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GUEST EDITORIAL

Cross-border health care in the European Union

An introduction

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In December 1985, the governments of the 12 member states of the European Community signed the Single European Act. This path-breaking act prompted the vision of 'Europe after 1992', with a single market for goods, services, labour and capital. It also paved the way towards further economic integration as set out in the Treaty of Maastricht of December 1991. Health care has been hypothesized to be affected by the '1992' measures in a number of ways, for example by the harmonization of drug approval procedures and by the opening of national insurance markets, including supplementary private health insurance.[1] Yet, throughout the efforts for economic integration, it has also been clear that the social security systems of the member states differed too much to be harmonized. Only the Union-wide concern about unemployment puts social security on the agenda, in the form of economic pressure to keep the statutory charges under control. Between member states, the exchange of health care, which is covered publicly or by social health insurance, remained a matter where different systems were to be coordinated. In fact, Community-wide rules governing cross-border health care were established a long time before the Single European Act and have not changed significantly since.

Accordingly, questions arise as to how this regulation performs in the context of increased European integration. If pharmaceuticals and supplementary health insurance may be sold throughout the European Union (EU), why not bypass surgery and hip replacements for socially insured patients? Of course, health care is a personal matter in which a familiar environment may play an important role for the patient, while cross-border care requires the patient to move to the provider. No-one would expect levels of trade between member states that correspond to easily tradable goods and services. Yet, under certain circumstances, trade of health care may very well occur, for example when specialized care is not available in one member state, but is in another; when waiting lists are significantly shorter elsewhere and when elective care is significantly less expensive across the border. In all these cases, cross-border care may become an interesting alternative to patients or to their insurers. Cross-border care also gains in relevance when mobility between member states increases due to tourism, business mobility or other short-term stays. Cross-border care is furthermore of high interest to cross-border workers who live near the border in one member state, but work – and are thus insured – in another. The existence of a health care market wider than the national one involves opportunities and risks. On the one hand, it increases the supply of health care and may reduce differences in the care actually available. It may also ease the conditions for general mobility within the EU. By increasing supply and competition, it may even play a special future role in those systems which are based on the principle of purchasing care. On the other hand, an increase in such trade in health care may cause coordination problems in its administration and may loosen the control of capacities and expenditure in national health care systems.

Given this, questions emerge over what the current level of exchange of health care between member states is, what its rules are, its implementation, its determinants and its prospects. During the last 3 years, these questions have been tackled by a group of researchers who joined the Concerted Action 'Health Care Financing and the Single European Market' (SEM project). This coordination research project has been funded under the BIOMED1 Programme of the European Commission, which is gratefully acknowledged. Six papers by the working group on cross-border care are presented here (other results of the SEM project are forthcoming[2]). The 6 papers comprise contributions from health services research, law, economics and the social sciences. They offer basic theoretical analysis, empirical research based both on routine and on survey data and various evaluation techniques. Together, they shape an interdisciplinary body of public health research and represent the first comprehensive attempt to investigate the issue of cross-border care.

A general overview is presented by the team led by Hermesse.[3] Their paper introduces the regulation of cross-

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border care in the EU with respect to socially insured patients and elaborates a detailed analysis of the most comprehensive data available, the aggregated documentation of national claims between member states which is collected in Brussels. The paper shows which are the most important categories of entitlements and care and which countries lead in terms of the demand and supply of cross-border care. This overview is followed by basic legal and economic research. In his deeply rooted analysis of the right to health care, of which cross-border care can be considered one example, Hermans[4] explains that this right is now increasingly considered a fundamental social right. This right is, however, constrained by the available financial means. In cross-border care, the tension between this social right and constraints upon it is mainly resolved informally by panels of physicians. Results vary widely and in some cases lead to law suits and court decisions, thus reflecting a lack of a more uniform legal basis. On the economic side, France[5] investigates cross-border care in terms of international trade theory. Improvements in the quality of care received are considered the most relevant determinant of demand. The approach is operationalized and its empirical relevance is first exemplified using health care trade between regions within Italy. This analysis of the behaviour of Italian patients is then applied to the analysis of cross-border care and it is stated that the approach is suitable for explaining the significant level of health care imported by Italy from other member states.

In the second part, papers examine case studies. As a privileged group of European citizens, frontier workers are free to choose their health care on both sides of the border on which they live. Calnan et al.[6] surveyed more than 540 residents of the frontier zones in northern France and Belgium. The knowledge and attitudes of frontier workers with respect to cross-border care are analysed as well as patterns of actual utilization. The findings indicate that, to some extent, information gaps exist with respect to the rights to and the mechanisms of cross-border care. The authors also found that attitudes towards this type of care differed between member states and that satisfaction with domestic care is an important determinant in seeking help abroad. In another case study in a border region, Starmans et al.[7] investigated cross-border care from the perspective of 4 hospitals in Belgium, Germany and The Netherlands. As opposed to simple hypotheses about the level of cross-border care, it is shown that this type of care is influenced by a wide range of partly promoting and partly constraining determinants. These determinants also differ according to the country of origin of the patient. At the end of the study, the project hospitals and insurers active in the region began further cooperation across the border, possibly changing the future shape and level of cross-border care.

The last paper tackles the problem of there being very little comparative information available on health care products and their characteristics in various member states. From an economic perspective, differences in price and efficiency of health care can, next to quality, be considered an important incentive to the trade in services. Starting from this proposition, Rhodes et al.[8] investigated to what extent prices and efficiency levels can be compared between member states in the case of hospital care. Referring to products which could be subject to cross-border care, they selected 5 in-patient treatments and compared, in 9 member states, the administrative prices to be paid for these treatments as well as average length of stay. This comprehensive endeavour could only be achieved by intensive cooperation with another Concerted Action of the BIOMED Programme, the CAMISE project ('Hospital Use, Case Mix, and Severity'). This project has built up a European research network and database for diagnosis-related groups, the classification system used to specify the 5 hospital products. The methodological problems of making comparisons of hospital products are explored and the study indicates that substantial differences in price and efficiency might exist between the member states investigated.

The results of our working group show that cross-border care is not a central issue in European health care systems. Its level is still low, many constraining factors play a role and its current impact remains restricted. Cross-border care is, however, by no means to be denied as an important issue in some circumstances. Its relevance to patients, both in emergency cases and in those cases where patients are unable to receive timely and qualitatively appropriate care in their national systems, should not be underestimated. Cross-border care is also of considerable relevance to those living on the borders of their home state. Finally, three factors are likely to increase the relevance of cross-border care in the future. First, the mobility of persons within the EU can be expected to rise with increasing integration of the community. Second, competition within national health care systems is also increasing. This may make purchasers of care and insurers think and act on more than a national scale. Third, the possible extension of the EU is likely to widen the differences in the amount and quality of services available at the national level. All three factors may promote cross-border care. Policy concerns at the EU level, but also in national administrations, can be directed at improving the information basis about health care across borders, at supporting cooperations in the border regions and at considering more explicit policies on this type of care. Because health care systems remain a matter of national responsibility, the framework the EU sets for the regulation of cross-border care in an economically integrated community is an important feature of European health policy. The following research introduces us to some of the crucial issues involved.

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