



Study on Cross-Border Cooperation

Capitalising on existing initiatives for cooperation in
cross-border regions

Cross-border.Care

Executive Summary



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Executive summary

Legal basis for cross-border healthcare

The concept of cross-border healthcare (CBHC) is legally enshrined in Article 168 of the Treaty on the Functioning of the European Union (TFEU), which aims to encourage cooperation between Member States to improve the complementarity of their health services in cross-border areas (European Union, 2012). Although healthcare is primarily a national responsibility, Directive 2011/24/EU on patients' rights in CBHC (European Union, 2011) – in accordance with TFEU and Regulation (EC) No 883/2004 (European Commission, 2004), which frames the coordination of social security systems and entitlements of beneficiaries – mandates the European Commission to ensure patient mobility in the European Union (EU), to facilitate cooperation in healthcare across Member States and to establish rules facilitating access to safe and high-quality CBHC.

CBHC is defined in Directive 2011/24/EU as follows:

'[C]ross-border healthcare' means healthcare provided or prescribed in a Member State other than the Member State of affiliation.'

In addition, this project draws on the definition of cross-border collaboration given by Irene Glinos (2011):

'Cross-border collaboration in the field of health care can involve a transfer, a movement or an exchange of individuals, services and resources.'

Main objectives of the study

The idea for this study arose during an informal meeting of health ministers in Luxembourg in September 2015 following a discussion paper prepared specifically by the incumbent Presidency on the topic. As a result, the Commission was requested to draw up a comprehensive overview of existing cross-border initiatives, which subsequently led to commissioning of this study.

The study analyses strengths and opportunities for future cross-border collaboration in healthcare driven by existing EU funded projects as well as by bilateral or multilateral agreements in place. The specific main objectives of the study are as follows:

- to present a comprehensive picture of CBHC collaboration across the European Union (EU), based on EU-funded initiatives (based on Chapter IV of Directive 2011/24/EU),
- to provide insight into potential future challenges and opportunities for cooperation in CBHC by identifying current driving factors, potential future scenarios which are not mutually exclusive and policy options for the period up to 2030,
- to provide documented support (a manual and a toolbox) for stakeholders interested in starting a healthcare-related cross-border collaboration project,
- to provide an overview of fraud and fraud mitigation strategies in CBHC in the EU,
- to assess take-up of the Joint Action on Patient Safety and Quality of Care (PaSQ) at the national, regional and/or local levels in the EU Member States.

Mapping of healthcare related cross-border projects

With some exceptions, cross-border healthcare collaboration is likely to evolve between **countries or regions with similar welfare traditions** and in **close geographical proximity** or connected via specific **historical ties**. Against that background, policy-makers in charge of public funding mechanisms are likely to be most effective in focusing on those projects that are most likely to be sustainable

and/or most successful in meeting patients' needs, e.g. by addressing gaps in availability of healthcare services.

Endeavours for **capacity building** could be stepped up, e.g. among hospital managers or regional authorities, to ensure long-lasting collaboration. Similarly, administrative hurdles should be kept low (both for patients and providers/purchasers) so as to reduce transaction costs for dedicated actors on the ground for **cross-border contracting procedures**. About a quarter of the projects identified involved patients moving across borders for treatment or diagnostics, whereas the large majority of projects were centred on cooperation of healthcare providers or knowledge sharing. In line with the business cases presented in other parts of the study, our findings show that **communication may represent a key prerequisite** for successfully carrying out cross-border collaborations. Regions with close ties may therefore be more likely to effectively deal with necessary adaptations to reimbursement procedures, administrative procedures to successfully exchange healthcare staff, or ensure timely access to emergency care in the respective patients' mother tongue.

Across Europe, a **diverse picture of collaboration in healthcare, social care and public health** emerges. Our study provides a snapshot of EU-funded collaboration initiatives in the period from 2007 to 2016/2017. The total list of identified projects may be accessed online¹. We identified cross-border projects by performing a systematic comprehensive search of online databases. Validation from experts and additional input from academic literature and grey literature in the field complemented the search. Out of 1 167 projects, a total of 423 projects met the selection criteria, i.e. projects implemented in the study period with at least two EU/EEA countries involved, with the exclusion of collaboration projects aimed at containing communicable diseases and collaboration projects related to European Reference Networks, as it would be premature to assess the latter part. While the mapping study provides a comprehensive picture of projects that were successful in acquiring EU funding, **gaps in data availability** do not allow for a systematic analysis of projects without EU funding. It should also be noted that our study provides a snapshot for the observed period, while **no direct assessment about financial and operational sustainability** can be made. Other parts of the study provide more in-depth insights into potential economic and social benefits.

