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Actief in Gezondheid

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Our ref.	A.245 B06.12.12 J.G.	Welfare and Sport
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Subject: National consultation

Sittard, 12 December 2006

Mr van Rijn,

At the meeting on 22 November 2006 in connection with the national consultation it was agreed that all the participants should submit their opinions and ideas in writing to your Ministry. With this letter we are fulfilling this agreement, on behalf not only of ourselves (the health care insurance organisation "CZ Actief in Gezondheid") but also on behalf of "OZ Zorgverzekeringen".

Our opinions and ideas are based on the following views and principles concerning cross-border care:

1. EU citizens must have simple access to health care in another Member State and have legal certainty concerning their health care entitlements within the EU.

2. The individual's health care insurer is the most appropriate body for providing information and advice on his entitlements to cross-border health care and on how best to exercise these entitlements.

3. EU Member States must facilitate claims on their health care system by citizens from fellow Member States. Adopting a protectionist policy with regard to their own health care system will turn out to be counterproductive in the long term.

4. EU legislation should not be developed on the basis of incidents, exceptions and regional problems. In our view, therefore, legislation should not be the primary route for resolving problems regarding cross-border health care.

5. Quality of health care
The country providing the health care is responsible and answerable for the quality of the health care delivered. This principle also applies if the location providing the treatment makes use of expertise from other Member States ("expertise" may also include modern technology).

6. Cross-border health care differs depending on the underlying care need and/or the category to which the insured person belongs, viz:
   - emergency treatment
   - planned treatment
   - specific target groups (cross-border workers, pensioners who have settled abroad, etc.)

A tailored approach needs to be adopted for each category and target group, based on the fundamental principle that the EU citizen must be served as well as possible, regardless of any conflicting interests between Member States.

7. Hospitals, (potential) centres of expertise and/or centres of excellence must be encouraged to subject their business case to a balanced business economics evaluation.

Each of the above principles is expanded upon below. Where possible the problem encountered is briefly described and a possible solution suggested. And where appropriate, possible EC actions are suggested.

Re 1 Easy access to health care and legal certainty.

Regarding access to cross-border health care, a distinction is made between emergency treatment and planned treatment.

Emergency treatment

The EHIC is primarily intended to give EU citizens the certainty that, if they should require emergency treatment during a temporary stay in another EU Member State, they will be able to obtain the necessary treatment in accordance with the entitlements existing in that country.

Problem:

- The EHIC has not been sufficiently taken up by EU citizens.
- The EHIC is not sufficiently accepted by foreign health care providers.
- There is little support for the EHIC from the health care insurers, because it generates disproportionately high costs in relation to the added value it offers.

Solution:

- Take-up by EU citizens.
  EU citizens staying temporarily in another country should not need to carry a separate card in addition to their local/national "*zorgpas*" (healthcare card). Accordingly, the EHIC should be incorporated as an electronic version (eEHIC) into the local/national "*zorgpas*" (healthcare card). This would involve the EHIC data set being stored in a universally readable way on the smartcard issued by the individual's own insurer. As long as smartcards remain widely used the EHIC should feature on the reverse of the local card, in accordance with the European standard.

- Acceptance by foreign health care providers.
  To reassure health care providers that payment is guaranteed under the terms applying in the country of treatment, development of a powerful credit-card-type EHIC logo at European level (along the lines of the MasterCard or Visa logos, for example), that will be recognised everywhere in Europe. This logo will feature on every local/national healthcare card within the EU.
  Additional European legislation will ensure that if, having been presented with a card bearing such a logo, the health care provider still demands full payment from the EU citizen, this will be classed as an economic offence.

- Support from the health care insurers.
  Support for the EHIC from health care insurers must be improved if the health care provider is to be able to check the insurance entitlement online with the help of the EHIC. The result will be that the card no longer needs to show an expiry date and thus no longer needs to be renewed periodically. This online checking is currently being tested in a number of Netc@rds pilot regions.
  www.netcards-project.com

Planned treatment

CZ's experience over the years in the German/Belgian/Dutch border regions is that simple access to cross-border care is valued by all players directly involved. For the insured person it means freedom of choice and an additional service (the nearest hospital is sometimes located in the adjacent country), for the health care provider it means extra income, a higher profile and healthy competition, and for the health care insurer it means distinctive capacity

and countervailing power when purchasing care.

