



“Cross-border territories: Day-to-day Europe”



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Workshop 8 “Health”

- ❖ **President**
Martín GUILLERMO RAMIREZ, Secretary General, Association of European Border Regions - AEBR
- ❖ **Presentation of the framing memorandum**
Pascal GAREL, Chief executive, European Hospital and Healthcare Federation - HOPE
- ❖ **Project 1: French-Spanish cross-border health cooperation**
Xavier CONILL, Secretariat manager, secretary of the board of directors of the Cerdagne cross-border hospital foundation (ES/FR) – Catalan health service (ES)
- ❖ **Project 2: French-Belgian cross-border health cooperation**
Henri LEWALLE, European affairs and cross-border cooperation officer, ANMC (national alliance of Christian mutual health insurance companies) (BE)
- ❖ **Project 3: Italy/Austria/Slovenia cross-border health cooperation**
Luigi BERTINATO, Veneto region, manager of the international social and health relations department (IT)
- ❖ **Presentation of the recommendations**
Stéphane JARLEGAND, Secretary General, Director of international affairs, Nice University Hospital (FR)
- ❖ **Discussion with the floor**
animated by Jean-Jacques ROMATET, Director, Toulouse University Hospital (FR)
- ❖ **Rapporteur**
Stéphane JARLEGAND, Secretary General, Director of international affairs, Nice University Hospital (FR)



Introduction

Cross-border health cooperation (cooperation measures between health professionals from two or more countries close to their borders) is now experiencing new developments. There are many forms of such cooperation, of which patient mobility gives only a partial picture. As national health systems have developed in relative isolation, health cooperation actions have encountered obstacles, leading to the implementation of some responses. European Community developments themselves have not been completely unambiguous. The emergence of the concept of the cross-border health community, broader than that of cross-border health cooperation, enables a new model to be put forward, though still recognising the existing obstacles.

The issues

❖ The development of cross-border cooperation in the health sector

Historically, states have always paid attention to their borders, for example attempting to check epidemics there. Other factors have led to the more recent development of cross-border health cooperation.

For health professionals, the development of procedures for response to disasters and other emergencies reveals more than ever the necessity of working together without taking borders into consideration. The growth of cross-border flows in general, including border workers, also alters the perception of patients. Increased awareness of the proximity of healthcare structures and new expectations of the populations motivate exchanges. The existence of innovative facilities and the perception of better quality or more rapid access to care on the other side of the border are factors leading to the development of exchanges. To this must be added the general reinforcement of the idea of Europe, and of course the Community funding made available to the actors.

Little by little, health workers and institutions have mobilised. They have established networked organisations on borders in order to work together. Sharing of good practices, joint training, prevention work and organisation of patient flows have all contributed to improving the medical environment for patients on either side of the border and sometimes to reducing inequalities between the territories.

Collaboration by health actors in cross-border areas soon encountered obstacles related to the fact that health systems have developed in relative isolation (with some Community exceptions such as mutual recognition of qualifications). Instruments for cross-border cooperation therefore appeared necessary.

❖ Adaptation of regulations to cross-border cooperation

Some member states have recently adapted their health service planning tools to cross-border cooperation. France, for example, included the cross-border dimension in the preparation of its regional health organisation schemes (SROS III) for the first time in 2006. Some state-region plan contracts also take account of the cross-border dimension.

Agreements have also been signed between states, regions, funding bodies and healthcare institutions. These can facilitate patient mobility by enabling reimbursement of healthcare expenses, and/or health worker mobility by granting authorisations to practise.

Bilateral instruments are also adopted at national level. Their objective is to facilitate existing cross-border cooperation or to develop such cooperation. For example, France

has signed two framework agreements, with Belgium and with Germany. Nevertheless, this type of agreement does not eliminate all the obstacles to the development of cross-border cooperation. Other than the fact that they can be used as factors of recentralisation, their application takes a certain time and does not resolve all the difficulties encountered locally.

France is planning to sign a third framework agreement soon, with Spain. This instrument will facilitate the achievement of a specific and unprecedented cooperation project, the establishment of the Cerdagne cross-border hospital.

❖ **Limited but growing influence of the construction of Europe on health systems**

Like the other components of social protection, healthcare is not one of the areas which the member states have chosen to harmonise. Some Community competences have nevertheless appeared explicitly, based on the treaties of Maastricht and then Amsterdam. They remain limited to substances of human origin, blood and blood products, and organs. The principle of subsidiarity gives member states the responsibility for the organisation and funding of their health systems.

However, the health sector was affected by the construction of the internal market well before these treaties. This influence has been indirect, on grounds other than health. The development of the internal market for goods, for example, has determined the adoption of directives concerning drugs and medical devices. Health services, as employers, buyers of goods and services and service providers, have been influenced.

The jurisprudence of the Court of Justice of the European Communities has also in a way speeded up this process by defining healthcare (Kohll and Decker decisions in 1998) and hospital care (Smits and Peerbooms decisions in 2001) as services and applying the principle of free circulation to them. The latter takes precedence over the need for prior authorisation to receive care abroad, at least with regard to non-hospital care. Raising doubts with these decisions about the coordination of social protection policies defined by regulation 1408/1971, the European Court of Justice has introduced some legal uncertainty.

