



JOINT OSP AMENDMENT PROPOSAL

Joint Decision C(2019) 5684 – LA Medical Scheme

Position paper for social dialogue with EEAS RM.BHR.5

September 2026

Note: This document incorporates outcomes of the Joint Staff Committees' and BHR.5 meeting of 18 March 2026, the updated LA Medical financial figures as of 31 December 2025, and the findings of the December 2025 LA Medical Staff Survey (960 respondents, approximately 37% of affiliated members). All proposed article texts are offered as a working basis for negotiation.

1. Background and legal context

Joint Decision C(2019) 5684 of the Commission and the High Representative, on autonomous or complementary medical cover for Local Staff in Union Delegations, entered into force on 1 June 2020. Its implementing rules are set out in Decision ADMIN(2020) 23 of the EEAS Director-General for Budget and Administration. Article 121 of the Conditions of Employment of Other Servants obliges the EU institutions as employer of local staff outside the EU to provide an autonomous or complementary social security system in countries where local coverage either does not exist or is insufficient.

At the Joint Meeting of 18 March 2026, BHR.5 confirmed that social dialogue on LA Medical reform will commence no later than Q1 2027 as part of a comprehensive package covering four instruments simultaneously: the Conditions of Employment, the LAPF decision, the LA Medical decision, and the salary adjustment methodology. The budget-neutrality constraint will apply across the package.

The above OSPs do not agree to the Q1 2027 start date, and is of the opinion that, since this comprehensive Draft document is now made available to the Administration, the Social Dialogues must start in September 2026 at the latest. Due to the global economic instability there should be no further slippage and the social dialogue must address substance, not just process.

This document is submitted in advance of that dialogue to allow BHR.5 to begin internal arbitration with full knowledge of the above OSP positions. It draws on the strongest evidence base available: a survey of nearly 1,000 affiliated members and financial data that demonstrates a structural surplus growing faster than the provident fund – an unmistakable sign that the scheme is collecting more than it returns.

2. Evidence base

2.1 Staff survey (December 2025)

The LA Medical Staff Survey, conducted in December 2025 with 960 respondents (approximately 37% of the 2,600 affiliated members), provides a statistically robust mandate for reform. A 37% response rate for a voluntary survey across approximately 145 delegations worldwide, spanning all function groups, geographies, and age brackets, significantly exceeds the threshold for representative findings.

Issue	Result	Implication
LA Medical is de facto primary coverage (local system poor or absent)	88.3%	LA Medical is not a complement – it is the frontline; scheme design must reflect this reality
Coverage has limited ability to access quality medical care	66%	Current reimbursement rates and ceilings are failing the membership
Maximum reimbursable amounts (MRAs) are outdated	54%	Ceiling update is the single most impactful short-term improvement
Employee contributions considered high	54%	Members paying into a scheme that grows rather than reimburses
Post-retirement coverage identified as highly valuable benefit	45%	Headline priority for 2027 social dialogue; surplus makes it fundable
Unaware of post-retirement extension possibility	51%	Half the membership does not know the current limited rules exist
Want ceiling adjustment annually	43%	Demand for at minimum annual indexation, not ad hoc updates
Unaware of direct billing option	74%	Critical communication failure – BHR.5 committed to note to HoDs
Favour extending affiliation beyond current limits	35%	One-third actively seek longer post-employment coverage
Current post-employment rules are fair – should remain unchanged	8%	Only 8% support the status quo; 92% see room for improvement
Value treatment abroad	>90%	Cross-border healthcare access is essential for staff in hardship postings

2.2 Financial position as of 31 December 2025

BHR.5 presented the following figures at the 18 March 2026 meeting:

Total scheme assets	€44.5 million
Investment portfolio (same vehicle as LAPF surplus, managed by DG BUDG)	€40.0 million
Extra-budgetary (HB) liquidity account (for short-term reimbursements)	€4.8 million

Active affiliated members	~2,600
Total subscribers (including dependents)	~10,500
Employee contribution rate (Section II)	1.21% of basic salary
Employer contribution rate (Section II)	2.42% of basic salary

The surplus has grown steadily year on year: total scheme assets stood at €37.5 million at end-2023, €41.0 million at end-2024, and €44.5 million at end-2025 (source: 2024 Activity and Financial Report of the LA-Provident Fund and LA-Medical, presented to the Inter-Institutional Joint Management Committee on Social Security, 26 March 2025; 2025 year-end figures presented by BHR.5 at the 18 March 2026 plenary).

A critical metric from the same financial report is the **utilisation rate** — total reimbursements paid out divided by total contributions received. For LA Medical, the utilisation rate in 2024 was **55.0%** (2023: 56.2%). This means that for every euro contributed by members and employers, only 55 cents was returned in reimbursements. The remaining 45 cents of every contributed euro was retained in the fund. By comparison, the LAPF — a savings fund from which virtually nobody withdraws until employment ends — had a higher utilisation rate of 58.2%. A medical insurance scheme that returns less of what members put in than their savings fund does is a scheme that is structurally failing to fulfil its purpose.