The access to health care in the border regions that CZ currently offers citizens takes various forms (sometimes a specific card, sometimes online checking). In the longer term, however, good possibilities are also foreseen for the EHIC as a means of access to planned cross-border care. Border regions and Euregios are excellently placed to gain experience with this and to develop good practices "bottom-up". The Euregios Maas-Rhine, Maas-Rhine-North and Rhine-Waal will certainly want to take the lead here.

The EC's contribution:
The European Commission's contribution in this area must be directed towards:
- promoting the incorporation of the eEHIC onto local cards, with a transitional situation in which the EHIC is incorporated onto the back of the local/national card,
- developing an EHIC logo with the power of the MasterCard/Visa logo,
- developing legislation introducing the concept of "economic offence",
- promoting a European health care infrastructure based on a European protection policy, making it simple to check entitlements online. An example of good practice here is Vecozo in the Netherlands (www.vecozo.nl),
- helping border regions and Euregios to gain experience with the use of the (e)EHIC for planned treatment.

Re 2. Information regarding cross-border health care.

Problem:
For the average insured person it is difficult enough interpreting his entitlements regarding health care at home, let alone his entitlements abroad. The latter are usually a blend of policy conditions, local arrangements which his insurer may have made with foreign health care providers, and international regulations, treaties and case law. In addition, the category into which he falls can also play a part. Examples are the cross-border worker, the student or the pensioner who has settled abroad.

Solution:
The insurer must give the insured person accurate and reliable information about his (policy) entitlements and the way in which he can best exercise these entitlements. This also applies *mutatis mutandis* to cross-border care entitlements.

In addition to the insured person, the health care provider must also be informed about the provision of health care to foreign patients, partly in his own interests but primarily in the interests of the person insured abroad, who does not want to be faced with any obstacles in terms of his treatment and/or the administrative procedures because of his foreign origin. This too is a (regular) task for the local health care insurer.
In the Euregio context (Germany, the Netherlands and Belgium) a model project is currently being implemented in the form of the Euregio health portal. www.euregiogezondheidsportaal.nl

The EC's contribution:
The EC's contribution could focus on promoting initiatives to provide content and information regarding cross-border care. We are thinking here, inter alia, of the eContentPlus funding programme, which is not (as yet) open to eHealth projects.

Re 3. EU Member States must facilitate claims on their health care system by citizens from fellow Member States. Access to health care must in principle be open for EU citizens. EU Member States must therefore do their utmost to support this principle.

Problem (in the Dutch-Belgian context):
For a number of years now, CZ has been concluding contracts direct with Belgian hospitals. This has been found to be an appropriate and effective alternative to the bureaucratic E112 procedure.
In addition, it makes effective care management possible.
For the treatment provided, CZ pays rates in accordance with those laid down in the *Belgische Nomenclatuur*.
The insured persons (in the border region), the specialists and the hospitals all regard this

system as extremely positive and efficient.
It now turns out that the Belgian hospital-funding system has a negative impact on the profits made by hospitals from care provided on the basis of contracts with a foreign agency. Care provided on the basis of the E112 form does not have this financial disadvantage, but it does have other disadvantages (see below).

This threatens to derail the continued use of a contracting model regarded as excellent by all parties. Making adjustments to the hospital-funding system in this area, or allowing cost-covering fees to be invoiced for health care provided to Dutch nationals (which would mean fees at a higher rate than laid down in the *Belgische Nomenclatuur*), is seen as undesirable by the Belgian competent authorities from the point of view of price discrimination.

A second problem is the Zeeuws-Vlaanderen scheme. Citizens living in the Zeeuws-Vlaanderen region of the Netherlands benefit from an expanded E112 scheme which gives them access both to inpatient and outpatient specialist assistance in Belgium.
The Belgian and Dutch competent authorities are considering scrapping this (tolerated) scheme.
Technically, if the Zeeuws-Vlaanderen scheme were to be scrapped, Dutch insured persons would only be able to use the E-112 entitlement for planned care. The Müller-Fauré judgment, however, is restricted to non-hospital care and as such does not offer an adequate replacement for their present entitlements.
In addition to this difficulty, the strict application of the E-112 option has the following disadvantages:

- a significantly increased administrative burden
- delays in invoice processing
- as a result of the severe delays in invoice processing, invoiced amounts can no longer be entered in the no-claim own-contribution processing. Nor can these costs be entered in good time in the high-costs offsetting scheme.
- the Dutch insured person is faced with (high) patients' own contributions applicable in Belgium.

