms of the EU. As mentioned by the ECJ it is up to the Member State to organise the social security in accordance with the EU rules. This means that the Member States must enable cross border care without prior authorisation.

For the EU patient this means a new option whereby the patient obtains treatment abroad and subsequently requests reimbursement in accordance with the scale of charges in the country in which the patient is resident. Remarkably, to the opinion of both the Dutch and the Belgian authorities, they do not have to change their legislation in order to fulfil this rule [8]. In Belgium cross border care is reimbursed without permission, based on EU regulation 574/72 art 34, if the costs of care are no higher than € 500 (in future € 1000). This rule does not apply to hospital costs and drug costs [9]. For the Netherlands it is stated that the system of benefit in kind [10] is not in conflict with the European Treaty. In this system, health insurance funds can contract a foreign health care institution [9]. If the patient, however, applies for care to a supplier, both in and outside the Netherlands, with whom his insurance company has no contract he has to get prior permission for this application.

Decker and Kohll have been followed by a number of ECJ-rulings stipulating which tariffs should be reimbursed (Ferlini C-411/98; Vanbraekel C-368/98) and regulating payment for non-emergency care and highly specialised or multidisciplinary care (Smits and Peerbooms C-157/99). These rulings can be expected to enlarge the possibilities for Mrs Janssen and her friend to obtain tailor-made care.

## **Integrated care across borders for Mrs Janssen: reality**

Let us now take a closer look at the actual possibilities and complexities for Mrs Janssen for integrated cross border care. Remember she is a Belgian patient who obtains tailor-made care when she can:

- Visit a rheumatologist in a Dutch hospital, 27 km from the Belgian town where she lives;
- Join a patient education group in the Dutch hospital;
- Attend the weekly sessions of the physical exercise group organised within the rehabilitation unit of the Dutch hospital;
- Change her work as a full time cook to a part-time secretarial job;
- Make use of a nurse practitioner who gives advice on rheumatoid arthritis and on adequate disease control;
- Be admitted to the Dutch hospital in case of exacerbation of her disease;
- Receive reimbursement for gastro-protective drugs in her own country;
- Receive reimbursement for tailor-made orthopaedic shoes made in another country.

For her friend Mrs Pieters continuity of care would include a total hip replacement within two weeks.

Given the current institutional context, would both ladies at the present time truly receive integrated care as earlier described? The first problem Mrs Janssen and her rheumatologist encounter in her medical journey to offer her the best rheumatologic care starts when she is referred to the patient education groups. In the Netherlands, a tariff exists for rehabilitation day-care but in Belgium, rehabilitation day-care is not officially enclosed in the nomenclature system and therefore will not be reimbursed. The same holds true for the vocational rehabilitation programme. Moreover, differences in regulations on sick leave and work-disability between Belgium and the Netherlands complicate cross border vocational rehabilitation programs. For example, in the Netherlands it is common to continue a part-time job while having a partial work-disability while in Belgium the possibility of work-disability combined with a part-time job does not exist. It is clear that this creates very different situations for reintegration in the labour force. Concerning the weekly sessions of the physical exercise group that Mrs Janssen continues to follow during the course of her disease, it is unclear if the Belgian health insurance company will reimburse these. Indeed, EU regulations mainly regulate medical but not paramedical care such as physiotherapy.

When Mrs Janssen needs to be hospitalised, she is confronted with another type of problem: regulations on reimbursement for hospitalisation in cross border areas do exist (European Union regulations and 15/25 km rule) but are subject to conflicting interpretation. Prior authorisation from the health insurance company is required but (because Mrs Janssen lives only 15 km

from the Dutch border) medical attestation for the request is not obliged and the authorisation cannot be refused. However, practical experiences (by one of the authors) indicate that very often the local offices of the health insurance company require a medical attestation anyway, causing confusion for the patient and delaying the hospital admission. Particularly in case of emergency admissions, these procedures are impractical.

A different type of problem emerges when she returns home after the hospitalisation. When she had to renew the prescription for the gastro-protective drug, it appeared that these types of drugs have a conditional reimbursement in Belgium, which means that one only receives reimbursement when one has had a gastric ulcer or oesophagitis proven by endoscope. Since this rule does not exist in the Netherlands, an endoscopy had not been performed during the hospitalisation. Consequently, Mrs Janssen will not be able to continue these drugs, despite the symptom relief they offer her. In addition, when she asked reimbursement for the orthopaedic shoes which were made for her in the Dutch hospital, problems arose. In Belgium, only a physician with a special authorisation can prescribe orthopaedic shoes. Theoretically, this authorisation is a Belgian matter and thus no Dutch physician can get this special authorisation to prescribe these orthopaedic shoes. Mrs Pieters had no more luck than Mrs Janssen did. Her public health insurance company has no contracts with the Belgian hospitals and surgeons and therefore, reimbursement of the hip replacement could not be granted. Therefore, much to her own regret and that of her employer, she had to wait for more than two months for her hip replacement in the Netherlands.

