European Committee of the Regions

Network of Regional Hubs for EU Policy Implementation Review

Implementation Report
Third Consultation, on Cross-border Healthcare

The content of this report has been approved by the European Committee of the Region's Subsidiarity Steering Group on 10 July 2020. More information on the Subsidiarity Steering Group is available on http://portal.cor.europa.eu/subsidiarity/Pages/default.aspx

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I. EXECUTIVE SUMMARY

This report on the *Implementation of the Cross-border Healthcare Directive in the European regions* assesses how well the cross-border healthcare directive has been taken up by regional authorities in the EU. It takes a detailed look at the successful examples of implementation, at challenges and also at obstacles. It is based on a large-scale consultation of the Regional Hubs network of the European Committee of the Regions.

The publication of this third report of the Regional Hubs network comes in the midst of the greatest global health scourge since the Spanish influenza pandemic. This naturally sheds new light on the findings of this consultation and rekindles the question of the responsibilities of the local, regional, national and European authorities in making sure that the health of their citizens is given the highest priority in all policies and actions.

The relevance of this report is therefore twofold: on the one hand, it provides the European Union and its Member States with the most up-to-date review of the progress in implementation and challenges on the ground. On the other, it also serves as a reminder that diseases know no borders and neither should healthcare provision. Supporting existing cooperation agreements and launching new ones, especially in border regions, should thus be prioritised.

Bearing in mind that the majority of regions in Europe are in charge of health systems, the first and only EU Directive on the rights of patients in cross-border healthcare was chosen as the subject of this review. Adopted nine years ago and in force since 2013, the directive remains a fairly little-known piece of European law – both for patients, health professionals and public authorities.

As expected by the European Committee of the Regions, most regions knew that people were free to access care or purchase health products abroad. Nevertheless, some had not made the connection between this right and the directive. This is not surprising, given how low awareness is in general, but further reflection is merited on what else could be done to better anchor the law in people's minds.

To address this knowledge and awareness gap, almost half of the hubs consulted have reported taking matters into their own hands and providing information themselves, rather than waiting for the National Contact Points to up their game. Not surprisingly, the border regions are more likely to have specific regional contact persons or structures to assist the public and professionals alike. This could in future be further strengthened through a network of border region contact points, as most participants felt they could do with more strategic advice, training and information-sharing.

Reporting on what is considered in the academic literature and in the EU institutions' reviews of the greatest obstacles to cross-border healthcare, namely the issue of reimbursement and the system of prior authorisation, the hubs at first shared no negative comments or views. Not a single mention of difficulties in charging or reimbursing patients and no differentiation on the basis of nationality or type of provider was reported back.

However, this initial assessment must be read in parallel with comments made by the hubs in different parts of the survey, where several of them complain about difficulties related to billing and

reimbursement procedures. Many ask for clearer EU rules and templates in this field. Some just want an exchange of information while others go so far as to request a fully-fledged system of standard cross-border medical bills.

Interestingly, prior authorisation, regarded critically by many, does not seem to bother the participating hubs. Most actually assess this safeguard as useful and necessary for keeping tabs on costs and the use of resources. Confirming that the list of treatments requiring prior authorisation should be publicly available, the hubs also express their positive attitude towards a much-less used arrangement under the directive, namely the system of "prior notification" which is not "permission" to access care but an estimate of cost that a patient can request before embarking on the journey abroad. Most regions consider that this should be introduced in their health systems to give patients more clarity.

Similarly, the hubs felt that the financial compensation mechanism, replacing upfront payment by patients with direct billing between the relevant health institutions, would have a positive impact on cross-border cooperation, with the potential to improve financial management and facilitate access to care.

Particularly interesting insights come from the hubs' assessment of cooperation agreements, especially in border regions. The hubs were invited to review some 25 factors grouped into six broad categories, and they reported that the key to success was to have:

- well-informed and supported healthcare professionals and public administrations;
- suitable regulatory frameworks and information on healthcare conditions abroad;
- trust and a shared language;
- public transport links;
- comparability of the level of tariffs for medical services and the content of the basket of healthcare goods and services available.

Drawing on experience from the past and looking to the future, the hubs were also invited to assess another 30 factors in four areas covering the reasons for setting up cross-border cooperation projects and the tools to keep them alive.

Not surprisingly, inspiration in most cases comes directly from the public and listening to their wishes. The most commonly selected response confirms that local and regional authorities are close to their populations, engage meaningfully in dialogue and take people's wishes to heart.

The key areas in which the new projects are likely to be set up include emergency care, specialist care and care for people affected by rare diseases. To make this happen, the hubs felt they needed better information on available EU funding. Combined with ongoing political support, long-term EU funding and committed medical staff, these elements keep cooperation agreements sustainable and operational over years.

Interestingly, the least chosen option (though still relevant for over 60% of respondents) was the European Cross-Border Mechanism.

It is also worth highlighting the fact that the majority of regional hubs would consider setting up cross-border healthcare cooperation in the near future.

Reflecting on the need to review the directive or its implementing measures, the hubs did not have a clear position, with their answers split almost 50-50. Some of their suggestions included harmonising certain protocols, better training, more visibility for National Contact Points and their linkage to regional health authorities, less red tape and simpler administrative procedures, and better communication with the public and health professionals.

These suggestions are not dissimilar to what the hubs expect from the European Union, namely a better flow of information between Brussels and the regions. They want more opportunities for sharing good practice and raising awareness. As expected, many argue for the removal of legal and administrative barriers identified, request support for research and development and call for sustainable long-term funding of cross-border healthcare initiatives, in particular via the Interreg programme.

Specifically, in terms of the CoR's role, the hubs expect it to give impetus to new cross-border projects and take on a more active role in promoting existing initiatives. The CoR could also assist the regions in their advocacy work to secure optimal funding conditions in the upcoming programming period.

This consultation thus proves that there is interest at regional level not only to keep up existing cooperation projects but also to develop new ones, making cross-border healthcare a more widespread and "normal" type of care. This is what people want and what makes sense logistically or financially in the planning and delivery of care, especially specialist care, in border regions. The report should therefore be read as an incentive to Member States and the EU to create better conditions for cross-border healthcare and support regions that wish to make it a reality.

Finally, reading this publication during the coronavirus crisis raises the question of whether the potential of the directive has been fully realised. The closure of national borders seemed to have an adverse impact on the majority of cross-border activities and opportunities, for example for cross-border healthcare workforce exchanges or patient transfers between the neighbouring hospitals, which have not been explored. These will need to be discussed further once the acute phase of the pandemic is over.

The CoR's commitment, as attested by over a decade of political work on cross-border healthcare, will not cease with the publication of this report. The CoR expects its findings to be reflected in the forthcoming implementation report of the European Commission and will share the views of the regions with other EU institutions, networks and public authorities keen to embark on the journey to better cross-border healthcare cooperation. Because good access to care matters in normal and in exceptional times.

II. INTRODUCTION

1. Why does this report matter?

Access to healthcare is one of the core values of the European Union. Enshrined in the Charter of Fundamental Rights of the European Union and repeatedly highlighted by the public in pan-European surveys as of key concern to them, health protection must be *"ensured in the definition and implementation of all the Union's policies and activities"*.

This report takes a detailed look at the matter. It focuses on the implementation of the first and to date only EU directive defining the arrangements under which Europeans can access healthcare abroad, be it in the public or the private sector.

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (hereafter referred to as "the directive") lays down the conditions under which a patient may travel to another EU Member State for medical treatment. It was designed to bring more clarity and coherence to the rights of citizens seeking care abroad, to explain the conditions for patient reimbursement for healthcare received in other Member States, to provide access to reliable information on medical treatment abroad, to promote cross-border healthcare cooperation in the interest of patients and, more generally, to improve EU health policy and patient mobility across borders.

Moreover, the directive provides rules for facilitating access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States, in full respect of national competences in organising and delivering healthcare[1].

The overarching goal of the directive is to ensure that patients are empowered to make informed choices on how and where to receive safe, high-quality and efficient healthcare abroad, while enjoying the same rights and entitlements as they would domestically. Whether this objective has been met nine years after the adoption of the law remains open to question.

At a time of demographic change, ensuring equal access to quality healthcare, as well as strengthening long-term care, is becoming increasingly important[2]. The complexity and overwhelming requirements for accessing cross-border healthcare make it difficult for patients to use this tool. EU patients still face challenges in benefiting from healthcare abroad and only a minority of potential patients are aware of their right to seek cross border healthcare, as pointed out by European Court of Auditors in its recent report[3].

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[1] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, Article 1.

[2] Communication from the Commission to the European Parliament, the European Council, the Council, the European Central Bank and the Eurogroup 2020 European Semester: *Assessment of progress on structural reforms, prevention and correction of macroeconomic imbalances, and results of in-depth reviews under Regulation (EU) No 1176(2011)*, p. 12.

[3] *EU actions for cross-border healthcare: significant ambitions but improved management required,* Special Report of the Court of Auditors from July 2019, p. 34.

The road to implementing this directive has been rocky. The first implementation report by the European Commission made clear that progress had been virtually zero and infringement procedures had been launched against almost all Member States. The second report, published three years later, welcomed the improvements made (transposition was deemed complete across all the EU-28) and hinted at challenges still lying ahead in terms of completeness of measures.

This RegHub report, coming before the third implementation report by the Commission is due, sheds light on regional experiences in implementing the directive. It highlights the regions' ingenuity in developing their own cross-border strategies and projects, it depicts their struggles in figuring a way out of impasses and it points out to hurdles that need removing at national and European level in order to fully realise the potential of this unique piece of European law.

2. How did this report come about?

This report is a reflection of the European Committee of the Regions' commitment to making EU legislation better tailored to the needs of cities and regions. As such, it is both political and practical, as technical information distilled from the regions participating in the CoR RegHubs pilot project is interwoven with political insights that the Committee came to develop over the course of the last decade.

The initial spark to look into this area of EU law came from the interest of the Committee's members, who in many European Member States design, finance, manage, oversee or inspect health systems. Their interest – and concerns – around access to healthcare services abroad and the implications for health insurers back home was evident. In the same vein, many spoke highly about the opportunities the directive created for their local populations to cut waiting times or to have a choice of treatment closer to home.

Then came the official request from the European Commission's Vice President Timmermans asking the Committee to look into the implementation of the directive from a local and regional perspective.

The suggestion was thus made to the regions participating in the RegHub project to be the evaluators of this piece of legislation.

First, all participating regions were provided with information and encouraged to reflect broadly on the theme. Some reported their concerns at this early stage, mainly to do with geography (for regions with no national borders) or limited competence in health matters (for regions in countries with more centralised health systems).

Second, the European Commission's Directorates-General for Health and for Regional Policy were brought in to share their expertise, answer questions and explain outstanding barriers to seamless implementation of the directive.