On the basis of this jurisprudence, the Commission initially proposed to include health services and the jurisprudence of the Court on patient mobility in the 2004 services directive (the Bolkenstein directive). The exclusion of health services at the near-unanimous request of the member states, the European Parliament and civil society led the European Commission, after a consultation from September 2006 to January 2007, to propose a health initiative which should result in a draft directive at the end of 2007. The issue for cross-border cooperation will be to see what place it will be given in relation to market principles.

❖ **The emerging concept of the cross-border health community**

A new concept is now emerging, the cross-border health community, which goes well beyond cooperation by actors of two border regions to meet common needs. A cross-border community is characterised by a shared history and culture, together with a determination to strengthen the feeling of belonging through concrete, global and sustainable actions. Health can be one of the pillars of such a cross-border community. Bringing together health services located on either side of a border reduces geographical disparities by ensuring simple and equitable access to and provision of healthcare. Management and planning of healthcare provision at local level are altered.

This requires adaptation of healthcare provision and local organisation of the health system to take account of all the local actors and the needs of the entire population of

the cross-border living area. For this it is necessary to set up local steering committees, which manage and coordinate the implementation of the cross-border health community.

The establishment of a cross-border health community is an opportunity to rationalise health services, adapt health policies to local realities, encourage the sharing of competences and expertise, and meet the specific needs of the population. This process must also allow health to be reincorporated into the cross-border territory project.

❖ **The problems raised by the establishment of cross-border health communities**

Several obstacles nevertheless hamper the emergence of cross-border health communities or even the development of cooperation. The first category are legislative and regulatory and are overcome only partly or not at all by existing instruments. The organisation of health systems differs between countries, along with the amounts and rules of reimbursement and the selection of the care and drugs covered. These different elements, the consequence of different social protection choices, make the drawing together of two health territories a complex exercise.

The other obstacles relate to increased mobility of patients and health professionals. A high flow of patients may unbalance the intake capacity of health services and have a negative effect on healthcare quality. Conversely, migration of healthcare professionals may lead to shortages in some regions and thus reduce access to healthcare. Foreign health professionals may not meet patient expectations, as their training, in particular that of nurses, differs between countries. There may also be language problems.

This means that, whereas one of the objectives of cross-border cooperation and communities is to ensure equal access to healthcare, these movements of patients and professionals may cause inequality of access to healthcare.

Another obstacle is competition between healthcare providers. The introduction of hospital funding mechanisms based on volume of activity may oblige hospitals to attract more patients, including those cared for previously on the other side of the border.

Despite these obstacles, it is nevertheless possible to find solutions for the development of cooperation and the establishment of cross-border health communities. Several recommendations can be addressed to Community institutions, competent authorities in the member states and cooperation actors.

Proposal for recommendations

❖ **Improvement of frameworks and instruments**

To Community institutions

1. Continue to fund cross-border cooperation projects with Community funds (European territorial cooperation Objective 3).
2. Provide clearer information about funding programmes, procedures for responding to calls for proposals and project selection; make experts available to help respond to calls for proposals.
3. Try to limit the legal uncertainty felt by citizens: do not allow jurisprudence alone to define citizens' rights.

To competent health authorities in member states

4. Adopt a legal basis for cross-border cooperation (agreements between healthcare providers and health insurance organisations; bilateral agreements; authorisations to set up pilot projects).
5. Participate in the development of assessment tools and in the assessment of cross-border initiatives.
6. Continue the opening-up of healthcare reimbursement between payment organisations in cross-border areas by means of framework and local agreements.
7. Encourage the establishment of centres of excellence.

To cross-border cooperation actors

8. Formalise cooperation by an agreement between all the stakeholders.
9. Incorporate cross-border cooperation projects into establishment projects.

❖ Assistance with project set-up and governance

To Community institutions

10. Develop an assessment procedure for cross-border cooperation projects which could be used by those involved (guidelines, methodological advice, indicators).

To cross-border cooperation actors

11. Ensure the relevance and satisfactory completion of projects by conducting analysis of the real needs, cross-border added value, and available human, material and financial resources, by making sure that all political partners (in particular local political leaders) are fully involved in all phases, by taking account of other cross-border cooperation projects (past and present), and by defining or adapting assessment tools before project start-up.
12. Reinforce the role of Euregios and similar cross-border structures.
13. Experiment with new instruments such as the EGTC.

❖ Information, sharing of good practices, networking

To all levels

14. Promote sharing of experience and information; support cross-border cooperation by developing databases and networks facilitating partner identification; promote examples of good practice by establishing networks between actors.
15. Organise conferences on health and the cross-border situation; establish an information centre on cross-border health activities; promote cross-border cooperation projects.

To cross-border cooperation actors

16. Encourage discussion with the committed partners on other cross-border cooperation topics.
17. Develop language training in order to speak that of the partners.
18. Communicate more with the population on European projects.

All of these recommendations must contribute to the emergence of true cross-border health communities incorporated into cross-border territory projects.