



European Cross-Border Cooperation on Health: Theory and Practice



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EUROPEAN CROSS- BORDER COOPERATION ON HEALTH: THEORY AND PRACTICE

Study conducted by Eric Delecosse, Fabienne Leloup and Henri Lewalle

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Foreword



Corina Crețu
European Commissioner for
Regional Policy

Health concerns us all. Whether we are health professionals or patients, we are all citizens and taxpayers who expect the health care system, a public service, to be of good quality, affordable and accessible.

Health does not know any borders. This means that a patient should be allowed to go to the

closest hospital, even if that is in a country different from the one that he lives in.

Innovative and sustainable solutions exist across Europe to ensure access to high quality healthcare in border areas. I can proudly say that for more than 25 years the Interreg funding has offered real potential to border regions planning to invest together in health and long-term care.

Cross-border cooperation in health aims to facilitate the mobility of patients and health professionals living and working in those regions, improving access to local care as well as developing joint facilities and services. This kind of cooperation is often necessary given the isolation of certain regions.

I am pleased with this study, not only because it provides an overview of the development of the existing European legislation that enables cross-border health cooperation, but also because it offers a useful insight into the obstacles and success factors of cooperation in different geographical contexts.

You will find in it several examples of forms of cooperation supported by Interreg funding, varying from the creation of a Franco-Spanish hospital in the mountains allowing ambulances to cross the border to enabling Polish patients to consult a German doctor without even travelling.

Particular focus of the study is put on the advanced cooperation at the Franco-Belgian border, which could serve as a benchmark for others. Thanks to the framework agreement on cross-border health cooperation between Belgium and France in 2005, seven areas of organised access to cross-border healthcare were created. The patients in those health zones can receive care on both sides of the border without any administrative or financial barriers. Since 2008, emergency medical services on both sides of the border are also working together.

Lastly, I want to congratulate all those individuals involved in cross-border health cooperation. Notwithstanding the various obstacles that you have to overcome, often of administrative or legal nature, I am glad that you remain convinced that working with each other is beneficial to everybody. It simply costs less if border regions act together than alone. Cooperation generates innovative solutions, which will in turn create opportunities and growth in border regions.



Vytenis Andriukaitis
European Commissioner for
Health and Food Safety

I very much welcome this study which provides a useful overview of cross-border cooperation in the area of healthcare initiatives. It outlines how European health policy has developed through the different European Treaties. This study also provides a number of good examples of fruitful cross-border cooperation between countries and regions

that illustrate that collaboration on healthcare between EU countries is worthwhile for everyone. Among many cross-border projects it puts particular emphasis on the mutually beneficial collaboration in the border region between Belgium and France.

Adopted in 2011, the Cross-border Healthcare Directive was a major step forward for European health policy, bringing the EU closer to the needs of citizens. It ensures patients' rights to access safe and high-quality healthcare across national borders in the EU and their right to be reimbursed of such healthcare. In addition, this Directive provides a strong framework for voluntary cooperation and today we can see the clear added value this has brought in the areas of eHealth, health technology assessment, and European Reference Networks.

The latter is an excellent example for innovative cross-border cooperation. In March this year, the Commission launched 24 thematic Networks which involve more than 900 specialised healthcare units in over 300 hospitals in 25 EU Member States plus Norway. The Networks will help those suffering from rare diseases or complex conditions all over Europe by improving access to medical specialists and diagnosis and treatment. This cooperation also has the huge potential, for example to boost medical research and develop new care models and eHealth tools which should encourage all actors to develop it further.

This study provides a number of good examples of fruitful cross-border cooperation between countries or regions that illustrate how collaboration on healthcare between EU countries is worthwhile for everyone. Last April, I had the pleasure to visit a hospital in a Franco-Belgian border region and see the excellent cooperation model between two countries in practice. It was a clear demonstration that with some good will as well as talented and dedicated people, the life of Europeans can be changed for the better. I am hopeful that such examples will inspire and encourage other countries to follow this example.

Let's take inspiration and advice from this study which, for its part, contributes towards the Cross-border Healthcare Directive delivering its full potential. We need to continue developing our ways of cooperation across national borders, for the benefit of EU citizens!

A handwritten signature in black ink, which appears to be the name Vytenis Andriukaitis. The signature is fluid and cursive, written in a dark color.

Glossary

ARH: Agence régionale d'hospitalisation
(Regional Hospital Agency - France)

ARS: Agence régionale de santé (Regional Health Authority - France)

SEA: Single European Act

EHIC: European Health Insurance Card

ECSC: European Coal and Steel Community

EEC: European Economic Community

CH: Centre hospitalier (hospital)

CHAPEA: Consumers, Health and Food Executive Agency

CJEU: Court of Justice of the European Union

CLEISS: Centre of European and International Liaisons for Social Security

CPAM: Caisse primaire d'assurance maladie (local healthcare insurance office - France)

DG SANCO: Directorate-General for Health and Consumers (now Directorate-General for Health and Food Safety)

DG SANTE: Directorate-General for Health and Food Safety

ESPON: European Observation Network

EGTC: European Grouping of Territorial Cooperation

WG: Working Group

RT: Response time

INAMI: Institut National d'Assurance Maladie Invalidité (National Health and Disability Insurance Institute - Belgium)

MRI: Magnetic Resonance Imaging

OMC: Open Method of Coordination

WHO: World Health Organisation

NGO: Non-governmental organisation

CSRs: Country-specific recommendations

SEDs: Structured Electronic Documents

SMUR: Service mobile d'urgence et de réanimation (mobile emergency and intensive care services - France and Belgium)

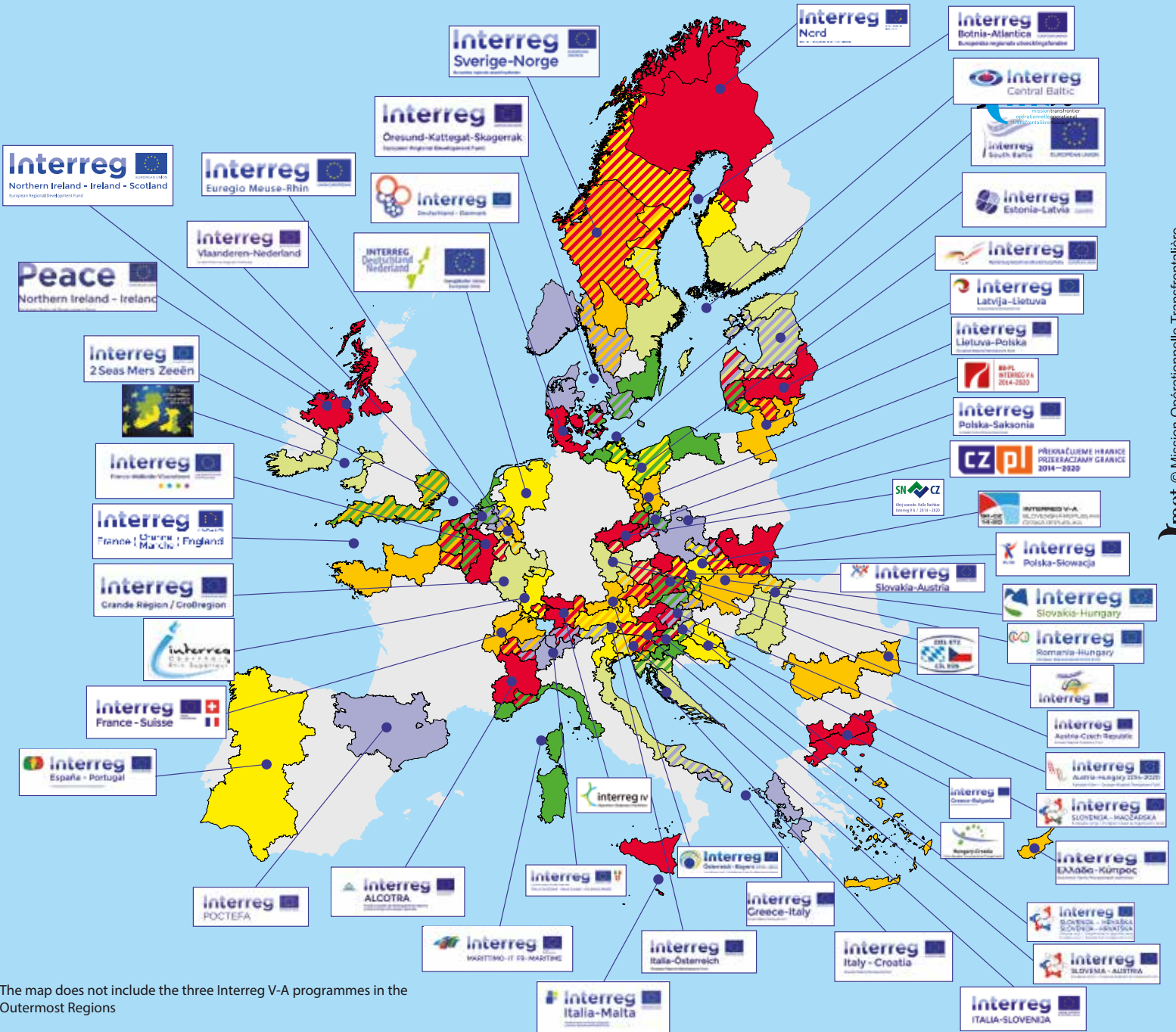
TFEU: Treaty on the Functioning of the European Union

EU: European Union

ZOAST: Zone organisée d'accès aux soins de santé transfrontaliers
(Planned cross-border health treatment zone)



Interreg V-A programmes 2014-2020



The map does not include the three Interreg V-A programmes in the Outermost Regions

Source : DG REGIO and internet websites of the Interreg programmes

Introduction

Interreg: a catalyst for cooperation

European Territorial Cooperation (ETC), better known as Interreg, celebrated its 25th anniversary in 2015. An integral part of cohesion policy since 1990, Interreg has become a key instrument to resolve the problems typical of border areas, to promote cooperation between partners across borders and to develop the potential of European border territories.

This initiative is unique both for its longevity - it has been around for a quarter of a century - and, most importantly, in terms of the emergence or strengthening of cross-border territorial dynamics. Each Interreg programme has a budget with which to implement a cooperation strategy that takes account of the strengths and weaknesses of each area. The local project promoters are at the origin of putting in place the practical actions on a voluntary basis.

From their start, the Interreg programmes have given generous support to cooperation. By encouraging a dynamic of cross-border cooperation, these programmes have enabled, and continue to enable, institutions, entities and partners on either side of the border to come together to develop joint measures and projects enriched by their separate experiences.

This support is hence transforming the border, once seen as an obstacle, into an opportunity for cooperation in various fields. For the period 2014-2020, Interreg V has been allocated a budget of some €10.1 billion to be invested in more than a hundred programmes promoting cooperation between the regions and their territorial, social and economic partners.

Cross-border cooperation on health

To mark the 25th anniversary of Interreg, health was identified as an area particularly representative of the building of Europe. Cross-border cooperation on health bears witness to the positive impact of the European unification process through the development of legislation promoting the mobility of workers and the free movement of people, the creation of the internal market, and the development of regional cooperation projects for access to health care and synergies between the healthcare systems across Europe.

Cross-border cooperation on health firstly aims to facilitate border crossing, that is to say, it encourages the mobility of patients and health professionals. Secondly, it aims to develop access to high-quality health care "at the border", through the use of common equipment, shared services and joint facilities in the cross-border area. Over time, cross-border cooperation in the field of health has seen numerous initiatives primarily thanks to Interreg funding.

The idea for this publication grew out of this observation. Given the exemplary nature of the Franco-Belgian cooperation on health care and the existence of many other innovative examples across the EU, the authors have aimed to provide an account of cross-border cooperation on health. This cooperation includes a vast programme of measures and regulations. It primarily concerns the patient, but also the coordination and support of health professionals, institutions and decision-makers concerned. It necessarily also affects the health systems concerned.

In parallel with the roll-out of cross-border cooperation, Europe has seen its role in health issues expand since the early stages of integration. The increase in life expectancy and progress in diagnosis and treatment, supported by technological innovations and other such developments, are creating new needs with a growing demand for treatment and high expectations of health safety. Health crises, such as the contaminated blood supply crisis or the mad cow disease, have made these demands all the more acute.

So little by little, public health has become an area of shared jurisdiction between the EU and its Member States. The protection and improvement of health remains the responsibility of the States. Nonetheless, they are invited to cooperate in improving the quality of life for their cross-border populations under the Lisbon Treaty (article 168) and by Directive 2011/24 on the application of patients' rights in cross-border healthcare.

The European Union's role in public health

An analysis of the background to European public health is a necessary first step in understanding European cross-border cooperation in the area of health.

As the first chapter explains, before the Single European Act (1986) health was not addressed at the EU level except indirectly or under exceptional circumstances. It was the Maastricht Treaty (1992) which created the legal basis of the EU's jurisdiction in the field of health. This basis was expanded by the Amsterdam Treaty, which authorises the adoption of binding decisions, and the creation in 1999 of the Directorate General for Health and Consumers (DG SANCO, now DG SANTE). This DG symbolises the EU's involvement in the sector.

Article 168 of the Lisbon Treaty, which came into force in 2009, sets out the ambitions of the EU in close collaboration with the Member States. Its overall objective is to ensure a high level of human health protection in all its policies and activities. This article also encourages cooperation between the Member States to improve the complementarity of their health services in cross-border regions. The article extends the EU's powers by including medicinal products and devices for medical use.

The second chapter addresses access to cross-border treatment in the European Union. It describes the emergence of social legislation unequalled anywhere in the world, since the early days of the European Coal and Steel Community (ECSC) and then of the Common Market. This legislation enabled first workers, and then European citizens, to benefit from free movement throughout the EU while preserving their rights to social benefits.

This body of law consists of European regulations coordinating social security systems, which allow patients insured under these systems, subject to prior medical authorisation, to receive hospital treatment in another Member State, which is then charged to their social security system. Since 2013 this legislation has been supplemented by the Directive 2011/24 on patients' rights in cross-border healthcare, the first and only health directive to date, which authorises a degree of patient mobility without prior authorisation for planned non-hospital treatments.

Today, the opening of the borders enables all European citizens to enjoy one of the most fundamental rights of the EU, which is the right of free movement, including the right to give or receive treatment, while preserving the social benefits to which they are entitled.

Cross-border health projects across Europe

The third chapter highlights a number of cross-border health cooperation projects in the European Union in terms of their implementation. The seven selected projects illustrate the diversity of cross-border contexts and circumstances, representing urban and rural areas, the North, South, East and West of the EU, recent projects and projects based on partnerships or experiences that have lasted for several decades.

All these projects demonstrate how human intelligence, in association with the openness of the partners and the emergence of common interests, can lead to often successful and innovative solutions despite often-restrictive legal and administrative contexts. These examples show how cooperation is transforming the border from a constraint into an opportunity, improving access to treatment and, therefore, public health.

The cases discussed emphasise the decisive support of the Interreg programmes, but they also reveal the creativity and proactive approach of the operators themselves. These cooperation projects are just the start of a long-term process which should lead to heightened visibility of the results and advantages of cooperation, but above all to the capitalisation on and, therefore, the dissemination of good practices.

This chapter was drafted on the basis of written or telephone interviews with the project managers, and also through desk research using sources that include the project files available on InfoRegio (the website of the Directorate-General for Regional and Urban Policy), the websites of the partners, scientific publications and press reports.



The Franco-Belgian experience as the benchmark in cross-border health cooperation

The fourth and final chapter offers an in-depth analysis of the progress made over the more than twenty-five years of constructing cross-border cooperation on health in the Franco-Belgian border area.

The experience along this Franco-Belgian border reflects the dynamics supported by the different periods of Interreg programming. Starting with the first forms of cooperation between hospitals, this chapter first describes the Transcards project, which allowed people with state health insurance to use their social security cards to be admitted into a hospital on the other side of the border. This form of cooperation then turned into the Franco-Belgian 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.

Finally, seven organised zones for cross-border access to healthcare (ZOASTs) were created alongside the Franco-Belgian border. Those ZOASTs, covering today the whole border, enable the pooling of resources and techniques in order to develop a wide range of care accessible to the population of the defined legal zone without any administrative or financial barriers. Those ZOASTs have become benchmarks for cross-border health care cooperation across Europe.

This chapter also explains the cooperation between France and Belgium in the area of emergency medical services and in the medico-social sector with a particular focus on people with disabilities. The achievements and gains are to the credit of Interreg's programmes and their objectives of cohesion and European integration.

Cooperation to the benefit of complementarity, growth and mobility

The recurrent theme in this publication is the importance of one particular sector to the cross-border areas: health, more especially public health. Approached in terms of public needs, public health constitutes a challenge for European and national authorities because of the free movement

and trade, a challenge that has been made more acute by the budgetary constraints experienced by the EU and its Member States.

As these chapters show, cross-border cooperation on health is necessary, given the marginalisation of certain populations and their areas. This cooperation enables the introduction of specific, innovative and adapted measures. It offers border citizens dignified healthcare conditions and in some cases initiates changes at the local level that are destined to be generalised at a European scale.

In health as in other sectors, local issues force people to think outside the box to find solutions and to create the opportunity for cross-border cooperation. This opportunity can then enable us to resolve other problems, transforming practices or even structures. It can also — if the context is

favourable — entail the spread of good practices to other borders or to cooperation in other fields.

Primarily reaching out to citizens in their daily lives, cross-border cooperation on health improves access to local healthcare but also contributes to the complementary nature of the healthcare provided on either side of a border. It enables the supply of healthcare to be pooled at the cross-border level, and makes it easier for both patients and professionals to move across the border.

People living in border areas, whether patients or health professionals, thus become symbols of border crossing, a vector of peace, cooperation and development.





CHAPTER 1

**THE EUROPEAN UNION'S
ROLE IN PUBLIC HEALTH**

Public health as defined by the World Health Organisation (WHO):

the science and art of preventing disease, prolonging life, and promoting mental and physical health and efficiency through organised community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organisation of medicine and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery to ensure to every individual a standard of living adequate to the maintenance of health, so organising these benefits as to enable every citizen to realise his birth right of health and longevity (WHO Technical Report Series No 55, 1952, p. 6).

Public health, in those aspects defined by the Treaty on the Functioning of the European Union, constitutes an area of shared competence between the European Union and its Member States: the protection and improvement of health remains the responsibility of the States and the EU supplements national guidelines through its policies.

As Willy Palm (2014) summarises¹, the history of European public health policy has developed from an indirect, almost exceptional intervention in the days before the Single European Act (SEA) in 1986 to today's more Community-based health policy.

This chapter retraces the major stages in the evolution of public health policy since the Treaty of Rome. It then addresses more contemporary aspects, such as Article 168 of the Lisbon Treaty which encourages

cross-border cooperation on health, the Directive on the application of patients' rights in cross-border healthcare, the link between public health and the "European Semester" initiative and the Open Method of Coordination (OMC) as applied to this sector.

1. Before the Lisbon Treaty (2007)

1.1. Health as a support to the single market

Initially, health was not specifically addressed by the European founding treaties. From the Treaty of Rome to the Single European Act (SEA), health was only an indirect factor, in particular where free movement was likely to be restricted.

In 1986, the SEA introduced legislation intended to protect the health and safety of workers in an integrated single market. At this time, health was essentially seen as an ancillary support to the single market, in particular to the free movement of workers.

1.2. Towards an EU health policy

During the years 1986 to 1997, an EU health policy was gradually introduced. These years saw the launch of programmes intended to cope with major health challenges, such as the fight against cancer or the HIV/AIDS pandemic.

Starting in the 1990s, multiple health crises occurred in Europe, such as the mad cow disease. Fighting these demanded a more coordinated health policy at EU level. This need was addressed in 1992 by the inclusion in the Maastricht Treaty of an article defining the Community's powers in public health matters.

Article 129 of the Maastricht Treaty thus created a legal basis to strengthen the actions of Member States in this area, stating that the Commission shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States including with third countries and international organisations, and, if necessary, lending support to their action. The article further stipulates that European Community action shall be directed towards

¹ Willy Palm is an advisor and head of communication at the European Observatory on Health Policies and Health Systems.



the prevention of diseases and major health scourges, by promoting research and information, defining the scope and the sphere of this new power. These indications are accompanied by the confirmation of the principles of subsidiarity and of the exclusive competence of Member States in matters of health.

At the same time, the social dimension of health was emphasised with the strengthening of European integration. As from 1992, therefore, European decisions in this area evolved while maintaining national preferences and particularities. From 1993, European public health programmes were established in eight areas for action: health promotion, health monitoring, 'Europe against cancer', drugs, AIDS and communicable diseases, injury prevention, pollution-related diseases and rare diseases. These programmes were implemented until 2002.

The Amsterdam Treaty, signed in October 1997, enabled an extension of the legal basis for the EU's activities and the adoption of binding

decisions: all this was a response to a search for regional balance in matters of public health.

Article 6 of the Treaty on the Functioning of the European Union (TFEU) of 1997 explicitly includes the protection and improvement of human health as an area of shared competence between the Member States and the EU. It is among the matters for which the text states that the Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States.

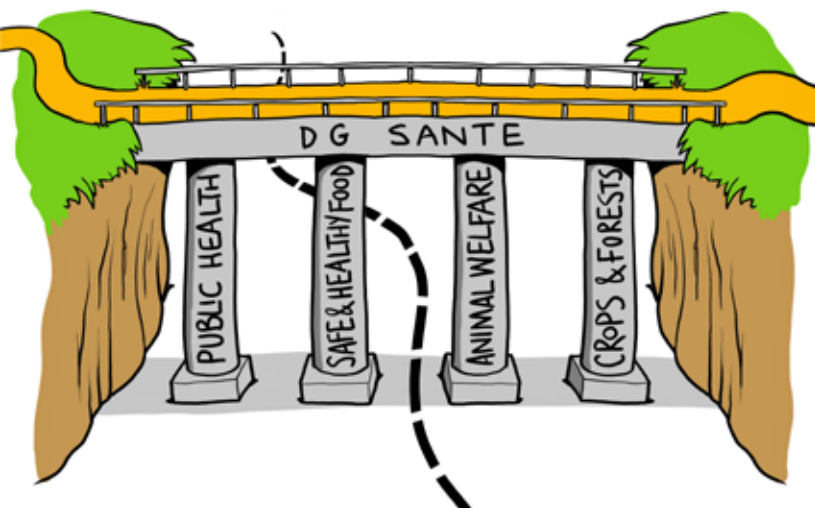
The EU's action thus supplements national policy, in particular in combatting major health scourges, or monitoring cross-border threats. The EU encourages the coordination of Member States' actions and can take initiatives.

