Managed by the Association of European Border Regions by an Action Grant (CCI2017CE160AT082) agreed with the Directorate General of Regional and Urban Policy, European Commission. Financed by the European Union.

b-solutions

FINAL REPORT BY THE EXPERT

Advice Case: Cross-border healthcare and the reimbursement of cross-border healthcare costs
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1. Description of the Obstacle

1.1 The obstacles as presented by Provincie Zeeland

Zeeuws-Vlaanderen is a Dutch region located on the border with Belgium. The shrinking and aging population of the region brings unique set of problems causing the deterioration of healthcare. Often Belgian inhabitants seek care across the border in the Netherlands due to its territorial proximity.

However, ZorgSaam, an organisation providing healthcare in the Dutch region of Zeeuws-Vlaanderen, has indicated that there is an obstacle hindering the cross-border access of Belgian residents to Dutch healthcare services. Often these people insured in Belgium are unable to receive reimbursements for their planned medical care in the Netherlands, for which they need a permission from their Belgian health insurance company. As a result, the cross-border access to healthcare for inhabitants of the border region is limited.

Arguably the obstacle applies to the whole Dutch-Belgian border region. Removing the obstacle would increase the access of citizens to health services in the border regions.

1.2 Analysis of Existing Obstacles by the Adviser

In the absence of a more detailed problem statement, this report provides an overview under which grounds Belgian inhabitants may seek healthcare across the border: more specifically, under which grounds prior authorisations for planned healthcare should be granted and reimbursed. For this purpose, it is relevant to look at EU legislation: Regulation 883/2004 and Directive 2011/24, both providing rules on planned care, and to examine the conditions on prior authorisation.

In addition, the report *Niet aanpassen maar afwijken*[1] specifies, and as presented by the Provincie Zeeland, there are some obstacles due to the differences in the way invoicing takes place in the Dutch and Belgian healthcare systems. In the Netherlands, billing is based on a product package of *diagnose-behandelcombinatie* (DBC), while in Belgium every treatment is subject to separate billing.[2] Therefore, it is necessary to examine whether this obstacle is leading to refusal of reimbursement in these cases.

Furthermore, it will be relevant to look at the implementation of the Directive in Belgium, and whether Belgian law provides additional routes for Belgian inhabitants seeking cross-border healthcare in the Netherlands.

[1] Rijksoverheid, *'Niet aanpassen, maar afwijken - Verslag van de bestuurlijke werkgroep grensbelemmeringen'* 20 October 2020, Section 3.5.6 *Kosten grensovershrijdende zorg.*

[2] More information on the Belgium invoicing: https://www.health.belgium.be/en/health/taking-care-yourself/patient-related-themes/cross-border-health-care/invoices-and-prices.

2. Indication of the legal/administrative dispositions causing the obstacle

Cross-border healthcare occurs when a person receives healthcare in a Member State other than the Member State where he or she is insured. The social security coordination Regulations (Regulation 883/2004 and Implementing Regulation 987/2009), and the Patients' Rights Directive 2011/24 (based on case law from the Court of Justice) regulate a variety of situations, laying down rules and conditions under which cross-border healthcare may be sought and reimbursed. Next to the EU-instruments, there are contractual agreements between the Member States, and an individual can obtain treatment in another Member State at their own cost or through private insurance. Before looking at how these rules are implemented in Belgium, the following sections present the rules on planned care and prior authorisation under EU law.

2.1 Cross-border healthcare under Regulation 883/2004

Regulation 883/2004 applies, among others, to EU citizens and their family members.[3] The Regulation covers number of social security benefits, including sickness benefits[4], where a distinction can be made between benefits in kind and cash. Benefits in kind, that consist of healthcare, are provided in accordance with the legislation of the Member State of treatment (where the healthcare is received), whereas benefits in cash are provided in accordance with the legislation of the competent State.[5] The problem at hand with this case lays with the benefits in kind: healthcare that the Belgian inhabitants are seeking across the border.