Following these exchanges, the majority of hubs decided to go ahead and assess the legislation. Their representatives provided comments and suggestions on the first draft of a questionnaire to be sent out; these improvements were incorporated into the final version of the survey that took form of an online

questionnaire with 35 main questions, several of which were broken down into sub-questions. The hubs had two months to complete their forms, and by 13 January 2020, 27 of them had provided their detailed answers. Each hub was free to consult relevant organisations and stakeholders within its local area.

Most of the participating hubs consulted relevant stakeholders within their respective regions, including care providers, regional and local administrations, regional health councils, patient associations, associations of healthcare professionals, management teams of EU-funded projects, labour market and trade coordinators, and health and insurance funds. The highest degree of stakeholder involvement was put forward by the **Thessaly hub**, which consulted 28 different stakeholders on all the questions covered by the consultation. Overall, more than 150 stakeholders were involved to different degrees in the consultation.

It is worth noting that the replies from regional hubs reflect different, and at times contradictory, views since in several questions respondents could select multiple answers. This captures the difficult and multifaceted reality on the ground, where the same legal solution may be judged differently by different actors operating in the field of healthcare.

The ultimate goal of the consultation was to take the measure of regional expertise and involvement in the implementation of the directive and use their insights to further improve the quality and usability of this European law. This report, capturing these views, is thus both technical and political, as it highlights both practice on the ground and describes the hopes and expectations of the European regions for the future.

3. What is the bigger picture?

Unlike Regulation (EC) No 883/2004 and its iconic European Health Insurance Card, the cross-border healthcare directive has not yet made it to the general awareness of Europeans. Rare are those who have heard about it – and even fewer those who have used its mechanisms. In 2015 (the latest available data are from that year) less than 20% of Europeans knew the directive existed and only about 200 000 benefited from care abroad under the directive: fewer than 0.05% of EU citizens (corresponding to 0.004% of the EU-wide annual healthcare budget). Most patient mobility has been between neighbouring Member States.

It is worth bearing in mind that the directive was born out of necessity. European citizens buying medical products (such as spectacles) or undergoing treatment abroad (e.g. for a hip replacement) were being turned down by health insurers, who were unwilling to cover the costs of these purchases. Yet the European Court of Justice systematically ruled in favour of these plaintiffs, recognising over and over again their right to buy medical products and services on the single market. The directive, negotiated painstakingly over three years, has finally codified this jurisprudence and provided clarity and reassurance for both patients and their health systems.

On the ground, however, the implementation process has proven complicated and required changes to over 500 national legal acts. It is only now, seven years after its entry into force, that the directive has slowly gained some visibility amongst health professionals and public bodies.

The time is therefore right to analyse how the regional authorities have fared so far in implementing it and what the remaining obstacles on the ground are. The report does not cover the entirety of the directive – the European Reference Networks for instance have not been included, as they are not managed regionally. The survey focused on the elements of the directive that were identified as most relevant to regional health systems, as well as those highlighted in the EU institutions' reports as being the most problematic (e.g. prior authorisation).

Although this study was conceived and delivered before the outbreak of the COVID-19 pandemic, its findings are relevant to current developments. Not only has this consultation highlighted the areas requiring improvement, but above all it has made a clear case for more structured, better funded and clearly supported healthcare in border regions. Diseases know no borders and neither should healthcare provision.

III. PRELIMINARY AND GENERAL OVERVIEW

1. General information

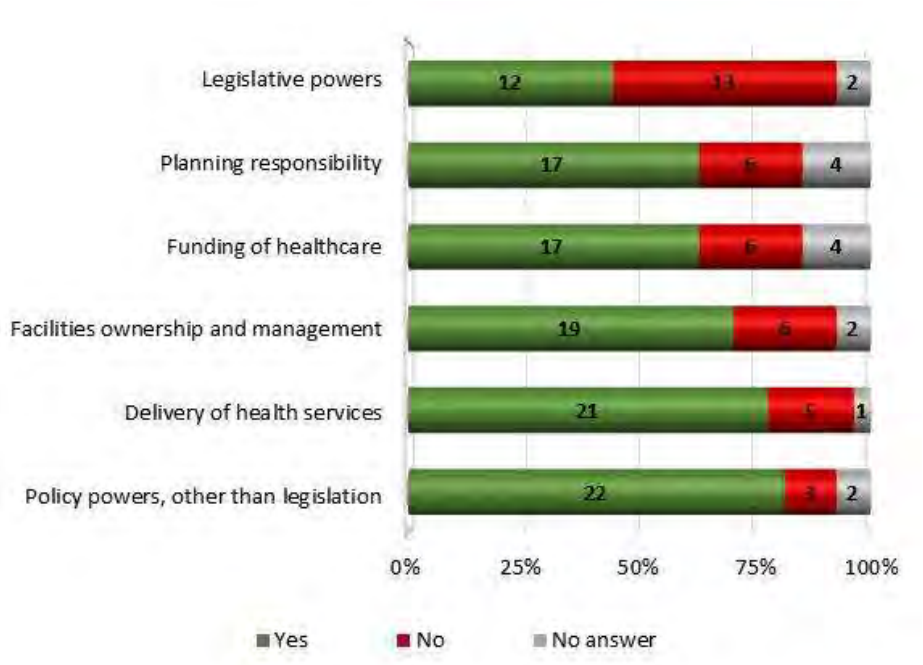
There is no "European" health system. Although all 27 systems in the Member States are to a greater or lesser extent based on the classic Beveridge and Bismarck models, they are in practice all different. The degree of decentralisation varies significantly. The reimbursement models are diverse. The organisation of health services, the system of referrals, the competences of various health professions – these are just some examples of areas where health systems, even between the closest neighbours, may diverge substantially.

This makes implementation of the directive on the ground considerably more complicated. This is why the first set of questions sought to define whether the participating regions had external borders and to clarify the type of responsibilities in terms of management of health systems and services.

The vast majority of the regions participating in the survey share a land border with a neighbouring country, while only nine of them share a maritime border, including **Brittany**, **Catalonia**, **Dubrovnik-Neretva County**, **Flanders** and **Hauts-de-France**. Only seven of the hubs that responded, comprising the **Community of Madrid hub**, the **Ialomita/Harghita hub**, the **Community of Valencia hub**, the **Mazovia hub**, the **Helsinki-Uusimaa hub**, the **Thessaly** and **Umbria (as part of the Umbria/Veneto hub)**, do not have regions bordering a neighbouring country.

In terms of health systems and services, 22 regions out of the 27 reported that they were in charge of health strategies, action plans, health promotion campaigns and other policy-setting responsibilities. The majority of participating regions deliver health services while 70% of them own and manage health establishments (typically hospitals) directly. Planning and funding of healthcare is a responsibility of two thirds of the participating regions.

Does your region have responsibilities in terms of management of health systems and services? (Q2)



Finally, only 12 hubs have regions legislative powers, among them the **Autonomous Province of Bolzano/Bozen – South Tyrol hub,** the **Brandenburg hub,** the **Catalonia hub,** the **Community of Madrid hub,** the **Community of Valencia hub,** the **Autonomous region of Friuli Venezia Giulia hub,** the **Region of Emilia Romagna hub,** the **Flanders hub,** the **North Rhine-Westphalia hub,** the **Voralberg hub** and the **Umbria/Veneto hub**.

The **Košice Self-governing Region** hub specifies that while its region does not enjoy legislative powers, it has devolved powers in the field of healthcare and pharmacies (issuing, revoking and amending authorisations), informal changes, waiving medical confidentiality, health districts, surgery hours and working hours.

2. Awareness

The second part of the opening questions related to the regions' awareness of the directive. Interestingly, while all participating regions knew that patients can move freely across borders to obtain health treatment in other countries, some did not make the connection with the directive. The **Brittany hub,** the **Brod-Posavina County hub,** the **Ialomita/Harghita hub,** the **Hauts-de-France hub** and the **Thessaly hub** state that they were not aware of its existence and application. The remaining 23 hubs had prior knowledge of the directive on cross-border healthcare before participating in the consultation.

With regard to the funding instruments to support cross-border healthcare, 23 hubs confirmed that they had prior knowledge of them. In particular, 17 were aware of the existence of Interreg, while six hubs said they knew of other funding instruments, such as the European Structural and Investment Funds (ERDF, EAFRD and ESF), Horizon projects, the EU Health Programme, the B-solutions pilot project

and the National Strategic Reference Frameworks. Three of the four hubs that were not aware of *ad hoc* funding instruments for cross-border healthcare have borders with a neighbouring country.

IV. RESPONSIBILITIES

1. National Contact Points

Context

The ultimate goal of the cross-border healthcare directive is to provide all EU citizens with equal access to quality healthcare, responding to their specific needs. Whether that means seeking a second opinion in another Member State or taking a child with a rare disease to a specialist on the other side of the EU, people need reassurance that they will receive the best care possible and that they will not be left to shoulder the financial burden alone.

For most patients considering care abroad, important questions arise: is a referral needed, what about prior authorisation, will I be reimbursed, can I seek follow-up care at home or abroad, are preventive measures covered, are they covered if I work in one country and live in another?

Ideally, all these answers should be available on the National Contact Points' websites, which each Member State was required to set up in line with Article 6(1) of the directive. The information must be easily accessible, sufficiently clear and adequate for well-informed decision-making by the patient. It should include information on the health system of the Member State in question, as well as information on individual patient rights and how these are implemented in daily practice.

Member States provide information in different ways and there is generally not much knowledge as to how this is done in practice. In some Member States, information on possible compensation insurance schemes may even be completely lacking. Nor can it be taken for granted that NCPs are aware of all the details of healthcare providers' insurance, especially if this is not regulated by legislation.

As earlier surveys and reports highlighted, most Europeans were not even aware of the fact that NCPs existed, let alone that they were there to help them make informed choices. Hence the regions were asked whether they were aware of the existence of the National Contact Point in their country created by the directive on cross-border healthcare under this article.

Findings

The majority of participating regional hubs (93%) were aware of their respective NCPs. Only two, the **Brod-Posavina County hub** and the **Hauts-de-France hub**, were not aware. This should serve as a reminder to national authorities to better communicate on health matters with their regions.

In Slovakia, as specified by the **Košice Self-governing Region hub,** the Healthcare Supervision Authority provides insured persons with information on their rights and entitlement to cross-border healthcare, reimbursement and the possibilities for settling disputes under Slovak and European law. Insured persons can also receive general information upon request from the National Contact Point.

Seven participating hubs said that they had a Regional Contact Point for cross-border healthcare. This was the case for the **Catalonia hub,** the **Community of Valencia hub,** the **Mazovia hub,** the **North**

Rhine-Westphalia hub, the **Primorje-Gorski Kotar County hub, Veneto (as part of the Umbria/Veneto hub)** and the **International Lake Constance Conference hub.**

In the **Dutch Provinces** there is a special foundation which deals exclusively with cross-border healthcare in the Maas-Rhine Euregio and is required to offer additional information in terms of National Contact Points and how to access them. In **Northern and Western Regional Assembly** the tracing of patients moving across borders for health treatment is monitored at national level.