In recent years, whilst **mobility of patients** has received some attention in the context of Directive 2011/24/EU and Regulation (EC) No 883/2004, our results clearly highlight the importance of provider movements too. More than one in 10 projects had a clear focus on **staff exchange and training** (12%), in addition to more than one-fifth of projects (23%) aimed at improvements in treatment or diagnostics and a small proportion identified as **emergency care** collaboration projects (6%). Further, collaboration projects between public authorities or hospitals are likely to represent an essential precondition for cross-border healthcare projects. In our analysis, we found that about half of all projects identified came under the category of **knowledge sharing** (50%), while only a small proportion (5%) involved **high-cost capital investments**. Finally, only a very minor proportion of projects involved knowledge production and research *about* cross-border healthcare (4%).

In line with a pool of previous studies, our findings point to the **importance of geographical and cultural factors** in driving cross-border healthcare collaboration. We cannot, however, rule out the possibility that legal and administrative drivers often rooted in historical ties also play a role, such as in the case of long-standing bilateral agreements, e.g. between Malta and UK. In our systematic mapping of European collaboration projects, we only considered collaboration projects based on EU funding.

¹ https://goeg.at/sites/default/files/2018-02/Final_Deliverable_Mapping_21Feb2018.xls

The majority of such collaboration initiatives identified take place between countries with similar welfare traditions, like among Scandinavian countries, or countries with a shared history, such as Italy and Slovenia or Italy and Austria. Others clearly result from geographical drivers, as is shown by the cases of Denmark and Germany or Spain and France (Pyrenees). As the literature confirms, such cross-border healthcare collaboration projects may help to **compensate for gaps in regional healthcare provision** or be driven by the **lower cost of service provision** abroad, such as in the case of Finland and Estonia or Austria and Hungary. Our findings also show that Central and Western European countries continue to be frontrunners with respect to leadership of cross-border healthcare collaboration initiatives, paralleling findings from the HealthACCESS study², which was carried out in the period before 2007. At the same time, Romania and Hungary, followed by Germany/ Netherlands and Norway/ Sweden are among the most frequent partners in cross-border healthcare projects. However, a number of projects were not included in our study as they may take place at the external borders of the EU and thus did not constitute the focus of this study. The largest number of projects was identified starting in 2011, coinciding with the publication of the Patients' Rights Directive. However, it needs to be taken into account that projects not concluded at the time of the research (summer 2016) were not included in the analysis.

Foresight exercise

In this study, the foresight exercise comprised two major components. First, a horizon scanning – mainly based on desk research – helped identify changes in the environment that have the **potential to affect CBHC policy (driving factors)**. It provided insight into the status quo of CBHC collaboration and serves as a basis for the development of scenarios. The second component refers to scenario-building, during which illustrations/simulations of visions of the possible future, but not future predictions are being discussed. This exercise helps **to identify strategic approaches based on knowledge and experiences from the past and present and to track potential future trends**. With the development of scenarios we aim to describe potential developments at the European level to promote CBHC. A **SWOT analysis** complemented the evaluation of each scenario in an expert and stakeholder consultation.

The **four future scenarios** developed in the study as part of the horizon scanning and foresight exercise illustrate **potential future CBHC set-ups**. They are not mutually exclusive and they assume that the Treaties remain unchanged. They provide illustrations of different degrees of (future) integration of healthcare across the EU, and address the question of the most important actors involved in setting up and/or implementing CBHC initiatives in the future. It is likely that those CBHC scenarios will be most relevant for policy-makers in the next two decades where either (i) geographical and/or cultural proximity play a role, or where (ii) gaps in availability of healthcare services drive patients to seek healthcare abroad, including patients in peripheral regions of the EU. Legal barriers may also play a role, but more systematic research is needed in order to identify drivers for bilateral agreements, including those between non-bordering countries with dissimilar welfare traditions.