Regarding sickness benefits in kind, the coordination rules in Regulation 883/2004 govern three situations: (i) unplanned cross-border healthcare during a stay in another Member State, (ii) planned care in another Member State, other than the competent Member State and (iii) persons residing in another than the competent Member State. In these situations, the cost of the treatment is covered by the competent Member State. As reported by Zeeland, the issue concerns the second situation, where Belgium inhabitants seek planned healthcare in the Netherlands.

The competent Member State is determined by the rules on applicable legislation. Based on Article 11(1) of the Regulation, the legislation of a single Member State is applicable. Overall, workers are insured by their state of employment (*lex loci laboris*), and inactive citizens by their state of residence *(lex loci domicilii*). In case of pensioners, the Member State of pension covers the costs of the healthcare (*lex loci pensionado*). In some situations, special rules apply, for example, in the case of posted workers[6] or persons pursuing activities in two or more Member States.[7] In this case, the

[3] Art. 2 in conj. Art. 1(c) of Regulation 883/2004
[4] Art. 3 Regulation 883/2004
[5] Art. 21 Regulation 883/2004
[6] Art. 12 Regulation 883/2004
[7] Art. 13 Regulation 883/2004

competent Member State is Belgium – as indicated by Provincie Zeeland, the Belgian inhabitants facing obstacles in obtaining cross-border healthcare are insured there.

When a person intentionally travels to another Member State to receive healthcare, the situation concerns planned healthcare that is covered by Article 20 of the Regulation. In order to be eligible for reimbursement under this provision, the patient needs to obtain an authorisation from their competent institution prior receiving the treatment in another Member State. The institution is obliged to grant the authorisation if it is included in the benefits provided at the competent Member State, and if the treatment could not be given in a medically justifiable time considering the current state of health and the course of the illness of the patient.[8] In case the same or equally effective treatment can be obtained at the competent Member State, authorisation may be refused. This decision must take into account the individual case of the patient. This includes an objective medical assessment of the patient's condition, history, probable course of illness, the degree of pain and/or the nature of the patient's disability.[9] Besides the obligation to grant prior authorisation, the institutions may grant authorisations at their own discretion.

In case prior authorisation is obtained, the reimbursement is provided according to the rates of the Member State of treatment. In some cases, it is possible to obtain the authorisation retrospectively, if in the first place the authorisation was wrongfully refused.[10] In practice, the patient presents a document (S2-form, before known as E-112) to the institution providing the care, obtained from their competent institution.[11]

On the basis of the Regulation, patients are only able to obtain planned healthcare in another Member State with prior authorisation. This changed after the landmark judgment in *Kohll* and *Decker*[12], where the Court ruled that the system of prior authorisation hinders the free movement of goods and services and should be, in principle, prohibited. These rules are now codified into Directive 2011/24/EU. Based on free movement of services, the Directive offers the possibility for patients to obtain care in another Member State without prior authorisation.[13]

2.2 Planned healthcare under Directive 2011/24/EU

Under the so-called "Patient Rights" Directive 2011/24/EU, adopted on 9 March 2011, patients who are insured in their home Member State are also eligible to travel cross-borders to receive treatment in another Member State. Next to conditions on reimbursement of cross-border healthcare, the Directive lays down obligations for the Member State on mutual assistance and cooperation.[14]

[8] Art. 20(2) Regulation 883/2004
[9] Art. 8(5) Directive 2011/24
[10] C-368/98 *Vanbraekel and Others* [2001]
[11] Art. 26 Implementing Regulation 987/2009
[12] C-120/95 *Decker* [1998]
[13] Art. 56 TFEU
[14] Art. 10 Directive 2011/24

The Directive defines healthcare in Art. 3(a) as: *"health services provided by health professionals to patients to assess, maintain or restore their state of health, including prescription, dispensation and provision of medicinal products and medical devices."* The Directive excludes long-term care, organ transplants and public vaccination programs.[15]