Overall, among participating hubs there is a good level of awareness of their respective National Contact Points, but these are not systematically given visibility on regional administrations' webpages. Only nine hubs have links to the National Contact Point on their regional administration webpages. These are the **Alentejo hub**, the **Catalonia hub**, the **Community of Valencia hub**, the **Emilia Romagna hub**, the **Flanders hub**, the **Mazovia hub**, the **North Rhine-Westphalia hub**, **Veneto (as part of the Umbria/Veneto hub)** and the **West Pomerania hub**.

2. Gathering information on patient flows

Context

The Commission is required to draw up a report every three years (the first was in 2015) on the operation of the directive. These reports should include information on patient flows and the costs associated with patient mobility. While the directive does not oblige Member States to collect data on patient flows, it specifies that they should provide the Commission with assistance and all available information for preparing the report. This is why, back in 2013, the Member States agreed to provide specific data to the Commission on an annual basis.

As the majority of Member States were late in adopting the national transposition measures, this delayed the provision of data to the Commission in 2015.

In 2017, 26 Member States provided the information, but for six of them the data were incomplete. In addition, data were not comparable from one country to another as some Member States reported all reimbursements without specifying whether they were granted under the directive or the regulation on the coordination of social security systems. The available data must therefore be considered as indicative and not complete.

The hubs were asked about their experience of data gathering and monitoring patient flows. While this is a task for national authorities, it can still be of interest – financially and for planning matters – for regions to know how many patients leave and enter their country for treatment.

Findings

According to the survey responses, only a limited number of regional hubs monitor patient flows across their borders. Regions monitoring outward and inward patient flows are **Veneto (as part of the Umbria/Veneto hub),** the **Autonomous Province of Bolzano/Bozen – South Tyrol, Emilia**

Romagna, the **Autonomous region of Friuli Venezia Giulia, North Rhine-Westphalia** and the **International Lake Constance Conference's** regions**.** All of them can separate the data on flows to or from the neighbouring regions from those to or from other countries or further away regions, except for **North Rhine-Westphalia**. Five other regions mostly monitor the flow of their patients seeking treatment in other member states.

There are ten regions that do not perform monitoring. Among them, six hubs specify that such monitoring is done at national level and two, namely the **Community of Valencia hub** and the **Alentejo hub**, indicated that they planned to establish such an overview of patient flows in the future. In particular, the **Community of Valencia hub** adds that it would be useful to have a standard model at the EU level setting out the minimum content requirements on what needs to be monitored.

The Dutch Provinces hub states meanwhile that in the Netherlands the flow of patients is monitored by health insurers. More specifically, however, in the Maas-Rhine Euroregio a dedicated foundation is in charge of all aspects of cross-border healthcare.

3. Providing information to patients and health providers

Context

National Contact Points are required by the directive to provide clear and comprehensive information on patients' rights to cross-border healthcare. This also means that patients should receive guidance on cross-border healthcare treatment pathways available under the directive and regulation.

The European Commission provided Member States with notes and reports[4] on these pathways; these proved not to be sufficient, however, and the dedicated survey of the NCPs highlighted the fact that over half of them had not made this information available in the first few years.

The 2018 implementation report found the information available to patients "generally adequate", so improvements had been made in the meantime. The Commission has also developed a special toolbox for NCPs to help them pass the information on to patients.

The 2019 European Parliament report did not echo this sentiment and noted that *"in-depth information on patient rights is generally lacking on the NCP websites. Insight into what to do in case of undue delay, information on complaint procedures and settlement of disputes, as well as information on the amount of time required to process reimbursement or prior authorisation requests is rather scarce"*[5].

Again, although the provision of such information is a Member State's obligation in the light of Articles 4(2)(a) and (b) and 5(b) of the directive, the regional hubs were asked whether they themselves provided

[4] Including: 2012 *Study on a best practice based approach to National Contact Point websites with recommendations to Member States and the Commission on how to provide the appropriate information on various essential aspects of cross-border healthcare through NCPs*; 2014 *Study on the impact of information on patients' choice within the context of the directive*; 2015 *Evaluative study on the operation of the directive containing inter alia a review of NCP websites*.

[5] https://www.europarl.europa.eu/doceo/document/A-8-2019-0046_EN.html

patients and healthcare providers with relevant information on rights, entitlement, reimbursement, costs, standards and quality.

Findings

Two separate questions were asked: first looking into who deals with cross-border questions and second on the type of information provided and to whom.

Twelve regions, including **Alentejo,** the **Autonomous Province of Bolzano/Bozen – South Tyrol, Flanders,** the **Autonomous region of Friuli Venezia Giulia, (all of the) Dutch Provinces**, **North Rhine-Westphalia, Umbria and Veneto**, tend to inform healthcare professionals and patients upon request. Moreover, upon request 10 of them clarify legal issues relevant to the administration.

The regions also have a common approach to the set-up of specific instruments, for instance a dedicated webpage, a dedicated entity, functional email and an information point to provide information on cross-border healthcare, or the sharing/provision of information through participation in cooperation programmes, projects and/or fora related to cross-border healthcare.

In 14 cases information is provided proactively. Because of the multiple choice format of the question, these 14 selections come from eight regional hubs, namely the **Autonomous Province of Bolzano/Bozen – South Tyrol hub,** the **Emilia Romagna hub,** the **International Lake Constance Conference hub,** the **North Rhine-Westphalia hub,** the **Thessaly hub,** the **Umbria/Veneto hub** and the **West Pomerania hub**. Out of these proactive providers of information, only **North Rhine-Westphalia**, **Veneto** and **West Pomerania** provide information to potential patients abroad while the others focus on regional citizens, patients and professionals. Moreover, the **Brandenburg** hub replied that the information was made available in a transparent and comprehensive manner via the National Contact Point (including on the Internet). The **Helsinki-Uusimaa hub** underlined that the obligation to inform patients under the provisions of the directive was met at national level.

On the other hand, the **Brittany hub** states that the region provides no information on cross-border healthcare. The **Košice Self-governing Region** hub adds that its region provides information in the case of a need that has yet to arise. Where appropriate, the hub forwards information to the Healthcare Supervision Authority.

4. Fees for healthcare

Context

Knowing in advance how much treatment abroad will cost – and how much one can be reimbursed back home – is a key criterion for people weighing up their options as to when and where to seek help.

In addition, patients need to be sure that they will not be overcharged if they come from another Member State – or that they will not be reimbursed less than they would have been if their treatment was delivered nationally.

As the directive makes no distinction between public and private providers, the Member States must not do this either. Indeed, according to Article 4(4) of the directive, Member States must ensure that healthcare providers apply the same scale of fees to patients from other Member States as they do to domestic patients in a comparable medical situation. Any price, charged to both national and non-national patients, must be calculated according to objective, non-discriminatory criteria.

Interestingly, during the transposition period, some Member States complained that the existing public tariffs did not represent a comparable price because important elements, for example regarding general taxation (e.g. capital investment costs), were not represented in the public tariff which did not fully recover costs.

Member States are therefore allowed to build a comparable cost-based price for the actual cost of the health service (based on objective and non-discriminatory methodology) for any given intervention. However, this is double-edged sword, meaning that the same pricing must then be used for outgoing patients and their reimbursement rights.

In general, information on the scale of applicable fees is not readily available. The Parliament called on the Member States *"to urge healthcare providers and hospitals to supply patients, in advance, with an accurate and up-to-date estimate of the cost of treatment abroad, including medicine, honoraria, overnight stays and supplementary fees"*.

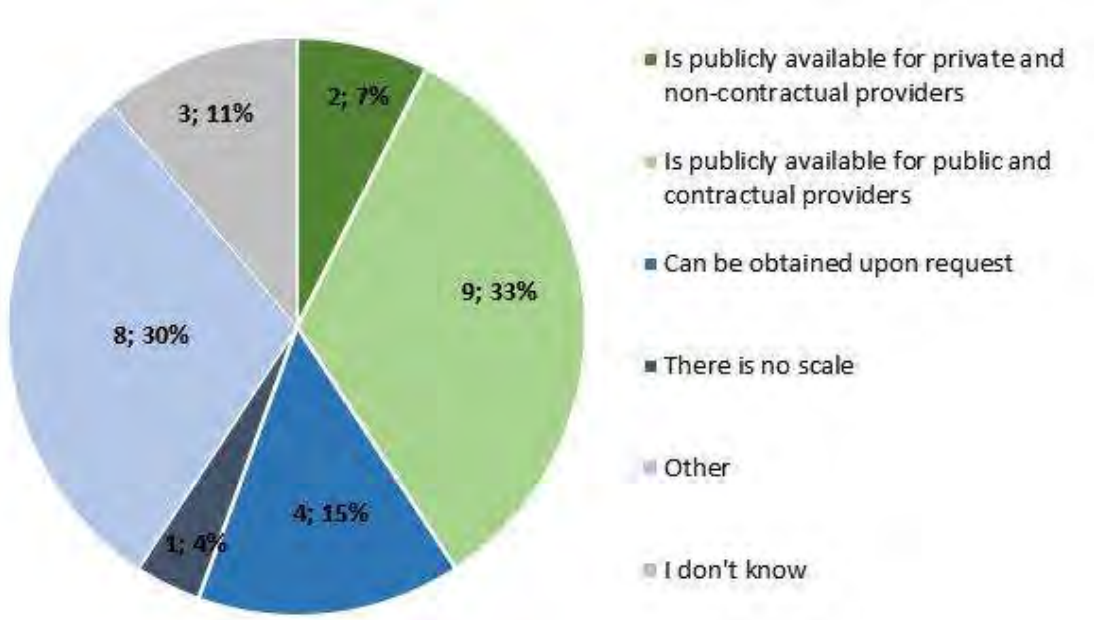
Findings

The participating hubs also report the same with regard to fees. In most of the participating regional hubs, a scale of applicable medical fees is not readily available. If it is available, the list is for the most part only shared with public and contractual healthcare providers or available upon request.

In nine hubs, the scale of applicable fees is publicly available for public and contractual providers. Only in the **Helsinki-Uusimaa hub** and the **West Pomerania hub** is the scale reported to be also available for private and non-contractual providers. In four regional hubs, it can be obtained upon request.

None of the hubs indicate that the scale of fees is available to healthcare professionals. However, the issue of chargeable fees is handled in very diverse ways across regions.

In your region, the scale of applicable fees… (Q12)



For example, in **Thessaly** healthcare providers issue detailed invoices and provide stakeholders with detailed information regarding pricing, as required by national law. Similarly, the **Mazovia hub** emphasises that healthcare providers give information on prices freely.

At the same time, the **EGTC Tritia hub** mentions that the Polish National Health Fund publishes a list of approximate rates which are used to reimburse the costs of cross-border care. On the other hand, in **Brandenburg**, the scale of fees is publicly available for all service providers but it is possible to diverge from the agreed fees. In **Flanders** pricing is managed at national level.