1.3. A policy fostering social values and principles

In 1998, before the Amsterdam Treaty had even come into force in May 1999, the European Commission launched a wide debate to consider the direction of future Community public health policy. The aim was to address the major changes that were taking shape, including the growing pressure on health systems. Tensions, indeed, were appearing between rising health expenditure, due to greater technical sophistication, demographic ageing and an increasing demand for quality healthcare on the one hand, and the reduction in the public spending of Member States on the other. To these pressures were added the changes brought about by the enlargement of the EU and the new Treaty provisions.

One of the major challenges of this period was the growing application of internal market principles to healthcare. As we will see below, the Kohll and Decker judgment issued by the Court of Justice of the European Union (CJEU) in 1998 confirmed, in part, the economic nature of health services and the need to develop a counterweight to market logic.

In 1999, the Directorate-General (DG) for Health and Consumers was set up within the European Commission. The action of this DG, now known as the Directorate-General for Health and Food Safety or DG SANTE, is based on four pillars: to protect and improve public health; ensure Europe's food is safe and wholesome; protect the health and welfare of farm animals; and protect the health of crops and forests.



The Lisbon strategy, launched in 2000, aims inter alia to achieve a better balance between the EU's economic aspirations and the European social model. Consequently, new Community approaches have been developed to modernise social protection systems.

The Charter of Fundamental Social Rights, adopted in December 2000, sets out the fundamental rights which lie at the heart of the European project and which must be respected by the Union and its Members. Article 35 of this binding legal instrument establishes the right to health care, i.e. access to preventive health care and the right to benefit from medical treatment, along with a high level of human health protection.

The draft Services Directive of January 2004 launched a debate on the liberalisation of the services sector, including healthcare. This Directive aimed to establish a genuine internal European market in services and to guarantee for the sectors in question both the free access of service providers and the free exercise of service activities in Europe. After two years of debate and controversy, health services were finally excluded from the scope of this Directive.

At this period, the EU was concerned with the prospect of enlargement to include the Central and Eastern European countries. In these countries, health systems faced significant disparities between Member States but also within the States themselves, inter alia in terms of state of health, access to care and performance. It was against the background of this historic enlargement, and in conjunction with the growing globalisation, that cooperation between the Commission and international organisations such as the WHO was strengthened.

In 2006, health ministers from Member States drafted a joint declaration asserting the values of universality, accessibility, equity and solidarity and the principles of quality, safety, patient involvement, confidentiality and redress. They called for respect for these common values and principles when proposals for health services were drawn up. While not binding, these values and principles are intended to inform the guidelines for health systems in Member States and to encourage European institutions to promote them in implementing Community policies.

2. From the Lisbon Treaty to today: significant progress

2.1. Promoting public health with article 168

Health, an area initially addressed indirectly or exceptionally through a diverse range of measures, has been gradually integrated into Community policy. In parallel, the European Commission has tended to develop a more horizontal and integrated approach to the new challenges facing health.

This approach to public health takes its current shape from the Lisbon Treaty, more particularly in article 168 (Title XIV).

The text starts by defining an overall objective: ensuring a high level of human health protection in all the Union's policies and activities. It then sets out the competences and methods of intervention existing in the various areas, and restates the primacy of Member States in defining health policy and in the organisation and financing of health services and medical treatment. On another note, article 168 includes a new aspect: the development of cross-border cooperation on health. Finally, the scope of competence is extended and now includes medicinal products and devices for medical use (article 168 4c).

Other articles in this Treaty also relate to health, in particular article 169 on consumer protection and article 191 on the work place environment.

TFEU (Official Journal of the European Union of 26 October 2012)

TITLE XIV

PUBLIC HEALTH

Article 168

(ex Article 152 TCE)

1. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. **It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.**

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

2.2. A legal framework for organising the right of patients to cross-border healthcare

The Directive on patients' rights in cross-border healthcare, adopted in 2011, is an important stage in EU health policy. This Directive resolves the question of reimbursement of healthcare provided outside the patient's Member State of affiliation, an issue raised by the CJEU's case law. At the same time, this new law creates a legal basis for developing a Community coordination policy for healthcare, with due respect for the responsibilities of Member States under article 168 (7) of the Treaty.

The Directive therefore provides a legal framework within which to organise structured cooperation between Member States in a range of areas such as health technologies, creating referral networks or eHealth.

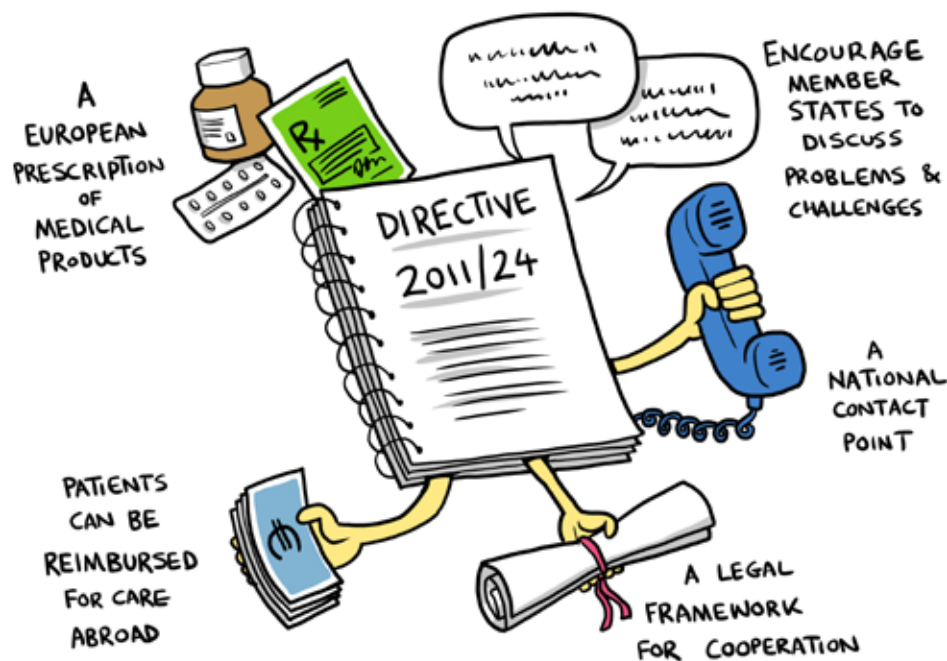
These developments have led Member States to a more open discussion, at the Community level, of the problems and challenges posed by

health policies and the management of their healthcare systems. Therefore, there is now a collective approach to the problem of shortages of health professionals (a shortage sometimes created by the right of free movement), the establishment of systems for assessing and ensuring the quality of care or the creation of an integrated approach in the prevention, treatment and follow-up of diseases like cancer.

2.3. The European Commission's main tools applied to health

Multi-annual public health programmes

Starting in 2003, multi-annual action programmes have been adopted: the EU Public Health Programme 2003-2008, followed by the Programme of Community Action in the field of Health and Consumer protection 2007-2013. These programmes organise and finance joint activities and projects in the field of health.



In continuation of these multi-annual action programmes, in 2007 the European Commission combined all its actions in the field of health in an integrated strategy entitled Together for Health: A Strategic Approach for the EU 2008-2013. Three broad targets are proposed:

- fostering good health in an ageing Europe by promoting health throughout the lifespan;
- protecting citizens from health threats (including communicable diseases and bioterrorism) and ensuring patient safety;
- supporting dynamic health systems and new technologies.

The EU's third multi-annual health programme relates to the period 2014-2020. Broken down into annual work plans, this is the European Commission's main tool for achieving the EU's health strategy.

The programme is managed by the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) This agency, which is the successor to the Executive Agency for Health and Consumers, began its work in 2014. It carries out the missions entrusted to it by DG SANTE, and inter alia manages the EU's health programme.

The multi-annual programme entitled, Health for Growth (2014-2020) has four main objectives:

1. to promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle;
2. to protect EU citizens from serious cross-border health threats;
3. to contribute to innovative, effective and viable health systems;
4. to increase access to better and safer healthcare for EU citizens.





The Europe Semester and the Country-Specific Recommendations

Since the economic and financial crisis in 2008, health systems, as an aspect of the socio-economic policies of the States, have attracted more in-depth attention at Community level. These systems have significant implications for Member States' budgets.

In the context of the European Semester², cycle, health systems have gradually come to be subject to Country-specific recommendations. Although these recommendations are primarily budgetary in nature, they also aim to encourage Member States to adopt reforms in order to achieve access to care, budgetary balance and better-performing health care systems.

The Open Method of Coordination (OMC)

In addition to these recommendations, the EU also collects in-depth data. This makes it possible to compare health systems, and enables the European Commission to issue opinions and recommendations to Member

States. A Joint Assessment Framework has also been developed in the context of the Open Method of Coordination. It mainly focuses on the issues of access, quality, equity and effectiveness of health systems.

Despite the limits on its powers in the field of health, the OMC, which was introduced in 2004 as a new policy instrument, makes it possible to establish operational joint policy objectives together with indicators and an evaluation process.

3. Current issues and challenges

Today, it must be admitted that there are still disparities in the supply of health care between and within Member States, even though health systems in EU countries are tending to converge. Indeed, they are becoming more and more interdependent, not least as a result of the improved conditions of mobility for patients and healthcare professionals alike.

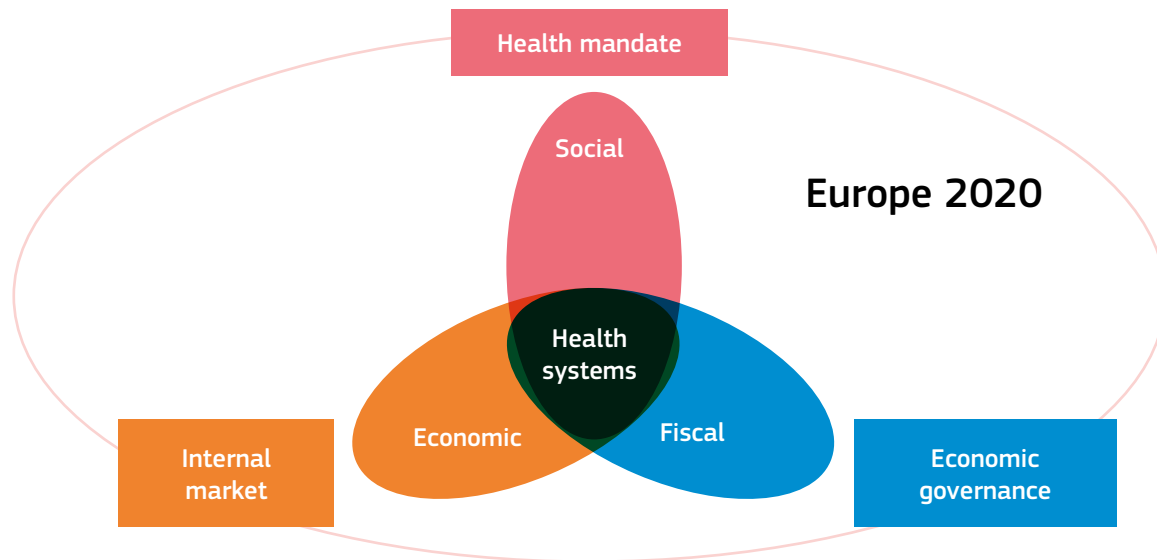
In the light of these movements, the Commission adopted an EU agenda on 4 April 2014 to encourage Member States to develop accessible and effective health systems capable of adapting to the new social challenges. The initiatives promoted by this agenda include improving the health of patients and reducing inequalities, in particular in terms of regional differences in the quality of health care.

The chronology that we have traced here might suggest that Community health policy has developed in a somewhat fragmented way, essentially in response to health crises. The reality is more complicated. Article 168 of the Lisbon Treaty unquestionably reflects the changes brought about by health crises, such as the blood contamination crisis in the 1990s. But following that crisis, genuine powers and a Community mechanism for standards were introduced. These standards are particularly strict when they concern guarantees of the safety of blood products and of human tissues, cells and organs.

It also appears that the process of European integration has had a real if indirect influence, expressed inter alia through policies for the free movement of persons, goods and services. It has thus acted as a factor for the inclusion of health in EU policies.

² A mechanism established in 2010 with a view to coordinating Member States' economic and budgetary policies.

Graphic 1: Health systems at the interface between social, economic and fiscal systems (Palm, 2014)



As the graphic shows (Palm, 2014), health systems stand at the interface between social, economic and fiscal systems.

As illustrated, the EU's approach to health rests on those three strands. Health is seen as a crucial element for growth and social cohesion of the populations of Member States. It is also an important economic sector, not least because it directly and indirectly creates large numbers of jobs. Finally, health constitutes a critical budgetary item, in particular in terms of the EU's measures for economic and monetary stability.

Public health, as defined by article 168, thus cuts across many Community policies.

There are marked tensions between the social needs determined by Member States on the one hand and the economic and budgetary constraints set by the EU on the other. However, there is a widespread and growing awareness of the political and social importance of the health sector.

The Europe 2020 strategy, which targets smart, sustainable and inclusive growth, regards health as an indispensable condition for achieving its goals.

Whereas the economic and financial crisis has led to a contraction in public spending, there is a growing need to develop a more consistent European policy for health and healthcare systems. The financial difficulties of Member States are leading them to cooperate more, transferring information and sharing good practices.

Faced with these challenges, the Commission can call upon a wide range of tools and institutions to achieve its objectives. For example, in addition to the bodies discussed in this chapter, there is also the European Food Safety Authority, the European Medicines Agency and the European Centre for Disease Prevention and Control.

Certainly, European integration in the area of public health remains rather hesitant compared with other sectors, as health is still an area that national governments tend to prefer to manage independently.

However, in light of the global stakes, the expectations and needs of populations, the free movement of people and goods and the cross-border dynamics, the EU has provided precise responses to some of the challenges in terms of public health. More generally, the EU must be able to contribute to bringing together ideas, regulatory frameworks and resources to promote a harmonised European public health policy worthy of the name.

The background of the entire page is a solid blue color with a white topographic map pattern. The map consists of numerous irregular, concentric contour lines of varying thickness and spacing, creating a sense of depth and terrain. The lines are more densely packed in some areas, suggesting steeper slopes, and more widely spaced in others, suggesting flatter ground. The overall effect is a textured, layered appearance.

CHAPTER 2

**ACCESS TO CROSS-
BORDER HEALTHCARE IN
THE EUROPEAN UNION**

Access to healthcare in the EU is a competence exercised exclusively by the Member States. Nonetheless, to encourage the mobility of workers and citizens more generally, a policy of coordinating the social security systems of the Member States was initiated in the earliest days of European integration. This has opened the way to healthcare access in the EU in various forms. It is therefore useful to retrace the origins of this measure, as it has opened up rights to care in another Member State with costs borne by the citizen's own social security system.

There are four distinct periods. The first concerns the agreements reached by the European Coal and Steel Community (ECSC); the second, the implementation of the Treaty of Rome; the third, the adoption of European rules coordinating social security systems and the fourth and last, the application of the freedom to provide services in the field of healthcare.

1. The origins of freedom of movement for workers

Access to cross-border healthcare emerged with the earliest form of European integration, in the form of the agreements setting up the European Coal and Steel Community (ECSC) in 1952. Originally, access to healthcare abroad was intended to facilitate and support the mobility of migrant workers.

The genesis of European social protection law is closely bound up with the history of the construction of Europe, the first form of which can be dated to the Paris Treaty signed on 18 April 1951. This Treaty was essentially economic in scope. It aimed to create a coal and steel market between six countries, the Federal Republic of Germany, France, Italy, the Netherlands, Belgium and Luxembourg.

Article 2 of the Paris Treaty states that the aim is to contribute to the development of employment and the improvement of living standards in the participating countries. This social purpose is confirmed in article 3, which speaks of improving the living and working conditions of the labour force so as to make possible the equalization of such conditions in an upward direction in the economic sectors concerned by the Treaty.

In this way, the Treaty affirms the interdependence of social and economic factors, namely that social progress will accompany a market engendering economic growth. This approach by the ECSC's High Authority

established a social policy that primarily extended to housing and vocational training.

The ESCS's social policy was thus part of a wider policy: that of employment. The vast coal and steel market could not be achieved without labour. This labour must be capable of adapting to economic changes and of relocating within the new economic space in order to respond to the demand for labour in the economic sectors concerned by the Treaty.

The Paris Treaty did not envisage the introduction of a supranational social security policy. For its part, the High Authority sought not to harmonise but rather to coordinate national regulations to remove the obstacles to the free movement of people within the ESCS market.

This objective is reflected in the text of the Treaty, which requires Member States to prohibit any discrimination between nationals and migrants in remuneration and working conditions, and to work out any necessary arrangements so that social security measures would not stand in the way of the movement of labour. It was on the basis of these provisions that the ECSC took the initiative in coordinating national regulations.

2. The definition of special social rights for migrant workers

Article 2 of the Treaty of Rome (1957) which created the European Economic Community (EEC) states that It shall be the aim of the Community, by establishing a Common Market and progressively approximating the economic policies of Member States, to promote throughout the Community a harmonious development of economic activities, a continuous and balanced expansion, an increased stability, an accelerated raising of the standard of living and closer relations between its Member States.

The social provisions of the Treaty of Rome are summarised in articles 48 to 51 on the free movement of workers and articles 117 to 128 on social policy, including the creation of the European Social Fund.

To encourage the free movement of workers, article 51 gives the Council of Ministers decision-making powers: *"The Council, acting by means of a unanimous vote on a proposal of the Commission, shall, in the field of social security, adopt the measures necessary to effect the free movement of workers, in particular, by introducing a system which permits an*

assurance to be given to migrant workers and their beneficiaries:

- *that, for the purposes of qualifying for and retaining the right to benefits and of the calculation of these benefits, all periods taken into consideration by the respective laws of the countries concerned, shall be added together;*
- *that these benefits will be paid to persons resident in the territories of Member States.”*

These provisions, which are set forth in the European Convention concerning the Social Security of Migrant Workers, signed on 9 December 1957, would be taken up in the first European regulations coordinating social security systems.

3. Developing a European social security system for workers

European social security legislation is the indispensable condition for the exercise of the right of free movement of persons in general and workers in particular.

European social security law does not set out to harmonise the social security systems of different Member States. Rather it aims to coordinate them, without altering the competences of Member States in this field. Consequently, each Member State remains free to determine, for example, who should be insured under its own legislation, what benefits should be paid and under what conditions.



3.1. The first European regulations coordinating social security systems

The first coordinating regulation, adopted by the Council of Ministers on 25 September 1958, and its implementing regulation constitute the first instrument for the coordination of national legislation on the social security of migrant workers.

These European coordinating regulations established rules and principles to facilitate the exercise of the right of free movement. They play a key part in guaranteeing equal treatment for citizens exercising their right of free movement within the EU and those who live and work in the same Member State.

They establish some important principles:

1. Equality of treatment between nationals and non-nationals enables a person residing in the territory of one Member State to be subject to the same obligations and enjoy the same benefits as the nationals of that Member State without (direct or indirect) discrimination on grounds of nationality;
2. The aggregation of periods of insurance, employment, self-employed activity or residence under the legislation of one Member State, so that these periods are taken into consideration, to the extent necessary, e.g. for the acquisition of the right to benefits under the legislation of another Member State;
3. The “exportability” of benefits so that they can be exported and received in cash in any other Member State;
4. The determination of the Member State whose social security legislation is applicable; in principle, one single social security system is applicable at any one time, so that a person can benefit from the appropriate social security cover without being simultaneously subject to the laws of two or more Member States. It also follows that this person may under no circumstances be obliged to pay a double contribution, nor, contrariwise, no contribution at all.

These principles enable insured persons to move freely from one Member State to another within the EU. Therefore, for workers, the principle of equal treatment and non-discrimination not only prohibits direct discrimination on the basis of nationality, but also indirect discrimination which is particularly likely to penalise nationals from other Member States.

3.2. The extension of European social security by new coordinating regulations

Regarded as very complex, the first regulations of 1958 gave rise to significant dispute before being replaced by two regulations in the early 1970s: Regulation 1408/71 and its implementing Regulation 574/72. Regulation 1408/71 concerns the application of social security schemes to employed persons and their families moving within the Community.

These regulations were adopted at the time when Denmark, Ireland and the United Kingdom became members of the Community. The health systems of these three countries are of the Beveridge-type, whereas the six founding members have Bismarckian systems of access to healthcare.

To define the concept of rights owners and benefit recipients, the coexistence of these two models within the EU necessitated an extension of the then-current concept of an insured person (the Bismarckian approach) to include residents (the Beveridge model) in the coordinating regulation in order to integrate the new Member States while respecting their social security systems based on place of residence rather than insurance.

The new regulations affirm the equal treatment of foreign and national citizens. They take a non-territorial approach to the legislation applied by the principle of aggregating insurance periods, both for acquiring rights to benefits and for maintaining these rights. They make it possible to transplant the legislation applied to residents of the territory of another Member State where the migrant worker's dependents live. These regulations enable workers to maintain the rights they have acquired on the territory of other Member States. They require the Member State that owes benefits in cash to extend its administrative system beyond its territory in order to pay the benefit due to a worker living abroad.