Under the Directive, it is possible for patients to receive treatment without obtaining a prior authorisation. However, in situations where healthcare is made subject to prior authorisation in order to ensure sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources, prior authorisation systems may be justified. This may occur when there is a serious risk of undermining the financial balance of a social security system, or when the objective is to maintain treatment capacity of a healthcare provider. The Member States may decide whether they introduce such systems and which healthcare is subject to prior authorisation, following the provisions of the Directive.[16]

To this respect, Article 8(2)(a) specifies that prior authorisation may only be required when the treatment requires in-patient overnight hospital care or highly specialised/costly equipment, or as Article 8(2)(b)-(c) states, where a treatment is particularly high risk for the patient or the population, or the healthcare provider abroad raises quality and safety concerns. Furthermore, when Member States implement systems of prior authorisation, they must be necessary and proportionate to the objective that is aimed to be achieved. Moreover, the system may not constitute a means of arbitrary discrimination or unjustifiably restrict the free movement of patients.[17]

As Article 8(5) stipulates, prior authorisation may not be refused if the treatment is included the benefit basket of the home Member State; and when the home Member State cannot offer the same treatment within a medically justifiable time limit. On the other hand, prior authorisation may be refused when there are quality and safety concerns, risks to the patient or to the general population, or the treatment is available in the competent Member State within a justifiable time limit.[18]

Article 7(4) lays down conditions on reimbursements. The reimbursements are provided only up to the level that would be provided in the home Member State ("*Member State of affiliation*") of the patient. This approach is substantially different to the regime provided under the social security coordination Regulation. The differences and the relationship between these two systems will be examined in the following section.

2.3 The relationship between the Regulation and the Directive

The relationship between the Regulation and Directive is complementary. As stated in Article 2 of the Directive, it applies without prejudice to Regulation 883/2004 and the Implementing Regulation

[15] Directive 2011/24/EU (9 March 2011), Art. 1(3)
[16] Rec. 42-43 Directive 2011/24
[17] Art. 8(1) Directive 2011/24
[18] Art. 8(6) Directive 2011/24

987/2009. This means that the Directive does not replace the coordinating rules, but rather exists as an additional system next to it. Therefore, in practise the patient can choose whether they seek care under the Directive or Regulation. However, when the conditions for prior authorisation under the Regulation are met, the authorisation is automatically granted under the Regulation unless the patient explicitly applies for the application of the Directive.[19]

Under the Regulation, prior authorisation for planned care is always required, and the care is reimbursed based on the tariffs of the Member State of treatment.[20] As comparison, under the Directive, prior authorisation is not always mandatory but the reimbursement is limited to the level of what the treatment costs in the competent Member State.[21] Therefore, if the patient is receiving care in a Member State where the costs are higher than in the competent Member State, under the Directive the reimbursement may be given only for part of the actual costs. This might be a less favorable result to the patient. A patient can also ask for prior authorisation for care where such authorisation is not required, in order to be fully reimbursed under the Regulation. Although under the Directive the competent Member State may limit the reimbursement on the basis of their tariffs, they are not obliged to do so.[22]

Under the Coordination Regulations the payment is often settled between the two institutions, but under the Directive, the costs are directly paid out-of-pocket by the patient. Afterwards, the patient can request reimbursement from the competent institution. Therefore, under the Regulation the patient may avoid the initial financial burden of the healthcare costs.

Next to the differences in reimbursement and whether prior authorisation is required, it has to be noted that Regulation 883/2004 only applies to healthcare sought from public healthcare providers[23]; whereas under Directive 2011/24 care from both public and private providers is reimbursable.[24] Therefore, the patient has more options to choose from healthcare providers under the Directive, and also enjoys more freedom as prior authorisation is not always required. However, on the other hand the absence of prior authorisation may cause uncertainty to the patient, as they will only receive decision on the reimbursement after the treatment has been obtained.