5. Professional liability

Context

The directive requires the Member State of treatment to ensure that healthcare providers offering their services have valid professional liability insurance (*"or a guarantee or similar arrangement that is equivalent or essentially comparable"*). The objective is to improve the quality of health services and increase patient protection.

Another directive - on the recognition of professional qualifications – adopted in 2005 includes similar requirements.

Yet in its 2018 report the Commission noted that this proved to be an issue for several Member States which lacked specific legislation on such insurance schemes. One year later, the Parliament reiterated that clarity and transparency were needed for patients and their health systems in order to know under which conditions healthcare providers operated.

Findings

The participants were invited to share their views on the matter of professional liability and the majority of them replied that public providers were legally insured. To a slightly lesser extent, it was also required or recommended for private providers. However, in several regional hubs this insurance was not applicable or the respondents were not aware of obligations.

Sixteen hubs, including among others the **Community of Madrid hub,** the **Dubrovnik-Neretva County hub,** the **Autonomous Province of Bolzano/Bozen – South Tyrol hub,** the **Ialomita/Harghita hub,** the **Helsinki-Uusimaa hub** and the **Mazovia hub,** replied that in their regions public healthcare providers are required to have professional liability insurance. This requirement also extends to private providers in thirteen region, while in the remaining three, the **Community of Valencia**, the **Autonomous region of Friuli Venezia Giulia** and **Veneto,** such insurance is merely "recommended" for private providers.

Finally, 41% of hubs report that professional liability insurance is either not applicable in their region or they are not aware of obligations in this respect.

V. REIMBURSEMENT OF COSTS OF CROSS-BORDER HEALTHCARE

According to Article 7(4) of the directive, the costs of cross-border healthcare should be reimbursed or paid up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory, without exceeding the actual cost of the healthcare received.

1. System of reimbursement

Context

Paying for care received abroad is probably the most problematic part of the directive, be it for patients, health providers and health insurers.

In some EU Member States, citizens are used to paying upfront and receiving reimbursement from their health insurers. In others, patients never open their wallets at the surgery, their health insurance card – or simply personal identification number – being sufficient to initiate a direct reimbursement process between the health provider and health insurer.

However even in those countries where it is customary to pay for a visit first and get the money back afterwards, there are specific mechanisms for more expensive treatment (e.g. including overnight stays in hospital), usually involving direct communication between the clinic and the health insurer.

The directive makes it mandatory for patients to pay upfront for their product or treatment and be reimbursed back in their country of affiliation.

When the treatment is exceedingly expensive or requires an overnight stay, there is usually an additional requirement to obtain what is known as "prior authorisation", i.e. a written promise that the health insurer will indeed cover the cost of treatment (and to what level).

Reimbursement issues are recognised in the literature as one of the biggest barriers in access to care abroad. The survey therefore sought the hubs' views on the arrangements covering reimbursement, rates and information to citizens.

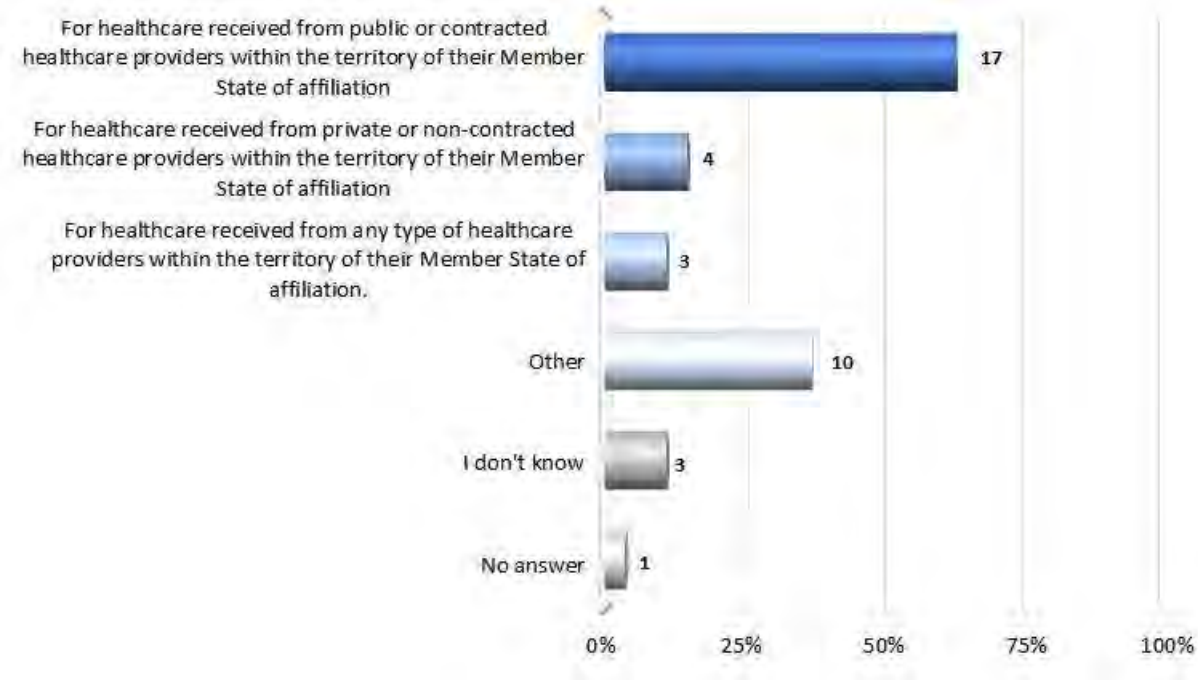
Findings

Several regional hubs reimburse their own citizens for healthcare received abroad up to the level charged by public or contracted healthcare providers domestically. Similarly, patients from abroad are mainly charged or pay up to the level that would have been billed to that country's regional or national insurance for treatment received from public or contracted healthcare providers.

The majority of regional hubs (63%) reimburse their citizens for healthcare received abroad up to the same level charged by public or contracted healthcare providers within the territory of their Member State of affiliation.

Three regional hubs – the **Community of Valencia hub,** the **Hauts-de-France hub** and the **Brod-Posavina County hub** – do not distinguish between public and private providers and reimburse their citizens up to the maximum level fixed domestically, arguing that if authorisation is given, medical treatment must be reimbursed in full.

Your region's citizens travelling abroad for treatment are reimbursed or paid up to the level... (Q14) *(multiple answers allowed)*



The **Flanders hub** and the **Thessaly hub** meanwhile point out that the question of reimbursement is a matter of national competence. Similarly, the **Brandenburg hub** and the **Helsinki-Uusimaa hub** indicate their regions apply the national rules for reimbursement.

Therefore, in case of **Flanders** for instance, if the patient is insured by an insurance company (national health service) of another Member State and wishes to obtain information on reimbursement for healthcare or treatment provided or fees charged by authorised care providers, that person should contact their own insurance company or the National Contact Point of the Member State in which they are insured. However, if the patient is insured by a Belgian company, for instance, then they are entitled to reimbursement of any medically necessary healthcare, taking account of the duration of their stay in hospital and the type of treatment concerned.

With regard to the charging of patients from abroad, in the majority of hubs (52%) patients from abroad are mainly charged or pay up to the level that would have been billed to the country's regional/national insurance scheme for treatment received from public or contracted healthcare providers.

A different arrangement is in place in **Catalonia**, where the first cross-border hospital in Europe is operating in the municipality of Cerdanya in the Pyrenees. Set up within the framework of Franco-Spanish cooperation and awarded the CoR prize for European Groupings of Territorial Cooperation in 2016, the hospital receives patients from both sides of the border without charging them upfront. The

medical bills are sent directly to the patients' health insurers, resulting in a more patient-friendly environment and reducing barriers to access for less affluent citizens.

In **Brandenburg**, all legally insured persons have a right to choose whether they wish to be treated as persons with statutory health insurance in the state of residence or as privately insured persons. For unplanned treatment, all costs which are reimbursable for persons legally insured in the state of residence are reimbursed, as are all costs that would have been covered had the same treatment for legally insured persons been received in Germany. For planned treatment there is a right to treatment only after prior authorisation by the health insurance fund. Only in certain legally defined cases (hospital care and cases where even in Germany prior authorisation from the health insurance fund would be required, e.g. in the case of dental prostheses, rehabilitation measures (e.g. cures), psychotherapy and behavioural therapy, orthodontic treatment, etc.) there is a prior authorisation requirement as a condition for entitlement. For private insurance holders in Germany, the right to reimbursement is determined on the basis of the relevant contractual conditions.

The **Helsinki-Uusimaa** hub confirmed that a patient from abroad seeking treatment in Finland would have to pay the full cost of treatment and seek reimbursement afterwards from the Member State in which that person has health insurance. It makes no difference whether the patient is seeking private or public healthcare.

In the Maas-Rhine Euregio a health card was previously all that was needed to see a health practitioner. This arrangement was beneficial to patients as they were able to access care in all three participating countries without the need to pay upfront. The decision to discontinue this form of cooperation (IZOM agreement) was made at national level and is regarded by the **Dutch Provinces hub** as a step backwards, limiting access to care in this geographical area.

In view of its geographical situation and cooperation between EU and non-EU countries, the **International Lake Constance Conference hub** specified that different arrangements apply. If the treatment is delivered in Austria, citizens are reimbursed for both public and private healthcare providers. However, if the treatment is offered in Germany and Liechtenstein, it can only be reimbursed in the case of public healthcare providers. The costs are not reimbursed if the treatment is provided in Switzerland.

Finally, the **Thessaly hub** states that the Greek National Organisation for Healthcare Provision covers the same amount of costs for healthcare from a public or private provider in an EU/EEA Member State as it would for healthcare from a domestic public or contracted provider for the same care. If the patient is entitled in Greece to the healthcare service received abroad, they will be reimbursed by the Greek healthcare provider. The amount of compensation will be equal to the cost of care had it been received in Greece. The National Organisation for Healthcare Provision also provides services for calculating payments and reimbursing those insured by Greek social security institutions.

2. Prior authorisation

Context

Prior authorisation was intended as one of the major safeguards of the system. On the one hand, its objective is to provide the prospective patient with the certainty that the cost incurred will be reimbursed by the system of affiliation; on the other, it gives the Member States applying this mechanism an option to review the request ahead of time and assess whether the patient meets the criteria for seeking help abroad. Ideally, prior authorisation systems should allow the Member States to plan their health spending and protect patients from treatment that raises serious and specific concerns about the quality or safety of care.

In practice, the system of prior authorisation turned out to be one of the greatest barriers to patients, alongside the systems of reimbursement, administrative requirements and charging of incoming patients.

In its 2019 implementation report, the European Parliament noted sombrely that *"certain prior authorisation systems appear to be unduly burdensome and/or restrictive with regard to the number of applications each year"* and warned that *"in some Member States insurance companies have discriminated arbitrarily or created unjustified obstacles to the free movement of patients and services, with adverse financial consequences for patients"*.