Equal Treatment in Social Security and Health Benefits

As part of the social dialogue, one of our main requests is that social security and related health benefits apply equally to all Local Agents, irrespective of whether they sign the modified employment decisions. Staff who pay the same contributions should have equal access to the corresponding rights and benefits. This is also consistent with ILO Recommendation No. 111 (1958), which promotes equal treatment in employment conditions and benefits, including social security and health-related benefits.

2.3 The surplus paradox: a medical fund that grows instead of financing health care

The LA Medical scheme holds €44.5 million in assets while approximately 2,600 active members and their families struggle with outdated reimbursement ceilings, inadequate dental coverage, and virtually no post-retirement protection. To put this in perspective: the fund holds approximately €17,100 per affiliated member, or roughly €4,200 per subscriber including dependents.

The surplus is growing faster than the LAPF — a provident fund from which virtually nobody withdraws until the end of their employment. As documented in section 2.2 above, the scheme's utilisation rate of 55% means that nearly half of all contributions are retained rather than returned to members. For a medical insurance scheme, where the entire purpose is to reimburse healthcare costs, this trajectory is an institutional indictment. Every euro sitting in that surplus is a euro that could have reimbursed a dental visit, covered a hospital bill at real-world prices, or funded post-retirement coverage for a colleague who paid into the scheme for decades.

The growth pattern tells us everything about how restrictively claims are being handled. Members pay in. Members submit claims. And the fund still grows. This is the financial signature of a scheme that systematically under-reimburses its members.

Key finding from the 18 March 2026 meeting: BHR.5 committed to advance ceiling updates during 2026 as a stopgap measure, outside the formal social dialogue. BHR.5 also committed to issue a note to all Heads of Delegation on direct billing and salary advance options, launch a quarterly newsletter, and examine simplified prescription processes for chronic conditions. Post-retirement medical coverage and old-decision/new-decision discrimination are confirmed as priority items for the Q1 2027 social dialogue.

3. Proposed amendments to Joint Decision C(2019) 5684 and Decision ADMIN(2020) 23

Amendments A1 through A12 are presented as a single integrated package. Joint Decision C(2019) 5684 must be opened for revision alongside its implementing rules; partial amendment would leave structural deficiencies unaddressed. Each amendment is self-standing in legal terms, but the package is designed to be coherent. Where BHR.5 has explicitly acknowledged an item at the 18 March 2026 meeting, this is noted in the justification column.

Amendment A1: Scope and definitions (Articles 2 and 3(4))

Article	Current text (summary)	Proposed amendment	Justification & basis
Article 2	<i>The Decision does not apply in Delegations covered by the general exceptions of Article 2, and no minimum-coverage guarantee is provided for them.</i>	<i>Add a new provision: Where LA Medical does not apply, a separate decision shall be adopted for the Delegations concerned to guarantee equivalent basic health-insurance standards and minimum coverage.</i>	Local Agents in Delegations outside the scheme's scope are currently left without any guaranteed minimum health coverage. A dedicated decision would close this gap and ensure equal treatment across the network.
Article 3(4)	— (new paragraph)	<i>Add new Article 3(4): For the purposes of this Article, local health insurance shall be considered insufficient where it does not provide Local Agents with effective access to adequate, timely and safe medically necessary healthcare. This includes situations where the local healthcare system does not meet reasonable standards of hygiene, safety or quality of care, where there are excessive delays in accessing treatment, inadequate medical facilities or specialist services, or where patients may face serious risks due to the lack of timely and appropriate medical care. It shall also be considered insufficient where significant exclusions, reimbursement ceilings, deductibles, co-payments or</i>	A clear definition of 'insufficient' local insurance is needed to prevent a restrictive interpretation of this clause. In several Delegations, local insurance exists but does not amount to adequate primary coverage; this should be made explicit in the wording.

		<i>other limitations result in inadequate effective coverage.</i>	
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Amendment A2: Post-retirement and post-termination medical coverage – LAM-R scheme and bridging provisions (Article 10 of C(2019) 5684 – new paragraphs)