In the case of sickness and maternity benefits, these regulations make it easier to become eligible and to deliver the benefits outside the territory of the debtor State.

SOCIAL PROTECTION SYSTEMS

Social protection systems (organisation, operation, financing) are built on two structural models: Bismarckian and Beveridge-type systems.

The Bismarckian or insurance-based system

This model is based on the social laws introduced by the German Chancellor Otto von Bismarck (1815-1898). They were adopted in the hope of simultaneously stamping out social movements and improving the living conditions of workers in order to increase productivity. The model established principles of compulsory sickness protection, which were inspired by insurance techniques. In this model, protection is of a category-based type, mainly by occupation on the basis of “social contributions” and managed by the social partners, which are representatives of the employees and employers).

Beveridge-type system

This model is based on the report of the economist William Beveridge (1879-1963) drawn up in 1942 at the request of the British government with a view to establishing a national health system after the Second World War. It is based on the principles of the universality of social protection, i.e. covering the social risks of the entire population; the uniformity of services based on individual needs; financing based on taxation and a centralised management by the government.

The Regulation applies to all employed or self-employed persons and to students, who are or have been subject to the legislation of one or more Member States and who are nationals of one of the Member States or who are stateless persons or refugees residing within the territory of one of the Member States, as well as to the members of their families and their survivors. Civil servants are not concerned by these regulatory

provisions. Finally, supplementary social security systems are excluded from the scope of these coordinating instruments

3.3. The new millennium and the modernisation of social security in Europe

The Court of Justice of the European Union (CJEU) has repeatedly been called upon to interpret the provisions of the coordinating regulations in such a way as to ensure the fundamental freedom of movement of workers, the freedom of establishment and, after the passing of the Single European Act, the free movement of persons.

The judgments delivered by the CJEU and the demands for changes in the regulations from Member States have brought about the adoption of many amendments which, over time, have greatly complicated the texts, making them difficult to use.

In December 1998 the European Commission, for reasons of efficacy, issued a proposal for the simplification and modernisation of the coordinating regulations. This proposal also aimed to improve the rights of insured persons by including non-active persons and pre-retirement benefits, by improving cross-border access to medical care for retired cross-border workers, by extending the unemployment chapter to cover self-employed schemes and by extending pensioners' and orphans' rights to family benefits.

The modernisation of the Regulations 1408/71 and 574/72 was completed in 2009 by the adoption of new Regulations 883/2004 and 987/2009, effective from 1 May 2010. These new texts partly incorporate the CJEU's case law, primarily in respect of judgments delivered from 1998 onwards.

Social security institutions should also communicate with each other, as the new regulation introduces a formal obligation to cooperate. The institutions must communicate all the information necessary for case management via a common electronic access point.

Thus the exchange of information in paper form accompanied by standard European contact forms is gradually being computerised by means of the Electronic Exchange of Social Security Information (EESSI). This system will help social security institutions to exchange information more

Regulation 883/2004 has the specific aim of enabling insured persons to exercise their freedoms under the Treaty more easily. It introduces a number of changes:

- **in the personal field**, the new Regulation applies to all nationals of a Member State, stateless persons and refugees residing in a Member State who are or have been subject to the legislation of one or more Member States, as well as to the members of their families and to their survivors (whether they are employees, self-employed, students, national civil servants, retired or even inactive);
- **in terms of simplification**, the sometimes complicated distinction between employees and the self-employed is abandoned, and the rule now applied is that of the “aggregation of periods”;
- **equality of treatment**: the new regulation no longer requires a person to reside in a Member State in order to invoke the provisions of the Regulation such as the principle of equality of treatment, but it covers the persons to whom the Regulation applies;
- **equal treatment of benefits, income, facts or events**: for example where legal effects are attributed to the occurrence of certain facts or events, a Member State shall take account of like facts or events occurring in any Member State as though they had taken place in its own territory;
- **the simplification of rules determining the legislation applicable**: all workers are insured in the Member State in which they work, whatever their State of residence; in general those who are no longer economically active are insured in their Member State of residence;
- **a frontier worker’s family members** are generally also entitled to healthcare in the Member State where the frontier worker exercises his or her activity;
- **access to healthcare in another Member State** must be authorised if the treatment in question is provided for in the Member State where the person concerned resides but cannot be given within a time limit which is medically acceptable, taking into account the patient’s current state of health and the probable course of the illness;
- **the principle of good administration** requires increased cooperation and mutual assistance between the social security institutions of Member States, which are expected to respond within a reasonable period with information necessary to assert the rights of migrant workers.

rapidly and in complete safety. Structured Electronic Documents or SED are designed to make the communication of data easier and more efficient. The EESSI electronic platform is currently under development by the Commission in close cooperation with Member States.

What is more, a dozen portable documents have been devised, such as the European Health Insurance Card (EHIC) which enables the holder to receive necessary medical treatment during a stay in another Member State, taking account of the nature of the treatment and the expected length of the stay.

Today, the European regulations on the coordination of social security systems apply in all EU Member States and in Iceland, Liechtenstein, Norway and Switzerland.

On 13 December 2016, the Commission put forward a new revision of the regulation. The proposal aims to make the existing rules more just, clearer and fairer. This is a proposal, which facilitates the mobility of workers and protects their rights while strengthening the tools required to combat the risk of abuse or fraud. The proposal also targets the introduction of more precise coordination rules for long-term treatment, inspired by the principles applied to sickness benefits. In the meantime, the existing rules remain in place.



4. The free provision of services and patient mobility

4.1. How the European Court of Justice applies the principle of the free provision of services

The intervention of the Court of Justice of the European Union (CJEU) in the area of access to healthcare marks a break with the one-track approach laid down by the ECSC agreements and the European regulations on the coordination of social security systems.

The keenest questions on free access to care abroad and its reimbursement are addressed in some famous judgments that are now part of CJEU case law. This has created a more favourable situation for patients and opened the way to the liberalisation of patient mobility in the EU, confirming the principle of the free provision of services in the area of health.

The first judgments in the 1995 cases of *Decker et Kohl*³ concern two Luxembourg residents who were refused reimbursement of non-hospital care provided abroad. In the Decker and Kohl judgment, the CJEU decided that the prior medical authorisation required for reimbursement of treatment provided in another Member State constituted an obstacle to the principle of the freedom to provide services which applies in the field of health. Consequently, the patient was entitled at least to the repayment of care on the basis of the scale existing in his State of affiliation. In the cases in question, this meant repayment of the costs of dental care provided by an orthodontist in Germany and reimbursement for the purchase of a pair of spectacles prescribed in Belgium.

In 2001, the CJEU confirmed this case law in the Smits and Peerbooms judgment⁴, but as these cases concerned hospital treatment, it decided that for overriding reasons to do with ensuring the financial balance of social security systems and maintaining a hospital service accessible to all, prior medical authorisation was justified in order to obtain reimbursement for treatment abroad.

Again in 2001, the CJEU stated in its *Vanbraeckel*⁵ judgment that an insured person who is treated in hospital in a Member State other than



his State of affiliation is entitled to repayment of the costs under contract if authorisation is granted after this hospitalisation. It held that the reimbursement must be at least the same as the payment which would have been granted if the insured person had been admitted to hospital in his Member State of affiliation. Therefore, the CJEU granted an additional reimbursement to the patient covering the difference between the repayment for care in the State where it was provided and the amount of reimbursement in the Member State of affiliation if it is higher.

In 2003, the CJEU made a clear distinction between the procedure applicable to non-hospital care and in-patient care (a stay of at least one night) in the *Müller-Fauré et Van Riet*⁶ judgment. The CJEU ruled that the regulation of a Member State requiring prior authorisation in the case of non-hospital care delivered in another Member State is contrary to the principle of the freedom to provide services. However, in the case of hospital services, the CJEU held that prior authorisation remained justifiable if proportionate and not arbitrary.

The *Watts* judgment⁷, delivered in 2006, concerned a British patient who had a hip replacement in France. The United Kingdom refused to repay

³ Kohl and Decker judgments, 28 April 1998, C-120/95 and C-158/96.

⁴ Geraerts-Smits and Peerbooms judgment, 12 July 2001, C-157/99.

⁵ Vanbraeckel judgment, 12 July 2001, C-396/98.

⁶ Müller-Fauré and Van Riet judgment, 13 May 2003, C-385/99.

⁷ Arrêt Watts, 16 mai 2006, affaire C-372/04.

the costs on the grounds that appropriate treatment could be given in the UK without undue delay. The CJEU ruled that the British health service should establish that the waiting time for treatment does not exceed the period that is acceptable in the light of the health and clinical needs of the person concerned. Since this was not the case, the United Kingdom was required to repay the cost of the healthcare provided to Mrs Watts in France.

Finally, the 2010 Elchinov⁸ judgment concerns a Bulgarian patient suffering from a rare form of cancer of the eye. The patient asked his social security institution to reimburse the cost of a cutting-edge treatment offered in Berlin (proton therapy), as this technique is unavailable in Bulgaria and hence reimbursable. The CJEU held that repayment cannot be refused if the list of non-reimbursable treatments does not include the method in question. In consequence, if Member States draw up the list of reimbursable treatments accurately, it becomes difficult for patients to obtain repayment for treatment received abroad if that care differs to the care offered in the country of affiliation.

From these judgments it is clear that the CJEU believes that the requirement for prior medical authorisation before the repayment of healthcare provided abroad in application of the European social security regulations constitutes an obstacle to the freedom to provide services.

Only overriding, objective and proportionate reasons in the general interest can justify an obstacle to this principle. The CJEU holds that this is the case for hospital care (with a stay of at least one night) but not for non-hospital care. To obtain repayment of the latter, on the basis of the free provision of services, the CJEU has created a new reimbursement procedure, independent of that set out in Regulations 883/2004 and 987/2009. This procedure establishes the reimbursement of non-hospital care abroad without prior medical authorisation at the rates current in the country of affiliation. In practice, patients must pay all their costs in advance and are then reimbursed by their health insurance body in their country of affiliation at the rates in that country. This system can benefit some patients but also disadvantage others, depending on the level of repayment in the country of affiliation.

CJEU case law only introduces partial mobility for patients in the EU, as it creates a distinction between non-hospital healthcare (external and out-patient treatment) on the one hand, giving a right to repayment pursuant to the free provision of services, and hospital healthcare on the other, which remains subject to the procedure set out in the coordinating Regulations 883/2004 and 987/2009, requiring prior medical authorisation.

4.2. The Cross-border Healthcare Directive

The Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, the first and only health directive to date, includes provisions for public health and for access to healthcare. This Directive incorporates European measures seeking to improve the operation of the internal market and the free movement of services, as set forth in the Treaty. It is a response to the EU's objective of achieving a high level of health protection.

While health remains the competence of each Member State in terms of financing and organising health systems, the European Union can oblige the Member States to apply in an identical manner European case law such as that established by the CJEU for access to healthcare abroad.

The Directive 2011/24 acknowledges the powers of Member States to determine the provider, the quality and safety criteria, the beneficiaries and the basket of healthcare that may be reimbursed. It creates a European prescription for medicines and requires Member States to develop a national contact point to provide information to patients on conditions for access to healthcare abroad and health systems.

But the main contribution of the Directive relates to the application of the CJEU's case law on the reimbursement of planned treatment provided in another Member State.

Since its transposition into the legislation of every Member State on 25 October 2013, patients can obtain repayment for planned non-hospital (external and outpatient) treatment provided abroad without prior authorisation at the rates applicable in the country of affiliation after paying the costs in advance.

⁸ Elchinov judgment, 5 October 2010 C-173/09.

For hospital stays of more than one night and specialised services (cost-intensive infrastructure), prior medical authorisation remains obligatory in most Member States and repayment is made at the rates current in the country of affiliation.

There are now two ways to be reimbursed for external and outpatient treatment received abroad. For hospital care and specialised services (cost-intensive infrastructure) for which prior authorisation is required, the procedures set out in the European coordinating Regulations 883/2004 and 987/2009 provide the best conditions for reimbursement.

- planned or intentional, with prior medical authorisation (form S2 or former E112);
- provided under agreements between States, such as those between France and Belgium.

Dependents living in a different Member State from the worker receive services in their State of residence. The entitlement document is form S1 (formerly E109).

5. Forms of access to healthcare abroad

European schemes authorise three forms of access to healthcare abroad: cross-border work, temporary stays and planned care.

5.1. Workers residing in a Member State other than the country of affiliation

This measure mainly concerns frontier workers, that is, workers whether employed or otherwise who exercise their professional activity on the territory of one Member State and live in another Member State, to which they return every day or at least once a week (article 1f of Regulation 883/04).

These insured persons receive benefits provided in their country of residence. The entitlement document, form S1 (formerly E106), covers the holder and their dependents.

This status enables workers to receive payment of healthcare provided in the territory of the country in which they work. Access to rights in this country of affiliation ceases when the holder ceases to be a frontier worker.

A frontier worker's family members do not have free access to healthcare in the country of work. However, they may be reimbursed for healthcare that is:

- necessary, during a temporary stay (European Health Insurance Card, EHIC);



5.2. Coverage of healthcare delivered during a temporary stay in another Member State

A temporary stay is characterised by travel outside the country of affiliation, for example for a holiday, study, vocational training, or job-seeking.

In the event of a temporary stay in another Member State, insured persons are entitled to the reimbursement of necessary healthcare, depending on the nature of the treatment and the probable length of the stay.

The entitlement document is the European Health Insurance Card (EHIC), issued in the competent country by the social security institution to which the patient or insured person is affiliated.

Necessary healthcare is reimbursed by the institution in the place of stay on the basis of the EHIC, in accordance with the legislation and rates applicable in the country of treatment. This treatment is then covered by the competent country on the basis of form E125 issued by the institution in the country of stay.

Where insured persons are unable to carry out these steps in the country of stay they may apply for reimbursement from their health insurance institution when they return home.



5.3. Scheduled treatment

Persons covered by the European regulations coordinating social security systems who voluntarily travel to another EU Member State in order to receive treatment must obtain prior authorisation from their competent health insurance institution and present it to the institution in the place of stay (formerly E112, S2 since 2010).

Form S2, formerly E112, certifies the right of access to care in the State of affiliation and the agreement of the competent institution to cover the costs of the medical treatment in question.

Member States may vary their policies for authorising healthcare abroad. However, article 20 (2) of the Regulation 883/04 states that authorisation cannot be refused where two cumulative conditions are fulfilled: the treatment is among the benefits provided for by the social protection system, and it cannot be given in the country of residence within a time limit which is medically justifiable, taking into account the patient's state of health and the probable course of the illness.

European case law has established that in taking this decision the insurance authority must take account of the degree of pain or the nature of the patient's disability, which might, for example, make it impossible or extremely difficult for him to carry out a professional activity.

Healthcare is reimbursed by the institution in the place of stay on the basis of Form S2 (formerly E112), in accordance with the legislation and rates applicable in the country of treatment. This treatment is then covered by the competent country on the basis of the account issued by the institution in the country of stay.

A judgment of the Court of Justice of the European Union⁹ has also held that the medical expenses of a person with an EHIC or Form S2 or former E112 who, for reasons of medical emergency, must be hospitalised in a third country must be covered by the social security institution of the State of stay, in accordance with its own rules, on behalf of the institution in the Member State of affiliation. Therefore, when a Member State has authorised one of its nationals to receive treatment in another State, it automatically transfers to it its decision-making power.



6. Summary

In its progress towards European integration, the EU has abolished borders between States by implementing the principles of the free movement of goods, services, persons and capital. Nonetheless, access to health care remains an area of national competence for each Member State. Happily, this has not prevented coordination in that area between the EU and Member States since the earliest days of European integration.

The mobility of workers, and then of European citizens more generally, has led Member States and the EU to create measures which have gradually established a degree of patient mobility. This mobility is particularly relevant and effective in the border regions.

The following two chapters will highlight a number of existing forms of cooperation, that offer innovative schemes for increasing access to healthcare in border regions. The Franco-Belgian cooperation as explained in chapter four, provides a structured and institutionalised model of such an arrangement. These collaborative projects, supported by the Interreg programmes, play a key part in improving the health of border populations and their access to quality treatment locally.

⁹ Keller judgment, 12 April 2005 – C-145/03.

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CHAPTER 3

SEVEN EXPERIENCES OF CROSS-BORDER COOPERATION



the Cerdanya hospital situated in the high mountain area between France and Spain. This chapter also highlights the programmes for infant protection and care (INTERSYC) at the Greco-Bulgarian border, support for patients, clients and families along the Irish border, the development of telemedicine in the Pomerania Euro-region, the inter-hospital partnership in the SaarMoselle Eurodistrict and the personalised healthcare project IZOM on the Belgo-Germano-Dutch border.

Each project is individual, building on its own history and mobilising its own public or private operators. Some have been set up more or less quickly, others have been held back. Nonetheless, each case study illustrates the same desire for partnership and mutualisation, the same human experience and the same commitment to cooperation for the general interest.

The projects chosen illustrate the diversity of cross-border contexts: urban or isolated mountainous regions, territories in the North and South of Europe, recent cooperation or projects that have been run over several Interreg programmes. They also highlight both recent initiatives and those based on partnerships and experiences that have lasted for decades.

The case studies were drafted on the basis of desk research using the project files available on the Directorate-General for Regional and Urban Policy website InfoRegio, and the sites of partners and press reports, as well as on the basis of written and telephone surveys with relevant project managers.

Although not addressed here, interesting to note is that transnational (Interreg B) and interregional (Interreg C) cooperation also covers health cooperation, as illustrated for example by the development of the telemedicine network in remote regions in the Aegean and in Cyprus.

1. TRISAN

A tool for structuring and coordinating cross-border health in the Upper Rhine (France–Germany–Switzerland)

1.1. A hyper-cross-border environment

The tri-national cross-border centre project TRISAN aims to identify, coordinate and amplify the synergies born of several decades of cooperation on health in the Upper Rhine. It is intended to support administrations and healthcare providers on every side of the borders in order to best structure and develop partnerships and projects.

The Upper Rhine region covers the Baden region and the Southern Palatinate (Germany), Alsace (France) and North-West Switzerland. It is a densely populated region focused around a number of urban centres, and has a significant presence of cross-border workers. In 2010 the tri-national metropolitan region was created to provide the area with a strengthened framework for cooperation. It coordinates the work of the main partners in the Upper Rhine, which are the High Council of the Upper Rhine, Cities Network, and Eurodistricts.

Overall, the area offers a full range of healthcare on all sides of the borders. Health is explicitly included in the many cross-border institutions: for example, the Upper Rhine Conference, which has a health policy working group — at the origin of the TRISAN project —, the Rhine Council, which includes a number of commissions tackling health issues, or the INFOBESTs. INFOBESTs are information offices providing information and advice on cross-border issues affecting Germany, France and Switzerland. There are four of these general public institutions spread across the Upper Rhine area.

The TRISAN project is run by the Euro-Institut at Kehl (Germany). This Franco-German entity for training, advice and support in matters of cross-border cooperation was founded in 1993. Now a local cross-border cooperation grouping, it plays an important role in the region as a bicultural and binational organisation (France and Germany) providing training and advice on cross-border cooperation. Its aim is to foster mutual understanding between the actors on either side of the border, to encourage cooperation and to support the development of cross-border initiatives.

OBJECT: The creation of a tri-national skills centre to coordinate and develop cross-border cooperation on health.

KEY DATES: Since 1991, multiple cooperation projects in the field of health. 2015: The health policy working group draws up plans for a cross-border centre. December 2016: TRISAN centre opens.

BORDER: Upper Rhine between France, Germany and Switzerland.

EUROPEAN PROGRAMME (CO-FINANCING): Interreg VA – France–Germany–Switzerland 2014-2020: total funding of €801 916, ERDF contribution of €367 750.

WEBSITE: <http://www.trisan.org/>

1.2. Multiple cross-border cooperation projects

Since Interreg I (1990-1993), several initiatives have made their mark on cross-border cooperation in the Upper Rhine area. In the area of health more particularly, a number of large-scale healthcare cooperation projects have been launched, and four cooperation agreements have been signed. These projects include the GRÜZ pilot project (grenzüberschreitende Zusammenarbeit Deutschland – Schweiz), for cross-border cooperation between Germany and Switzerland in the frontier region of Bâle-Ville, Bâle-Campagne (Switzerland) and the Landkreis Lörrach in Germany. This project aims to set up a cross-border healthcare access zone inspired by those created on the Franco-Belgian border (see Chapter 4).

There are also initiatives relating to emergency medical care. Since 2002 there has been close collaboration between the mobile emergency and intensive care services (SMUR) in Wissembourg in France and the members of the Deutsches Rotes Kreuz (equivalent of the Red Cross) in Bad Bergzabern in Germany.

In order to mitigate the shortage of healthcare professionals in the case of pre-hospital emergencies occurring at night, a combined team takes



Rhineland
Palatinate

Germany

Grand Est

FRANCE

TRISAN

Franco-Germano-Swiss
conference for the
Upper Rhine

Baden-Württemberg

Strasbourg • Kehl*

Freiburg im
Breisgau

Mulhouse

Bâle

Switzerland

Imot © Mission Opérationnelle Transfrontalière

* Seat of the Euro-Institut, managing structure of the TRISAN project



action, regardless of the country where the call originates. When the call centre alerts the SMUR team to respond in Germany, the German alarm system is automatically activated. Of the 862 calls attended by the Wissembourg SMUR in 2013, 126 were on German territory, representing around 15% of its activities.

1.3. A centre to boost coordination

The idea for the TRISAN project came from the difficulties experienced by the Euro-Institut and its partners when conducting cross-border health projects. Not only do these projects involve rules and protocols which vary greatly from one side of the border to the other, but they also concern multiple administrative levels.

In 2015, in response to the experiences gained in the Upper Rhine area, the institutional partners came together in a healthcare working group to consider setting up a centre to develop cross-border healthcare cooperation in collaboration with the Euro-Institut. During the 18-month-long preparation and development phase, appropriate partners and funding were found for the actual launch of the project.