The Parliament also reminded Member States that any limitation of access to care abroad *"should be necessary and proportionate and [can] not give rise to arbitrary or social discrimination"*.

Findings

In the view of regional authorities participating in the survey, the system of the prior authorisation is not a major source of concern. Most hubs perceive prior authorisation as necessary to ensure sufficient and permanent access to a balanced range of high-quality treatments, and to some extent, a way of avoiding wasting resources and of controlling costs. A list of treatments that are subject to prior authorisation is publicly available in most of the hubs that apply this system.

Fourteen of the participating hubs state that they use a system of prior authorisation. Its use is most often related to treatment requiring highly specialised and cost-intensive medical infrastructure or equipment. Eleven also report that its use is mandatory for treatment involving at least one overnight stay in hospital.

Interestingly, in **Helsinki-Uusimaa**, prior authorisation as provided for in the directive is not required. Likewise, the **Alentejo hub** specifies that nowadays prior authorisation is not as common as it used to be, when some medical procedures or equipment were not available in the region.

Overall, hubs have a positive opinion of the system of prior authorisation introduced by their national governments. The majority of them (17) believe that such a system is necessary to ensure access to quality healthcare. 48% of hubs believe that prior authorisation is necessary to avoid wasting resources, while 44% consider that it can actually control costs at regional level.

The **Hauts-de-France hub** considers prior authorisation to be an additional security measure that allows patients to access care, irrespective of their financial means.

Finally, in the opinion of five hubs – the **Brandenburg hub**, the **Brittany hub**, the **Autonomous region of Friuli Venezia Giulia hub**, the **Ialomita/Harghita hub** and the **International Lake Constance Conference hub** – the system represents an obstacle to the free movement of patients.

The directive specifies in Article 8(7) that in order to give patients clarity and ensure transparency, a list of the treatments which are subject to prior authorisation should be publicly available. 19 regional hubs indicate that a list of these treatments is publicly available. Of these hubs, 12 consider the list to be sufficiently detailed and clearly defined, while the others are less convinced that the degree of detail provided is sufficient for patients. In one hub there is no such a list, while five hubs are not aware of its existence.

3. Prior notification

Context

Alongside the system of prior authorisation, the directive introduced another mechanism, in Article 9(5), providing for a voluntary system of prior notification whereby the patient receives written confirmation of the amount to be reimbursed on the basis of an estimate. This in principle helps patients to have more clarity regarding their entitlement and to calculate the costs more accurately before embarking on the journey abroad.

Findings

Prior notification is applied by less than half of the hubs' regions but it is largely perceived to be a useful tool for providing patients with clarity and supporting the authorities in complying with their obligations. The **Emilia-Romagna hub,** the **Ialomita/Harghita hub,** the **Košice Self-governing Region hub,** the **Mazovia hub,** the **North Rhine-Westphalia hub**, the **Primorje-Gorski Kotar County hub**, the **Thessaly hub**, **Veneto (as part of the Umbria/Veneto hub)**, the **International Lake Constance Conference hub** and the **West Pomerania hub** believe that it would be worth introducing this system in their region.

The majority of hubs have a positive view of this arrangement. 19 hubs indicate that prior notification is a useful tool for providing patients with more clarity while 17 (including the **Northern and Western Regional Assembly hub,** the **Primorje-Gorski Kotar County hub, Veneto (as part of the Umbria/Veneto hub),** the **West Pomerania hub** and the **International Lake Constance Conference hub**), indicate that it is useful for supporting national or regional authorities in complying with their obligations.

The **Community of Valencia hub** states that currently patients only receive notification if they have prior authorisation for their treatment. In such cases, the costs of treatment are fully covered and patients are informed of the maximum accommodation and living allowance they can receive.

The **Hauts-de-France hub** mentions that patient information is considered to be important, particularly when it concerns costs arising due to the need for care, to know which actions should be carried out, details regarding the financial impact and whether or not it is possible to obtain the treatment.

Conversely, the **Helsinki-Uusimaa hub** does not consider this possibility to be necessary. The hub states that the position is determined by the activities of the relevant national authorities. There does not appear to be any reason to change the system.

4. Financial compensation

Context

Under Article 9(5) of the directive, Member States may choose to apply the mechanisms covering financial compensation between the competent institutions as provided for by Regulation (EC) No 883/2004. Consequently, the hubs were asked whether such mechanisms, replacing upfront payment and reimbursement to patients by direct billing between competent bodies, are applied in their regions.

Findings

Almost half (13) of the participating hubs' regions apply mechanisms of direct financial compensation between competent bodies. Among those who do, seven hubs report that this mechanism is managed by healthcare insurance or social security. This is the case in **Brandenburg, Brod-Posavina County,** the **Košice Self-governing Region,** the **Dutch Provinces, North Rhine-Westphalia, West Pomerania** and the **International Lake Constance Conference**. In four regions, namely **Mazovia**, the **Dutch Provinces**, the **Northern and Western Regional Assembly** and **Thessaly** this mechanism is managed nationally.

Overall, however, financial compensation is generally looked upon favourably as a way to enable closer cross-border cooperation, improve financial management and facilitate access to care.

The stakeholders consulted by the **Hauts-de-France hub**, in particular Assurance Maladie and the Franco-Belgian Health Observatory, both expressed their support for such a mechanism.

A more nuanced view emerges from the responses of the **Alentejo hub** highlighting the fact that the coordination between involved entities can be challenging. The stakeholders consulted in this Portuguese region worried about difficulties in liaising with different entities and feared that providers would end up not knowing whom to bill for treatment.

Conversely, the **Mazovia hub** and the **International Lake Constance Conference hub** have a less favourable view and find this arrangement to be a burden financially and administratively.

Finally, the **Helsinki-Uusimaa** regional council decided to leave financial compensation to the relevant national authorities to consider. As far as the hub is concerned there is no need to change the current system.

VI. COOPERATION IN HEALTHCARE

1. Agreements among the Member States

Context

More than one in three Europeans live in a cross-border area. Cooperation between health services, facilities, providers and authorities has the potential to transform proximity to a border from a common problem into a joint opportunity leading to better health outcomes, local innovation, jobs and growth.

The directive promotes this kind of cooperation between border regions and encourages Member States to conclude agreements and cooperate in healthcare across borders. Accordingly, the hubs were asked whether this kind of agreement was respected and implemented in their regions.

Findings

Almost half of the participating hubs reported that there were cooperation agreements on cross-border healthcare with neighbouring countries. Often, the regional authorities had not been involved in negotiating these agreements. Few new cross-border cooperation agreements were reported to be under discussion and a significant number of hubs considered it relevant to have one in place.

In 13 of the participating regional hubs, cooperation agreements on cross-border healthcare with neighbouring countries are in place. In seven of these regional hubs, the regional authorities were not involved in negotiations leading to the agreement. Several of the agreements are between hospitals, as is the case with the **Košice Self-governing Region**.

This particular agreement, set up in the framework of an Interreg cooperation project[6], involves two hospitals and their cooperation via teleradiology units, enabling data to be sent to the hospital in Miskolc (Hungary) for examination by the advanced radiology unit there. In practice, X-rays and computer tomography images can be sent via the Internet, which considerably shortens waiting times and improves the quality of diagnostics. As a result, patients from the Medzibodrožie area no longer have to go to hospitals located far away for examinations.

Three hubs – the **Catalonia hub**, the **Dubrovnik-Neretva County hub** and the **North Rhine-Westphalia hub** – state that new cooperation agreements are currently being discussed and another 11 hubs say that it would be relevant for their regional authority to have a cooperation agreement with a bordering country in place.

In the **Dutch Provinces hub**, for instance, agreements exist between hospitals and health insurers across borders. The **Dutch Provinces hub** also mentions that agreements on cross-border ambulance services are of particular importance. It is still the case that ambulance operational catchment areas all too often stop at borders, while in practice this could be dealt with more efficiently by ambulances operating across borders.

[6] More details about the project can be found on http://www.skhu.eu/spf

The **Dubrovnik-Neretva County hub** reports on cross-border cooperation agreements in the field of healthcare service provision between Croatia's hospitals or medical centres and the Republic of Montenegro's Clinical Centre as well as with Bosnia and Herzegovina's Federal Ministry of Health.

Among the comments provided by respondents, the **Alentejo hub** highlights the fact that new agreements can be considered when there is potential for leverage on both sides of the border. At the same time, the **Autonomous Province of Bolzano/Bozen – South Tyrol hub** states that agreements have already been set up under EU law and that medical costs are reimbursed directly by the South Tyrol Health Authority to entities abroad.

On other hand, the **Helsinki-Uusimaa hub** acknowledges that there were no agreements at regional level, the national level being responsible for concluding agreements.

The **Brod-Posavina County hub** specifies that this kind of agreement has been signed not only with EU Member States, but also with non-EU ones, such as Bosnia and Herzegovina.

For **Umbria (as part of the Umbria/Veneto hub)** it is not possible to report on similar agreements, as the region is not on the border (on the contrary, it is located in the centre of the country) and is relatively far from the borders with other EU Member States. Therefore, health mobility between Umbria and the rest of the EU is not easy from the point of view of travel and occurs only exceptionally. Agreements with neighbouring Italian regions are therefore more useful, as there is a considerable degree of patient mobility in this respect. In exceptional cases, where patients need and are prepared to travel from Umbria to another part of the EU, as in the case of rare diseases or the need for technologies that are not available anywhere else, the authorisation system is considered sufficient.

2. Cooperation in cross-border healthcare provision in border regions

Context

Beyond the national agreements to work together on health matters, Article 10 of the directive further specifies that the Commission should also encourage Member States to cooperate specifically in cross-border healthcare provision in border regions and that Member States should facilitate such cooperation at regional and local level.

The EU has 40 internal land border regions, representing 40% of the Union's territory. These regions, according to DG REGIO, *"generally perform less well economically than other regions within a Member State"*[7] and their populations face difficulties in access to health, social and educational services.

This makes cross-border healthcare initiatives in border regions particularly relevant. It goes without saying that factors such as the geographical context, lifestyle habits, culture, language and the political and administrative constellation have a significant impact on the sustainability of cooperation.

[7] More details are available at: https://ec.europa.eu/regional_policy/en/information/publications/communications/2017/boosting-growth-and-cohesion-in-eu-border-regions

Findings

The hubs were invited to assess several factors, identified in the literature and reviews by the European institutions, as key to the success – or failure – of cross-border cooperation projects.

The factors were divided into the following broad categories:

a) awareness and support;
b) legal and administrative issues;
c) language and socio-cultural matters;
d) physical access to healthcare across the border;
e) economic factors;
f) specific issues inherent to health systems.

Each category included two to six sub-questions and a scale ranging from "absolutely not important or relevant" to "highly important or relevant", as well as a "not applicable" option and an open field for additional comments and suggestions.