Scenario 1 is the status quo, where cooperation between national healthcare systems is encouraged. Scenario 2 focuses on **local and regional needs**. In this scenario, cooperation developed mostly at regional level is at the centre, where regions themselves represent the main trigger for cooperation. In scenario 3, we imagine **patient choice** as a central factor in CBHC developments, with eHealth playing an important

² http://ec.europa.eu/health/ph_projects/2003/action1/docs/2003_1_22_frep_en.pdf

role. Integration in this scenario would be quite selective or involve only certain groups of patients (in certain disease groups). Scenario 4 focuses on **strategic networks** of selective collaboration. In scenario 5, Member States' **payers' organisations** are central to launching and maintaining CBHC, while in scenario 2 regional and local needs drive CBHC developments. In addition, local and regional key actors are most important for initiating or sustaining CBHC initiatives in scenario 2. Each of the scenarios represents certain **equity-efficiency trade-offs**, as a SWOT analysis involving experts and stakeholders from different fields and different EU countries highlighted clearly. Strong consideration of local and regional needs, and thus collaboration at the regional level (scenario 2) may create economies of scale in border regions, e.g. as regards joint investments, cross-border contracting or specialised healthcare networks, but geographical inequities may increase as a consequence. Similarly, while younger or highly informed patients might benefit from online support fora and patient-driven innovations in scenario 3, equity concerns may arise for less well-informed patients or patients with complex healthcare needs.

A **mix of mainly qualitative methods** was used to develop the four scenarios branching out of the status quo baseline. First, the foresight model on cross-border healthcare cooperation started by identifying potential developments or changes in the environment that have the potential to affect CBHC policy in the next 10 to 15 years ('horizon scanning' with a time horizon of 2030), based on a systematic search of academic and grey literature. In this context, the concept of 'fluid borders', developed by Glinos and Baeten, stands out as an important factor for understanding CBHC initiatives. As opposed to 'rigid borders', these are easy to pass from the patient's perspective, i.e. there is no or almost no geographical, cultural or administrative barrier present that would prevent patients from seeking healthcare abroad. Cultural familiarity may be determined, for instance, by a shared language, common habits, practices or history and cooperation in other fields than healthcare. The presence of fluid borders is likely to result in great ease of cooperation in border regions i.e. between neighbouring countries or regions. With respect to health travel from the patients' perspective, geographical proximity, unavailability of healthcare services and low access barriers, e.g. travel cost, travel time and immigration laws, are key elements for patients seeking health services abroad. Patients benefit from fluid borders through lower transaction costs and a relatively large degree of cultural familiarity, even if domestic health care systems tend to differ substantially from each other. In a second step, four scenarios were drafted. These were evaluated during an expert and stakeholder workshop in September 2017. Experts also played a part in ranking driving factors according to their predictability (certainty) in the future, and their potential impact (importance). The ranking subsequently helped to refine and further interpret the implications of the four future scenarios.

The results of the literature review allow for driving factors to be grouped into **four dimensions** (geographical/demographic, cultural/societal, regulatory and economic/technological), as depicted above. In line with the findings of the mapping exercise, we found that geographical and cultural proximity are among the most important drivers for CBHC initiatives in the EU. Our results confirm that the **concept of 'fluid borders' remains central** in determining CBHC in the EU. The existence of fluid borders may also extend to the regulatory dimension, as regionally driven collaboration requires less political commitment or even just a 'handshake' agreement to launch cooperation. Finally, relative geographical isolation or medical deserts (i.e. rural areas with provider shortages) may also drive CBHC, even if context-specific characteristics may determine which form of CBHC collaboration is being sought. For instance, regions with a higher degree of innovative capacity might be able to compensate for geographical disadvantages by showing a higher commitment to eHealth technologies. In our study, we present six examples of collaborations that may emerge: collaborations focusing on workforce, emergencies, high-cost capital investment, knowledge production, knowledge sharing, or treatment/ diagnostics.

Cross-border.Care Manual and Tools

The Manual and Tools developed in this study serve the stakeholders and regional or local authorities interested in starting a cross-border cooperation project. There is no “one-size-fits-all” concept for cross-border collaboration in healthcare, as projects strongly depend on their specific environments, such as geography, culture, healthcare systems and the experiences of stakeholders who initiate them. Driving factors and forces that enable collaboration and the resources burden differ from collaboration project to collaboration project and across collaboration categories. Examples of different forms of collaborations are highlighted throughout the study, covering six types. Depending on the type of collaboration, a transfer, a movement or an exchange of individuals, services or resources may take place.