The TRISAN project was established in June 2016. It created a tri-national skills centre with multiple aims: networking healthcare actors, supporting project design and the improvement and dissemination of experiences in the matter of cross-border medical knowledge.

The project is organised by the Euro-Institut, on the French side by the Grand-Est regional health authority (ARS), on the German side by the Ministerium für Soziales und Integration Baden-Württemberg, the Regierungspräsidium in Karlsruhe, and the Ministerium für Soziales, Arbeit, Gesundheit und Demografie Rheinland-Pfalz, and on the Swiss side by the Bâle-Ville health department, the cantons of Bâle-Ville, Bâle-Campagne and Argovie, and the Swiss Confederation. The centre opened on 19 December 2016.

1.4. Long-standing cooperation does not prevent obstacles

Although the partners have known and worked with each other for many years, setting up TRISAN was not straightforward; no cross-border healthcare project is.

It appears that health systems differ widely from one side of the border to another, and consequently the parties involved had to work hard to identify and negotiate their common denominators. This solid basis was the essential precondition enabling the operators to plan the implementation of the project. Linguistic and cultural diversity, coupled with the differences in terms of background and working methods, also complicated the process.

Developing and piloting cross-border projects calls for certain aptitudes; for example, openness towards others and a real desire to learn about the neighbouring system. It is essential to show great flexibility and a capacity for innovation. These qualities do not enable to erase the differences between the systems concerned, but rather to overcome them by integrating them into the reasoning and modes of action within these territories.

The added value produced by health cooperation seems easier to identify in the field of research. Firstly, it enables the teams to develop synergies between their strengths; and secondly, it develops the capacity to work collectively. This type of scientific collaboration is a genuinely experimental field.

1.5. Key factors for consolidating cooperation

For such dynamics to succeed, it is essential to conceive the health project as a multi-sectoral project, consequently calling for solutions that are at the intersection of the sectors concerned (medical, administrative, policy, insurance, communication, managerial, legal, etc.). Common objectives must be established right from the start, with a continuously developing process of dialogue. The project also requires sufficient long-term political, financial and administrative support.

Communication, both external and internal, is an important aspect. Among the main obstacles identified to local cross-border healthcare is the lack of transparency as to the patient rights and the possibility or not of reimbursement. The low profile of cross-border healthcare is a major obstacle which must be resolved upstream, by disseminating the maximum possible information about current projects and, in particular, their results.

Finally, two other factors are indispensable: commitment and a sense of community. Success often relies on a few key people with unflinching commitment, often of a personal nature. This is both a strength and a weakness for healthcare cooperation, because some of these people may be assigned elsewhere. It is also essential for the project to develop a feeling of belonging that creates a real sense of community, drawing on methods of win-win cooperation for all the stakeholders, including patients



A FIRST-HAND WITNESS: ANNE DUSSAP

TRISAN project head Anne Dussap joined the Euro-Institut in 2007, where she is responsible for training. She has also supported the conferences held by the health policy working group and several associated projects.

“The idea for the project came from the fact that implementing healthcare projects is very complicated, firstly because you need to harmonise arrangements, ways of working, and regulations governed at different administrative and policy levels in the different countries, and secondly because it covers different sectoral fields... The divergences between systems do constitute a non-negligible difficulty in achieving these projects, but apart from the actual differences there are also lots of received ideas about these differences and stereotypes that form a real obstacle to cooperation, fostering distrust, fear of cooperation and a tendency to look inwards.”

2. INTERSYC

Treating and protecting children together (Greece, Bulgaria)

2.1. The Greco-Bulgarian border

The border between Greece and Bulgaria runs through a mountainous region remote from any urban centres. This remoteness causes significant challenges on both sides of the border in terms of public services, in particular in the area of health.

This translates into gaps or even a total absence in healthcare provision in the area. This situation also creates shortfalls in prevention and social protection. It became also apparent that the remoteness was causing an even more serious absence of coordination in case where child abuse or trafficking were observed but not acted upon.

The INTERSYC project (INTEgrated TERritorial SYnergies for Children, Health and Protection) was established between 2013 and 2015. It was set up by the organisation The Smile of the Child in coordination with the Bulgarian non-profit association Chance, the Bulgarian Nadja Centre Foundation, the towns of Kavala and Paggaiou (Greece) and the Kardzali regional health inspectorate (Bulgaria).

Bringing together these diverse skills and expertise made it possible to overcome regional isolation. The partnership made it possible to carry out a series of measures, seminars and training courses to improve protection, prevention and healthcare, particularly for children and their families.

2.2. Prevent, act and educate

The INTERSYC project has included a range of activities targeted on children through three priority axes. The first addresses the emergency situations caused by the disappearance of children, the second concerns prevention and care, and the third offers health and social services to families and children in difficulty.

OBJECT: Coordination of activities to improve prevention, protection and health for children and families.

KEY DATES: Creation of The Smile of the Child in 1996 in Greece and the Nadja Centre Foundation in 1998 in Bulgaria. Launch of the joint INTERSYC “INTEgrated TERritorial SYnergies for Children, Health and Protection” project in 2013.

BORDER: Central Macedonia, eastern Macedonia and Thrace (Greece) and the southern centre and south-west regions of Bulgaria.

EUROPEAN PROGRAMME (CO-FINANCING): Interreg IV 2007-2013: budget: €624 362 including ERDF contribution of €530 708

WEBSITE: <http://intersyc.eu>

The first axis targets cases of child disappearance or trafficking. It offers training and knowledge transfer so that people can find information and, above all, it focuses on taking action when these situations arise. On the Bulgarian side, the use of existing European tools in the field were encouraged, in particular the use of the missing child hotline 116 000 and the coordination platform combining the European Child Alert Automated System (ECAAS) and the Amber Alert system. The Southeastern European Centre for Missing and Exploited Children (SEEC) was also promoted in Bulgaria.

Secondly, INTERSYC develops activities to improve child health, particularly through prevention. This objective is achieved through mobile medical units and specialist visiting staff on both sides of the border. These mobile services include the medical prevention units run by The Smile of the Child, including a unit specialising in ophthalmology, and a mobile multi-clinic called Hippocrates which has audiology, cardiology, paediatric and dentistry departments. These units are intended to provide support to local doctors, especially on the Bulgarian side of the border. Prevention activities have exposed flagrant shortcomings in the prevention of ill-health, and in addition to the medical impact they have uncovered cases of child abuse or neglect. Prevention has therefore been extended beyond medicine into the psychological and social fields.



South-East

BULGARIA

southern centre

INTERSYC

Kardzali •

Eastern Macedonia
and Thrace

• Kavala

• Pangaio

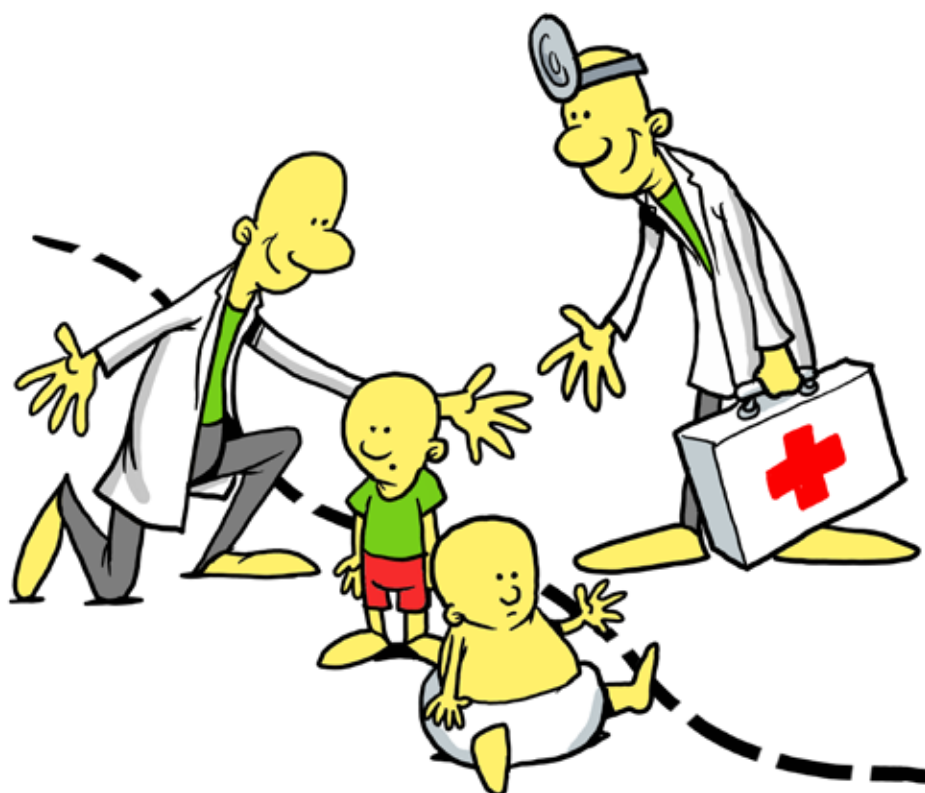
Central
Macedonia

Greece

Finally, the third priority axis targets a more general improvement in the availability of health and social services directed to children and families in difficulty. It offers training courses for staff working with children. In both Greece and Bulgaria, it encourages the setting-up of aid centres for families. Seminars providing first-aid training are offered to volunteers and staff working with children. These courses are based on the recommendations and principles of the European Resuscitation Council (ERC) or the Bulgarian Red Cross and are organised in the municipality of Paggaiio in Thessaloniki in Greece and in Kardjali and Razlog in Bulgaria.

2.3. Impacts, keys to success and capitalising on good practices

The project has definitely improved the situation of children and families, but its success does not stop there. In more general terms, it has encouraged public stakeholders, NGOs and associations to collaborate on both sides of the border and together to establish sustainable actions for children. It is interesting to highlight the diversity of the partners who have been involved in setting up this project, including educational institutions, health bodies, and national police services through the ECAAS platform and the fight against the disappearance of children.





The strength and expertise - dating back to 1996 - of The Smile of the Child in Greece, in collaboration with numerous organisations, have enabled the partners to share the know-how and facilities required.

Another key to this success was the fact that The Smile of the Child and the Nadja Centre Foundation in Bulgaria had already worked together for many years in the South Eastern Europe Centre for Missing/ Exploited Children (SEEC) and that different partners of the same nationality were already working together locally.

The question of capitalising on good practices has also been integrated into the approach by organising training. Social workers now have the necessary knowledge, in particular for the local management of first aid. The dissemination of information about prevention and communication with local populations has been developed, in particular using brochures.

The SEEC, which takes action in missing child cases or child exploitation, has expanded its work in Bulgaria through a National Plan to combat child trafficking headed by the Bulgarian foreign affairs ministry.

A FIRST-HAND WITNESS: ANTONIA TSIRIGOTI

A manager of international cooperation projects and programmes for The Smile of the Child and a researcher, Antonia Tsirigoti is also a psychologist and coordinates various programmes and projects, inter alia for child protection.

"The very practical planning of the project has ensured its operability but also the sustainability of the results, which extend beyond its benefits to the children who are its direct beneficiaries. Further functional and institutional collaborative projects have been created between public operators on both sides of the border, private or social sector players and institutions devoted to education and/or health at the cross-border level".

3. “Putting Patients, Clients and Families First”

A cross-border health partnership (Republic of Ireland and United Kingdom)

3.1. Cooperation and working together

On both sides of the border between Northern Ireland and the Republic of Ireland, the region has significant shortfalls in health and social services. This can be explained by the marginal nature of the area, geographically remote from centres, by the rural character of some of these territories and by the years of conflict between Northern Ireland and Ireland. Against this background, cross-border cooperation does not just meet health and social needs, but is also an experiment in collaboration and the sharing of experiences between the peoples and the institutions concerned.

Cross-border experiments started to emerge in the 1980s. Little by little, the need to formalise this collaboration became clear. The Ballyconnell Agreement of 10 July 1992 formalised the partnership Cooperation And Working Together for health gain and social welfare in border areas (CAWT), which brings together the North Eastern and North Western Health Boards in the Republic of Ireland and the Western Health and Social Services Board in Northern Ireland. This organisation was developed in order to provide expertise, research capacity and practical support for cross-border activities.

CAWT delivers the programme entitled Putting Patients, Clients and Families First, which covers a series of projects for improving access to services, promoting health, well-being and social inclusion, and reducing health inequalities in these rural border areas. These projects, supported by the 2007-2013 Interreg IV programme Northern Ireland, the Border Region of Ireland and Western Scotland and by Peace II, consist of a range of medical and social care initiatives. The approaches identified include social inclusion, the establishment of specialist hospital services, the improvement of cross-border mobility and support for older people.

OBJECT: Improving health and social care for people living on either side of the Irish border through a range of projects.

KEY DATES: 1992: signing of the Ballyconnell Agreement and creation of the partnership entitled Cooperation And Working Together (CAWT); 1996-2000: health and social cooperation projects (Peace I); 2002-2008, CAWT as vector of projects co-financed by Interreg III A and Peace II.

BORDER: Northern Ireland (United Kingdom) – Border, Midland and Western Regions (Ireland).

EUROPEAN PROGRAMME: Interreg IV A (Northern Ireland, Republic of Ireland, western Scotland): budget of €30 000 000 devoted to the project of which €22 500 000 is financed by the ERDF.

WEBSITE: <http://www.cawt.com>

3.2. Twelve projects for better health and more mobility

The twelve projects that make up Putting Patients, Clients and Families First form an ambitious programme aiming to grow and diversify the services offered, create cross-border networks and facilitate mobility. They cover:

- developing new specialist medical services, such as otolaryngology services (ENT),
- setting up family planning centres,
- developing eating disorder networks,
- alcoholism prevention,
- support for families and children in difficulties,
- domestic help for older people,
- support for people with disabilities,
- the fight against diabetes targeting at-risk people,
- a programme of prevention and management for childhood obesity
- actions to combat health care inequalities,
- support to professional mobility by sharing knowledge and expertise,
- measures addressing autism.



West Region

Border Region

Midland Region

United Kingdom
Northern Ireland

Galway

Donegal

Londonderry*

Cavan

Newry

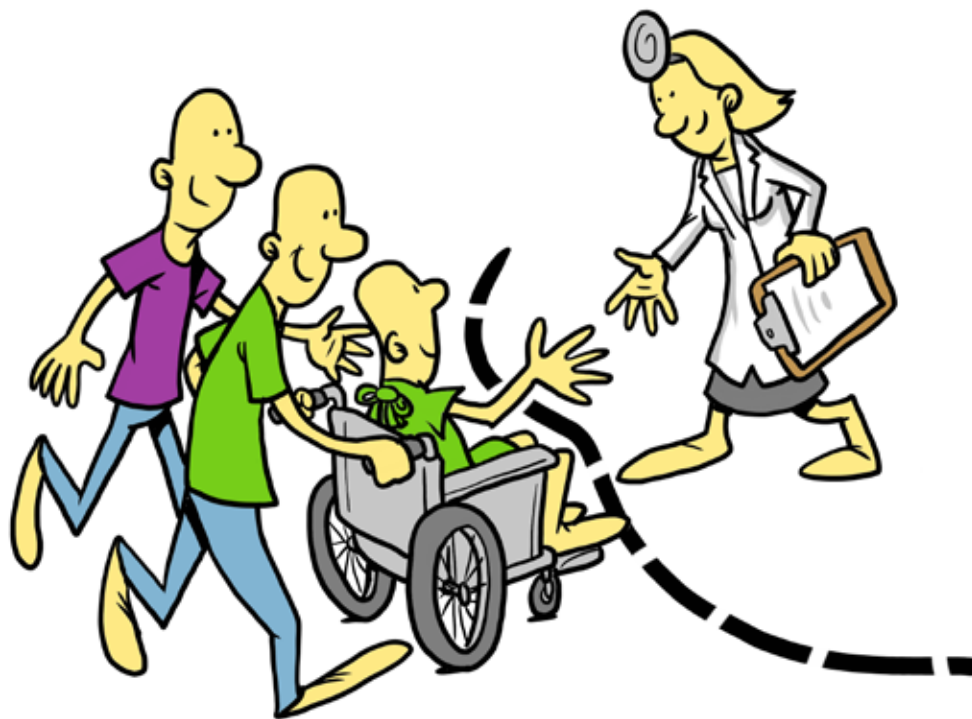
Dundalk

Belfast

Ireland

Imot © Mission Opérationnelle Transfrontalière

* Seat of Cooperation And Working Together (CAWT), managing structure of the project



The provision of those cross-border medical and social services does not only care for and improve the well-being of the people concerned; it is also a means of restoring links and trust between the two communities still marked by the war.

3.3. Factors for success

The key interface role played by CAWT is a major factor for success. Its expertise and networks facilitate coordination between the administrative services of the Ministry of Health in Northern Ireland and its Irish equivalent. Its arrangement by strategic groups (traveller health, older people, mental health, primary care, etc.) facilitates project organisation. CAWT also ensures the proper running of all the activities, in accordance with the criteria set by the ministries in the two partner countries and by the Special EU Programmes Body (SEUPB) which manages all the Peace and Interreg programmes between Northern Ireland and the Republic of Ireland.

From the start of the project, the coordination created by CAWT has been reflected in communication and information through a newsletter entitled CAWT in Action. This quarterly publication provides regular progress reports on the projects. As well as the dissemination of good practices across the cross-border region, the newsletter also presents the results to date, strengthens the links between partners and identifies pathways for future projects.

3.4. The main obstacles

The cross-border cooperation between Northern Ireland and the Republic of Ireland is set against a background that is both politically and humanly more difficult than on other European borders. The years of violence still seem very close to people here, and the very idea of cooperation sets out to overcome this barrier.

Furthermore, and more pragmatically, British and Irish health systems are very different. Free medical and social services are guaranteed in Northern Ireland, whereas the Republic of Ireland has a mixed system, both public and private. The way in which powers are allocated between authorities is also country-specific. Both health policy and employment systems are also different. Coordination therefore entails significant time spent in meetings, which causes expensive and time-consuming travel.

3.5. Progress has been made, but the task is unfinished

An assessment of the projects conducted under the Interreg and Peace programmes shows that around 50 000 people have benefited from the services and care offered during the seven years of activity (2008-2014). Projects have also succeeded in reaching out to sometimes very marginalised groups: for example, the project to promote social inclusion and reduce healthcare inequalities (Promoting Social Inclusion and Tackling Health Inequalities) has reached more than 4000 residents, including travellers and women in precarious situations.

It is clear that in 2013, financial pressures and significant health policy reforms on both sides of the border increased still further the need for cooperation and partnership between players on either side.

The sustainability of the approach is in part ensured. The cross-border ENT service established between Northern Ireland and the Republic of Ireland is continuing its work, four of the additional family planning clinics are still active, the alcoholism project has been extended and the autism project (Turning the Curve autism support) has led to the creation of permanent jobs.

The impact of these projects also affects institutional aspects. For example, the reorganisation of existing services will encourage the cross-border sharing of resources and the expansion of networks including between community organisations.



A FIRST-HAND WITNESS: DR LINDA KING (CAWT in Action, no 40, June 2014)

Dr Linda King is member of Castleterg GP Practice/General Surgery. She took part in the project for improving the condition of patients with disabilities, particularly in the Strabane and Donegal council areas.

“Our participation in this cross-border programme has given us a unique opportunity to improve our patient services. For example, disability awareness training has made our staff more confident in dealing with patients with physical, learning or sensory disabilities. All these changes, both large and small, are already making a significant difference to the health and well-being of our patients, particularly those with disabilities.”

4. TELEMEDICINE EUROREGION POMERANIA

Move the data, not the patients (Germany, Poland)

4.1. How can we overcome isolation?

The project is situated in remote and sparsely populated border regions (69 inhabitants per km²) in the Pomerania EuroRegion. This EuroRegion, created in 1995 on the Germano-Polish border, has developed projects in economic growth, education, infrastructure and environmental protection.

These regions share a common reality. On both the German and the Polish side of the border, there are increasing medical shortages. These sparsely populated areas have an ageing population, subject to multiple ailments. Secondly, they are becoming medical deserts: young doctors, whether GPs or specialists, prefer to work in urban areas and in large healthcare structures with access to technologies and a stimulating environment. Consequently, accessing specialist care for people in these isolated places means that they have to travel, sometimes over long distances. These journeys are also expensive.

The time and transport conditions, not only for patients but also for medical samples taken locally, are factors that harm optimal care. This isolation can also be critical in the detection of cardiology cases, or where a patient has suffered a stroke (CVA). In these cases, diagnosis must be rapid, or the condition may be life-threatening.

Under these circumstances, the telemedicine project offers improved access to health services and infrastructure. More exactly, it works to improve the prevention and treatment of certain diseases and to establish sustainable communication structures that provide better treatment for patients.

OBJECT: Information, diagnosis and therapy for certain diseases by telemedicine, which is using telecommunications to facilitate medical practice).

KEY DATES: 2001: telemedicine experiment in Germany; 2002-2006: cross-border telemedicine network established in the Pomerania EuroRegion; 2007-2013: expansion of the network to other operators.

BORDER: West Pomeranian Voivodship (Zachodniopomorskie) in Poland, the länder of Mecklenburg-Vorpommern and Brandenburg in Germany.

EUROPEAN PROGRAMME(CO-FINANCING): Interreg IV (2007-2013): €12 024 316 including an ERDF contribution of €10 088 374.

WEBSITE : <http://www.telepom.eu>

4.2. Moving the data

Telemedicine initiatives began to be developed on the German side of the border in 2001. Telemedicine covers all the medical activities that bring together patients or their data and a geographically distant doctor or institution by using information and communication technologies. It targets diagnosis, therapies and treatments in accordance with the standards and rules applying to any medical act.

In 2002, a first Germano-Polish cross-border telemedicine network was set up based in Vorpommern (Germany) focusing on telepathology, teleradiology and videoconferencing.