Awareness and support

When it comes to *awareness and support* to facilitate cross-border healthcare, regional hubs think that awareness and support among healthcare professionals is the most important factor, followed by awareness and support at the public administration level. Awareness among citizens is also generally deemed important.

To illustrate the matter, the **Dutch Provinces hub** highlights the fact that is widely known in the **Dutch Provinces** area that waiting lists for specialist care and operations are, on average, much shorter in the neighbouring Belgian region of **Flanders**. This encourages Dutch nationals to seek treatment from Flemish providers. Conversely, many Flemish medical staff are working in Dutch hospitals in border areas as working conditions are more favourable there.

Legal and administrative issues

Looking at *legal and administrative factors*, information on conditions for accessing healthcare abroad is deemed the most important factor in cross-border healthcare provision. It is followed by the presence of suitable regulatory frameworks and by appropriate infrastructure for the transfer of information.

For instance, the **Catalonia hub** indicates that in a future scenario for the Hospital of Cerdanya a data transfer system, the harmonisation of billing processes and the simplification and harmonisation of administrative structures will be required. Harmonisation of electronic prescription or referral systems and medical records will be of no lesser importance.

Language and sociocultural aspects

Concerning *language and sociocultural aspects*, trust and the ability to communicate freely with neighbours are deemed "highly important" or "important" by the majority of regions. Therefore, the **Dutch Provinces hub** states that at national level, there can be major differences in treatment methods

and medical views. This is reflected in cross-border healthcare and can constitute an obstacle for patients.

Physical access

On *physical access* to healthcare across borders, road infrastructure and the number and frequency of public transport connections are both deemed to be important factors in facilitating cross-border healthcare. However, the **Košice Self-governing Region hub** underlines that these factors, although important, fall only partially within the remit of regional councils at a general and planning level.

Economic factors

Among the *economic factors* influencing cross-border healthcare cooperation, the level of tariffs for medical services is generally deemed the most important. The basket of healthcare goods and services available to patients in cooperating regions and the type or amount of fees for medical professionals are also generally considered important. Economic factors appear to be a constraint for both healthcare professionals and patients.

The **Helsinki-Uusimaa hub**, for instance, mentions that economic aspects were not a competence of regional councils.

In the hospital of Cerdanya, the recruitment of professionals across borders is reported to be a serious problem as there are major differences in salaries and social security conditions between France and Spain. These differences create inequalities and difficulties in implementing cross-border cooperation.

The Hauts-de-France hub underlines that from patients' perspectives, the directive does not actually improve access to healthcare for all. As a matter of fact, for patients with limited financial means, the fear of not being sufficiently reimbursed outweighs the interest of benefiting from care outside their home country.

Factors inherent to health systems

Finally, regarding *factors inherent to health systems,* most hubs believe that education and skills requirements for medical staff are highly important. Actually, this factor and the previously mentioned level of tariffs for medical services are considered the two most important factors influencing cross-border cooperation.

VII. LESSONS FROM THE PAST AND PLANS FOR THE FUTURE

1. Inspiration for interregional cooperation for healthcare

Over more than 25 years, projects and initiatives to build, coordinate or improve interregional cooperation in healthcare have thrived all over the EU. Interreg, as part of EU Cohesion Policy, has financed many of these cross-border healthcare projects and allowed EU citizens to benefit from better access to and quality of healthcare services. Other funding instruments supported similar projects, especially between EU and non-EU regions. The main interest was therefore to find out more about regions' experience of cross-border cooperation and recommendations for future policies.

Various factors are deemed to be important in inspiring cross-border cooperation in healthcare, with one of the key reasons for setting up cross-border healthcare cooperation being the capacity to guarantee access to specialist care.

Regional hubs consider listening to people's requests to be the most important factor in cooperating across borders in healthcare. Talking to colleagues from other EU and/or non-EU regions already involved in cooperation and running cross-border projects is deemed a highly important factor and as well as a source of inspiration.

19 hubs consider that attending conferences where cross-border cooperation projects are discussed – such as the December 2018 event[8] on *Enhancing Healthcare Cooperation in Cross-border Regions* – is also of great importance.

Among the main reasons for setting up cross-border healthcare cooperation is that of guaranteeing access to specialist care that is lacking or insufficient in the region. This includes treatment for rare diseases and emergency healthcare.

Similarly, cooperation is sought to reduce waiting time for medical procedures and to react to people's requests.

It is worth noting that better access to care (be it specialist or simply in terms of shorter waiting times) was identified as "important" or "highly important" by 80% of the hubs.

For instance, the **Catalonia hub** states that in their case cross-border cooperation was useful in establishing a local hospital, particularly as the highly specialised alternatives are an approximately two-hour journey by land transport and 20 minutes by air for critical cases. Better cooperation would be able to offer a first response to any emergency or critically urgent case.

The **Brittany hub** adds that the main reason for setting up cross-border healthcare cooperation is the actual need experienced by a region for this kind of cooperation.

[8] https://ec.europa.eu/regional_policy/en/conferences/cbc_health

For the authorities in **Hauts-de-France** it is important to have the possibility to create cross-border structures which bring together public, private and not-for-profit partners, and the hub specifically mentions the French-Belgian Health Observatory[9] (OFBS), a European Economic Interest Grouping with 20 years of experience in promoting Franco-Belgian cooperation along the 620km border.

The **Community of Valencia hub** emphasises the importance of a coordinated system to record patient movements and facilitate the integration of patients into the healthcare system on both sides of the border.

The **North Rhine-Westphalia hub** points out to the need for a comparative study of national laws in order to be able to implement meaningful healthcare provision in border regions.

2. Useful tools for interregional cooperation in cross-border healthcare

The directive contains a series of provisions on the need for cooperation and mutual assistance between EU Member States on medical prescriptions, on the development of European reference networks, on the development of diagnostic and treatment capacity for rare diseases, and on e-health and medical technology assessment. All these are aimed at providing high-quality cross-border healthcare and the insured person's access to optimal diagnosis and treatment procedures for their state of health.

Presented with a list of options, the participating hubs identified "information on available EU funding" as the most helpful tool for setting up cross-border cooperation projects in healthcare. At the same time political support, long-term EU funding and committed medical staff were also recognised as critical to keeping cooperation agreements alive and sustainable.

The least-chosen option (though still relevant for over 60% of respondents) was the European Cross-Border Mechanism. The mechanism enables the application, in a given Member State and, in relation to a common cross-border region, of the laws of a neighbouring Member State if the laws of the former are a legal obstacle to the delivery of a joint project. Proposed by the European Commission in May 2018, this draft regulation is still under discussion between the European Parliament and the Member States.

Several hubs decided to provide details of their specific considerations and shared additional ideas on how to set up and maintain successful cross-border cooperation projects in health.

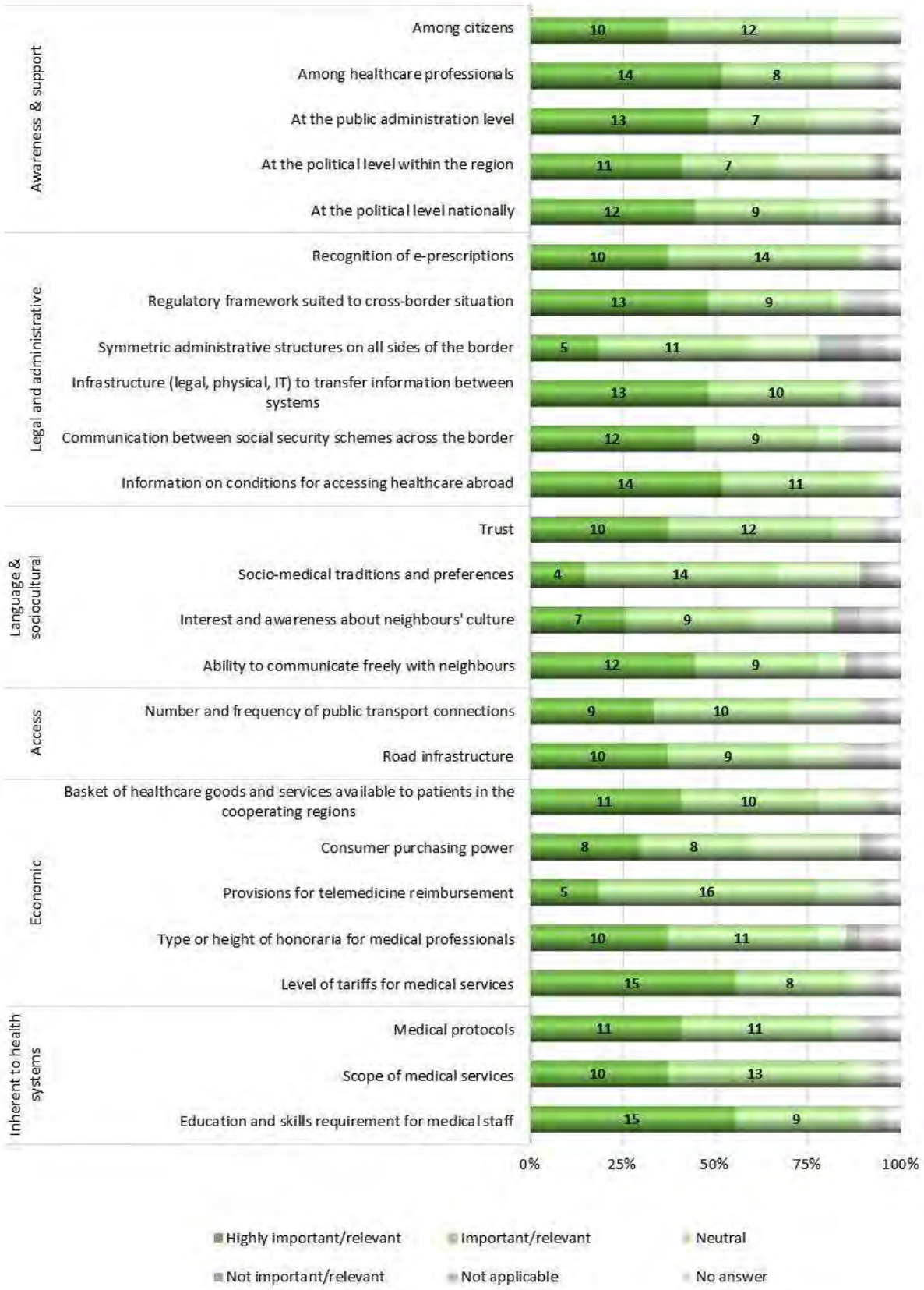
The **Catalonia hub** highlighted the importance of regional attractiveness for current and future professionals. For instance, professionals at the hospital of Cerdanya need to be proficient in three languages, they need to be familiar with the administrative procedures of two separate public health systems (French and Spanish) and they must adapt scientific protocol and clinical practices, striving not only for excellence, safety and quality but also to ensure that users are aware of all of this. Care and administrative staff aim, as appropriate, to provide patients and families with an experience that resembles the experience they would have in a French or Catalan centre as closely as possible and to help them in areas where differences cannot be avoided.

