

AIM feedback on “Cross-border healthcare – evaluation of patients’ rights”

I. Introduction

The not-for-profit health insurance funds and health mutuals of AIM have been deeply involved in the legislative process of the cross-border healthcare directive and in its implementation. They cooperate with their European neighbours when it comes to reimbursement of cross border healthcare. The pandemic has shown the crucial added value of the cooperation between hospitals and health professionals between EU countries, in particular at cross-border level (e.g. Germany and France). That has proven the importance of cross-border cooperation in healthcare and the need to maintain EU internal borders “open” during the crisis, to ensure access to health to cross-border populations.

The legal framework on cross border healthcare is very complex because of different legislation at national and at European level. Not-for-profit health insurance funds and health mutuals are involved in numerous projects at national and euregional level, which serve to facilitate cross-border health care with the neighbouring countries in terms of patient and health professional mobility and cooperation with/between hospitals (e.g. ZOAST¹, GeKo SaarMoselle). In addition, contracts with hospitals in the neighbouring countries were concluded (e.g. in Belgium and the Netherlands). Nevertheless, health mutuals in charge of compulsory health insurance, have always favoured the application of Regulation 883/2004 in the context of cross-border healthcare because it provides the maximum price security for the patient, this should still be the case in the future. Crossing the border to access healthcare might be necessary for some patients (e.g. patients with ultra-rare diseases). AIM members point out that, especially for these patients but also for others, digitalisation will facilitate treatments by allowing patients to benefit from knowledge abroad without having them to travel. The expertise is centralised, and the treatment is as nearby and local as possible. However, this does bring on new challenges in reimbursement and the need to regulate telehealth and its reimbursement. With this paper, we point out some obstacles that still exist today:

II. Recommendations

1. Access to cross-border healthcare can't be seen separately anymore from telemedicine. We need regulation and the creation of a level playing field in Europe on providing digital consultations in which the digital provision of services by healthcare professionals should be bound to tariffication (and quality) of the country of a patient (not the location of the healthcare professional).
2. Pro-actively informing patients should consider the following: Healthcare professionals should inform patients in advance whether care takes place within a public or private healthcare facility/ context. Healthcare professionals should always provide patients from

¹ EMRaDi (expertise « mobility »), GeKo SaarMoselle (GeKo-SaarMoselle-resume-FR.pdf (interreg-gr.eu); 580.914.001.001.1949_CZ_Infolder_Zorg_in_Belgie_en_Duitsland_2017.indd).

another member state with a cost-estimation before they cross the border to access healthcare.

3. Collaboration between public health bodies, healthcare providers and health insurance funds and their members is necessary to identify hurdles and develop solutions.
4. There is a need to secure that health insurance funds and health mutuals are more inclined to use the regulation and if not possible to get a minimum of reimbursement for the affiliates in private health hospitals using the Directive.
5. There is a need for comparable data based on international standards to help Member States to identify the national care needs.
6. There is a need to simplify the legal framework for patients and for professionals.
7. Information to patients needs to be continued and patients are advised to pro-actively consult and engage with their mutual/health insurance fund to examine their cross-border mobility.

III. Main obstacles

1. Reimbursement of cross-border healthcare

- Patients do not know about their reimbursement rights.
- When going cross-border, there are sometimes substantial out-of-pocket expenses, patients find the administrative procedure burdensome. Patients should be encouraged to pro-actively contact their health insurance fund/mutuals to discuss their patient mobility need (to avoid out of pocket payment).
- When it comes to rare diseases the expertise to diagnose or set up a treatment for a rare disease isn't always be possible on the spot: It should be encouraged that *knowledge travels*. At national level a number of tele-consultations at reduced fees should be made available. This is in addition to the existing regular consultations and should also be considered in the context of European reference centres for rare diseases.
- High-cost medicine: Because they are expensive, the procedures of getting medicines reimbursed are harder than it is for medicine administrated for common diseases.

2. More risks concerning reimbursement caused by the directive

- Immediate payment by the patient to the healthcare service provider in other Member States is prerequisite. The reimbursement follows later.
- Not everyone can afford it.
- Risks for patients regarding reimbursements – e.g., if prices abroad are higher.
- Cross border health care providers set their own price and not the price agreed in the public system – the difference has to be paid by the patient
- Additional costs due to unexpected complications
- Additional costs of accommodation, translations, travel expenses

3. Complexity of the legal framework

- An additional procedure of authorisation (through the Directive) makes the legal framework even more complex: Using the reimbursement of the directive is a big risk of no or limited reimbursement in the compulsory health insurance.
- Little awareness or 'literacy' of patients regarding reimbursement, or from whom they could get help to answer their questions. There is a need to empower national contact points.

4. Lack of data

- No clear, complete & comparable statistics on regulation & directive
 - Sometimes there is no differentiation between urgent and non-urgent care
 - Some Member States do not differentiate between the regulation and the directive
- Some Member States do not deliver any data because there is no legal basis that country
- There is a lack of international standards of data registration, which hampers cross-border exchange of data.



AIM Healthcare and social benefits for all

The International Association of Mutual Benefit Societies (AIM) is an international umbrella organisation of federations of health mutuals and other not-for-profit healthcare payers. It has 57 members from 30 countries in Europe, Latin America and Africa and the Middle East. 33 of its members, from 20 countries, are based in the European

Union. AIM members provide compulsory and/or supplementary health coverage to around 240 million people around the world, including close to 200 million people in Europe, on a not-for-profit basis. Some AIM members also manage health and social services. Collectively, they have a turnover of almost €300 billion.

AIM members are either mutual or health insurance fund.

They are: private or public legal entities; solidarity based; not-for-profit oriented organisations: surpluses are used to benefit the members; democratically-elected members play a role in the governance of the organisation.

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