[19] Art. 8(3) Directive 2011/24
[20] Art. 35 of Regulation 883/2004
[21] Art. 7(4) Directive 2011/24
[22] Art. 7(4)(2) Directive 2011/24
[23] In some Member States, also private healthcare providers who are affiliated with the statutory health system are included.
[24] Art. 1(2) Directive 2011/24

2.4 Implementation in Belgium

The Patient Rights Directive has been transposed into national law in Belgium in Article 294, § 1 of the Royal Decree of 3 July 1996.[25]

As stated above, under the Regulation the patient receives prior authorisation as a S2-form. Under Belgian legislation, if prior authorisation is granted pursuant to the Directive, an *ad hoc document* is issued to the patient.[26] The prior authorisations are not, in principle, given for packages of treatment[27], but are granted for one treatment. This may possibly explain why the DBC-method of billing (compilation of treatments) in the Netherlands leads to refusal of the reimbursement by the Belgian insurer. It also must be noted that although the Regulation and Directive lay down rules on the access of healthcare in another Member State, the organisation and delivery of health services and medical care is the responsibility of the Member States, where differences as regards invoicing might occur.[28] Nevertheless, it has to be recalled that the Directive requires Member States to render mutual assistance and cooperation, also by clarifying the content of invoices.[29] Therefore, in principle, the different method of billing is not a ground for refusal of reimbursement under EU law, and the Member States should cooperate to avoid any administrative difficulties leading to restricting the patients' right to seek healthcare in another Member State.

As stipulated by the Directive, in case the conditions on prior authorisation are fulfilled, generally the more favourable legal instrument is applicable (i.e. the Regulation). Under the Belgian procedure, when the insured person submits an application for prior authorisation to his insurer, the insurer must ask the person to confirm whether he opts for the application of the Regulation or the Directive (Article 294 §1). The insurer must also clearly provide information of the consequences of this choice.[30]

Section 2.2 described that although in general no prior authorisation under the Directive is required, the Member States may require prior authorisation for certain medical care. The official Belgian list of medical benefits subject to prior authorisation is included in the Ministerial Decree of 24 June 2014,[31] and as stated in Article 294(1)(14) of the Royal Decree, published on the website of the National Institute for Health and Disability Insurance (RIZIV). Next to the overnight stay, prior authorisation is required for outpatient benefits that require heart catherization, the use of CT/MRI/PET scanner or radiotherapy service.[32]

[25] Royal Decree of 3 July 1996 implementing the Act on compulsory insurance for medical care and payments, coordinated on 14 July 1994 (*Koninklijk besluit tot uitvoering van de wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, gecoördineerd op 14 juli 1994).*

[26] Art. 294, § 1 of the Royal Decree of 3 July 1996, Section 2.2 Omzendbrief VI nr 2014/440 14 november 2014.

[27] Package of treatment, for instance consisting of preoperative, operation and follow-up care. Section 2.4.1 Omzendbrief VI nr 2014/440 14 november 2014.

[28] Art. 168(7) TFEU, Art. 1(4) and Rec. 10 Directive 2011/24

[29] Art. 10(1) Directive 2011/24

[30] §1 Section 2.4.5, D. Omzendbrief VI nr 2014/440 14 november 2014.

[31] Ministerieel Besluit van 24 juni 2014 gepubliceerd op 22 juli 2014.

[32] Rijksinstituut voor ziekte- en invaliditeitsverzekering (RIZIV), https://www.inami.fgov.be/nl/themas/kost-terugbetaling/internationaal/verzorgen/Paginas/geplande-geneeskundige-zorg.aspx.

Next to the application of the Regulation and the Directive, the Belgian legislation provides an additional route for inhabitants of border regions to seek hospital care or dialysis in another Member State. According to Article 294(1)(7°) of the Royal Decree, persons living in border areas[33] may also receive treatment in a care facility situated outside the national territory within a maximum radius of 25 kilometres from the border, provided that there is no similar facility closer to the patient in Belgium. For the care, a prior authorisation may be requested (S2-form or ad hoc document for treatment at a private hospital). Nevertheless, the care must consist of medical benefits that are reimbursed under the Belgian compulsory insurance.[34]

Table 1: Simplification of the three routes presented to seek planned healthcare in another Member State