Article	Current text (summary)	Proposed amendment	Justification & basis
Art. 10 (new §4–8)	<i>Article 10(2)–(3) of C(2019) 5684 permits extension of Section II affiliation for a maximum of 1 year (all staff), with further extensions of 1 month per year of service, capped at 3 years and 6 months.</i> <i>The affiliated member bears 100% of contributions (employee + employer share = 3.63% of last basic salary).</i> <i>Coverage terminates if the member moves country or takes new employment.</i> <i>51% of survey respondents were entirely unaware these limited rules exist.</i>	<i>Add Article 10(4): ‘A Local Agent Medical – Retirement (LAM-R) scheme shall be established to provide continued medical coverage for retired local agents and their eligible dependents. The LAM-R scheme shall be open to all affiliated members with a minimum of 10 years of LA Medical affiliation.’</i> <i>Add Article 10(5): ‘LAM-R coverage shall be structured in tiers: (a) comprehensive coverage at 80% of active-service benefit levels; (b) critical illness and hospitalisation coverage only; (c) basic coverage with an annual ceiling. The contribution structure shall reflect years of service: 10–20 years – retiree pays 40% of combined contribution, surplus subsidy covers 60%; 20–30 years – retiree pays 30%, surplus subsidy 70%; 30+ years – retiree pays 20%, surplus subsidy 80%. Coverage shall continue until the death, voluntary withdrawal, or the affiliated member obtaining equivalent coverage through a new employer or state system. Survivor benefits for the spouse shall continue for a maximum of 2 years following the death of the retired affiliated member.’</i> <i>Add Article 10(6): ‘The LAM-R scheme shall be initially funded from the existing LA Medical surplus for a period of 10 years. The administrative manager shall present an actuarial assessment of long-term sustainability to the Inter-Institutional Joint Management Committee within 18 months of entry into force and every 5 years thereafter.’</i>	Survey: 45% identify post-retirement coverage as their top priority; only 8% consider current post-employment rules fair. In many countries of assignment, private medical insurance is impossible to obtain at retirement age or prohibitively expensive. Local agents in Sub-Saharan Africa, South Asia, Central Asia, and Latin America face healthcare systems that are absent, non-functional, or require out-of-pocket payments that consume retirement income entirely. The current maximum extension of 3.5 years is structurally inadequate: it assumes the retiring member can transition to a local system that may not exist and or is inadequate. The €44.5 million surplus can fund the initial phase without any increase in active-member contributions. Confirmed as a priority item for Q1 2027 social dialogue (18 March 2026 meeting). Comparable international organisations (UN, World Bank) provide substantially longer post-retirement medical coverage. Post-termination bridging (Art. 10(7)): The Western Balkans modernisation process has resulted in economic redundancies where staff lose LA Medical coverage at the point of greatest vulnerability – when they are

		<i>Add Article 10(7) – Post-termination bridging coverage: ‘Where the contract of an affiliated member is terminated by the institution (including economic redundancy under Article 26(4) LA-CE), or where an affiliated member serves in a crisis duty station where medical coverage outside the workplace is unavailable or severely limited, LA Medical affiliation shall be extended for a minimum of 24 months from the date of termination, without prejudice to the longer extensions available under Article 10(2)–(3). During the bridging period, the employer shall continue to pay the employer contribution. The affiliated member shall pay the employee contribution at the rate applicable immediately before termination. Coverage shall include the member and all previously covered dependents.’</i> <i>Add Article 10(8) – Contribution waiver for involuntary termination: ‘Where an affiliated member’s contract is terminated by the institution and the member subsequently enrolls in the LAM-R post-retirement scheme, the employee contribution to LAM-R shall be waived for the first five years of LAM-R enrolment, or until the member obtains equivalent coverage through a new employer or state system, whichever is earlier. The waived contributions shall be funded from the LA Medical surplus. This provision applies regardless of the member’s years of service at the time of termination.’</i>	unemployed, often in their 50s, and unable to obtain affordable private coverage. In crisis duty stations, medical coverage outside the workplace may be unavailable; terminated staff in such environments face immediate health risks. A 24-month bridging period with continued employer contribution is the minimum safety net for involuntarily terminated staff. Contribution waiver (Art. 10(8)): Requiring involuntarily terminated staff to pay LAM-R contributions from severance income adds financial insult to institutional injury. The surplus paradox applies with particular force here: the fund can absorb five years of waived contributions without any sustainability risk, while the affected individual faces immediate healthcare costs with no income. This aligns with the EU’s own duty of care obligations.
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Amendment A3: Automatic reimbursement ceiling indexation (ADMIN(2020) 23 – Annexes 1 and 2, and new Article in C(2019) 5684)

Article	Current text (summary)	Proposed amendment	Justification & basis
ADMIN(2020) 23	<i>Local reimbursement ceilings and maximum reimbursable amounts</i>	<i>Add to C(2019) 5684 Article 14: ‘Local reimbursement ceilings and maximum reimbursable amounts</i>	Survey: 54% say MRAs are outdated; 43% want annual adjustment; combined 84%