For the Zeeuws-Vlaanderen scheme too, CZ sees the model based on direct contracts with Belgian hospitals as an excellent alternative. However, in the Belgian hospitals this model comes up against the funding problem described in the previous paragraph.

Solution:
As all the players directly involved (patients, specialists, hospitals and health care insurers) view the direct-contracts model as the most desirable system, and in view of the difficulties linked to the E112 procedure, reverting to the E112 system is not an option.
The beginnings of a solution are therefore seen in a CZ pilot project with a Belgian hospital, over a period of one to two years, with the agreement and support of the Belgian competent authorities.
The starting point for this pilot project will be a contract concluded between the hospital and CZ for the provision of health care to persons insured in the Netherlands in return for payment at rates which cover the costs (and which are in line with Dutch market costs).
The aim of the project is to gain an objective insight into all the pros and cons in a controllable practical situation.

To achieve this objective, during the pilot project:

- the cost structure of the care provided by the Belgian hospital will be made transparent, with the help of the Dutch DBC model (DBC = Diagnose Behandeling Combinaties = diagnosis treatment combinations) ,
- on the basis of this cost structure, real (market) prices will be paid by the Dutch health care insurer, even if these differ from the *Belgische nomenclatuur*,
- Belgian hospitals will not be financially penalised for being paid these cost-covering rates,
- the effects will be monitored on the basis of maximum transparency,
- the pilot will be evaluated on the basis of pre-determined criteria. The evaluation will provide the basis for the development of a structural model of good practice which can be further rolled out in the Belgian-Dutch context and possibly also be usable by other regions in Europe.

The EC's role:
The European Commission must encourage Member States (on the basis of the principle that they should offer "simple access to insured persons from other Member States") to conclude practical bilateral agreements offering the actors directly involved scope to experiment "bottom-up" with efficient and effective cooperation models. Countries which frustrate this basic principle should be taken to task by the competent European authority.

Re 4. EU legislation should not be developed on the basis of incidents and exceptions.

Problem:
Incidents and problems are often the trigger for measures to promote desired effects/prevent undesired effects. Both nationally and internationally, in such cases the solution is commonly sought in legislation and regulation.
Cross-border health care is, and remains, a marginal phenomenon. Consequently, recourse to legislation and regulation should be, and remain, in proportion to the scale of the phenomenon.
Because the situations are so different in different regions of the EU, it is not desirable to resort to blanket European legislation to solve specific “problems” (or, more accurately, “challenges”) in any particular EU region.

Solution:
Generally speaking, the existing legislation and the related case law provide an adequate framework for resolving health care entitlement issues. In other words, with the exception of one or two subject areas addressed in this letter the solution must not primarily be sought in more legislation.

Where European regions find themselves disproportionately disadvantaged as a result of the general principle that every EU citizen should have simple access to cross-border health care, this should be resolved either by mutual arrangement between the Member States or by the EU on the basis of mutual (financial) solidarity.

The EC's role:
In the case of EU Member States that suffer a disproportionate financial burden, European pooling of costs that exceed the standard rate could be an option.
Such pooling would also serve to accentuate the mutual solidarity between the EU Member States.
Where the burden suffered is primarily of an organisational nature, local solutions should be sought and, where possible, encouraged by the EU (e.g. encouragement of a selective establishment policy)

Re 5 Quality of health care

Problem:
Selecting a care provider on the basis of quality is difficult enough for an EU citizen in his own country, never mind in another Member State.
Even more importantly, he needs to know how to obtain legal redress against the health care

provider if the quality of the care provided falls below expectations, and which country's legal system applies.
In addition, he needs to know more, certainly if the health care he seeks in a foreign country is planned, about what the possible (later) consequences could be. This is certainly true if he is going to need follow-up treatment in his own country. Points to be considered here include the communication between the patient's own doctor and the treating doctor, and Member States' differing policies on the prescribing of antibiotics. This latter issue in particular can cause a great deal of inconvenience for patients who receive treatment in countries where the prescribing of antibiotics is not rational or is less rational, and who are subsequently re-admitted to hospital in a country with a rational prescribing policy.