The telepathology project was based on associating hospitals that had their own pathology structures with hospitals which did not. In this way, tissue analysis could be carried out by telemedicine. Teleradiology comes into play where a second opinion is required, in an emergency or when a local radiology centre is temporarily closed, for example during holiday periods. Lastly, videoconferencing makes it possible to conduct multi-disciplinary meetings remotely. It creates the opportunity to dis-



Rostock

Koszalin

Schwerin

Mecklenburg-Vorpommern

Szczecin

West Pomerania

POLAND

GERMANY

Potsdam

Brandenburg

Cottbus

Telemedicine

cuss complex patient cases that demand complementary skills. It can be used to organise training sessions or seminars where attendance can be guaranteed without the need for the participants to travel.

From 2006 a digitalised mammography service was added, used on both sides of the German-Polish border to provide a regular programme for early breast cancer detection.

Between 2002 and 2006, 12 German institutions, including a university of applied sciences that is able to store medical data, and four Polish hospitals collaborated in the network of Telemedicine.

Thanks to the funding from the Interreg IV Mecklenburg-Vorpommern / Brandenburg-Zachodniopomorskie programme in 2007-2013, 22 German hospitals and 15 Polish hospitals could take part in the Telemedicine network.

Today the telemedicine network covers urology, cardiology, oncology, ophthalmology and stroke care, in addition to the original forms of cooperation. For example, there is a fortnightly meeting of the Pomeranian council against prostate cancer bringing together EuroRegion urology specialists and resident doctors and radiotherapists from the hospitals in Szczecin (Poland) as well as Greifswald and Schwedt (Germany).

Thanks to the cooperation in telemedicine, the attending physician based locally along the border can obtain a second opinion from a specialist. The rapid, almost instantaneous transmission of the information is used for the effective treatment of the patient. Furthermore, these exchanges reduce the costs and difficulties of transport of both medical samples and people as well as they improve the working environment for local doctors.

4.3. Distrust and differences

The development of telemedicine, as such, constituted a first major challenge: some hospital staff — doctors and healthcare professionals — were initially very resistant to technology and the use of digitalisation for diagnosis or therapy.

The project was also delayed on the Polish side by a budgetary stalemate. It was not until 2006 that Polish hospitals were really able to join

the German network. The digitalisation of medicine was not initially regarded as a priority, particularly given the cost of the equipment needed.

Cultural difficulties between the partners have also arisen throughout the project, whether over organisational methods or over the role of associations for example. Under such circumstances the role of the translator is not merely to translate the information exchanges from one language to another but also to draw attention to differing perceptions and representations. This is why translators are still being used during the videoconferences and meetings.

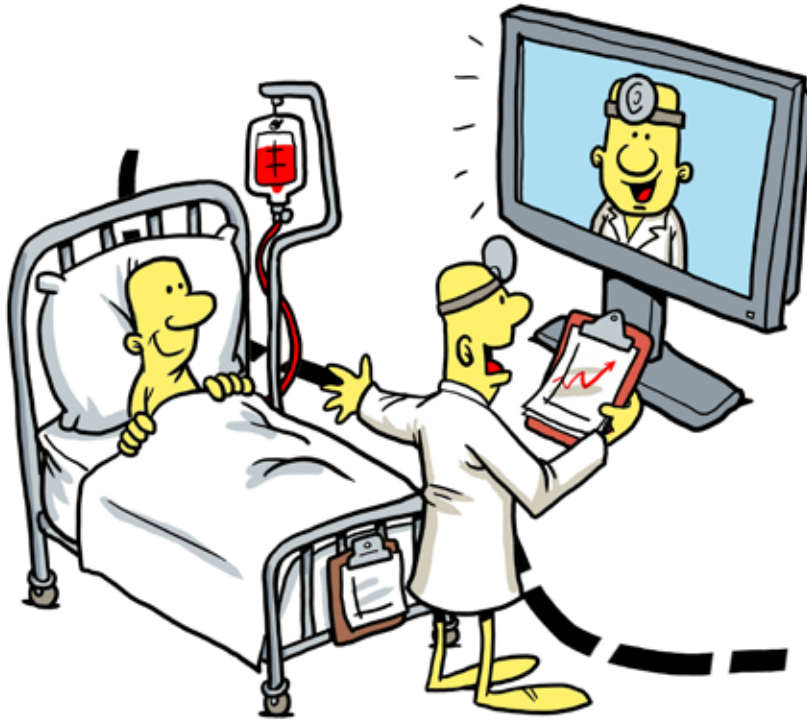
The project has also needed input from legal experts, in order to settle the very many legal questions intrinsic to the cross-border context, which has complicated the operational implementation of the project. As the legal experts were more used to working in a commercial environment, it was necessary to regularly remind them of the health sector context and the institutions and staff involved.

A final obstacle, still current on the German side, concerns the reimbursement of medical expenses. This is because the social security system is based on the place of hospitalisation and does not yet take account the specific features of telemedicine.

4.4. The spread of telemedicine

Telemedicine was first developed in German Pomerania particularly because of the geographical and social context. The expertise then spread, not only in Germany but also in Poland thanks to cross-border cooperation. It now benefits many institutions and patients. Overall, medical equipment for the digitalisation of hospitals has developed and improved, resulting in particularly high-performing technology. Foundations have been set up to guarantee the exchange of medical data all along the German-Polish border.

The Telemedicine project was initially developed through frequent — and physical — meetings between the partners. These meetings created an in-depth understanding of the systems on either side of the border, and lasting links were forged. The financial support of the Interreg programmes was a critical factor. The stability of the medical staff who, unlike institutional committee members, have remained in place, has contributed to the consistency and sustainability of the dynamics set in motion.



The institutional network remains open to the participation of new partners. It collaborates with other networks, including the Mecklenburg-Vorpommern teleradiology network (TeleRad M-V). This network, launched in 2009 and including 17 hospitals, is now directly financed by the participating hospitals.

Although it currently focuses on the most serious and complex cases, the Telemedicine project has undeniable added value. The transfer of data to medical centres, the reporting of results and the provision of a second medical opinion are all among the solutions to the difficulties encountered in those isolated regions, namely remoteness, mobility difficulties and the demographic deficit in terms of specialist professionals.

In the future, the project hopes to expand to other countries, including Ukraine, and to target specific pathologies, in particular paediatric conditions.

A FIRST-HAND WITNESS: PROF. DR MED NORBERT HOSTEN

Prof. Dr med Hosten is Professor of radiology in the radiology department of the Universitätsmedizin Greifswald, and, since 2008, the Director of the Telemedizin Euroregio POMERANIA e.V project committee.

"We have built up a network of more than 25 German and Polish hospitals. Alongside the technical success, it is clear that the regular meetings between the Polish and German committees have benefited me a great deal. I knew nothing about Poland at the start of the project, and my Polish colleagues, similarly, knew nothing about Germany. Over time, we have become friends and it is easier and easier to work together. In my eyes, these transnational projects are a vital tool for understanding the people of Europe independently of official policies, which — as we can see — have their ups and downs."

5. The Franco-German inter-hospital cardiology partnership project (France, Germany)

5.1. An acute need for cardiovascular care

The Lorraine coalfield area in France has alarming mortality statistics for cardiovascular diseases. In addition, the area encounters two major difficulties: a shortage of doctors, and an increasing marginalisation by comparison with Metz.

The idea of a project for medical cooperation on cardiology emerged in 2002, at the joint initiative of a French cardiologist in Moselle and a German cardiologist in Völklingen. To establish this partnership, the two cardiologists contacted the health insurance funds in their respective countries, but these showed little enthusiasm for taking part in a joint project. For some years, nothing came of these steps to create closer ties, even if synergies between the border health structures of Forbach and Völklingen would have made it possible to meet the needs of patients suffering from acute myocardial infarction.

In 2011, in the course of the reorganisation of healthcare in the Lorraine coalfield area, the Regional Health Authority (ARS) designated the hospital at Forbach (France) as a cardiac intensive care unit. This unit then ran into difficulties in meeting the necessary conditions for commissioning. However, just a dozen kilometres away, the HerzZentrum Saar - the German cardiology centre attached to the SHG-Kliniken (Saarland Heilstatten GmbH) in Völklingen - had substantial resources for treating cardiac problems. These resources are similar to those offered by the hospitals of Nancy, Metz and Strasbourg, all located more than 60 km from Forbach. Forming a partnership project with Völklingen was the obvious thing to do.

OBJECT: Cross-border cooperation between the cardiology units in the hospitals in Forbach (France) and Völklingen (Germany) as part of the Santransfor project.

KEY DATES: 2002: first discussions of cooperation on cardiology between the Moselle and the Saar. 2007: recruitment of a person responsible for cross-border cooperation in Völklingen. 2013: entry into force of a cross-border cooperation agreement on cardiology.

BORDER: The SaarMoselle Eurodistrict, more particularly, the department of Moselle (Forbach) in the Région Grand Est on the French side, and the Saarland (Völklingen) on the German side).

EUROPEAN PROGRAMME: (Co-financing) Interreg IV A 2007-2013: Total budget: €525 851 of which €236 633 contribution from the ERDF.

WEBSITE: <http://bit.ly/2f3mhhB>

5.2. Fertile ground for collaboration

The two towns, Forbach and Völklingen, have been twinned since 1964. It takes barely 15 minutes to get from one to the other. And it is clear that, when a patient's life is in danger, as it is during a heart attack, the geographical proximity of the healthcare institution is what matters. What is more, since 2010, the Centre Hospitalier Intercommunal (CHIC) UNISANTE + Marie-Madeleine hospital in Forbach and the SHG-Kliniken centre in Völklingen have been having discussions on this proximity.

The Franco-German framework agreement on cross-border cooperation on healthcare, signed on 22 July 2005, offered a propitious context for the signature of a cross-border cooperation agreement. So in application of this framework agreement, 19 March 2013 saw the signature of the cross-border cooperation agreement on cardiology by seven partners representing the German and French regional health authorities, health insurers and the managements of the health establishments concerned.



Germany

LUXEMBOURG

Rhineland
Palatinate

Saarland

SHG-Klinik Völklingen **H** • Sarrebruck

Forbach **H**

Sarreguemines

Eurodistrict SaarMoselle

Grand Est

France

The implementation of this agreement relied on Interreg funding, in particular the Santransfor project. This project, financed by the Grande Région/ Grossregion Interreg IV A programme, has fostered the signature of bilateral international framework agreements and collaboration agreements on health in order to improve healthcare access for people living in the cross-border region. The project has been developed, inter alia, in the Saar and Moselle regions.

5.3. A pragmatic partnership

The aim of the inter-hospital partnership is the joint organisation and development of cardiac care in a sustainable manner, in complement with the already existing partnerships, for example with hospitals in Nancy or Metz-Thionville.

It should be emphasised that the inter-hospital agreement is applied in the SaarMoselle Eurodistrict, which covers the existing Grand Est Region and seven intermunicipal structures on the French side, and the urban community of Saarbrücken in Saarland on the German side. This Eurodistrict adopted the form of a European Grouping of Territorial Cooperation (EGTC) on 6 May 2010. The eventual objective is to create a more integrated cross-border agglomeration in order to grasp the challenges of the territory, which is undergoing profound economic and social changes.

The cardiology partnership has a threefold aim:

- optimisation of patient care for heart attack victims within the sector covered by the mobile emergency and intensive care services (SMUR) in Forbach;
- despite the medical problems of demography, the maintenance of high quality cardiac care at the Centre Hospitalier Marie-Madeleine in Forbach and strengthening the medical team in the care unit;
- organisation of the sharing of good practices between health professionals and encouragement of bilingualism among medical and non-medical staff.

In practice, while guaranteeing patient choice, residents in one of the involved French municipalities can be treated in Völklingen within a much shorter time than if they had to be transferred to Metz. This agreement integrates the clinical centre in Völklingen into the network of cardiac care on the French side of the border.

The second aim focuses on the development of a cross-border medical team in order to attract young specialists and maintain continuity at the cardiac intensive care unit in Forbach. This is given practical effect by the arrival of cardiologists from Völklingen to strengthen the medical team at the cardiology ICU (for example to provide on-call care). Finally, the third aim of the project focuses on the organisation of training placements or seminars held between the institutions on both sides of the border.



5.4. A slow institutional process

A coming together between medical institutions in Völklingen and Forbach in 2010 enabled doctors on the different sites to get to know each other, to train in the use of one or another cardiology technique and to practise at each of the sites. They first worked to create and strengthen bonds between the staff concerned. A rapprochement between hospital managers was then also encouraged.

Several obstacles appeared during the implementation of the agreement signed in March 2013 formalising the cooperation project. First among these were cultural differences. Even though the operators live geographically close to one another, they do not speak the same language or have the same customs. In order to be implemented and secured, the

project required participants to become more aware or even to take training — language training, for example.

Secondly, again despite the geographical closeness, there are real differences in the way health systems are organised and payment systems are reimbursed in France and Germany. These institutional differences also slowed down the implementation of the agreement.

Another obstacle was posed by the difference in the institutional levels of the contracting parties. On one side was the hospital in Völklingen, and on the other side the Regional Health Authority (ARS), which is directly answerable to the French health ministry. These two entities were very unequal contracting parties in terms of institutional level. Here, as in any project, each public player prefers to negotiate with its counterpart; but in the pre-



sent case, that was impossible. On the German side, the partner signing the agreement is the operational player, namely the SHG-Kliniken in Völklingen, a local hospital. In contrast, on the French side, the framework agreement states that the player authorised to sign the agreement is the competent administrative entity - here, the ARS of Lorraine.

This type of imbalance is frequently found among cross-border partners and success calls for negotiating strength and an open mind.

Furthermore, during the negotiation phase, the administration of local services was reorganised under a single regional health authority (ARS), which also contributed to the delay. Along with this reorganisation, there were management changes in the hospitals and at the ARS, and this also tended to slow the process down.

5.5. The cooperation is effective though limited

The agreement between Forbach and Völklingen has been operational since 2 April 2013, to the great satisfaction of health professionals, patients, hospital managers, the ARS and the health ministry in Saarland.

Since the project was set up, a growing number of staff at the two hospitals are becoming bilingual. More specifically, since the project came into force, the SHG-Kliniken in Völklingen has been recruiting bilingual doctors.

Overall, the inter-hospital partnership provides high quality cardiac care in Forbach through strengthening the medical team with bilingual cardiologists from Völklingen. In practice, this care is initially provided in Völklingen; after three days on average, patients can be transferred to Forbach.

Although the project is a success, it remains relatively limited. Firstly, at the geographical level, it only applies to certain border municipalities, and thus to a restricted area. Secondly, it only concerns diagnoses of acute ST+ infarction, so it is highly regulated and limited.

The collaboration that is now in place was originally launched in the hope of extending it to other cardiac diagnoses including other types of heart attack. Currently, the parties concerned do not seem to be planning any projects of that kind.



A FIRST-HAND WITNESS: KARINE MERTENS

Karine Mertens has been involved since 2008 in setting up collaborative health projects in the SaarMoselle EuroDistrict. Since 2016 she has been responsible for international relations at the Grand Est Regional Health Authority, which is directly answerable to the French health ministry.

"The starting point was proximity, you had to give the patient the chance to be treated close by. You must remember that with a diagnosis like heart attack, every second counts, so it seems logical to care for the patient in the nearest appropriate hospital [...] We have worked to build and strengthen the medical links, the links between hospitals. But also, at the administrative level, we have worked to bring together the different hospital managements involved [...] The personal commitment of the doctors has played an important role."

6. The IZOM project

Tailored healthcare in the Meuse-Rhine Euregio (Belgium, Germany, the Netherlands)

6.1. An open cross-border region

The Meuse-Rhine Euregio (EMR) combines the south of the province of Limburg (Netherlands), the provinces of Limburg and Liège (Belgium) and the Zweckverband Region Aachen (Germany). Created in 1976 as a working group, the Meuse-Rhine Euregio constitutes a very old partnership for cross-border cooperation. In 1991, the Euregio acquired a legal status, becoming a Dutch stichting, a status comparable to that of a non-profit association (asbl). In general terms, the cross-border dynamic is firmly established in these territories through a number of collaborative bodies.

The region is densely populated (3.8 million inhabitants) and has many healthcare facilities. In the 1990s, a number of problems emerged around healthcare in the area. There were abnormally long waiting times to see certain specialists and, in some areas, local health services were in short supply or even lacking.

The IZOM project (Integratie Zorg Op Maat: tailored healthcare) enables residents of the region to receive healthcare on either side of the border. It consists of a simplified administrative procedure for accessing care abroad and a process for spreading specific information.

IZOM is not the only healthcare cooperation project developed in the Meuse-Rhine Euregio. In 2005, for example, the Cross-Border Emergency Medical Assistance in the Meuse-Rhine Euregio scheme was set up (EUMED). Its activities started at the end of the 1990s and were part of a disaster management project supported by Interreg between 2005 and 2007 known as EMRIC (Euregio Maas-Rijn – Interventie in geval van Crisis).

OBJECT: Collaboration to facilitate patient mobility in the Meuse-Rhine Euregio.

KEY DATES: 1997: IZOM project set up by the Dutch health insurer CZ in cooperation with the Belgian Mutualité Chrétienne and the German AOK Rheinland. 2000: launch of the project with 13 partners. 2013: development of the eIZOM project: issue of an electronic card. 2016: two German signatory partners terminate the collaboration agreement. A decision is taken to abandon the IZOM procedure on 31 December 2017 and to restore the application of community law in the Euregio.

BORDER: The Euregio Meuse-Rhine (EMR), more particularly the Noord-Brabant and Limburg provinces (the Netherlands), the provinces of Limburg and Liège (Belgium), the Aachen region and the districts of Bitburg-Prüm and Daun (Germany).

EUROPEAN PROGRAMME (CO-FINANCING): Interreg II 1994-1999 and Interreg III 2000-2006: budget of €2 723 702, of which €1 361 019 was funded by the ERDF.

WEBSITE: <http://www.grenzgaengerinfos.org/soziales4.5.html>

6.2. Expanding healthcare for border patients

As from 1997, health insurance entities in Belgium, the Netherlands and Germany began to consider how to set up an initiative to facilitate patient mobility across the border. Three years later, in September 2000, IZOM was launched. All the health insurers concerned agreed to sign the partnership agreement.

The IZOM project enables residents to be treated in the institutions of their choice and optimises the health care services provided in the Euregio. For example, IZOM enables residents of Belgian Limburg (many of





whom are originally from Dutch Limburg) to be treated in the hospitals where they used to be seen previously; these residents can, to some extent, continue to consult “their” doctor and “their” hospital. IZOM also enables the residents of the German-speaking community of Belgium to take advantage of university healthcare delivered in their own language, as they now have easier access to hospitals in Aachen.

To use the IZOM scheme, patients wishing to receive care abroad must first contact their health insurer to obtain the form 112+ before any care or treatment dispensed abroad. This form is only used in the IZOM project. It is based on form E112 (or the recent form S2)¹⁰ with a “+” added to distinguish the care authorised under the IZOM procedure from access

through the simple application of the social security coordinating regulations. Through this scheme, patients are treated in the same way as patients living in the country in which they receive care.

Choices and personal reasons are thus valid reasons for receiving care on the other side of the border. Form E112+ is granted for a period of between three and twelve months, and indicates, on a case-by-case basis, the medical specialties for which the patient intends to travel abroad. However, certain categories of doctors and healthcare are not covered by the IZOM scheme, including GPs, dentists and physiotherapists. Finally, in Belgium, for a series of particular treatments identified by the National institute for sickness and invalidity insurance, the issue of form E112+ remains subject to the approval of the health insurance fund.

In 2013, the health insurance funds AOK Rheinland/Hamburg (Germany) and the Mutualité Chrétienne in Verviers (Belgium) developed a new project, eIZOM, to issue an electronic card enabling German specialists to treat affiliated Belgian patients directly.

6.3. Administrative and legal inflexibility

During the implementation phase of the IZOM project, administrative and legal inflexibility was a significant problem. Legal texts were required that could establish agreements between partners from different countries, confirming their decisions. It was also necessary to assess the administrative burden inherent in innovations of this kind. To enable patients to cross the border easily, the aim was to reduce the complexity of these processes as much as possible.

Overall the project seemed to meet the expectations of people living in Belgium. In an interview with the local Belgian media in 2014, Danny Havenith, Director of the St. Nikolaus-Hospital (Eupen, Belgium) mentioned the matter of unfair competition: he pointed out that, under the IZOM project, more Belgian patients crossed the border than Dutch or German patients. This imbalance was especially striking in certain specialist branches of medicine, such as paediatrics.

¹⁰ Form E112 was replaced by form S2 following the reform of the coordination of social security schemes in May 2010.

6.4. Undeniable results

In 2014, 15 807 S2 forms (or old E112+ 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.

The success of IZOM led to similar initiatives in other regions. In 2002, a similar scheme (known as ZOM) was launched in the Rhine-Waal Euregio between the Netherlands and Germany. Patients benefit from the added value of the project, but also professionals, because the project has led the partners to share experiences and become better informed about the provision available and the patient needs.

6.5. The end of the IZOM project

In the years from 2010, significant changes in both Europe and the partner countries have directly or indirectly affected the IZOM project.

The regulatory framework for cross-border access to healthcare has changed at the European level following the 2013 transposition into national law of Directive 2011/24/EU on patients' rights. This amendment raises questions as to the added value of the IZOM scheme, as this Directive now offers the same options as those provided by the tri-national project.

The imbalance in flows and these changes also led the procedure to be questioned. In 2016 two German signatory partners terminated the IZOM collaboration agreement, so the AOK Rheinland/Hamburg is now the only partner on the German side.

In Belgium, the IZOM collaboration agreement was evaluated by the ministry for social affairs and public health in 2016. Partly because of the withdrawal of the two German partners, a working group was set up at the end of this same year to consider the future of IZOM or to propose

alternatives. It was decided that the IZOM scheme would be definitively abandoned on 31 December 2017. Between June and December, there will be a transitional period to take account of current treatment.