Annexes 1 & 2; C(2019) 5684 Art. 14 (new §)	<i>(MRAs) are set in local currency with no built-in adjustment mechanism.</i> <i>BHR.5 conducts periodic hospital surveys to update ceilings, but intervals are irregular and unlinked to healthcare inflation.</i> <i>54% of survey respondents consider MRAs outdated; a further 30% say they mostly reflect costs but need more frequent updating. Only 5% find them appropriate.</i>	<i>shall be reviewed and, where necessary, adjusted no less frequently than every two years. The review shall take into account local healthcare cost inflation, delegation-specific hospital surveys, and any material change in local healthcare provision. The administrative manager shall publish the results of each review and notify affiliated members and staff committees within 30 days of adoption.'</i> <i>Amend ADMIN(2020) 23 Annexes 1 and 2: 'Maximum reimbursable amounts for dental prostheses and implants, spectacle frames and corrective lenses, hearing aids, and physiotherapy shall be reviewed biennially against a basket of representative costs in the country of employment. Where biennial adjustment is not feasible, an interim adjustment of no less than the annual consumer price inflation rate for the country of employment shall be applied automatically.'</i>	demand more frequent updates. BHR.5 committed to advance ceiling updates as a 2026 stopgap (18 March 2026 meeting). This amendment institutionalises that commitment as a permanent mechanism. Ceilings fixed in local currency without indexation represent a systematic ongoing transfer from members to the surplus. In countries with high inflation (Turkey, Nigeria, Argentina), this renders the scheme largely illusory within 2–3 years of a ceiling being set. Dental prostheses and implants are the highest-priority MRA category identified by respondents.
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Amendment A4: Dental coverage equalisation and enhancement (ADMIN(2020) 23 Annex 1, Article 1(5) – revision; ADMIN(2020) 32)

Article	Current text (summary)	Proposed amendment	Justification & basis
ADMIN(2020) 23 Annex 1, Art. 1(5); ADMIN(2020) 32	<i>Under ADMIN(2020) 23, the maximum reimbursable amount for dental prostheses and implants is €700 for any seven-year period per affiliated member or beneficiary.</i> <i>Orthodontic treatment is reimbursable only if started before the age of 16.</i> <i>Members under the old framework rules (pre-June 2020) receive different dental coverage,</i>	<i>Revise Annex 1, Article 1(5): 'The maximum reimbursable amount for dental prostheses and implants shall be €2,000 for any five-year period per affiliated member or beneficiary. This ceiling shall be reviewed biennially in accordance with [new Article 14 provision].'</i> <i>Revise ADMIN(2020) 32: 'Orthodontic treatment shall be reimbursable when started before the age of 18, subject to medical justification and prior authorisation.'</i> <i>Add: 'All affiliated members shall receive identical dental coverage regardless of contract framework (old framework rules or new conditions). The enhanced ceilings</i>	Dental prostheses and implants are by far the highest-priority MRA category identified by survey respondents. €700 over seven years is functionally meaningless: a single implant in most countries costs €1,500–€3,000. The two-tier system between contract types violates the principle of equal treatment for equal work. Funded from the surplus: the annual cost of enhanced dental coverage for 2,600 members is manageable

	<i>creating a two-tier system.</i>	<i>shall apply from the date of entry into force of this revision.'</i>	against a €44.5 million reserve.
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Amendment A5: Reimbursement rate enhancement (C(2019) 5684, Article 11 – revision)

Article	Current text (summary)	Proposed amendment	Justification & basis
C(2019) 5684 Art. 11	<i>Article 11 sets the standard reimbursement rate at 80% of eligible costs. Hospitalisation and emergency care may be reimbursed at up to 100% subject to authorisation. The weighted satisfaction average for reimbursement levels is 5.3 out of 10. Two-thirds of respondents report that coverage has limited their access to quality medical care.</i>	<i>Amend Article 11: 'The standard rate of reimbursement for eligible medical costs incurred in the country of employment shall be 85%. Hospitalisation and surgical costs: 100%. Emergency care: 100%. Preventive care (as defined in ADMIN(2020) 23 Article 2(5)): 90%. Treatment outside the country of employment shall remain subject to prior authorisation in accordance with Article 2 of Annex 1 of ADMIN(2020) 23 and shall be reimbursed at the standard rate applicable in the country of employment, unless the prior authorisation specifies otherwise on the basis of documented medical necessity and cost-effectiveness. The standard rate shall be reviewed every five years as part of the periodic assessment.'</i>	Survey: satisfaction at 5.3/10; 66% report coverage has limited access to quality care. For 88% of respondents, LA Medical is their primary (not complementary) coverage. An 80% reimbursement rate leaves a 20% gap that, in countries without a functioning public system, comes entirely from the member's pocket. The 5-percentage-point increase is conservative and fundable from surplus investment returns alone, without drawing down capital. Comparable international organisations operate at 80–90% as standard. The proposal brings LA Medical to the lower end of the comparator range. Treatment abroad is explicitly preserved within the prior authorisation framework to prevent misuse. The enhanced rate applies to costs in the country of employment; treatment outside the country of employment is reimbursed at the country-of-employment rate unless the prior authorisation specifies otherwise on medical necessity and cost-effectiveness grounds. This safeguards the surplus against disproportionate claims while preserving access for members with genuine medical need.