Solution:
The first step is to make sure accurate and reliable information is available to, and is circulated to, EU citizens.
The information platform mentioned at the point "Re 2" regarding cross-border health care is a suitable instrument for this. Especially where the insured person deliberately elects to have treatment in another Member State, he needs to be able to weigh up the pros and cons properly.
His health care insurer could support him here, by providing objective criteria on which to base his decision. Once the choice has been made, part of the responsibility must also be shouldered by the insured person himself.

Where it is (still) insufficiently clear at European level how liability stands in the case of (poor) medical service, additional European legislation has a role to play. New technologies such as telemedicine must also be anticipated in this connection.

With regard to the rational prescribing of antibiotics, there are initiatives at both European and euregio level (e.g. ECDC and Euregio Maas-Rhine). As the European-level initiatives are not expected to produce results until the longer term, there are better and more effective prospects in the euregio border regions. And it is precisely in these regions that the scale of the problem is biggest.

The EC's role:
In addition to (re-)evaluating the quality and liability aspects at European level, the EC should be able to develop initiatives geared towards:

- creating a universal communication protocol (prepared in a digital version) for the patient's own doctor and the treating doctor, the better to ensure the continuity of the care,
- speeding up European harmonisation/convergence in the field of antibiotics prescribing policy, and supporting euregio projects in this field.

Re 6. Cross-border health care differs depending on the underlying care need and/or the category to which the insured person belongs, viz:

- emergency treatment
- planned treatment
- specific target groups (e.g. cross-border workers, pensioners who have settled abroad, etc.)

Emergency treatment and planned treatment have already been adequately discussed above.
That leaves the category of specific target groups (cross-border workers, pensioners who have settled abroad, foreign seasonal workers, etc.).

Problem:
In the majority of cases these specific target groups experience obstacles arising from the fact that the health care (insurance) schemes of their countries of origin and of residence are not aligned.
Here too, the basic principle is that the citizen must be able to exercise his right to health care in the foreign country. Where this is hampered as a result of non-harmonised schemes and systems, the Member States involved should bilaterally find a solution to the problem, without causing any hindrance to the EU citizen. The increasing mobility of European citizens will tend to increase rather than reduce the scale of this problem.
In its day-to-day work, CZ has experience of certain problems in this field, and these are discussed in more detail in the annex to this letter. (see Annex).

As well as the abovementioned target groups, it is not inconceivable that entitlement to treatment in more than one Member State could lead to some of the more calculating EU citizens indulging in selective health care tourism.

Solution:
Where no attempts are being made in Europe to harmonise health systems, these problems must be accepted. The problems should therefore not be solved via the EC but between the Member States concerned. In view of the often lengthy bureaucratic processes, provisional decisions should be taken for citizens, to ensure that they do not suffer legal uncertainty and/or negative financial consequences. Once an agreement has been reached, the Member States can, if relevant, reapportion the costs already incurred between themselves.

As regards the less acceptable form of health care tourism, the question arises as to whether these (possibly unintended or undesired) effects should be countered with (incident-prompted) legislation or should be accepted as inherent to the choices made in Europe. Here too, recourse to legislation should be kept in proportion. Consideration could be given to ensuring that where a Member State is disproportionately affected, European solidarity could compensate that State.

Re 7 Hospitals, (potential) centres of expertise and/or centres of excellence must be encouraged to subject their business case to a balanced business economics evaluation.

Problem:
In practice, care providers within a Member State often make substantial investments in human and material resources, geared towards innovations and specific skills, while the same sort of thing is also happening just across the border. In a commercial setting this phenomenon (even within one country) is normal and is often based on deliberate strategic assessments. However, since health care is predominantly financed from the public purse, this sort of approach within the health care sector must be viewed as wasteful rather than normal.