An alternative solution has been put forward to facilitate access to certain kinds of healthcare in Germany for German-speaking citizens of Belgium who have benefited from the IZOM project. It involves establishing a list of healthcare items and a precise geographic area on either side of the Belgian-German border. It will target medical needs for which the German language is an essential aspect and where there is insufficient provision for the residents concerned.

On 1 January 2018, the Euregio will revert to the application of EU law, like everywhere else in the EU, namely the European coordinating regulations and Directive 2011/24 on patient rights.

A FIRST-HAND WITNESS: PATRICK CARNOTENSIS

Patrick Carnotensis took part in the IZOM project as representative of the Christelijke Mutualiteit in Limburg.

"When we set up the IZOM project, we encountered a major legal problem. It turned out that there was no legislative basis for partnership projects between different health insurers in different countries. Such a legislative basis would make it easy to set up collaborations like this working across the borders... [to conduct such a project, it's essential to] properly evaluate the administrative approach before getting started, and to keep it in mind throughout the process. You also need to try to simplify the administrative tasks and the procedures for supporting patients."

7. The cross-border hospital in Cerdanya

One hospital, two States (France-Spain)

7.1. Healthcare provision in remote mountain areas

The Cerdanya is a remote and mountainous plateau on the Franco-Spanish border at an altitude of 1200 metres, where the population can go from 32 000 residents to more than 150 000 in the tourist season.

In the early years of the century, Catalonia (an autonomous region of Spain) decided to rethink all its hospitals, including in Cerdanya. There was a hospital in Puigcerdà, but there was no way of expanding it.

On the French side, emergency and obstetric care could only be provided in Perpignan (France), more than 100 km away. Because of this distance, some French patients went to Spanish hospitals for healthcare, in particular under the hospital agreement then existing between the regional hospital authority in Languedoc-Roussillon and the Centre hospitalier in Perpignan (F), and the Puigcerdà hospital in Spain. But this was a source of administrative, regulatory and financial difficulties.

A feasibility study was launched in January 2003, following the signature of a Memorandum of Understanding between the president of the Languedoc-Roussillon Regional Council (France) and the president of the Generalitat de Catalunya (Spain), with their partners the regional hospital authority in Languedoc-Roussillon (ARH LR) and the Servei Català de la Salut (CatSalut). The study was to evaluate local needs and analyse a project for building a joint hospital.

In 2005, the French Minister of Health and Solidarity and the Catalan Health Advisor signed a joint declaration of intent for the construction of a hospital in Puigcerdà, on the Spanish side, two kilometres from the French border. Around 60% of the construction cost would be financed by the ERDF. The remaining 40% would be borne by France (two-fifths) and Catalunya (three-fifths).

OBJECT: The creation, construction and cross-border management of a hospital in a mountainous area, integrating French and Spanish staff and receiving French and Spanish patients under the same conditions.

KEY DATES: 2002: agreement between the Catalan hospital in Puigcerdà, the French regional health authority and the French hospital in Perpignan. 2003: launch of a feasibility study under Interreg III 2000-2006. 2005: joint declaration of intent regarding the building of the hospital in Puigcerdà. 2010: creation of the European Grouping of Territorial Cooperation (EGTC) 2014: hospital inaugurated.

BORDER: France-Spain-Andorra - Cerdanya plateau / Montagne Catalan, in the Pyrenees.

EUROPEAN PROGRAMME (CO-FINANCING): Interreg III; Interreg IVA – France-Spain 2007-2013: total funding: €28 615 385; with ERDF contribution of €16 600 000.

WEBSITE: www.hcerdanya.eu

The statement was followed by a declaration of intent to cooperate on healthcare, signed on 19 March 2007 between the same authorities.

7.2. From a private foundation to the creation of a European Grouping of Territorial Cooperation

The project is complex. Multi-level, it concerns a national competence on the French side and a regional competence on the Spanish side. Public bodies with divergent interests and objectives must therefore be involved. Furthermore, as Raymonde Séchet and Régis Keerle have repeatedly shown in their work¹¹, Catalan pragmatism, which makes for rapid deci-

¹¹ Séchet, R. & Keerle, R., 2010, Le projet d'hôpital commun transfrontalier de Cerdagne : des difficultés de la coopération transfrontalière en matière de santé dans un contexte pourtant favorable. *Annales de géographie*, 675, (5) similar to those of the Ardennes hills.



A n d o r r a

F R A N C E

O c c i t a n i e

Hôpital de Puigcerdà



Hôpital de Cerdagne

Perpignan



Hôpital de Perpignan

EGTC – Hospital de Cerdanya

C a t a l o n i a

S p a i n

• Barcelona

• Montpellier

sion-making, regularly comes up against the political and administrative complexity of France, requiring agreements and multiple procedures in order to make progress.

Finally, the hospital of Cerdanya was created as a private foundation in July 2006. It included elected representatives of the Generalitat de Catalunya and CatSalut, and on behalf of France, local elected representatives, the health ministry, the Languedoc-Roussillon regional hospital authority and the management of hospitalisation and healthcare services. This foundation set about the construction project, such as the calls for tender, choice of architect, building permits, appointment of contractors, or launching the works.

To manage the hospital and its construction, it was then decided to create a European Grouping of Territorial Cooperation of the Cross-border Hospital of Cerdanya (EGTC-HC). The EGTC does appear to be the appropriate legal tool. Because of its specific legal and financial autonomy, this tool enables French health insurers to finance a healthcare facility established outside the national borders.

The EGTC-HC took over the organisation from the foundation in April 2010. Its organs are composed of representatives of the two partners, the French State and the Catalan Region. Note that French elected representatives could not sit on the management board of the EGTC-HC, since health is still a centralised competence in France. It is the EGTC which has implemented and secured the project.

7.3. A simple project, an arduous process

The hospital project is located in a remote area whose inhabitants share a common regional identity. The project was developed at a time when changes and restrictions were affecting public healthcare policies in both countries. These trends undermined the institutions and exacerbated competition between hospitals. They risked intensifying the difficulties of the situation, reducing local health provision still further. At the same time, they made the cross-border perspective all the more timely and even inevitable.

The choice of Puigcerdà as the location of the hospital was justified by proximity of the border, but also and primarily because of the hospital expertise present in the municipality due to the previous hospital and because of the grant of the land by the Spanish authorities.

From the conception of the hospital to its opening, various problems arose. The opening was planned for 2012 but did not take place until 2014, despite the fact that the works were completed in 2012 and that the operating funds were available at that date.

Furthermore, the closure of the previous Puigcerdà hospital managed by the private Cerdanya hospital foundation and its transfer to the Cerdanya hospital was a complicated manoeuvre both politically and administratively. Everything had to be discussed and resolved, from employee status (private under the Foundation versus public in the EGTC-HC) to the organisation of primary healthcare, initially planned for the premises of the Cerdanya hospital and eventually maintained at the former Puigcerdà hospital site. In turn, Catalonia was experiencing severe financial difficulties, and was unable to fund the €10 million of hospital equipment.

The combination of 184 Catalan professionals and 60 French professionals posed a problem as well, because of the lack of existence of a European employee status. It was then decided that the Cerdanya hospital would operate by turning to local hospitals for some healthcare provision of services and staff. The entire radiology service was placed under the responsibility of the Centre hospitalier in Perpignan (France), and the dialysis service under the Manresa hospital (France) with the participation of the referring institution for dialysis replacement therapy in cases of chronic kidney disease.

For specialist external consultations, a number of agreements were reached with local health institutions both in Catalonia and France. Logistical services (catering, bio-cleaning, linen), representing 24 FTE jobs, were provided by the Pôle Sanitaire Cerdan of which the EGTC-HC is a member.

In another example of adaptation, the creation of a unified Franco-Spanish emergency service required the transfer of the French emergency and intensive care services (SMUR) to the hospital site in 2016. In addition, medical care protocols had to be formalised. Some of these could be finalised when the hospital opened (surgery, obstetrics, dialysis) and others have been resolved since or will be resolved in the future.

Finally, and more generally, the differences in reimbursement methods had to be accommodated. For example, cover for new-borns at birth has been simplified thanks to an exceptional procedure introduced by the local healthcare fund (CPAM) in the Pyrénées-Orientales (France).



7.4. Tangible results, but continuous adaptations

The cross-border hospital at Cerdanya has been providing its services since 19 September 2014. With bi-national staff and patients, it is unique in Europe.

Its day-to-day work entails continuous adaptations, whether to patient reimbursement procedures, employee status or healthcare procedures. There is no doubt that the project has led to some very specific progress in the field of European cooperation. For instance, in 2016, the bi-national agreement was signed between France and Spain, which authorises the transfer of deceased nationals of either country to their native soil without the use of lead coffins all along the border.

In addition to the construction and management of the hospital, the project increased the mutualisation and cooperation between French and Spanish health professionals. Thanks to this cooperation, other projects have been developed, for example the emergence of a cross-border centre for social and healthcare research bringing together the universities of Gerona and Perpignan.

The utilisation rate has steadily increased over the last years, with 24 000 patients attending the emergency service in 2015. Elected representatives in Cerdanya regularly express their satisfaction and that of people living locally, although the location of the hospital on the Spanish side of the border probably accounts in part for the fact that a higher proportion of the patients are Spanish.



In 2016, the Cerdanya hospital received the European Committee of the Regions award for the best project created and delivered by a European Grouping of Territorial Cooperation.

Health is a complex domain, highly regulated and sensitive, governed by voluminous technical legislation that varies from one country to the next. The success of the cross-border hospital project reflects the determination of both the French and Spanish teams, who have overcome, step by step, the obstacles and hindrances associated with this apparently straightforward project. The project, the launch of which was widely reported in the media, represents a flagship example of the capacity for innovation in cross-border cooperations.

A FIRST-HAND WITNESS: CATHERINE BARNOLE

Since 2010, she has been head of mission for the EGTC-HC within the Languedoc Roussillon Regional Health Authority (now the Occitania Regional Health Authority), secretary of the EGTC-HC management board and currently a member of the executive bureau.

“The opening of the cross-border hospital was a first in Europe. There were many challenges (...).

The differences in powers between Catalonia, which has a high degree of autonomy, and the French local authorities, which are answerable to the State in many domains, together with the fact that health issues are highly regulated at the national level and very little at the European level, have defined the challenges of the project.

The rules to establish for the functioning of the hospital (health procedures, safety standards, staff skills, etc.) could differ from one side to the other and were the subject of intensive debate. The principle of systematically adopting the higher of the two standards enabled us not just to remain compliant with both sets of legislation; it also enabled us to build an exceptional facility [...] There is no shortage of ad hoc solutions.

We would like to hope that the project will serve as an example for other regions and at the European level that it would facilitate cross-border efforts.”



CHAPTER 4

**FRANCO-BELGIAN
COOPERATION**

1. Interreg, the driving force behind cooperation

Between 1992 and 2017, the Franco-Belgian cooperation in the area of health was developed along three axes: healthcare cooperation, emergency medical care and medico-social cooperation.

The successive Interreg programmes have provided heavyweight backing to cross-border cooperation on the Franco-Belgian border. The programmes Interreg I, II, III and IV have provided a lot of support and technical assistance to the local partners to develop, embed and secure structured cooperation, in particular by encouraging inter-hospital agreements and defining a first cross-border health area.

The testimony from the Managing Authority of the Interreg France-Walonia-Flanders programme confirms this approach.

2. Healthcare cooperation

The healthcare cooperation projects developed across the Franco-Belgian border area have from the start aimed to improve access to healthcare for the border populations, to promote prevention and health education and to tackle the main challenges linked to problems with healthcare availability.

They have made it possible to create synergies between the healthcare capacities of the two sides of the border, collaboration between border area medical teams, access to equipment located one or other side of the border and to develop responses to the issues of an inadequate medical and paramedical demography.

2.1. The first form of cooperation: inter-hospital agreements

Under the Interreg I programme Pacte Hainaut/Nord Pas de Calais agreement (1992-1994), an initial project enabled actors responsible for planning and financing healthcare to meet and exchange information on the organisational, operational and financial models of their healthcare systems. A comparative study was conducted to analyse the management mechanisms of the two healthcare systems: their

capacities, their practices, the characteristics of their structures, the medical equipment, but also their shortcomings, their difficulties and new needs which were hard to meet.

By identifying the strengths and weaknesses of each system, the project operators were able to develop a cooperative approach on the provision of care in the two border areas through the perspective of their complementary nature.

This approach brought about the first inter-hospital agreement for local cross-border healthcare access between two hospitals located north-east of the Lille conurbation (Lille France), namely Mouscron in Belgium and Tourcoing in France. These two hospital structures, located a few hundred metres apart, were unable to meet the specialist care needs of certain patients unaided, but were able to do so in partnership. This agreement was the starting point for a real dynamic of cross-border cooperation on healthcare.

Following preparatory work conducted by the operators of the first Interreg projects and meetings organised between the administrative and medical directors of these healthcare structures, it emerged that synergies between the two technical services could be created to provide a local solution for patients suffering from certain conditions.

In this way those responsible for financing healthcare services on each side of the border, the medical staff and the administrations of the care institutions concerned decided to authorise people with AIDS covered by Belgian health insurance who lived in the border area of Tournai-Mouscron to attend the university infection diseases service of the hospital in Tourcoing for treatment. This meant that these patients were no longer required to make long and costly journeys to healthcare structures in Brussels which at the time were the only ones capable of treating these patients suitably.

At the same time, people covered by French health insurance with chronic liver function impairments living on the French side of this border area whose health required dialysis three times a week have since 1994 been able to get treatment at the hospital in Mouscron, less than ten minutes from their homes, saving them and their carers more than an hour of additional travel.

Interreg: a catalyst for progress in Franco-Belgian healthcare cooperation



Sabrina Curzi, Wallonie-Bruxelles International – Managing authority for the Interreg France-Wallonia-Flanders programme

When the internal market was established, it could not escape notice that the border areas of Europe generally have a lower gross domestic product and higher rates of unemployment than regions closer to the centres of power. Europe was thus inspired to set up an instrument called Interreg in an attempt to alleviate these problems and difficulties.

After 25 years of cross-border cooperation, we can now affirm that Interreg is a catalyst, a facilitator, a matchmaker even, in the development of cross-border cooperation. This multifunction tool allows the border once perceived as an obstacle to become an opportunity. Over time Interreg has also been adjusted to increase its effectiveness and positive impact on the European integration project.

I consider Interreg as a multifunction tool as it offers both an implementation framework and the financial resources needed. In other terms, each Interreg programme has its own budget to draw up its own strategy, taking account of the socio-economic context as well as the strengths and weaknesses of the area concerned. The programme must also ensure that the strategy fits in with the broad policies of the EU.

The context for the first steps in developing cooperation was a little like a laboratory for new practices. The positive results of these first forms of collaborations led to the removal of administrative obstacles and to securing the progress made. By setting the frontier aside, Interreg made it possible in various areas, such as healthcare cooperation, to identify requirements, scope for synergy and potential economies of scale. In brief, by progressively treating these areas as living areas in themselves, seeking common solutions for harmonious development. Within these areas, thanks to the Interreg projects, economic actors and citizens have also become aware that Europe and its tangible outcomes contribute to improving their quality of life.

In this current period when Europe is suffering from a confidence deficit, not unreasonably in a variety of ways, the Interreg programmes continue to demonstrate fundamental European values. To cooperate across the borders, it is vital to learn to know each other, respect each other, gain confidence in each other, stand together and be ready to compromise to ensure that everybody is a winner in the end. Finally, let us not forget that more than a third of the European population lives on the EU's internal or external borders. For all these reasons, Interreg remains a relevant and valuable tool.

In 1999, André-Louis Sanguin wrote “instead of being barriers and fractures, the borders of Western Europe have become hinges and seams”. In 2016 this statement still holds. The border must be understood as a resource and not a handicap.

This first inter-hospital cooperation agreement demonstrates the prevailing approach in the development of Franco-Belgian healthcare cooperation, namely complementary provision of healthcare on the two sides of the border. It relies on the application of procedures set up under the European regulations for the coordination of social security systems, (presented in chapter 2) for the reimbursement of care provided under a defined cooperative arrangement on the other side of the border, by removing the obligation of prior medical authorisation.

Another agreement between the hospitals in Mouscron (Belgium) and Tourcoing (France) on medical imaging allowed access to be opened up to nuclear magnetic resonance (NRM) equipment in Tourcoing for Belgian patients and the scintigraphy facility in Mouscron for French patients, starting in 2005.

In the Ardennes, since the early 2000s, women in the canton of Givet (France) have been able to use the maternity facilities in Dinant (Belgium) following the closure of the clinic in Givet.

The agreement between the hospitals of Mons (Belgium) and Maubeuge (France), and subsequently Tournai (Belgium) and Valenciennes (France) on intensive care and resuscitation has opened up the option of using provision across the border in the event that these specialist hospital services are saturated, thus saving lives or improving the outcomes after accidents.

Thanks to the use of these administrative and financial procedures, inter-hospital cooperation agreements have allowed beneficiaries of health insurance to take the opportunity to cross the border with no administrative or financial obstacles.



2.2. The Transcards project, the first experiment with a cross-border health district

During the 1994-1999 programme period of Interreg, a study was conducted in the Thiérache district which spans the Franco-Belgian border¹², with an eye to developing experiments with complementary provision of hospital infrastructure on each side. The aim here was to provide solutions to healthcare access problems in an isolated area with a low population density, deserted by healthcare professionals and with only small hospital structures. These conditions left the populations of this cross-border district needing to travel a considerable distance to access suitable healthcare. By authorising cross-border mobility for patients, they were able to access a broader range of provision and find an answer to their care needs near where they lived.

¹² Thiérache is a natural region which covers areas in France (Nord, Aisne and Ardennes departments) and Belgium (provinces of Hainaut and Namur) with features similar to those of the Ardennes hills.

This approach led to the “Transcards” project, launched in 1998, which for the first time in Europe allowed health insurance beneficiaries from one Member State, France, to use their social security cards to be admitted in a hospital in another Member State, Belgium. Belgian patients could likewise use a French establishment.

Developed under the European “information and communication technologies” (ICT) programme, the project enabled the interoperability of the French and Belgian social security card readers. This “socio-technological” innovation purely and simply removed the administrative and financial barriers to access to healthcare abroad in Thiérache.

This procedure, simplifying the administrative management of registering patients into the healthcare structures of the Thiérache cross-border health district removed the obligation on patients in the area who wanted to access care on the other side of the border to obtain medical authorisation in advance in order to be reimbursed for the treatment provided, as required by the European rules on the coordination of social security systems.

During the trial phase of the project, between 1998 and 2002, it was observed that around a thousand French patients crossed the border to the hospital at Chimay (BE) for nursing, out-patient or brief in-patient care (one to three nights). Belgian patients mainly attended the hospital at Felleries Liessies (F), a functional rehabilitation establishment, for hospitalisation of three weeks or more.

This experiment showed that patient mobility made it possible to mitigate shortages of equipment and infrastructure on one or other side of the border. The fundamental concept of healthcare cooperation was thus met, namely, the complementary nature of two healthcare systems, or, because of the mobility of patients, the implicit sharing of cross-border provision.

However, the aim of this project was not merely to improve access to healthcare abroad for patients in the area. The idea was to develop complementary provision of existing equipment and medical services and reduce the negative impact of the unattractiveness of the area to healthcare professionals.

On 22 November 2002, leading officials from the health ministries of the two countries and the French and Belgian health insurers met at the

national institute of health insurance (INAMI-RIZIV) in Brussels to sign a permanent healthcare cooperation agreement for this area and to start negotiations for a framework agreement on healthcare cooperation between the two states.

2.3. The 2005 Franco-Belgian framework agreement on healthcare cooperation

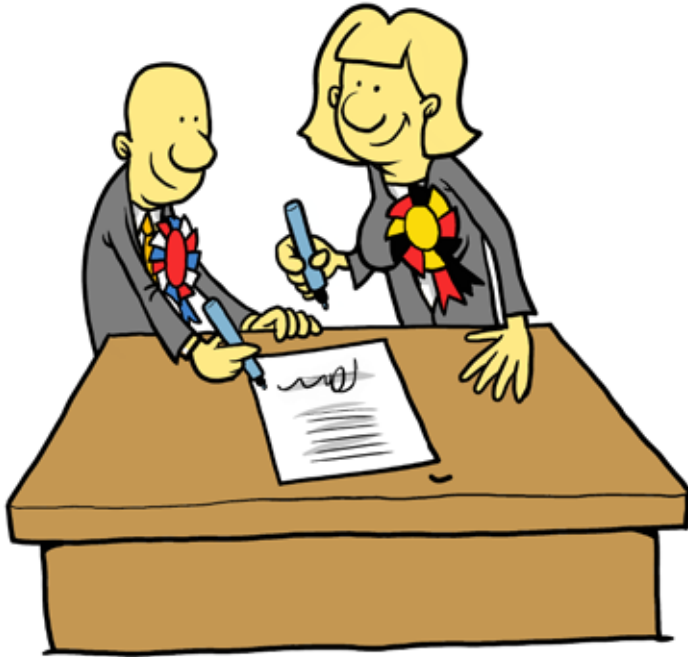
The various Franco-Belgian healthcare cooperation initiatives launched between 1992 and 2002 highlighted the slow and cumbersome nature of the procedures for validating proposals for agreements. On several occasions the national administrative authorities involved also underlined the absence of the legal basis needed for validating proposed projects and agreements.

To push the cooperative approach forward, to legitimise it at the highest level and to implement planned arrangements still at the theoretical stage, the idea of a framework agreement on cross-border healthcare cooperation between France and Belgium was born, based on the global Franco-Belgian cooperation agreement signed between the two states in 2002.

The negotiation of this framework agreement and its administrative arrangements took nearly three years. It was finally signed on 1 June 2005 by the French and Belgian health ministers on behalf of the two governments.