Amendment A6: Direct billing and upfront payment reform (ADMIN(2020) 23, Article 9 – revision)

Article	Current text (summary)	Proposed amendment	Justification & basis
ADMIN(2020) 23 Art. 9	<i>Article 9 restricts direct billing to hospitalisation, surgery, delivery, and collective immunisation only.</i> <i>In all other cases, the affiliated member must pay and then claim reimbursement.</i> <i>74% of survey respondents were entirely unaware that even the limited direct billing option exists. A further 16% were aware but unsure when it applies.</i> <i>PAR request in case of follow up after emergency situations accidents etc</i>	<i>Amend Article 9: ‘Direct billing shall be available for (a) hospitalisation, surgical interventions, and deliveries; (b) collective immunisation; (c) any medical cost exceeding €500 where the affiliated member requests it and the Delegation has an established relationship with the provider; (d) chronic condition treatment where recurring costs are predictable and documented. The administrative manager shall establish a network of preferred providers in each country of employment where feasible, enabling automatic direct billing for affiliated members.’</i> <i>Add Article 9(2): ‘The Delegation shall inform all affiliated members of the direct billing and salary advance options within 30 days of recruitment and annually thereafter. This information shall be included in the standard onboarding documentation.’</i> <i>Add another article as there is a legal gap</i> Article X – Emergencies - Accidents <i>In the event of an emergency or accident, all medically necessary emergency and follow-up treatment directly resulting from the accident shall be covered. No prior authorisation or PAR shall be required. The LA shall inform the LA Medical Service and provide the relevant medical documentation as soon as reasonably practicable, but reimbursement shall not be conditional upon prior notification or authorisation.</i>	Survey: 74% unaware of direct billing; the pre-financing burden is identified as a major financial stress factor in qualitative responses. BHR.5 committed to issue a note to Heads of Delegation and Heads of Administration on direct billing and salary advance (18 March 2026 meeting). This amendment institutionalises that commitment. The upfront payment requirement effectively makes LA Medical a reimbursement lottery rather than a functioning insurance scheme. Members in low-salary function groups face the greatest hardship. In case of accident: The procedure for reimbursement is not sufficiently clear, particularly regarding whether a PAR is required. This should be clarified in the rules. In the event of an accident, the necessary follow-up treatment should not be subject to prior authorisation. The LA Medical Service should be informed of the treatment, but reimbursement should not be conditional upon prior notification or authorisation, particularly where the treatment is medically necessary as a consequence of the accident.

Amendment A7: Chronic condition prescription simplification (ADMIN(2020) 23, Article 7 – new paragraph)

Article	Current text (summary)	Proposed amendment	Justification & basis
ADMIN(2020) 23 Art. 7 (new)	<i>Current rules require prescription renewal every 3–6 months for all medications, including stable chronic conditions (blood pressure, diabetes, thyroid). This imposes repeated consultation costs, administrative burden, and claim processing delays for conditions that are clinically stable and require long-term medication.</i>	<i>Add Article 7(new): ‘For affiliated members with documented stable chronic conditions – defined as conditions managed on the same medication and dosage for at least 12 months – the attending physician may issue an annual prescription. The annual prescription shall be accepted for reimbursement purposes without the requirement for interim renewal, subject to confirmation that the condition remains stable at the member’s regular health check-up.’</i>	Raised by OSP/USHU at the 18 March 2026 meeting. BHR.5 committed to examine the issue and explore an administrative solution. This is both a cost-saving and member-welfare measure: fewer consultations means lower costs to the scheme and less administrative processing time in BHR.5. Standard medical practice supports annual prescriptions for stable chronic conditions in virtually all developed healthcare systems.

Amendment A8: Elimination of contract-type discrimination (C(2019) 5684, Article 10(3)(b) and transitional provisions)

Article	Current text (summary)	Proposed amendment	Justification & basis
C(2019) 5684 Art. 10(3)(b); Transitional provisions	<i>LA Medical is a jointly financed social security scheme established under Article 121 of the Conditions of Employment of Other Servants. All affiliated members contribute at identical rates regardless of contract framework: 1.37% of basic salary from the employee (1.21% for Section II medical costs + 0.16% for Section I incapacity cover) and 2.74% of basic salary from the employer, plus additional employer contributions for occupational accident and disease coverage. The Decision on contributions (ADMIN(2020) 25)</i>	<i>Amend C(2019) 5684 transitional provisions: ‘All affiliated members, regardless of contract framework, shall receive identical medical coverage with effect from the entry into force of this revision. Coverage levels, maximum reimbursable amounts, and post-employment extension rules shall be harmonised upward to the most favourable provisions. Entitlement to benefits under the LA Medical scheme shall not be made conditional upon the acceptance of any contractual instrument external to this Decision, including without limitation the addendum to the LA-CE referred to in Article 33 of Joint Decision C(2019) 5686. No affiliated member shall experience a reduction in existing benefits as a result of harmonisation.’</i>	LA Medical is a jointly financed solidarity scheme. Because all affiliated members co-finance the fund through mandatory contributions, all affiliated members hold a shared ownership in it. The employer may freely differentiate entitlements in matters where the employer is the sole financier — salary, leave, promotion, severance — but LA Medical is not such a matter. Benefits from a co-financed fund cannot lawfully be withheld from contributing members and conditioned upon the acceptance of an unrelated contractual instrument. Under the current arrangement, access to the full benefits of a co-financed fund is made conditional upon signing the LA-CE addendum.