The Cross-border.Care Manual & Tools aim to help healthcare providers, payers and public authorities start cross-border collaboration projects. The *Cross-border.Care Manual & Tools*, which are practice-oriented, were developed according to a multi-stage research approach combining elements of surveys and literature review. For validation and revision, we consulted stakeholders and experts in the field of CBHC throughout the study. A peer review study completed the validation process.

The *Cross-border.Care Manual & Tools* are designed as a manual consisting of five modules: 1.) Project preparation, 1.) Project development, 3.) Contracting, 4.) Project monitoring, 5.) Successful business cases for cross-border collaboration. The first four modules deal with aspects of the life cycle of a cross-border project, while module 5 gives practical examples of cross-border collaboration projects in the form of case studies of business cases.

Modules 1-4, which comprise 40 tools, provide relevant general information about project management. The five case studies (for workforce and training, for emergency care, in the field of high-cost capital investment, in knowledge sharing/ management and in treatment/ diagnostics) provided in module 5 summarise elements of real-life projects and describe circumstances that need to be considered when initiating a cross-border collaboration project. These circumstances have illustrative value and are broken down into the following dimensions: legal/regulatory, financial, administrative, operational and medical. Altogether 33 projects were suitable for inclusion in the case studies. We analysed incentives for starting cross-border collaboration in healthcare. Further, we collected information on factors that enable or hinder sustainability of cross-border collaboration in healthcare for each case study.

Fraud and fraud mitigation in cross-border healthcare

As part of the study, the existence of fraud and fraud mitigation in CBHC was investigated. Its scale remains unclear, and there is no reason to assume that fraud in CBHC exceeds the extent of fraud in other health care settings. Policy-makers in charge of public funding should foster communication between competent organisations in order to mitigate CBHC fraud.

A systematic review was conducted of academic publications and grey literature on fraud and fraud mitigation in the field of CBHC. Additional information was collected by conducting a consultation of stakeholders from eight EU Member States. The stakeholders in our study panel were not fully aware of the scale of CBHC fraud in either their own countries or in other EU Member States. Sources reviewed in the ‘grey’ literature found various attempts to estimate the scale of healthcare fraud. However, we did not find any specific data on the magnitude of CBHC fraud on a national or EU level.

The results of our stakeholder consultation (both direct opinions of stakeholders and the HELFO risk matrix) largely suggest that **policy and research should chiefly prioritise fraud involving healthcare professionals**. One priority area mentioned

relates to patients, namely EHIC, S2 or insurance fraud. The stakeholders in our study also mentioned **communication between competent institutions as a key fraud mitigation factor in CBHC**, in addition to a system of monitoring and control (e.g. a competent international auditing group) and adequate legal competences of healthcare professionals. The absence of those factors combined with other risks (e.g. insufficient time, resources and investments in healthcare) may reduce the effectiveness of fraud mitigation in general and particularly in CBHC. Fraud mitigation mechanisms in CBHC need to account for the motivations and behaviour of the various healthcare actors, and for differences between healthcare systems. They should also consider contextual factors, e.g. social perceptions of illegality.

PaSQ take-up evaluation

The 'European Union Network on Patient Safety and Quality of Care (PaSQ)' European Joint Action took place between 2012 and 2015. Its focus was to improve Patient Safety and Quality of Care through sharing of information, experience, and the implementation of good practices. The take-up of PaSQ activities and deliverables was found to be good while the Joint Action was running. However, discontinuation limited the sustainability of take-up, as many activities relied on vital infrastructure (Wiki, website). Additional key factors for the sustainable success of PaSQ activities and deliverables were the availability of financial resources, support (political and leadership), communication and information transfer.

The assessment of the take-up of the 'European Union Network on Patient Safety and Quality of Care (PaSQ)' European Joint Action was based on a review of previously (un)published PaSQ reporting and a subsequent survey among National Contact Points for patient safety from 16 EU Member States. In addition, research findings were validated by the study's stakeholder panel, which also provided valuable input for drafting policy options.