	Regulation	Directive	294(1)(7°) of the Royal Decree
Healthcare provider	Public	Public or private	Public or private. Only for hospital care or dialysis
Prior authorisation required when	In all cases	Only when: • Over-night hospital care • Highly specialised or costly equipment • Risks to patient or population • Quality and safety concerns of treatment • Not included in the insurance package	Not compulsory, may be requested
Prior authorisation must be given when	• Treatment is included in the insurance package, and • Treatment cannot be given in a medically justified time in the home Member State (Belgium)		• No similar healthcare facility is available in Belgium closer to the patient, and • The patient is resident of border region (15km from border), and • Facility located within max. radius of 25km
Reimbursement	Based on the tariffs of the Member State of treatment (the Netherlands), bill settled between health insurers	Only up to the level that the treatment costs at home Member State (Belgium), patient pays upfront	Depending which document is granted
Form of prior authorisation	S2 form (E-112)	Ad hoc document	S2 form (E-112) or Ad hoc document

[33] The applicant must reside within 15km of the border.

[34] §1-§3 Chapter 3: Special system of prior consent, Section 2(2) Omzendbrief VI nr 2014/440 14 november 2014.

3. Description of a possible solution

The above sections examined under which conditions cross-border healthcare may be sought, and under which grounds prior authorisations may be granted or refused. In the absence of more precise information, it is difficult to draw conclusions as to why the Belgian inhabitants are refused by their insurer to receive care in the Netherlands. It is possible that the Belgian inhabitants do not meet the conditions as set out in the Regulations or Directive, or under Belgian legislation. Indeed, often prior authorisations are refused on the grounds that the care is available in the patients' home Member State.[35]

Next to these routes, Member States may adopt bilateral or multilateral parallel procedures between other Member States or regions. This might be a solution as it would better reflect the needs of a border region, that are very different to the EU legislation that assumes more a "medical touristic" approach.[36] The Directive also encourages neighbouring countries to conclude agreements among themselves and urges Member States to cooperate in cross-border healthcare provision in border regions.[37] Cooperation on multiple levels should be facilitated: between the healthcare providers, purchasers, and regulators of different Member States at national, regional or local level. The Directive acknowledges that cooperation is especially essential to border regions, where cross-border provision of services may be the most efficient way of organising health services for the local population, requiring cooperation between the health systems of different Member States on a sustained basis.[38]

In the section below, several bilateral agreements are put forward that could be applied – *mutatis mutandis* – to the case at hand. In any case, it offers clues of what shape a possible solution for the underlying issue could take. However, it would be helpful to collect individual cases in order to get a better picture concerning the reasons why planned care across the border is not granted or reimbursed. In addition, it is to be noted that before getting involved in such a bilateral agreement, it must be ensured that there is a sufficient legislative basis for these partnership projects between different health insurers in different countries. For instance, as regards the ZOAST agreements, the legal basis is the Franco-Belgian framework agreement on healthcare cooperation.

3.1 Belgium-Germany: IZOM and Ostbelgien-Regelung

Belgium is involved in numerous cooperation agreements in border areas (i.e. IZOM, ZOAST…) where, depending on the cooperation agreement, prior authorisation (S2-form) often becomes a simple

[35] European Commission, Member State data on cross-border patient healthcare following Directive 2011/24/EU: Year 2019, https://ec.europa.eu/health/sites/default/files/cross_border_care/docs/2019_msdata_en.pdf.

[36] EU legislation provides also rules on access to healthcare of pensioners, students or those needing immediate care during a temporary stay in another Member State; which is not necessarily medical tourism. However, Article 20 (as applied in this report) arguably fits better the needs of persons who travel to another Member State for the sole reason to receive healthcare (wording of the provision), and not to persons who live in a border region and due to the territorial proximity seek care across the border from the closest care facility.

[37] Art. 10(3) Directive 2011/24

[38] Rec. 50 Directive 2011/24

administrative authorisation that is granted automatically.[39] Under these agreements the national legal arrangements on health care (e.g. on provision, funding, insurance cover) of each of the three countries are left intact.