	<i>applies these rates uniformly to all affiliated members.</i> <i>Despite paying the same contribution rate into the same fund, members under the old framework rules (pre-June 2020, who have not accepted the new conditions under Article 33 of the LA-CE) receive materially different benefits: different coverage levels, different post-employment extension rules, and no dental prosthesis or implant coverage at all. The difference in benefits is conditional upon accepting an unrelated contractual instrument (the LA-CE addendum), not upon any difference in contribution.</i> <i>The coexistence of three legal bases (SCEs, LACE, and the unified instrument) perpetuates unequal treatment among colleagues performing identical work in the same Delegation.</i>		This converts the addendum into a de facto fee for equal treatment within the scheme, which members have already paid for through their contributions. It is constructive coercion: members are asked to pay a contractual price for rights they have already earned through equal contribution. This is particularly damaging for long-serving colleagues who have contributed to the scheme for decades and now find themselves, at the point of greatest medical need, in a less favourable position than colleagues who have just begun contributing. The current arrangement also violates the contributory principle fundamental to every social security scheme: equal contributions must entitle members to equal benefits. That identical contribution cannot lawfully purchase different levels of protection based solely on contract date. The comparator position is the Joint Sickness Insurance Scheme (JSIS) for officials and contract agents: all contributors are covered on identical terms irrespective of recruitment date. LA Medical must apply the same principle. BHR.5 acknowledged at 18 March 2026 that the reform must achieve a sufficient critical mass under unified conditions before launch. This amendment supports that objective by removing the discriminatory legacy provisions. The surplus is more than sufficient to fund upward harmonisation. Confirmed as a priority item for Q1 2027 social dialogue (18 March 2026 meeting).
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Amendment A9: Surplus management, transparency, and member oversight (C(2019) 5684 – new Article)

Article	Current text (summary)	Proposed amendment	Justification & basis
C(2019) 5684 (new Article)	<i>No provision in C(2019) 5684 or ADMIN(2020) 23 addresses what happens to accumulated surplus, how it should be invested, or what role members have in surplus allocation decisions.</i> <i>The surplus is invested in the same vehicle as the LAPF (DG BUDG-managed sovereign bond portfolio). No separate reporting or transparency obligation exists for LA Medical surplus.</i>	<i>Add new Article: ‘The administrative manager shall publish an annual LA Medical financial report, including total assets, contribution income, reimbursement expenditure, investment returns, and surplus movement. The report shall be made available to all affiliated members and staff committees within three months of the reference period.’</i> <i>Add: ‘The Inter-Institutional Joint Management Committee shall adopt a surplus utilisation framework within 12 months of this revision’s entry into force. The framework shall establish (a) a target surplus level expressed as a percentage of annual reimbursement expenditure; (b) an allocation mechanism for surplus exceeding the target level, prioritising coverage enhancements, ceiling updates, and LAM-R scheme funding; (c) a prohibition on indefinite surplus accumulation without periodic justification.’</i> <i>Add: ‘Staff committee representatives shall participate in surplus allocation decisions and investment strategy reviews on an equal footing with institutional representatives within the Joint Management Committee.’</i>	A €44.5 million surplus that continues to grow while members face coverage gaps represents a failure of governance, not prudent management. The official utilisation rate of 55% (2024 Activity and Financial Report) confirms that the scheme systematically retains nearly half of all contributions rather than returning them to members. No annual financial report is published or made accessible to affiliated members. Individual members have no visibility into how their contributions are managed. The LAPF at least has a dedicated chapter in the EU Delegates Guide; LA Medical surplus reporting is effectively absent. A surplus target (e.g. 150–200% of annual reimbursement expenditure as a contingency buffer) would redirect excess accumulation toward member benefit.

Amendment A10: Mental health and expanded preventive coverage (ADMIN(2020) 23 Annex 1, Articles 2(3), 2(4), and 2(5) – revision)

Article	Current text (summary)	Proposed amendment	Justification & basis
ADMIN(2020) 23 Annex 1, Art. 2(3)–(5)	<i>Psychotherapy requires prior authorisation with restrictive session limits.</i>	<i>Amend Annex 1, Article 2(3): ‘Psychotherapy and psychological counselling shall be reimbursable up to a maximum of 24 sessions per calendar year at the standard</i>	EU Delegations operate in high-stress environments including conflict zones, political instability, and hardship postings. Mental