[9] More details can be found at: https://www.ofbs.org/

Umbria (as part of the Umbria/Veneto hub) is of the opinion that cooperation between health professionals, as well as cooperation between centres of excellence in the area of rare diseases, presents a highly significant tool for interregional healthcare. Additionally, another useful tool is to be proactive in conveying the message to the European institutions regarding problems in implementation and possible areas for improvement in the EU legislation, pointed out by the regions.

Additionally, the **Thessaly hub** explains that a beneficial mechanism for cross-border cooperation is the simplification of several administrative procedures, such as national standards of professional responsibility of health care providers, national standards of quality of care and safety of patients, provision for special funding requests (for instance translation services, electronic publications, etc.), administrative and technical cooperation or interconnection of a National Contact Point with health regions and other public and private bodies involved.

Factors influencing cross-border cooperation (Q22 to Q27)



The **North Rhine-Westphalia hub** on the other hand calls for a comparative study of legal rules applicable to healthcare services located along EU borders. In its view, such a study would facilitate the setting up and running of cross-border healthcare projects. In practice, it could be similar to the *Ostbelgien-Regelung* that in 2017 replaced the previous IZOM agreement and clarifies the rules under which population of Ostbelgien (Belgium's German-speaking region) can access healthcare services in neighbouring Germany[10].

The **Hauts-de-France hub** indicates that creating cross-border structures to bring together public, private and not-for-profit partners would be a very useful tool. It points to the potential for better quality healthcare based on cross-border complementarity and advocates innovative forms of organisation, responding to local realities and current health challenges, such as an ageing population, medical demography problems, advances in health technology, etc. The hub believes that the health sector represents a real lever for cross-border cooperation development in general.

The **Košice Self-governing Region hub** reiterates that in the area of healthcare, it is a matter of breaking down administrative and legal barriers that have long hindered the development of cross-border cooperation. In the case of the Slovak-Hungarian border area, there has been a long-standing discussion on cross-border emergency care (ambulances). It would make a huge difference to the life and health outcomes of the population in border regions if Slovak and Hungarian ambulances were allowed to cross borders to pick up patients who were geographically nearer to them.

Overall, almost 60% of the hubs indicate that long-term EU funding is highly important in keeping cross-border healthcare cooperation alive and sustainable. Targeted communication, awareness-raising activities and discernible cost-efficiency for the regional budget were also highlighted as relevant factors.

The intention is for both the exchange and use of information within a supranational interoperable system to build within each region's legislation making for an operational and sustainable cross-border healthcare system. This mechanism primarily aims at guaranteeing protection of personal data which is as complete as that of the processes more uniformly applicable to all Member States.

On ways of keeping cross-border healthcare cooperation alive and sustainable, almost 60% of the hubs indicate that long-term EU funding is highly important. Factors generally found to be significant in this respect include communication and awareness-raising activities and discernible cost-efficiency for the regional budget.

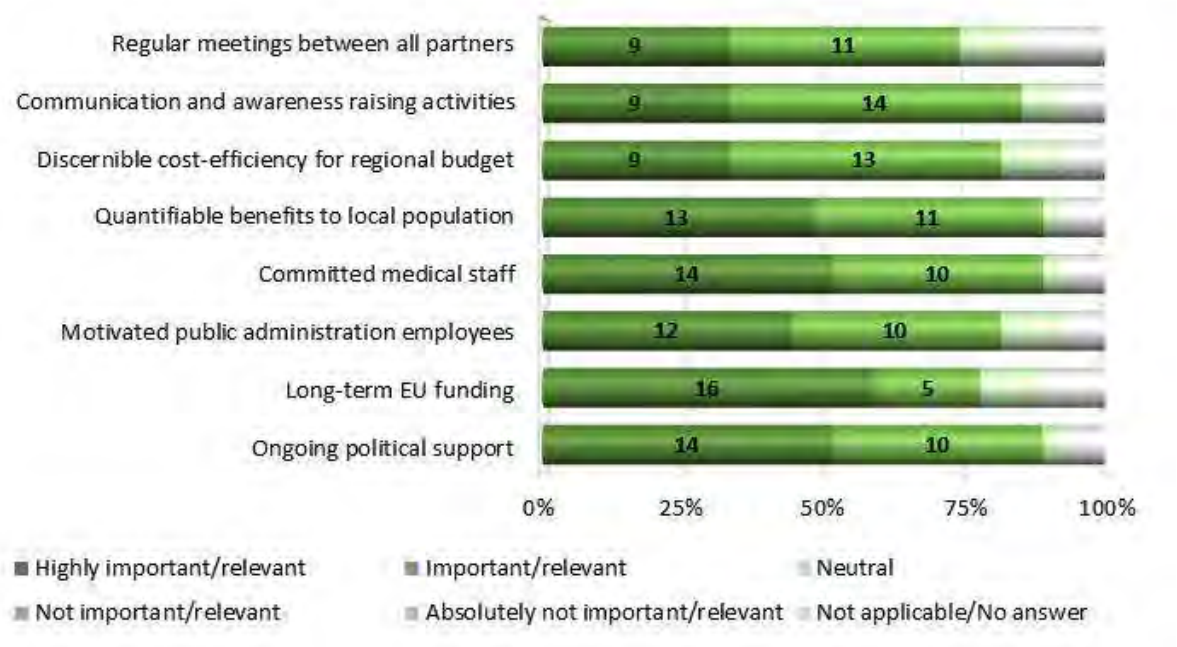
However, two regional hubs also had their own opinions on this matter.

The **Catalonia hub** believes that remaining attractive to professionals, which would imply an employment agreement of their own drawing on the most relevant aspects of employment would be a considerable contribution to cross-border healthcare cooperation.

[10] https://www.ostbelgienlive.be/desktopdefault.aspx/tabid-6225/ (available in German only)

The **Helsinki-Uusimaa hub** states that an additional considerable contribution lies in valid factors for collaboration and development, as well as EU-level resources which always help by catalysing action.

What helps to keep cross-border healthcare cooperation alive and sustainable? (Q31)



3. Review of the directive

When asked whether there was a need to review either the directive or its national or regional implementing measures, the hubs did not have a clear position.

While 10 regional hubs believed that the directive should be reviewed, eleven shared the opinion that in actual fact no changes were needed for the directive. This was the view of the **Northern and Western Regional Assembly hub**, the **Flanders hub**, the **EGTC Tritia hub**, the **Primorje-Gorski Kotar County hub**, the **Autonomous region of Friuli Venezia Giulia hub**, the **Helsinki-Uusimaa**, the **North Rhine-Westphalia hub**, the **Community of Madrid hub**, **Veneto (as part of the Umbria/Veneto hub),** the **Brittany hub** and the **Thessaly hub**.

As multiple answers to this question were possible, 10 regional hubs also chose to indicate that implementing measures needed to be reviewed at the national and/or regional level. Some of the regional hubs even provided individual suggestions on how the directive may be improved.

The **International Lake Constance Conference hub** is in favour of reviewing the directive. The hub believes that it should become mandatory to cover treatment costs or calculate private medical fees for people insured abroad who receive outpatient treatment in Germany.

The **Autonomous Province of Bolzano/Bozen – South Tyrol hub** suggests improving the compensation methods, whereas the **Brod-Posavina County hub** highlights the fact that the

implementing protocols for the directive must be made available to individual regional authorities and that training should be delivered. Meanwhile the **Hauts-de-France hub** and the **Ialomita/Harghita hub** encourage better information to be provided for health professionals and for the public. Accordingly, in the opinion of the hubs, better communication would lead to awareness-raising, to regular meetings of all partners and to ensuring motivated administrative and healthcare staff.

The Mazovia hub suggests looking into the question of more stringent control over service providers, especially private ones, offering their services in the framework of cross-border care. This oversight, in the view of the hub, could be strengthened.

The **Dubrovnik-Neretva County hub** believes the national and regional implementing measures which transpose the directive into Members States' legislation should be reviewed. It adds that what should be changed is ensuring that patients have access to safe and good quality healthcare beyond their national borders within the EU, as well as being entitled to reimbursement for such healthcare. Finally, it suggests establishing regional contact points to inform people of their rights regarding cross-border healthcare. These changes would facilitate better cooperation in the field of e-health, including cross-border exchange of patient data.

The **Dutch Provinces hub** believes that the directive is currently too optional in nature to be truly effective. The competences of NCPs, as well as the financial structure, should be reviewed since the directive now requires too much pre-financing which does not benefit people with fewer financial resources. An upfront payment requirement for patients constitutes, in the hub's view, a significant barrier to access to care.

The **Emilia-Romagna hub** states that closer integration with social security systems is required. The hub believes that the financial impact on individuals, even if they are subsequently reimbursed, is not as efficient as it could be.

The **Autonomous Province of Bolzano/Bozen – South Tyrol hub** is convinced that cross-border healthcare may stay alive and sustainable if regional hubs played a more active role in informing the European institutions of their problems in implementing the directive.

Umbria (as part of the Umbria/Veneto hub) acknowledges that in reality the directive has not been used much in the region, at least as regards mobility from Umbria to the EU. For instance, in 2017 and 2018, not one patient in Umbria asked to be treated in another EU Member State under the directive. Since Umbria is far from the border, mobility from Umbria to the EU does not concern outpatient or basic services, but primarily involves highly specialised treatment and/or hospital treatment, which would in any case be subject to authorisation including under the directive. Moreover, in Umbria, in line with the national rules, the rates applied are in practice lower than in most other western European countries. This means that any Umbrian patient choosing to be treated abroad under the directive needs to be prepared to cover the difference in cost out of their own pocket. For the above mentioned reasons, Umbrian patients seeking treatment in other member States prefer to do it under the regulation rather than under the directive.

At the same time, the **Alentejo hub** mentions that there is still a need to work under the directive and make some adjustments at national level, so that the regional level can follow suit and proceed accordingly.

Generally speaking, the suggestions to improve the directive could be summarised as follows:

- Give the directive its own European character and autonomous management system and make it less optional thereby relying less on sub-national authorities, for example by making implementing protocols and training on implementation available.
- Review the competences of the National Contact Points and strengthen their role, for example by providing them with the tools to exercise their duties or by better linking them to regional health authorities and other relevant public and private stakeholders.
- Cut red tape/bureaucracy and simplify administrative procedures. One way this could be done is by reviewing financial and reimbursement structures in order to reduce the financial burden on people (this aspect is reiterated several times by different hubs), for example by improving compensation methods through coordinating and integrating with social security systems. Additionally, the prior authorisation criteria could be supplemented with social reasons.
- Better informing the public and health professionals, for example by establishing more regional contact points to inform patients of their rights or by publishing EU tenders for projects on communication and awareness-raising.