For the German-speaking Community in the Eastern part of Belgium ('Ostbelgien') a special arrangement had been drawn up encompassing particular rules on access to specialist health care in Germany as well as special rules on reimbursement, building on Directive 2011/24/EU. This so-called *Ostbelgien-Regelung* (OBR) - led by the National Institute for Health and Disability Insurance (RIZIV) - succeeded the IZOM ('Integratie Zorg op Maat') agreement in July 2017.[40] Since October 2000, IZOM had facilitated access to care for the population of the entire Meuse-Rhine region. Under this agreement, patients no longer needed prior authorisation when going across the border for general care provided by specialist doctors, on both therapeutic and diagnostic levels, the prescribing of medicines within this framework of treatment and the relevant hospital care.[41] The services were billed via the health insurance funds. However, during the implementation phase of the IZOM project, administrative and legal inflexibility were found to be a considerable issue, since legal texts were required that could establish agreements between partners from different countries.

The *Ostbelgien-Regelung* allowed people to continue seeing a specialist, and to visit hospitals or day clinics in the direct German border area. It regulated access to specialist services, insofar as these are reimbursed by the Belgian statutory health insurance and defined the corresponding cost reimbursements. The special arrangement applied to all citizens, covered by statutory health insurance in Belgium; having their residence in either Ostbelgien[42] and the municipalities of Malmédy and Waimes, or in the municipalities of Baelen, Bleyberg (Plombières) and Welkenraedt; and claiming a health-care service in the German border area, i.e. the Aachen region and the districts of Bitburg, Daun and Prüm. Thus, the territorial scope of application was restricted clearly, allowing to mitigate the risk of 'medical tourism'. As regards the reimbursement of benefits, merely benefits that were also provided for in the Belgian statutory health insurance scheme were reimbursed:

- outpatient medical treatment by a specialist, with or without prior referral by a Belgian specialist;
- certain diagnostic imaging procedures, exclusively in the framework of a consultation with a specialist doctor;
- hospitalisation if the patient had to spend at least one night in hospital or one day in a day-care hospital.[43]

[39] European Commission, *Planned cross-border healthcare*, PD S2 Questionnaire, June 2014, p. 5.
[40] European Commission, *Study on Cross-Border Cooperation: Capitalising on existing initiatives for cross-border regions (Cross-border care),* p. 38.
[41] See also Coheur, A. (2001). *Cross border care - New prospects for convergence. European Integration and Health Care Systems: A Challenge for Social Policy*, Ghent, Belgium.
[42] Consisting of nine municipalities: Eupen, Kelmis, Lontzen, Raeren, Amel, Büllingen, Burg-Reuland, Bütgenbach and Sankt Vith.
[43] See https://www.ostbelgienlive.be/desktopdefault.aspx/tabid-6225.

These costs were reimbursed pursuant to the following general principle: if a person visits a German specialist in the German border for outpatient treatment on his own initiative, he must advance the fee demanded by the German specialist. In this regard, on peoples' own initiative refers to the case of no referral from a Belgian specialist and without prior authorisation from the health insurance fund (S2 OBR document).

However, two German contractors terminated the agreement in 2016, mainly due to imbalances in healthcare utilisation caused by an increasing number of Belgian patients being treated in Germany.[44] Partly in response to the withdrawal of the two German partners, the Belgian Ministry of Social Affairs and Public Health evaluated the project in 2016, and subsequently the decision was made to end the project by the end of 2017 following a transition period of six months. From 1 January 2018, the Euregio Meuse-Rhin will revert to the application of the coordinating regulations and Directive 2011/24.

Although this Ostbelgien-agreement was terminated, it is exemplary of a bilateral agreement in border areas that succeeded to facilitate healthcare provision across the border. While observing national legal agreements, and rules stipulated in Directive 2011/24/EU on health care, patients were provided automatically with prior authorisation when crossing the border for general care and services were billed via the health insurance fund.