	<i>Preventive medical examinations are limited to a list adopted by the administrative manager, and only permitted every 18 months.</i> <i>Qualitative survey feedback highlights psychotherapy and physiotherapy as areas with insufficient MRAs and overly restrictive prior authorisation requirements.</i>	<i>reimbursement rate, subject to a medical prescription. Prior authorisation shall be required only beyond 24 sessions.'</i> <i>Amend Annex 1, Article 2(5): 'Preventive medical examinations shall be permitted annually for affiliated members aged 40 and above, and every 18 months for members below 40. The list of approved examinations shall include cardiovascular screening, cancer screening appropriate to age and sex, diabetes screening, and comprehensive blood panels. The administrative manager shall review the list every three years against WHO preventive care guidelines.'</i>	health support is not a luxury; it is an operational necessity. Qualitative survey data: physiotherapy and psychotherapy identified as areas with restrictive prior authorisation approvals and insufficient MRAs. Annual preventive screening for staff aged 40+ aligns with WHO guidelines and EU occupational health standards. Early detection reduces long-term scheme costs. Raised by OSP/USHU at the 18 March 2026 meeting: expansion of the 18-monthly health check-up to include additional screening tests.
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Amendment A11: Periodic review obligation (C(2019) 5684, Article 17 – revision)

Article	Current text (summary)	Proposed amendment	Justification & basis
C(2019) 5684 Art. 17	<i>Article 17 of C(2019) 5684 provides for periodic assessment of the Decision's implementation but does not prescribe a fixed review cycle or enforceable timeline.</i> <i>No formal assessment has been launched since the Decision's entry into force on 1 June 2020.</i>	<i>Amend Article 17: 'The implementation of this Decision shall be assessed every five years from its entry into force. The first assessment shall be completed no later than 31 December 2026. The administrative manager shall present findings to the Inter-Institutional Joint Management Committee and the staff committees party to this Decision within three months of the assessment's completion. Social dialogue on any revision shall commence within six months of the assessment. Where the assessment identifies material failures in coverage adequacy, contribution equity, or surplus management, an emergency review may be triggered by the staff committees at any time, requiring a response from the administrative manager within three months.'</i>	Mirrors the LAPF periodic review amendment (A10 of the LAPF proposal). The same structural problem – missed deadlines with no accountability mechanism – exists across all four instruments. BHR.5 acknowledged at 18 March 2026 that the obligation is to start an assessment, not complete it by the deadline. This amendment creates an enforceable cycle. An emergency review trigger for identified failures ensures that members are not held hostage to a five-year cycle when urgent problems arise.

**Amendment A12: Treatment abroad — transparency, criteria, and expanded access
(C(2019) 5684, Article 13 — revision; ADMIN(2020) 23 — new implementing provisions)**

Article	Current text (summary)	Proposed amendment	Justification & basis
C(2019) 5684, Art. 13; ADMIN(2020) 23 implementing provisions	Article 13 permits the administrative manager to grant prior authorisation for treatment outside the country of employment "in exceptional cases and without prejudicing the financial balance of the LA-Medical," subject to three conditions: (a) does not prejudice the complementary nature of the insurance; (b) LA Medical does not incur more costs than for treatment in-country; (c) treatment abroad does not delay return to work. The EU Delegations' Guide adds that authorisation "should be requested only if the required medical care would not be available or would be of clearly insufficient quality in the country of employment." No published criteria exist for how the "quality" or "availability" of local care is assessed. Transportation costs are not reimbursable. The process is described by BHR.5 as "case-by-case."	Amend Article 13: 'The administrative manager may authorise an affiliated member or their dependant beneficiaries to receive medical treatment under Section II Insurance in a country other than the country of employment. Authorisation shall be granted where local medical care for the condition in question is unavailable, of insufficient quality, or involves unreasonable delay.' Add to Article 13 — new paragraph: 'The administrative manager shall publish and maintain an assessment framework for determining the availability and quality of medical care in each country of employment. The framework shall include: (a) a list of medical specialties and procedures for which local care is deemed insufficient, updated annually with input from Delegation medical advisers; (b) transparent criteria for evaluating the quality of local providers, including clinical outcomes data, accreditation status, and available technology; (c) a mechanism for affiliated members to challenge an adequacy assessment by providing independent medical evidence. The framework shall be made accessible to all affiliated members.' Add to Article 13 — new paragraph: 'Where an affiliated member serves in a Delegation classified as a hardship posting (LCA category 3 or above), prior authorisation for treatment abroad shall be presumed justified for any condition requiring specialist consultation, surgery, or hospitalisation, unless the administrative manager can	Survey: 90.3% of respondents highly value the possibility of treatment abroad. Of these, 80.94% specifically want extended possibilities when the local system does not provide adequate treatment. Only 9.69% consider local care sufficient. 88% of respondents rely on LA Medical as their primary coverage; 53.44% describe their country's public health system as poor quality. Treatment abroad is currently framed as "exceptional," yet for LAs serving in countries with non-functional or severely limited healthcare systems, it is not an exception — it is a medical necessity. The absence of published assessment criteria means the decision is entirely at the discretion of individual desk officers in BHR.5, with no transparency and no basis to challenge their decisions. The cost condition (Art. 13(b) — LA Medical must not incur more costs abroad than in-country) is structurally illogical for staff serving in countries where in-country care is unavailable: zero cost in-country means any cost abroad is "more." A hardship-posting presumption reverses the burden of proof where the EU itself has already acknowledged that living conditions are difficult. Transportation and accommodation costs are currently excluded, creating a perverse barrier: the authorisation is granted but the member cannot afford to get there. The proposal aligns with the approach used in