This healthcare treaty also sets out the authorities competent for the drafting of agreements. Their primary aim is to set the procedures for implementing cooperative arrangements and to specify which of the three financial models provided for by the framework agreement is to be used for covering care costs on the other side of the border, namely: the European regulation on coordination, CJEU case law and/or the negotiation of specific charges.

This first healthcare cooperation framework agreement negotiated in the EU was then duplicated between France and Germany, between Spain and France and, more recently, between the Grand Duchy of Luxembourg and France. It still stands as the reference for regulatory provision for flows of patients generated by cooperation between bordering states or border regions in the EU.



This type of arrangement is in line with the spirit of the European legislator who encourages states to develop stronger forms of cooperation. Indeed, it is a concrete expression of the intention of the European legislator, expressed as article 168(2) of the Lisbon Treaty and article 10(3) of directive 2011/24 on the application of patients' rights in cross-border healthcare.

2.4. Beyond 2005: The emergence of cross-border health areas

The signing of the framework agreement by the representatives of the French and Belgian governments gave fresh wind to the dynamic of healthcare cooperation between the two countries.

Since its signing the regional authorities in charge of planning, organising and financing the healthcare system have the authority to negotiate and validate agreements.

The Franco-Belgian framework agreement defines the aims of cross-border cooperation on healthcare:

- to improve access to care for the populations of the border area,
- to simplify administrative and financial procedures,
- sharing the provision of care,
- encouraging exchanges of best practice,
- reduce social costs by reducing the distance to travel, numbers of journeys, interruptions to work and the duration of hospital stays.

It also delineates the areas covered by this cross-border cooperation, namely:

- the Belgian border districts (Veurne, Ieper, Kortrijk, Mouscron, Tournai, Ath, Mons, Thuin, Philippeville, Dinant, Neufchâteau, Virton and Arlon),
- the French border regions (Champagne, Lorraine, Nord-Pas de Calais and Picardy).

This provision has encouraged the deployment of other forms of agreement authorising access to cross-border care more extensively within a defined area. The idea of setting up cross-border health pooled care took practical shape in the creation of two organised zones for cross-border access to healthcare (ZOAST), one in a rural environment (the Ardennes) and the other in an urban setting (the north-eastern part of the Lille conurbation).

This marked a move from the negotiation of inter-hospital agreements to agreements on cross-border healthcare districts. Since then, the healthcare offer on the two sides of the border no longer takes the form of targeted synergies for the treatment of particular pathologies or the use of specific equipment, but by pooling the resources and techniques made available in each border area. Cross-border cooperation provides a better structure for patients and, above all, helps reinforce the potential of the area and its attractiveness so that healthcare professionals are encouraged to come there to practise.

Progressively, the idea has emerged that the regional healthcare planning and management authorities in border areas should engage with each other and come together to promote the development of a suitable range of care in a common area, agreed in joint consultation. This idea was later to take concrete form in recital 50 of directive 2011/24 on cross-border access to healthcare.

2.5. Organised zones for cross-border access to healthcare (ZOAST)

Between 2008 and 2015 seven ZOASTs – true regulatory arrangements for cross-border healthcare districts – were set up. Today they cover the whole Franco-Belgian border area and have become references for healthcare cooperation in the EU.

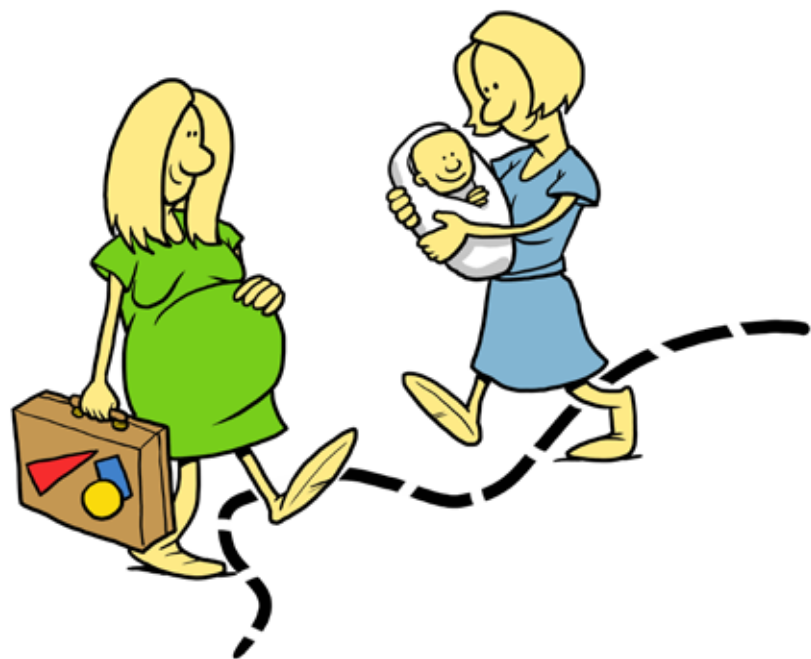
2.5.1. ZOAST ARDENNES

Created on 1 February 2008, the *ZOAST ARDENNES* opens access to care in hospitals located in a cross-border area where the population of the northernmost part of the French department of Ardennes would need to travel long distances to receive hospital care, as would those in the west of the department.

In the early 2000s this particularly difficult access to hospital care led the Director of the regional health agency (ARH) of Champagne-Ardennes in France to authorise women in the canton of Givet to use the maternity facilities across the border in Dinant, following the closure of the clinic in Givet. This requires them to travel less than twenty minutes from where they live, while it takes an hour and a quarter to travel to the hospital in Charleville-Mézières, France. The need to reduce the access times for care also affected the sick, particularly those suffering from conditions requiring continual attention.

For all these reasons, the removal of the border for the purposes of access to healthcare seems to be the only appropriate response to the particular needs of this area and those who live there.

Thanks to the ZOAST, when they receive care across the border, patients are covered by their social security system, via the European regulations

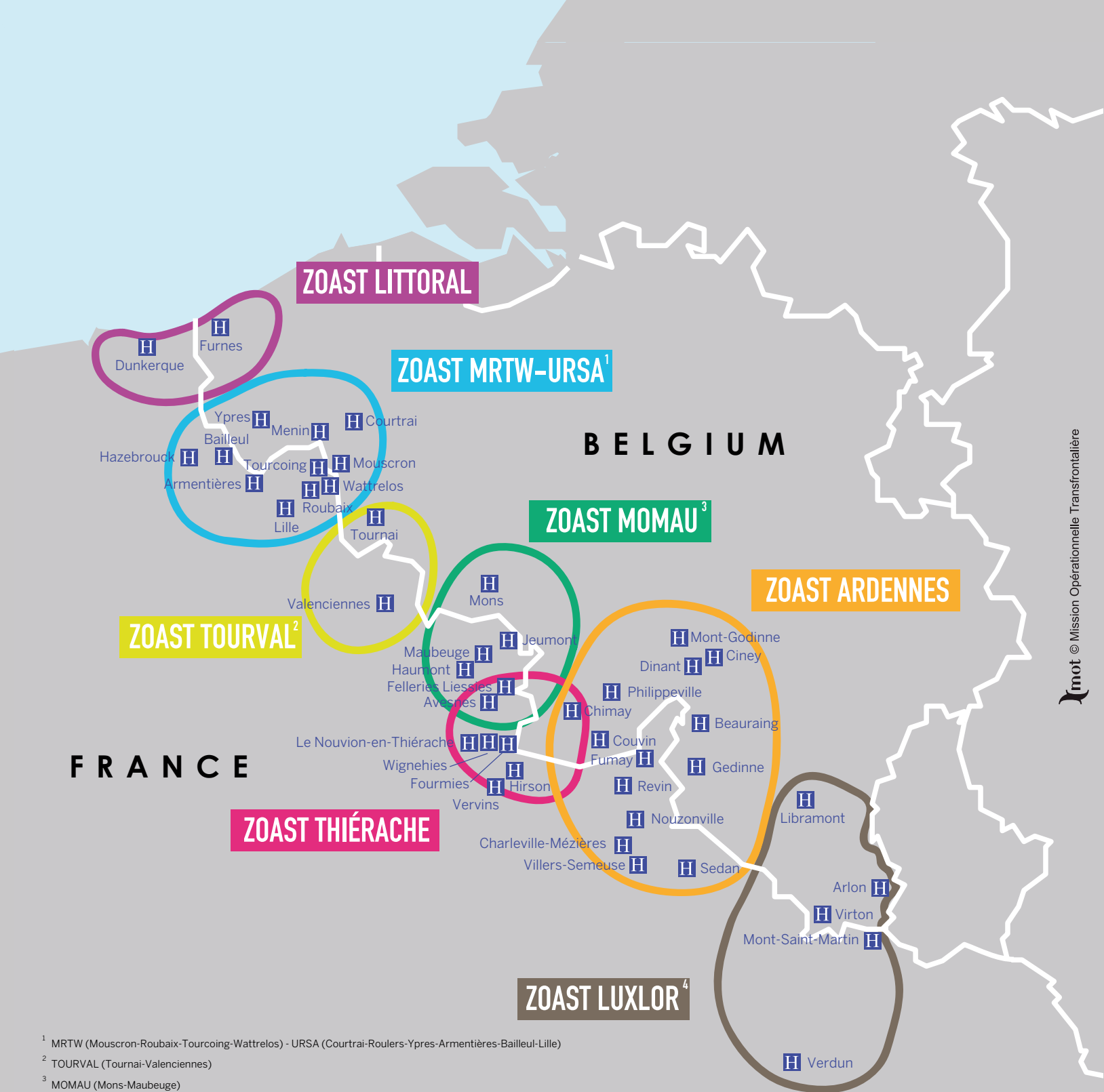


on the coordination of social security systems, with no need to apply in advance to their insurer.

For French patients treated in Belgium, French social security card readers have been installed in Belgian institutions. They enable patients to be registered in the Belgian social security system and for care to be invoiced to the accredited Belgian social security body. This recovers funds paid to the Belgian hospital from the French liaison agency under the European regulation on the coordination of social security systems.

The third party payer – a management technique through which the provider (hospital or healthcare professional) invoices the costs of care covered by social security directly to the patient's health insurer – is applied to French patients as it is to Belgian patients. This avoids their needing to pay fees and then reclaim them. In consequence, patients benefiting from cross-border cooperation agreements are treated in the same manner, without discrimination, as patients from the Member State in which they receive care.

At the end of 2009, French patients living in the west of the department of Ardennes were authorised to receive treatment at the hospital



¹ MRTW (Mouscron-Roubaix-Tourcoing-Watrelos) - URSA (Courtrai-Roulers-Ypres-Armentières-Bailleul-Lille)

² TOURVAL (Tournai-Valenciennes)

³ MOMAU (Mons-Maubeuge)

⁴ LUXLOR (Province de Luxembourg-Lorraine)

in Chimay, since they were otherwise obliged to travel considerable distances on French territory to use a French establishment.

Since early 2012, Belgian patients have been able to be admitted to the functional rehabilitation and re-education establishment in Ardennes department (France) to receive often protracted treatment appropriate to their needs.

Since the launch of ZOAST Ardennes, it has been observed that this arrangement responds above all to the absence of hospital infrastructure in the canton of Givet in France. More than 95% of patient movements (between 8 000 and 9 000 since 2012) originate in this border area. Using institutions in Belgium is a necessity for French patients not only because of access time to hospital facilities, but also because of the shortage of both general and specialist healthcare professionals in the canton of Givet. This cross-border mobility has had no incidence on healthcare access for Belgian patients. The Belgian hospitals concerned have enough capacity to handle demand for care greater than that of the area in which they are based.

2.5.2. ZOAST MRTW URSA (Mouscron, Roubaix, Tourcoing, Wattrelos, Armentières, Bailleul, Hazebrouck, and Ieper)

The *ZOAST MRTW URSA*, created on 1 April 2008, concerned first the hospitals of Mouscron, Roubaix, Tourcoing and Wattrelos (MRTW), all four close to the border and located in an urban area (the north of the Lille conurbation) with high population density. These four institutions had concluded various medical collaborations between 1994 (first inter-hospital agreement) and 2008, to bring a local response to the demand for care for the particularly large number of cross-border workers in this area and were able, with members of their families, to access care in both France and Belgium.

As the border effect had almost vanished for many purposes in this frontier area, it seemed opportune to offer the right of access to healthcare locally to the whole population along the same lines as that offered to frontier workers.

As in the rural *ZOAST Ardennes*, patients in this urban ZOAST accessing care across the border do not need prior medical authorisation from their health insurer. They obtain reimbursement for their care costs via the

procedures defined in the European regulations on the coordination of social security systems. They are treated in the same way as residents of the country in which care is provided. French patients are registered at Mouscron hospital using their medical card while Belgian patients provide the French administrative services with a “vignette” (sticker identifying the holder as covered by insurance) issued by their insurance body.

This ZOAST gave rise to medical collaborations in various fields, to the point of creating a joint urology service for the hospitals in Mouscron and Tourcoing. Since the ZOAST was first set up, the flows of patients across the border have been balanced.

In 2009, this arrangement was extended to another group of partner hospitals under another project, Interreg URSA, funded through the Interreg France-Wallonia-Flanders programme: the hospitals of Ieper on the Flemish side, Armentières, Bailleul and Hazebrouck on the French side.

In 2014, the agreement ZOAST was extended to cover the L'Espoir care and functional rehabilitation centre in Hellemmes (France). Since then, Belgian patients from this border area suffering from major neurological disorders have been treated close to their family and living environments, often involving long stays.

Today this arrangement covers more than 500 000 inhabitants and 11 hospital care structures, some very large such as the 3 000 bed CHRU in Lille.

2.5.3. ZOAST LUXLOR

ZOAST LUXLOR (from the Belgian province of Luxembourg and the French region of Lorraine) was established on 1 July 2008.

At the time this ZOAST was launched, the French hospital of Mont Saint Martin (Longwy) was having serious difficulty in recruiting specialist doctors and had no MRI (magnetic resonance imaging equipment). Additionally, its surgical facilities were only used for minor operations. Since the early 2000s, French patients in this area have been sent to Arlon in Belgium for MRI scans. For administrative and financial reasons, they were hospitalised for a day for this diagnostic examination.

The ZOAST stimulated a process of medical collaboration between practitioners from the hospital at Arlon and those of Mont Saint Martin. Gas-



troenterologists and urologists from Arlon held consultations at Mont Saint Martin. Belgian radiologists set up an economic interest group to manage the radiology facilities at Mont Saint Martin and operate the MRI, installed in 2011, on the basis of an agreement between the Lorraine regional health agency and the Belgian doctors.

This arrangement has made it possible to maintain the provision of hospital care on the French side of the border, through the contributions of Belgian practitioners performing consultations and operations at the hospital of Mont Saint Martin which was encountering serious difficulties in recruiting specialist doctors and was often forced to use expensive temporary practitioners, putting the establishment into some financial difficulty.

As this Franco-Belgian area also borders the Grand Duchy of Luxembourg, once this ZOAST had been launched approaches were made to extend it to people covered by Luxembourg social security. Following various meetings with the authorities in charge of social security in the Grand Duchy, a first agreement was reached to allow frontier workers to benefit from this cooperation, before being extended to all those covered by Luxembourg social security resident in the Franco-Belgian area from 2012.

In 2014, the cross-border agreement was extended to cover the department of Meuse (France) and Neufchâteau district (Belgium). This enabled the inclusion of hospitals in Verdun in the former and Libramont in the latter. This extension now allows patients from the north of Meuse to go to Virton for radiology appointments. This agreement generates a flow of between 3000 and 3500 patients each year.

2.5.4. ZOAST MONS-MAUBEUGE

ZOAST MONS-MAUBEUGE was set up in early 2010 to encourage and support medical collaboration between the hospitals of Mons (BE) and Maubeuge (F). At the start of 2004, the institutions initiated an agreement on intensive care which allowed French patients to be directed to Mons if hospital services were over capacity in Maubeuge. This collaboration led to a number of interactions between the two hospitals and constituted solid foundations for the plan to set up a ZOAST in the border area comprising the district of Mons and the catchment of the healthcare insurance office of Maubeuge.

The arrangement has led only to limited patient mobility, being used around a hundred times a year. However in administrative and financial terms it runs alongside provision for patients who benefit from cross-border medical collaboration in various fields such as urology and oncology.

2.5.5. ZOAST TOURNAI VALENCIENNES

ZOAST TOURNAI VALENCIENNES, created in 2010, opened up the prospect of collaboration between two major regional hospitals, the Centre Hospitalier de Valenciennes (F) and the Centre Hospitalier de Wallonie Picarde in Tournai (BE).

Like *ZOAST MONS-MAUBEUGE*, it has as yet resulted only in limited patient mobility, again just over a hundred uses per year. For medical cooperation, there have been meetings between specialists in medical

imaging and emergency paediatrics which have drawn up outlines for collaboration.

The development of this inter-hospital cooperation between two institutions of more or less comparable size has been held back by the long-term internal restructuring process which both hospitals have been undertaking in recent years.

2.5.6. ZOAST THIERACHE

Since 1 January 2012, *ZOAST THIERACHE* has replaced the Transcards agreement described above.

It was vital to reconfigure the existing arrangements in the light of the Franco-Belgian framework agreement on healthcare cooperation. This legal necessity created the opportunity, in Thiérache, to meet the needs expressed by those involved in cross-border healthcare locally, expanding on the Transcards arrangement. Firstly, people covered by all the existing French social security regimes were included as beneficiaries of the ZOAST and, secondly, the territorial cover on the Belgian side was extended to another municipality to the north of the area originally covered.

In Thiérache, various attempts had been made to mobilise all the stakeholders in healthcare locally over two decades, without any real success. Undoubtedly the fear of consequences for the functioning or even the survival of each hospital had taken precedence over the idea of complementary provision.

Thus the joint medical project of the principal hospitals of Thiérache, drawn up between 2012 and 2014, envisaging the formation of a European Grouping of Territorial Cooperation (EGTC) to provide guidance for synergies between hospitals, has as yet not had the concrete outcome of transforming the ZOAST into a common hospital structure shared by the two sides of the border, managed in partnership by the different players in healthcare in Franco-Belgian Thiérache.

2.5.7. ZOAST LITTORAL

ZOAST LITTORAL, in effect since January 2015, relates to hospitals in Dunkirk (F) and Veurne (BE) which have cooperated on various occasions under the 2000–2006 and 2007–2014 Interreg programmes. In 2017, the hospital in Dunkirk will have a PET scanner which may be accessible

to Belgian patients. It will be operated with support from Belgian specialists in nuclear medicine.

Summary

The fruit of a long process of constructing social and health care cooperation, ZOASTs currently constitute an appropriate response to the care needs of patients in urban or rural border areas in the EU. They put the complementary approach to the healthcare systems of neighbouring countries into practice.

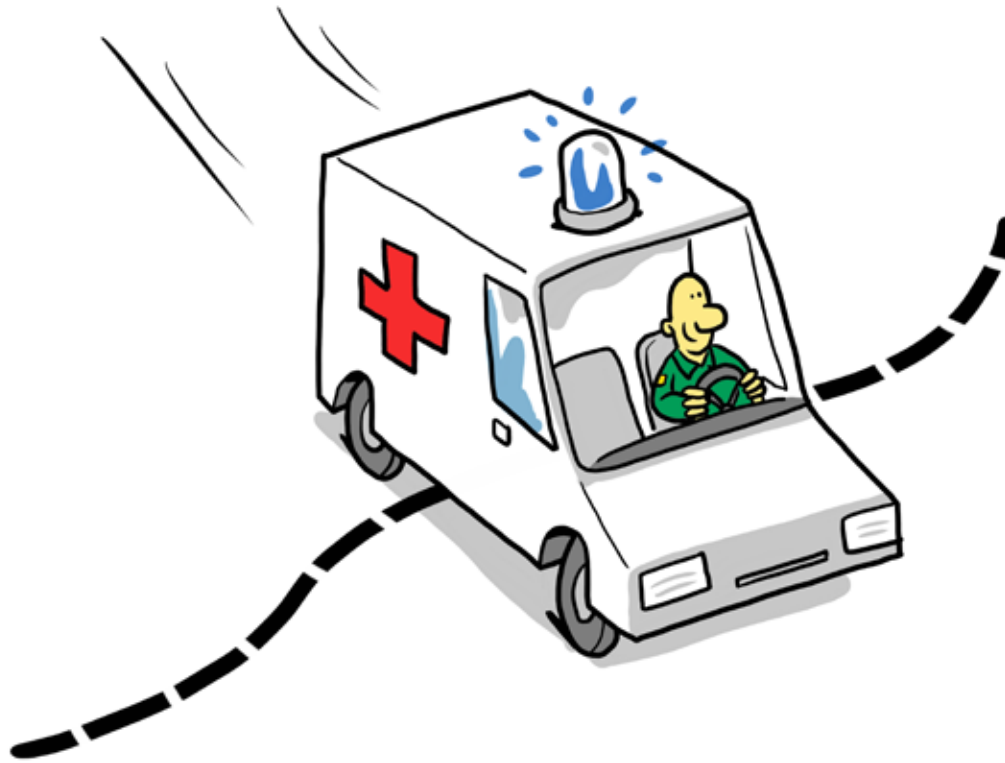
In 2015, some 20,000 French and Belgian patients have thus received treatment without discrimination on either side of the Franco-Belgian border under these cross-border arrangements, without any administrative or financial barriers.

The legal basis for the ZOAST agreements has been the Franco-Belgian framework agreement on healthcare cooperation. In part I, they regulate the financial coverage for healthcare for patients under their obligatory health insurance; in part II they incorporate the French supplementary cover given by the mechanisms to correct social imbalances defined in legal texts and by health insurers.

In addition, in France, the vast majority of the population is covered by legal or private supplementary protection (mutual fund, insurance, provident body) giving full reimbursement for care costs. For the French patient, the protection has to be complete and incorporate additional cover which complements compulsory health insurance.