3.2 Franco-Belgian: ZOAST

On the French-Belgian border there are several so-called ZOAST's (*Zone organisée d'accès aux soins de santé transfrontaliers*). These planned cross-border health treatment zones find their (legal) ground in a framework agreement for healthcare cooperation providing the regional authorities in charge of planning, organising, and financing the healthcare system with the authority to negotiate and validate agreements in the area of health.[45] Where in part 1 of this framework agreement the financial coverage for healthcare for patients under their obligatory health insurance is regulated, part 2 incorporates French supplementary health insurance cover. These ZOASTs have been set up between 2008 and 2015, and today they cover the whole Franco-Belgian border area.

Seven organised zones for cross-border access to healthcare (ZOASTs) were created alongside the Franco-Belgian border:

- ZOAST Ardennes

[44] For instance, in 2014, 15 807 S2 forms were issued for healthcare in Germany, representing patients with Belgian social insurance. These were mainly members of the German-speaking community of Belgium. Conversely, there were 1281 forms, mostly from the Netherlands, issued for healthcare in Belgium (mainly in Genk and Tongeren), for Dutch and German patients. Dutch patients coming for treatment in Belgium do so because of waiting times in the Netherlands. See European Commission, European Cross-border Cooperation on Health: Theory and Practice, 2017, p. 63 (https://ec.europa.eu/regional_policy/sources/cooperate/crossborder/cbc_health/cbc_health_en.pdf).

[45] European Commission, European Cross-border Cooperation on Health: Theory and Practice, 2017, p. 11 (https://ec.europa.eu/regional_policy/sources/cooperate/crossborder/cbc_health/cbc_health_en.pdf).

- ZOAST MRTW URSA (Mouscron, Roubaix, Tourcoing, Wattrelos, Armentières, Bailleul, Hazebrouck, and Ieper)
- ZOAST LUXLOR (the Belgian province of Luxembourg and the French region of Lorraine)
- ZOAST MONS-MAUBEUGE (Mons (BE) and Maubeuge (F))
- ZOAST TOURNAI VALENCIENNES (Centre Hospitalier de Valenciennes (F) and the Centre Hospitalier de Wallonie Picarde in Tournai (BE))
- ZOAST THIERARCHE
- ZOAST LITTORAL (Dunkirk (F) and Veurne (BE)).[46]

These ZOASTs cover the whole border and apply to the population of the defined legal zone without any administrative or financial barriers. These zones have become benchmarks for cross-border health care cooperation across Europe and constitute an appropriate response to the need of care of patients in cross-border regions. For instance, in 2015, around 20 000 French and Belgian patients have received treatment without discrimination on either side of the Franco-Belgian border under these ZOASTs.[47] These ZOASTs leave the application of European (social security) legislation unaltered as, when they receive cross-border care, patients are covered by their social security system, via the European regulations. Moreover, the patients are not required to obtain an authorisation in advance from their insurer. From a practical perspective, French social security card readers have been installed in Belgian institutions for French patients treated in Belgium. This enables patients to be registered under the Belgian social security system, and the care will be invoiced to the Belgian social security body. Under the European social security Regulation (883/2004) the Belgian institute will recover the funds paid to the Belgian hospital from the French liaison agency. Costs will be invoiced at the rate of the country in which the care is provided. This allows patients to seek care across the border, without any prior medical authorisation from their health insurer, and it avoids them to pay fees in advance, and the subsequent request for reimbursement.

Moreover, to ensure full cover for French patients treated in Belgium, procedures were developed for the reimbursement of residual charges (co-payments) from supplementary policies concluded by these patients. This was achieved by using a third-party payer mechanism, requiring software development work to implement these repayment procedures. This allows cross-border patients to have their care costs covered fully in the same manner in which it would have been handled in their home country.