Solution:
Increasingly, economic principles must be applied in the health care sector too. The question whether to invest alone, or to share the investment (and hence also the results of the investment) with partners, is one that hospital management boards must increasingly ask themselves.
A secondary advantage of competition is that the bar must be set high in order to gain pole position within the market. We also need this trigger within the health care sector.

Against this background, it seems wisest not to focus on enforced cooperation but instead to develop incentives that promote cross-border cooperation and networking.

On a small-scale, within the euregions there are several examples of good practice geared towards cooperation, resource-sharing and knowledge-exchange, involving cross-border hospital projects and university hospitals. Examples are the cooperation between the Radboud hospital (NL) and the hospital in Moers (D), or the cooperation between the Academisch Ziekenhuis Maastricht (NL) and the Klinikum in Aachen (D).

The EC's role:
Both national governments and the EC have a role to play in promoting cross-border cooperation between partners, both in the euregions and on a cross-European level, as well as the opportunities and the instruments for doing so. A policy of restraint with regard to enforcing cooperation will result in better innovations in the long term.

Although we have not addressed all the issues raised in the consultation paper, we hope that this response represents a constructive contribution to the national consultation.
By amalgamating our reactions with the others that you receive, you will no doubt be able to deliver a contribution from the Netherlands to the European Commission that addresses all the issues raised.
We look forward with interest to seeing it.

Yours sincerely,

M.A.M. Leers
Chairman of the Board

CC. Zorgverzekeraars Nederland
AIM
dh r. J.G.H. Draijer
drs. N. Stiemer

Annex: 1

Annex

This Annex presents a brief overview of problems we have experienced arising from the lack of harmonisation between (Member) States' healthcare systems (See the point, "Re 6" in our letter)

Cross-border worker problem, Germany and Belgium:

* Unmarried persons covered by the insurance of cross-border workers.
  Unmarried persons covered by the insurance of cross-border workers (living in the Netherlands and working in Germany) cannot obtain a KV-Karte (German health insurance card) and cannot therefore avail themselves of health care in Germany and must therefore use the EHIC/E112.

* Dutch cross-border workers working in Belgium
  Dutch cross-border workers working in Belgium cannot take out supplementary hospitalisation insurance and are therefore faced with paying a high non-refundable personal contribution towards their medical costs.

Germany:

* Private insurance for Dutch residents earning low incomes in Germany (part-time employed).
  Residents of the Netherlands who work in Germany and earn less than € 400 per month are not obliged to take out insurance in Germany. In the Netherlands they are not subject to compulsory insurance under the AWBZ (Exceptional Medical Expenses Act), nor, consequently, under the *Zorgverzekeringswet* (Health Care Insurance Act), because of their foreign income. The drawback for these individuals is that, although on a low income, they must take out (expensive) private insurance (usually in Germany). Undesirable consequence: they give up working abroad.

* Double insurance for individuals working in the Netherlands and entitled to unemployment benefit in Germany.
  Residents of Germany who work in the Netherlands, and also have entitlement in Germany to partial unemployment benefit are doubly insured.
  In the Netherlands they are subject to compulsory insurance under the *Zorgverzekeringswet* (Health Care Insurance Act) because of the wage they receive for their work. Germany, however, imposes the rule that these individuals are also subject to compulsory insurance in Germany because of a benefit payment of more than € 400 per month. Although insurance in the Netherlands because of the wage they receive for their work takes precedence (to which purpose CZ issues an E106 form), this is not confirmed by the German Krankenkasse, because of the statutory insurance obligation in Germany Without this confirmation no insurance cover can subsequently be taken out. The same problem arises for individuals who, for example, have a number of weeks' unpaid leave during the construction sector annual holiday and are officially still in employment but also apply for unemployment benefit in Germany.

General:

* Issuing and verification of the BSN (*Burger Service Nummer* = Citizen Service Number) by the Dutch Tax Administration.
Foreign workers coming to work in the Netherlands for the first time must apply to the Tax Administration for a BSN (*Burger Service Nummer* = Citizen Service Number).
At the times of the year when seasonal work is available, the waiting time for a BSN number can be in excess of six weeks.
The legislation prevents us from registering these foreign workers before they have been issued with this BSN identification number, which means that they spend weeks uninsured.
Even at less busy times of the year, the average waiting time is four weeks.
The Tax Administration makes arrangements with the job agencies allowing these workers to start work before they have received their BSN identification number, as a result of which they find themselves performing (often high-risk) jobs without any insurance cover.