To ensure full cover for French patients treated in Belgium comparable to that defined in the ZOAST agreements, for the most vulnerable patients, it was vital to develop procedures for the reimbursement of residual charges (co-payments) from supplementary policies concluded by these patients. Since 2009, beneficiaries of *ZOAST ARDENNES* have been able to obtain reimbursements of their co-payments from their supplementary insurer using the third party payer mechanism.

Software development work was required in order to implement these repayment procedures. This allowed cross-border patients to have their care costs covered fully in the same manner in which it would have been handled on the French side. It is anticipated that this will be extended to each cross-border health area (ZOAST) during 2017.



Consequently, within the Franco-Belgian border area, for healthcare insurance beneficiaries the administrative and financial aspects of access to healthcare on the other side will then be almost identical to those in their country of residence.

3. Cooperation on medical emergency provision

In parallel with the development of inter-hospital healthcare cooperation and cross-border health areas, little by little Franco-Belgian cross-border cooperation has been developed for emergency medical services. This is today governed by a specific Franco-Belgian agreement on emergency medical care ("AMU franco-belge").

The agreement, concluded between France and Belgium on 20 March 2007, created a vital new form of cross-border collaboration to improve the survival chances of patients and mitigate the outcomes of accidents and conditions such as strokes and heart attacks. The system has been

implemented in each subregion of the Franco-Belgian cross-border zone (Lorraine, Ardennes-Thiérache, Nord) since the first half of 2008.

In order to reduce the response time — the time elapsing between a call to a unified emergency call centre (European number: 112) and medical handling by a care provider at the patient's bedside — the French and Belgian mobile emergency and resuscitation services now operate on both sides of the border.

In practice, the services based each side of the border can provide second line cover when the local service is unavailable at the time of the call, following an order of priority for operations defined for each border area on the basis of the location of emergency service bases.

Furthermore, in certain border zones where the response time can exceed 20 minutes (the maximum set out in national legislation), first line operation has been developed with the agreement of the authorities and players concerned in certain municipalities on the border. Under this arrangement, the unified call centre for the area calls the emergency

services of the neighbouring country directly to request their intervention.

In Lorraine, around 125 interventions of this type take place each year, with a hundred in the Ardennes.

Suitable procedures for the administration and finance of this cooperation based on the mechanisms used in the European social security regulations have been developed. More specifically, first the hospital responsible for the emergency service operating across the border completes a form S (formerly E112) on the basis of the patient's identification data, which does not require prior medical authorisation since the agreement removes this constraint.

Second, the cross-border emergency call is paid for under the procedures of the European regulations on the basis of a flat rate charge. The French services receive the half-hourly rate which they could claim for operations in France. Belgian services which cross the border receive a half-hourly rate corresponding to the average half-hourly charge for French services that can operate in Belgium.

This payment mechanism was created specifically in the Franco-Belgian emergency services cross-border cooperation agreement, since the method of financing for these services is based on different charging rates

on each side of the border. Thus the application of a flat-rate charge for Belgian services operating in France replaces the payment by service operated for services in Belgium.

This negotiated tariff is one of the ways of financing for cross-border healthcare provision provided for in the Franco-Belgian healthcare cooperation framework agreement. It has been duplicated in other cross-border agreements of the same type in other border areas within the EU.

4. Cooperation in the medico-social sector

Franco-Belgian cooperation in healthcare covers hospital services and emergency medicine, but also the medico-social sector.

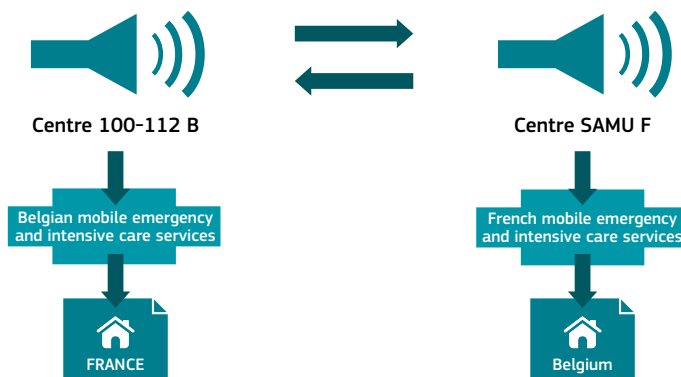
For decades French elderly people and people with disabilities have been taken into Belgian institutions, primarily in the francophone part of the country. In the Interreg projects developed between 1992 and 2010, this mobility was the subject of questions and concerns at various junctures because of the absence of regulation at the level of national and regional authorities. Through lack of political will or interest, only studies and comparisons of legislation were conducted.

Bringing the hospital and medico-social sectors together under regional health agencies (ARS) in France in 2010 opened up the way to a cross-border cooperation facility in this area.

With the regionalisation of powers in the medico-social sector in Belgium and in particular the care and accommodation of people with disabilities, it was necessary to choose between a Franco-Walloon and a Franco-Flemish arrangement. As almost all French elderly people and people with disabilities who have chosen to settle in Belgium live in Wallonia – and hence Francophone – establishments, negotiations on a cross-border arrangement are under way with Wallonia.

The placement of French people with disabilities in French institutions in Wallonia goes back more than a century. This mobility started after the resettlement of various French religious orders in the francophone part of Belgium following the adoption of the law on the separation of church and state in France in 1905. However, recourse to Walloon care and residential facilities is also explained by the chronic shortage of places in France, particularly for children with learning difficulties.

Franco-Belgian cooperation process for medical emergency provision



The mobility from France to Belgium developed in an informal manner. The competent authorities on the French side (health insurance for minors and General Councils for adults) acted almost exclusively as funding bodies. Institutions in Wallonia housing only French people with disabilities were able to carry out their activities without necessarily being approved or even inspected by the competent authorities. It was 1995 before a Walloon government decree defined a regime for “authorisation to provide care” to establish Walloon administrative controls independently of the funding of residential care for French people with disabilities by the competent French bodies.

In 2009, a new Walloon regulation defined a structure for institutions operating under “authorisation to provide care”, fixing standards of operation and setting up an inspection regime conducted by the Walloon agency for the integration of people with disabilities, which has now become the Agency for Life Quality (AVIQ).

Until recently, there were no exact records of French people (adults and minors) with disabilities resident in Walloon institutions.

In his report to the French National Assembly in 2013, parliamentarian Philip Corderoy cited a figure of 6620 people with disabilities resident in Wallonia.

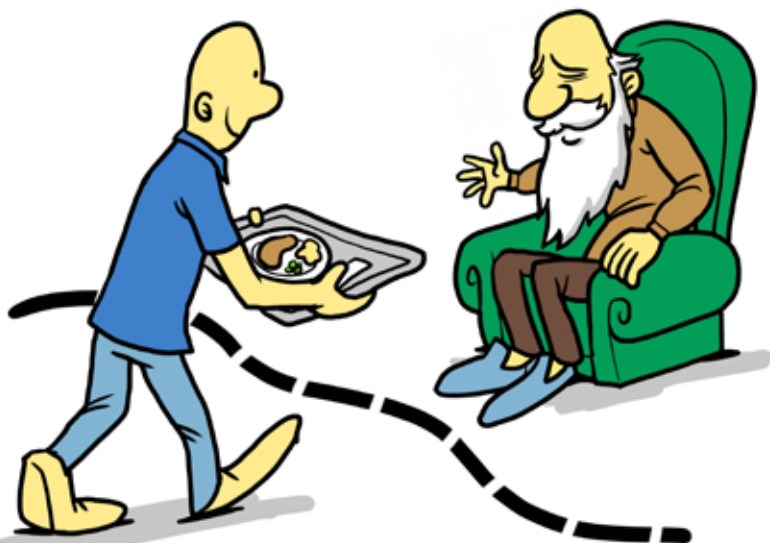
They mainly came from the parts of France close to Belgium. However, people with disabilities living in Wallonia came from 42 French departments and 17 (former) regions (report of the general inspectorate for social affairs (IGAS) of September 2005) In her 2008 report on her study for the minister for social affairs on “residential care for elderly people and people with disabilities in Belgium”, deputy Cécile Gallez observed “a very approximate knowledge of the phenomenon (number of patients, types of disability, etc.); a fragmented view of its financial impact, except for expenses relating to children and paid by healthcare insurance, which covers only a small fraction of total expenditure; an absence of supervision of institutions...”.

This observation passed on to the highest levels of the French state and Wallonia encouraged the adoption of a cross-border regulatory measure for these movements.

This was the situation when, in the course of the Interreg programme France-Wallonia-Flanders (2007-2013), operators concerned by the issue felt it would be appropriate to draw up a medico-social framework agreement, which they submitted to the relevant French and Walloon ministries in the second half of 2010. For specific reasons, they decided to limit the scope of the planned arrangement to people with disabilities and to delay the prospect of a similar provision for elderly people.

The final version of the framework agreement, signed on 21 December 2011 by the French Secretary of State for people with disabilities and Walloon minister for health and social action relates only to adults and children with disabilities in specialist residential institutions and residential care for some children in special needs education. However, the text did not concern the education of children with disabilities.

A record of all French people with disabilities in residential care in Wallonia was not easy to compile. Although the minors could readily be counted, as they are all covered by one health insurance scheme, this was not the case for adults, whose cover is provided by more than forty French departments. Cooperation between all those involved on both sides of the border was vital for the completion of this mission.





Since coming into force on 1 March 2014, the framework agreement has supported compiling statistics on people with disabilities in Walloon institutions, drawing up new agreements on cover for children with disabilities, the implementation of joint inspections by the competent French and Walloon authorities and a draft reform of the Walloon decree on care for people with disabilities.

The background of the slide is a solid green color with a white topographic map pattern. The map consists of numerous irregular, concentric contour lines that represent elevation changes across a landscape. The lines are more densely packed in some areas, indicating steeper slopes, and more widely spaced in others, indicating flatter terrain. The overall effect is a textured, geographical aesthetic.

GENERAL CONCLUSION

Since its earliest days, the European project has sought to associate the free movement of workers, and later of citizens, with the preservation of their social rights. This is the very essence of the European social model. Its ambition is to maintain acquired social rights and to extend them to all European citizens.

As described in the first chapter, public health is now an area of shared competence between the European Union and its Member States. But Member States remain competent for defining health policy and for the organisation and financing of health services and medical treatment.

The emergence of cross-border cooperation on health

The chronology sketched in the first chapter shows that EU health policy developed slowly in the early days. Health, an area initially addressed indirectly or exceptionally through a diverse range of measures, has been gradually integrated into Community policy. It was not until the Lisbon Treaty, more particularly in article 168 (Title XIV), that this approach to public health took its current shape. Today, the Commission has a wide range of tools and institutions in this policy area. The Europe 2020 strategy, which targets smart, sustainable and inclusive growth, regards health as an indispensable condition for achieving its goals.

The second chapter explains how European decisions on access to cross-border healthcare emerged with the earliest form of European integration, given concrete shape by the agreements of the European Coal and Steel Community in 1952. Though EU law does not seek to harmonise the social security systems of Member States, it nevertheless ensures their coordination, without affecting the powers of Member States to organise and manage their social security.

Through these different judgments, the Court of Justice of the European Union has emphasised the application of the principle of the freedom to provide services in the healthcare sector and has opened up new prospects for patient mobility in the EU. Patient mobility is addressed in the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, the first and only health directive to date.

The studies of cross-border cooperation appearing in the third chapter have all been supported by Interreg programmes. They illustrate how,

across Europe, cross-border experiences of healthcare offer practical and sustainable solutions to isolation, medical deserts and social and health inequalities.

The final chapter gives an account of cross-border Franco-Belgian cooperation, which has gradually developed over several generations of Interreg programmes. This cooperation undoubtedly provides a model for EU border regions. Cooperative arrangements cover the whole Franco-Belgian border area, including many innovations in the form of new structural provision and administrative and financial settlement mechanisms (ex. ZOASTs) based on the application of European regulations on the coordination of social security systems.

The impact of cross-border cooperation on health

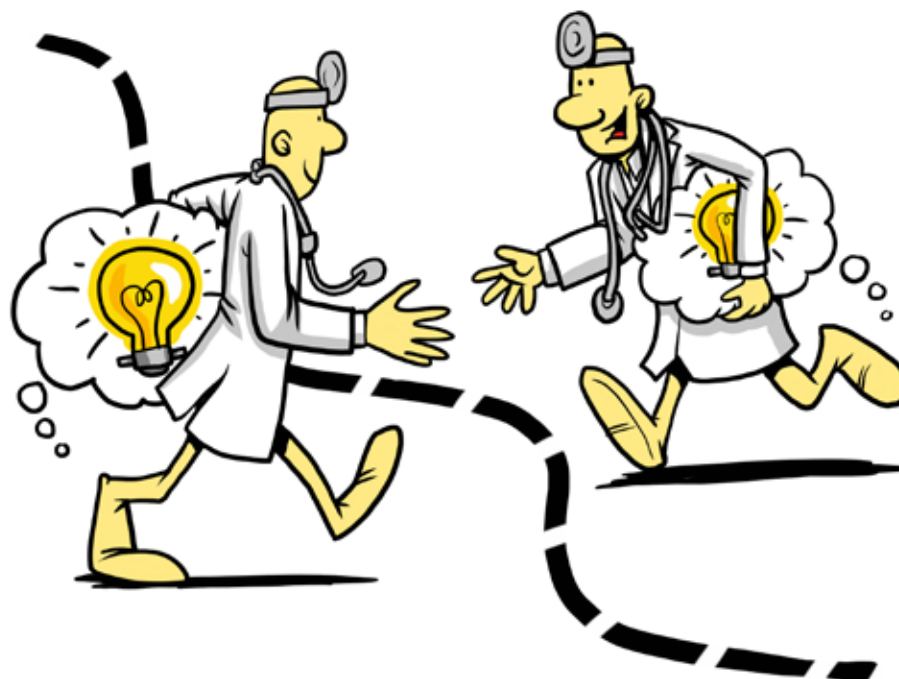
The treaties, successive European agreements and the European health and social security directives aim to gradually diminish the impact of the borders dividing Member States to the benefit of European citizens.

Today's cross-border cooperation on health generally entails two forms of related effects: the increase in cross-border mobility of the border populations and the emergence or strengthening of cross-border territorial dynamics.

The increasing flow of European citizens due to cross-border cooperation can be seen among health professionals as well as patients. This dynamic also intensifies the use of hospital services and medical facilities in border areas.

The emergence or strengthening of cross-border territorial dynamics concerns the organisation in an area, in this case a cross-border area, of healthcare provision, services, or training. As these border regions were traditionally less well-provided with means and resources due to their location on the national periphery, cross-border cooperation aims to establish healthcare provision that meets the needs of patients on both sides of the border in a multi-national area.

Cross-border cooperation on health is thus a way of managing shortages and failings, or of taking advantage of opportunities. In this respect, cross-border regions are like a laboratory where two, three or even four national regulations, cultures and health systems meet.



Some keys of success

The cooperation projects described here suggest some of the success factors to developing collaboration on health in cross-border areas. These are not so much recipes but rather good practices that can inspire project leaders, healthcare managers and decision-makers.

We should stress from the outset that every project reflects local particularities, the public or private operators concerned and its own dynamics. Cross-border cooperation extends the field of the possible in both tangible and intangible ways, from the construction of a hospital to the sharing of professional or even cultural knowledge. It makes it possible to resolve problems in ways specific to the cross-border region concerned.

Every project is different, naturally, but each also illustrates a collective pursuit of the general interest. All the witnesses of the cooperation projects presented talk about the need for trust and “building together”.

Despite the support of the Interreg programmes, cross-border cooperation essentially rests on a voluntary basis. Although the Treaty of Lisbon and the patient rights Directive invite Member States to work together, there is nothing to force health professionals or authorities to create links with their neighbours across the border, or to develop a partnership and common activities.

Another characteristic of such cooperation is that it demands the support and partnership of a wide range of players: local authorities, hospitals, health professions and medico-social institutions, health insurance entities and other systems for financing healthcare, administrative staff, and last but by no means least the patients themselves.

A requirement for all cross-border cooperation, in health as in other fields, is the ability to get to know each other, to speak the same language and to use shared concepts, to establish an atmosphere of trust, and to ensure as much institutional stability as possible. This learning concerns all the players mentioned, including patients, and it takes time. Many



cooperation projects have struggled to survive when faced with problems caused by the instability of operators or the representatives of the competent authorities concerned.

Cross-border cooperation on health also requires specific procedures for cross-border governance. The diversity of health systems demands that specific problems must be resolved, and calls for appropriate solutions

such as the use of legal forms like the European Grouping of Territorial Cooperation on the Cerdanya plateau. The authorities and institutions that have to work together are not necessarily at the same hierarchical level, nor do they have the same powers and legitimacy; nevertheless, they have to coordinate with each other. The solutions adopted must also involve the local players and be adapted to each individual situation. Finally, it is essential that the rules and mechanisms provide responses that are both flexible and sustainable.

Another precondition for cooperation projects is the proactiveness of operators, and the presence of support for such proactiveness. Cooperation requires strong commitment, because only then will there be the energy necessary to overcome the obstacles and achieve a convincing long-term result. It is relatively easy to get the players to commit to a cross-border project, but this commitment needs to endure over time, despite administrative and language difficulties, or problems of trust. It is also necessary for the elected representatives in the area to support the general interest of the project, which often extends beyond their constituencies.

The impact of cross-border cooperation on health is ultimately proved by its practical achievements, such as access to a hospital that is closer, or the existence of a more effective emergency system. Ongoing evaluation is necessary in order to demonstrate that the project still represents a win-win situation for the players on both sides.

An approach that increases visibility, capitalises and secures

The various forms of cooperation detailed in this publication illustrate the importance of the support of territorial cohesion policy in the introduction of innovations. They also demonstrate the value of liaison and interface structures, given the significant differences between border areas, and also because of the complexity and extreme specialisation of these cases.

Cross-border cooperation on health benefiting from the leverage effects of cohesion policy and Interreg finance aims to secure and amplify these effects beyond the periods for which financial support is obtained.

In this area of cooperation as in others, two steps seem indispensable to realise and secure the results: heightening visibility to spread information and capitalisation to disseminate and amplify the effects.

Heightened visibility must enable all workers, residents and citizens to see the results and advantages of cooperation. The provision available by crossing the border or through cross-border organisation must be clearly explained, along with the conditions under which citizens and patients can benefit. A maximum of effort must therefore be brought to bear to facilitate comprehension of these opportunities and simplify these steps.

Secondly, capitalisation of these experiences is essential if their future is to be ensured and the benefits multiplied. Analysing the various experiences of Franco-Belgian cooperation and more broadly of other European experiences, and the consultation of the Internet and other available summaries show that much has been done but much remains still to do. Capitalisation is necessary since what is being done here, if known and understood, can make it easier to find a solution over there. Of course this solution will be adapted, but, based on experience elsewhere, it may generate its own capacity to innovate.

This is the main objective of this publication: to provide information on the various forms and possibilities of cross-border health cooperation in the context of European legislation and thus inspire other cross-border areas to cooperate in order to improve the welfare of their citizens.

As the World Health Organisation has declared, health concerns us all. This is true because we are active in the healthcare sector, because we are potential patients but also, and perhaps above all, because, as citizens and payers of health contributions, we are seeking to make the provision of care as a public service the more appropriate, accessible and of a higher quality for all.

The European citizen, worker, student or mere tourist, is today cared for and protected adequately everywhere in Europe thanks to the social security and healthcare regulations. More globally, the EU contributes to real public health policies, particularly tackling the scourges of AIDS and cancer.

Cross-border cooperation, a true laboratory of European integration, goes even further. It has sought and continues to seek to provide optimal conditions for access to care in border regions and more broadly across the EU. It has created a Franco-Belgian "health card", it has built a Franco-Spanish hospital, it takes ambulances across borders, it allows a Polish patient to consult a German doctor – without travelling; so much experience to be spread and indeed generalised on a European scale!

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Maps and illustrations

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Alex has been a professional cartoonist, caricaturist, and illustrator since 1995, and has honed his ability to draw 'in the moment' at a wide range of events over many years. In 2009, he has formed Drawnalism with Matthew Buck to enable businesses, public bodies and other organisations to benefit from their ability to visually capture the key moments of events and conversations, and to create a unique paper or digital record for those taking part that promotes further engagement.



The Transfrontier Operational Mission (MOT) is an association that was set up in 1997 by the French government. It is supported at national level by: the Commissariat Général à l'Égalité des Territoires (CGET - General Commission for Territorial Equality); the Ministries of Europe and Foreign Affairs, the Interior and Overseas France and the Caisse des Dépôts, and its networks is comprised of players in border territories : regions, provinces, municipalities, groupings of local authorities and territorial authorities, cross-border structures, government , public enterprises, chambers of commerce and industry, federations, networks, urban planning agencies, etc. This positioning facilitates structured dialogue between national and European authorities and local and regional players.

The MOT's role is to assist project developers and cross-border territories, to promote the interests of cross-border territories and to facilitate the networking of players and the sharing of experiences. It acts as the interface between the different stakeholders in order to find cross-border solutions at the right levels.

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¹³ The Institute of Borders and Discontinuities (IFD) is a Scientific Group launched through an agreement between four research laboratories from five Belgian and French universities: the Université Catholique de Louvain (UCL), the University of Artois, the Université du Littoral-Côte d'Opale, the University of Lille and the University of Reims Champagne-Ardenne. The Institute is recognized by official research entities in Belgium and in France. This cross-border network facilitates the work of researchers specialising in borders in a multidisciplinary approach. It brings together the proven and multiple skills of its members and plural skills, enabling them to address contemporary issues related to border and cross-border areas. More information: <https://ifd.hypotheses.org>.

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Interreg project database:
<http://www.keep.eu>

World Health Organisation:
<http://www.who.int>

List of national contacts in all Member States:
https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/cbhc_ncp_en.pdf

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