[46] For further details see European Commission, European Cross-border Cooperation on Health: Theory and Practice, 2017, p. 77 ff. (https://ec.europa.eu/regional_policy/sources/cooperate/crossborder/cbc_health/cbc_health_en.pdf). In 2017, 15 653 patients from France received care in Belgian hospitals within the framework of the ZOAST agreements. Nearly two thirds of the treatments related to traditional admissions, and the remainder to day-hospitalisation and ambulatory care. The largest share of in-patient interventions provided was in internal medicine and surgery (including disease-related operations), abdominal and gastroenterological procedures, cardiovascular interventions, abdominal and gastroenterologicalorthopedic and urological), intensive care/resuscitation, geriatrics and rehabilitation. The patient in-flow from France under ZOAST in 2017 represented 9.6% of all care provided to foreign patients, who as a whole made up 1.53% of all patients who receive care in Belgian hospitals. See https://www.mc.be/media/rapport-flux-zoast_tcm49-55254.pdf

[47] European Commission, European Cross-border Cooperation on Health: Theory and Practice, 2017, p. 81 (https://ec.europa.eu/regional_policy/sources/cooperate/crossborder/cbc_health/cbc_health_en.pdf).

These bilateral agreements – discussed in the section above – constitute a best practice in terms of overcoming obstacles for the provision of cross-border healthcare. Under both agreements, the most prevailing obstacle – refusal of prior authorisation – had been resolved. In doing so, they can be used as examples of agreements that could be concluded in the border area of Zeeuws-Vlaanderen, providing alternative routes for Belgian inhabitants to seek care in the Netherlands without the obstacle of prior authorisation as presented by the Provincie Zeeland. At this point, it should be emphasized that, in order to succeed, it must be ensured that there is a sufficient legislative basis for the agreements concluded between different health insurers in different countries.

4. Pre-assessment of whether the case could be solved with the ECBM

The European Commission presented in 2018 a proposal for a "mechanism to resolve legal and administrative obstacles in a cross-border context" COM(2018)373 - the so-called European cross-border mechanism (ECBM).[48] Article 1 of the proposal stipulates the ECBM's objective, i.e. "to allow for the application in one Member State, with regard to a cross-border region, of the legal provisions from another Member State, where the application of the legal provisions of the former would constitute a legal obstacle hampering the implementation of a joint Project". The ECBM is, thus, aimed at resolving a legal conflict due to different national laws or administrative obligations that are applicable at the same time for the same specific project.

In preparation for the ECBM, a study has been done to the legal and administrative obstacles in EU border regions.[49] The study categorised the gathered obstacles into three types:

1. EU-related legal obstacles: caused by the specific status of an EU-border or by EU legislation (or the implementation thereof), where the EU has exclusive or shared competency;
2. Member State-related legal obstacles: caused by different national or regional laws, where the EU has no or only limited competence;
3. Administrative obstacles: caused by non-willingness, asymmetric cooperation or lack of horizontal coordination, or by different administrative cultures or languages.

The presented case belongs probably more to category 3. There is no evident clash of different national pieces of legislation nor is there a clear obstacle linked to EU legislation or the implementation of EU legislation. The conflict solving "cross-border mechanism" whereby a Member State accepts parts of the legislation of the neighbouring Member State on its own territory is not a solution to the problem. The question at stake is whether in line with EU rules and based on national legislation, a more generous or less bureaucratic solution can be found via bilateral agreements as in the given "best practice" examples. Hence, it is unlikely that the issue in the present case can be solved through the ECBM. Moreover, the ECBM delineates projects as "any item of infrastructure with an

[48] Proposal for a Regulation of the European Parliament and of the on a mechanism to resolve legal and administrative obstacles in a cross-border context COM(2018) 373 final.
[49] J. Pucher, T. Stumm & P. Schneidewind, Easing legal and administrative obstacles in EU border regions, Luxembourg: Publications Office of the European Union, 2017.

impact in a given cross-border region or any service of general economic interest provided in a given cross-border region" (Article 3(2)). Since the underlying issue is not necessarily limited to a given cross-border region, nor a specific project, the issue cannot be solved through the ECBM.

5. Other relevant aspects to this case

Information on why, and on what grounds, prior authorisations are refused is still missing. Hence, the report is not able to investigate the tenability of these grounds of refusal under EU law. This constitutes a possible avenue for future research.

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