During PaSQ, the infrastructure set-up (PaSQ Wiki/website and Exchange Events) was successful in facilitating the 'take-up of patient safety' by strengthening international and national networks, enhancing the exchange of patient safety expertise at the clinical or strategic levels and supporting the implementation of specific measures. Accordingly, both the take-up of the Wiki and the Exchange Events were promising during the Joint Action. However, the Wiki's political impact and concrete outcomes were regarded as limited. Furthermore, the sustainability of take-up was affected by the discontinuation of active maintenance of the infrastructure. **Many of the activities that were initiated during PaSQ had relied to a great extent on the vital infrastructure.**

Formal and informal exchange mechanisms (e.g. Exchange Events) facilitated networking during PaSQ. (National) networks are still active even after discontinuation of the Joint Action. However, survey participants reported a 'decline' in exchange events.

Although **enabling factors for the success of PaSQ activities or deliverables** differed depending on the respective level (national or regional level of healthcare providers), some factors are found to be facilitators across PaSQ activities, such as availability of financial resources, political and leadership support and communication and information provision, including the sharing of knowledge.

Challenges for the success of activities or deliverables varied across the PaSQ activities studied. Common challenges observed were: a lack of resources (including infrastructure), deficiencies in communication and information transfer, insufficient support (including the involvement of stakeholders), the lack of a patient safety strategy, and the lack of a patient safety culture.

Limitations of the study

The mapping provides only a snapshot of recent or ongoing projects in Europe, as only projects with at least some degree of EU funding were included. The identification of and research on business cases also included several limitations. Publicly available information on projects in CBHC is very limited in most cases, specifically information on economic aspects including costs and potential savings. In order to receive reliable information and data, a thorough stakeholder consultation is necessary requiring respective stakeholder commitment to provide the requested data. Publicly available information on business cases showed that a final evaluation of projects in CBHC rather seems to be an exception. However, such information might just not be publicly available. Moreover, in numerous cross-border projects economic aspects are of secondary importance and rather characterised by social benefits, mainly affecting and benefiting patients. Further research on the balance of social and economic benefits is desirable to better understand the relation of economic and social benefits associated with CBHC. The relation of economic and social benefits might also differ for different categories of CBHC. What is more, political commitment of public authorities for CBHC projects is a supporting factor. As some cases show, missing political commitment may lead to a discontinuation of CBHC projects, disregarding patient preferences. Such cases show that it is insufficient to study only successful CBHC projects in greater detail. Lessons learned from cases facing challenges in the course of the cooperation might contribute greater to better understand the mechanisms of CBHC.

The results of the foresight exercise need to be interpreted in the light of two main limitations. First, while the study is characterised by a high commitment of experts and stakeholders in the field, the survey in which the importance and certainty of driving factors were ranked was filled in by a total of ten respondents only. Respondents came from EU countries in different geographic regions and different welfare settings, and some of the most important expert think tanks in the field of CBHC were involved. However, it would have been desirable to cover all EU countries and allow for a more detailed assessment of CBHC driving factors in different contextual settings.

Second, the study did not identify any factors assessed as being of high importance and of high uncertainty, even though these would have lent themselves particularly well for interpreting the developed future scenarios. For example, somewhat surprisingly, technology uptake and innovative capacity were not evaluated as high-impact driving factors for CBHC in the EU, albeit being evaluated as being among the factors associated with a large degree of unpredictability.

Lessons learned in Cross-border Cooperation in Healthcare

The study enhances an in-depth understanding of CBHC collaborations and provides new knowledge to the field on different aspects of CBHC research. Seven lessons are summarised in the following:

- CBHC initiatives are more effective in regions where ease of cooperation is already established, e.g. due to similar welfare traditions or close historical ties.
- Support should be given to key players such as regional policy-makers or hospital managers to reduce transaction costs of CBHC. The toolbox developed in this study can provide help³.
- There are several scenarios for future CBHC, one of the most realistic ones being one which builds regional networks oriented towards addressing local and regional needs.

³ https://goeg.at/study_on_cross-border_cooperation

- Regional networks are likely to represent a low-cost option, but the downsides are that they are likely to remain small-scale and they may create inequities by not benefiting all regions equally.
- Top categories of CBHC initiatives to receive EU-funding over the past 10 years are 1) knowledge sharing and management, and 2) shared treatment & diagnosis of patients.
- Collaborations such as high-cost capital investments and emergency care tend to have more discernible economic and social benefits, but require more formalised terms of cooperation.
- Although information on the effectiveness and sustainability of current CBHC initiatives is scarce, funding of CBHC projects could help achieve these aims.

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