## Conclusions, discussion and remarks

After Decker and Kohll, the legal barriers for cross border care seem to be reduced. Theoretically and literally, this opens up the borders for cross border integrated care. However, if we compare the ideal patient situation with reality we notice that features of the separate health care systems as well as different (inter) national regulations prevent integrated care across borders to develop on a larger scale. Evidently, many barriers are still present. This raises different policy questions. Given the fact that the formation of integrated care arrangements in itself is already a complex and time-consuming matter and integrated care across borders can be expected to complicate matters even more, would it not be better to promote integrated care *within* borders first? On the other hand,

given the fact that borders are already actually opening up, would it not be wise to take integrated care as an integral part of cross border care policies? Why not jump on the policy train that has already taken off? Within the context of further integration of health services and the further development of cross border care, we believe that the latter course should be followed. Why?

First, because cross border care enlarges the possibilities to achieve the main goals of integrated care. Similar to integrated care, cross border care is directed at tailor-made care. Demand orientation implies that there is a link between (the *type*, *time* and *number* of) services and products offered and specific features of care demand. Through our case, we have illustrated how cross border care arrangements provide opportunities to achieve tailor-made care (e.g. patient education groups (*type*); weekly sessions of a physical exercise group (*number*); a hip replacement within two weeks (*time*)). In this sense, cross border care enhances integration: it offers additional means to achieve the goals underlying the integration of health care services.

Second, because cross border care reduces the obstacles currently present for many initiatives aiming at the integration of health services. One could even argue that cross border care induces the preconditions that are necessary for a feasible integration of these services. A good example is financing. In our description of Belgium and the Netherlands, we have seen that differences in the financing schemes of both countries are the main reason why practice differs from our ideal patient situation. Given these obstacles, a priority feature of cross border care in current policies concerns the integration of financing schemes. The integration of financing schemes is also a prerequisite for the integration of health services. Currently, one of the major obstacles to such integration in the Netherlands is the complex and non-integrated financing scheme [1, 4]. Integration of financing schemes through cross border care in turn enhances the integration of health services.

Finally, cross border care offers regional organisational and behavioural role models for different actors who want to co-operate and co-ordinate various activities. We have seen that the organisational design for

cross border care is usually a regional arrangement. The same is true for many integrated care arrangements [1]. It is possible to draw lessons for regional integrated care arrangements from the major hindrances to regional cross border arrangements. Such a comparison is possible, as the main organisational activities (co-ordination and co-operative behaviour) are the core features of both types of care. In this sense, cross border care can function as a role model for the integration of health services. The opposite is also true. Since the underlying activities of both types of care are the same, the integration of health services can also serve as a role model for cross border care. Likewise, the integration of financing schemes *within* countries (in order to stimulate the integration of health services) also enhances the necessary preconditions for cross border care.

In the statements and questions we have raised, we adapted the patient point of view. In reality of course, there are numerous actors with different and sometimes conflicting responsibilities. National governments for example have budgetary commitments. Cost containment in health care is an important responsibility. The EU has been concerned for several years with the supply of health and social care and the free movement of professionals and products, leading to a number of rules on the licensing of pharmaceuticals, the mutual recognition of medical qualifications and a free movement of professionals. Evidently, these rules will also influence the development, introduction and usage of integrated care across borders but also within borders. Furthermore, we have only concentrated on Belgium and the Netherlands in our example. Nevertheless, given current EU regulations, similar problems can be expected to arise for patients in other EU countries. In this paper, we merely want to point out that in cross border areas, integrated care can bring extra opportunities and offers health care systems the possibility to balance each others weaknesses and strengths. In our example for rheumatoid arthritis, historic differences between Belgium and the Netherlands for instance can combine the diverging attention for cure and care as well as the different capacities of health care services in both countries. We believe that balancing can enhance integrated care across borders. Moreover, we believe that cross border care enhances tailor-made care, while the integration of health services enhances cross border care.

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