		<i>demonstrate that adequate local care is available. The burden of proof shall rest with the administrative manager, not the affiliated member.'</i> <i>Add to ADMIN(2020) 23 implementing provisions: 'Where treatment abroad is authorised, reasonable transportation costs for the affiliated member (and one accompanying person where medically justified) shall be reimbursable up to economy-class airfare to the nearest country offering adequate care. Accommodation costs outside the hospital stay shall be reimbursable up to a daily ceiling equivalent to the applicable mission per diem rate for the destination country, for a maximum of 7 days before and after the authorised treatment.'</i>	JSIS for EU officials, where transfer to a centre of excellence is standard practice for complex medical conditions
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4. Summary of proposed amendments

The table below lists all eleven proposed amendments. The 'BHR.5 signal' column records explicit acknowledgements made at the Joint Meeting of 18 March 2026 where applicable; all amendments require a revised Joint Decision regardless of whether BHR.5 has pre-signalled them.

Ref.		Article(s) affected	BHR.5 signal (18 Mar 2026)	Survey / evidence basis
A1	Scope and definitions	Art. 2; Art. 3(4)	Not yet addressed	Restrictive interpretation of 'insufficient' insurance; coverage gap for out-of-scope Delegations
A2	Post-retirement coverage (LAM-R), post-termination bridging, and contribution waiver	C(2019) 5684 Art. 10 (new §4–8)	Confirmed as priority for Q1 2027 dialogue	45% top priority; only 8% support status quo; 51% unaware of current rules; WB modernisation redundancies; crisis duty station coverage gaps
A3	Ceiling indexation	ADMIN(2020) 23 Annexes; C(2019) 5684 Art. 14	Stopgap ceiling update committed for 2026	54% say MRAs outdated; 43% want annual adjustment
A4	Dental equalisation	ADMIN(2020) 23 Annex 1, Art. 1(5); ADMIN(2020) 32	Not yet addressed separately	Dental prostheses top-priority MRA; €700/7yr is functionally meaningless
A5	Reimbursement rate	C(2019) 5684 Art. 11	Not yet addressed	Satisfaction 5.3/10; 66% report limited access; 88%

				primary coverage; treatment abroad ring-fenced via PAR
A6	Direct billing expansion	ADMIN(2020) 23 Art. 9	Note to HoDs committed	74% unaware; pre-financing stress documented
A7	Chronic prescriptions	ADMIN(2020) 23 Art. 7 (new)	BHR.5 committed to examine	Raised by OSP/USHU; cost-saving for both members and scheme
A8	Contract-type equality	C(2019) 5684 transitional provisions	Confirmed as priority for Q1 2027 dialogue	Jointly-financed scheme; shared ownership; 1.37% employee / 2.74%+ employer contribution identical; benefits cannot lawfully be conditioned on LA-CE addendum
A9	Surplus governance	C(2019) 5684 (new Article)	Not yet addressed	€44.5M surplus with no reporting or utilisation framework
A10	Mental health & prevention	ADMIN(2020) 23 Annex 1, Art. 2(3)–(5)	Screening expansion raised by OSP/USHU	Psychotherapy/physio restrictive; hardship postings
A11	Periodic review	C(2019) 5684 Art. 17	Overdue review acknowledged	Mirrors LAPF A10; enforceable cycle needed
A12	Treatment abroad — transparency, criteria, and expanded access	C(2019) 5684, Article 13 — revision; ADMIN(2020) 23 — new implementing provisions	Not yet addressed	The survey data is devastating: 90.3% value treatment abroad , of which 80.94% want extended possibilities when local care is inadequate. Only 9.69% say local care is sufficient. The current legal basis is Article 13 of C(2019) 5684 — "exceptional cases" with opaque criteria.

5. Process commitments sought from BHR.5

In parallel with the substantive amendments, the above OSPs request the following process commitments to be formalised before September 2026:

- A firm timetable for the 2026 social dialogue: commencement date, indicative number of sessions, and expected timeline for conclusion.
- Confirmation that staff committees receive BHR.5's internal assessment document (reflecting internal arbitrations on LA Medical) at least eight weeks before the first social dialogue session.
- Publication of the first annual LA Medical financial report (covering the 2025 reference year) before the social dialogue commences, so that negotiations proceed on the basis of transparent data.

- Delivery of the committed 2026 stopgap ceiling updates no later than Q3 2026, with a progress report to staff committees by end-June 2026.
- Issuance of the note on direct billing and salary advances to all Heads of Delegation and Heads of Administration no later than end-May 2026.
- Launch of the quarterly LA Medical newsletter no later than Q2 2026.
- An actuarial assessment of LAM-R scheme feasibility, commissioned from an independent actuary, to be presented to staff committees before the social dialogue session addressing post-retirement coverage.
- Proactive notification, within two weeks, if the Q1 2027 start date cannot be met.