  In addition to the delays in the issuing of the BSN number, this number, after having been submitted to CZ, also has to be verified by the Tax Administration. Since there are no clear agreements about this, it takes months before CZ can present a file with BSN numbers for verification. During this period, these foreign workers are also not in possession of any (official) proof of insurance (policy document with BSN number and CZ insurance card). They do admittedly receive a policy document without a BSN number, but the Tax Administration does not regard this as constituting sufficient proof for entitlement to *Zorgtoeslag* (translator's note: this is a rebate in compensation for having to pay higher insurance premiums).

* Verification of compliance with compulsory insurance under the AWBZ (Exceptional Medical Expenses Act) / *Zorgverzekeringswet* (Health Care Insurance Act)
Especially in the case of foreign workers who are working temporarily in the Netherlands and who remain registered at their main address in their country of origin (e.g. Poland), it is not possible to verify the accuracy of the employer information given on the application form. The temporary address does not need to be given, and nor is it. It is not possible to confirm directly with the municipality or with the tax office via a BSN check whether an individual is illegally working in the Netherlands or is wrongfully claiming to have complied with the insurance obligation on the basis of an old BSN number. It used to be possible to check electronically (RINIS) and via paper employer declarations. But now that these are no longer issued/requested, verifying whether individuals have complied with their health care insurance obligation has become difficult, not to say impossible. Another problem is the deregistering of any worker who has registered individually with CZ and does not therefore come under a collective employer, as a result of which CZ must find out from the individual himself whether the employment relationship (= legal basis) is still valid. A second problem concerning compulsory AWBZ/ *Zorgverzekeringswet* insurance) concerns stand-by workers (i.e. workers called in by the employer only when he has work available for them). Foreign workers are only paid when they actually work. At the same time, they are not registered with the UWV (body responsible for implementing employee insurance schemes). Hence, they have no insurance if they fall ill.

* Work-placement trainees and housewives residing abroad but working part-time in the Netherlands.
These categories often work only a few hours in the Netherlands, or they receive a minimal work placement allowance. However, under the new *Zorgverzekeringswet* (Health Care Insurance Act) they are required to be insured. Work-placement trainees usually earn around € 200 per month, and find themselves having to spend at least half of that on their insurance, while at the same time they are often still covered under the insurance of their family or partner in their country of residence.

* Pensioners who have settled abroad.
A known problem: pensioners who have settled abroad.

The individuals concerned were originally privately insured and must now use the "*woonlandpakket*" (the "country-of-residence package") in their country of residence.

* Posted workers, the self-employed and expatriates
The legislation regarding this group of individuals has proved to be unclear.
Such people were previously privately insured, but now they must take into account the many rules relating to secondment.
Moreover, businesses themselves often do not know what the rules are, which makes obtaining the correct information a lengthy process.

* Students aged under 30 coming from abroad
Insurance is not compulsory for this group, nor can it be obtained. There is a great deal of misunderstanding, as those involved think they can claim compulsory insurance entitlement on the basis of their being registered in the GBA (the Municipal Personal Records Database). If they take up a job, however, then insurance does become compulsory.

* Issuing of E-forms
Issuing of the E-106 (or the Tur-106) to obtain the CZ agreement policy (CZ body of the place of residence) by countries such as Austria, Ireland, Greece, Spain, the UK and Turkey to the insured person going to work in one of those countries is a tortuous process. We either do not receive the form at all, or only very belatedly or for short periods, as a result of which gaps occur in insurance periods.
This defective procedure results in individuals often being doubly insured or not insured at all.

* Retired employees of international organisations
Retired employees of international organisations with an AOW (statutory old-age pension) are not eligible for AWBZ (Exceptional Medical Expenses Act) insurance and are therefore also not obliged to be insured under the *Zorgverzekeringswet* (Health Care Insurance Act). Members of their families, however, are subject to compulsory insurance under these two Acts.

There are many unclear issues with regard to this group.