Finally, those who do not see the need to review the legislation point out that patient mobility is already to a large extent covered by Regulation (EC) No 883/2004. The regulation, covering both planned and unplanned healthcare in another EU Member State, offers the advantage of no upfront payment and is therefore likely to be more advantageous for Europeans.

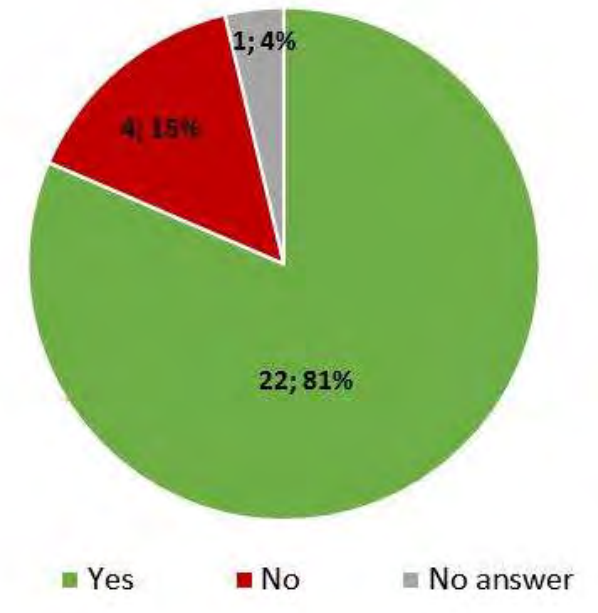
4. Looking towards the future

Despite all the barriers identified, the majority of regional hubs would consider setting up cross-border healthcare cooperation projects. 22 would be ready to do so in the near future. They would focus mostly on research and innovation (16 selections), followed by primary care (14 selections), specialised care and training and education (13 selections each).

The areas of specialised care which are most frequently mentioned are ophthalmology, oncology, dialysis and rare diseases. Among the reasons for prioritising these types of specialised care in setting up cross-border healthcare cooperation are:

- the level of patient demand;
- availability of specialist staff;
- costs;
- safety and quality considerations;
- the possibility to provide care for specific target groups such as vulnerable persons and irregular foreign nationals/asylum seekers; and, last but not least;
- the opportunity to learn from one's neighbours.

Would your organisation/institution consider setting up a cross-border healthcare cooperation in the near future? (Q33)



For **Umbria (as part of the Umbria/Veneto hub)**, the key areas of interest for future cross-border cooperation would be in cooperation between health professionals and between centres of excellence for rare diseases. In contrast, the **Autonomous region of Friuli Venezia Giulia hub**, bordering on both Austria and Croatia, would prioritise primary and emergency care, as well as training and education.

The **EGTC Tritia hub** on the Polish-Slovak border on the other hand does not envisage any cross-border healthcare projects. The **Brittany hub** concurs, explaining that due to the lack of a land border with any other Member State, there is no need to develop such projects.

Meanwhile the **Brandenburg hub** selected all the possible answers, thus demonstrating its strong interest in developing future cooperation projects with its neighbours. The hub additionally highlights the fact that it would in particular be interested in cooperation in geriatrics, laryngology, ophthalmology and oncology.

The **Ialomita/Harghita hub** and the **Emilia-Romagna hub**, on the other hand, opted for a single answer, favouring "research and innovation" and "specialised care" respectively.

For the **Community of Madrid hub**, a project focusing on the health of disadvantaged groups would be of interest, assistance to irregular foreign nationals and asylum seekers being highlighted in particular.

The **North Rhine-Westphalia hub** points out that any cooperation must be based on the needs of both partners, meaning that knowledge of the neighbouring system and services helps to identify areas of common interest. For this hub, such areas include both primary and specialist care, as well as emergency

care. What is usually decisive for patients, they note, is the geography, i.e. distance and ease of access to the nearest health professional.

Emergency care on the one hand and research and innovation on the other are what interests the **West Pomerania hub** most.

The **Thessaly hub** adds another specific category, highlighting the need to initiate cooperation in the area of organ transplants. At the same time, the hub recognises that the lack of expertise, infrastructure and specialisation within the Greek national system may hamper such projects, as well as the country's complicated geography.

VIII. REGIONAL HUBS' EXPECTATIONS OF THE EUROPEAN UNION

1. Expectations of the European Union

European cross-border cooperation in health matters is not a new phenomenon, as attested by almost three decades of support through Interreg and other funding mechanisms.

The directive includes among its objectives that of further promoting this cooperation, while providing patients with information on procedures, reimbursement limits and waiting times and with quality assurances.

The final question put forward to the hubs, therefore, sought their views on how the European Union could support further cross-border healthcare cooperation between its regions.

As expected, most of the hubs saw the need to improve the flow of information between Brussels and the regions and called for better communication and awareness-raising activities.

Many argued for the removal of legal and administrative barriers, requested support for research and development and made the case for sustainable and long-term funding of cross-border healthcare initiatives.

The **Alentejo hub** asserts for instance that regions above all need more support: be it in the form of specific assistance mechanisms or targeted information on funding. Finally, regions could also benefit from EU help in setting up and implementing innovative projects. The **Mazovia hub's** comment is similar, with the hub calling for ready-made models for such cooperation agreements.

The **Autonomous region of Friuli Venezia Giulia hub** and **Veneto (as part of the Umbria/Veneto hub)** go a step further and put forward an ambitious proposal for a common legal framework for projects in cross-border healthcare cooperation. Such a European framework could guide the changes needed in national and regional legislation.

Several regions used the question on the role of the EU to express their support, and outline their hopes, for the Interreg programme.

The **Brandenburg hub** highlights the importance of political impetus for pilot projects (including start-up funding where appropriate). The hub also puts forward a range of specific requests for the next programming period, including:

- securing adequate Interreg funding;
- maintaining the co-financing rate at 85%;
- prioritising health-related projects;
- or even moving towards a separate funding mechanism for health cooperation.

The **Northern and Western Regional Assembly hub** is also committed to Interreg and reiterates how fundamental the Interreg peace programmes have been to supporting cross-border cooperation in health and social care between the Republic of Ireland and Northern Ireland.

The **Dutch Provinces hub** adds that the EU *"could do more to open the Interreg A programme to healthcare initiatives"* while the **Hauts-de-France hub** observes more generally that the European Territorial Cooperation programme should be reinforced to boost its overall visibility and communication on its outputs.

The **Košice Self-governing Region hub** wants the EU to continue to support cross-border programmes *"such as Interreg SKHU and ENI HUSKROU"*, which in their view have implemented successful projects in the field of healthcare, improving the quality of life of patients living along the border.

Finally, the **Thessaly hub** makes a specific recommendation to better connect National Contact Points under Directive 2011/24/EU by means of special services for managing European Territorial Cooperation Interreg programmes.

Several regional hubs refer in their comments to the costs related to implementation of cross-border healthcare cooperation. They call for adequate and long-term funding to be available for new and existing projects.

The **Brod-Posavina County hub** would welcome European recommendations for cooperation in the field of emergency care, coupled with adequate funding to make it a reality.

The **Catalonia hub** does not make any recommendations to the EU, though it reiterates that cross-border projects – such as the well-known hospital of Cerdanya – do not come cheap and require long-term financial backing.

The Transylvanian county of the **Ialomita/Harghita hub** joins the ranks of other regions calling for long-term EU funding for cross-border healthcare projects. The hub also believes that regular meetings of regional partners would help to keep staff motivated and well-informed.

A number of hubs also point out to difficulties related to billing and reimbursement procedures and ask for greater involvement of the EU in this field. From an exchange of information to a fully-fledged system of standard cross-border medical bills, the recommendations from the hubs attest to the difficulties encountered not just by patients, but also by health providers and health insurers in the provision of cross-border health care.

The **Community of Madrid hub** wishes in this regard to see more structured and systematic coordination between the Member States, leading in the future to a standardised billing system for cross-border care, including automatic information-sharing on patients who cross borders to receive treatment.

Similarly, the **North Rhine-Westphalia hub** sees the EU role as one of simplifying the rules, mainly on reimbursement and billing procedures. The hub would welcome a reflection on more optimal billing structures and cross-national health insurance law.

For the **Community of Valencia hub**, the added European value would come from setting up working groups on information and on reimbursement issues. The EU could also do more to support cooperation in research, development and innovation.

Another category of comments includes requests for better information and knowledge-sharing, and regular meetings of parties.

From the perspective of the **Dubrovnik-Neretva County hub**, Europe should be more active in knowledge and expertise-sharing. The hub believes that while overall awareness of cross-border health initiatives in border regions has risen in recent years, there is still a lot of learning to be done. Geography, shared history, language, politics and administrative environment matter a lot, but the EU can bring additional value and support, thus paving the way for more cooperation in border regions. This would ultimately mean better health outcomes for local populations.

This call is also echoed by the **Hauts-de-France hub**, which is concerned about the lack of awareness among the general public. To improve the situation, the hub recommends improving the information flow towards healthcare professionals who can in turn encourage patients to look into alternatives abroad. Regular meetings and better information-sharing between healthcare planners, providers and insurers would also help.

The **Thessaly hub** also feels that workshops for managers who are involved in transposing/implementing the directive on cross-border healthcare would be helpful. In addition, National Contact Points would certainly benefit from more interaction and a database with standardised information on the healthcare systems of the EU/EEA Member States.

The **Autonomous region of Friuli Venezia Giulia hub** and **Veneto (as part of the Umbria/Veneto hub)** call for more dialogue between the political level and the public and for better sharing of good practice. Finally, they reiterate that health systems need to be well-resourced if they are to be able to engage in cross-border projects.

A few comments were also made with regard to vulnerable patient groups.

The **Emilia-Romagna hub** highlights in its comment the need to strengthen the connection between the directive and national social security systems. In a similar vein, the **Community of Madrid hub** would also like to see a reflection on a "solidarity fund" – or a mechanism enabling access to care for those who do not have the right to public care. Such a mechanism should have the same access criteria across the continent.

The **Mazovia hub** suggests that prior authorisation for rare diseases especially in children should be waived, so as not to hinder access to care. The stakeholders consulted by the **Autonomous Province of Bolzano/Bozen – South Tyrol hub** also reports that certain categories of patients, for example those with chronic and rare diseases, would benefit from streamlined administration. In their view, there should be specific provision for exemptions depending on the seriousness of the condition and urgency of the need for treatment.

In relation to digitalisation in health, a couple of hubs made suggestion to the EU and its Member States.

The Hauts-de-France hub would like to encourage the Member States to also offer telemedicine and teleconsultations in the framework of cross-border cooperation.

The **Autonomous Province of Bolzano/Bozen – South Tyrol hub** meanwhile calls for electronic exchange of expenditure and information data.

Reflecting more generally on whether the EU is doing enough, the hubs come up with diverging answers. On the one hand, **Umbria (as part of the Umbria/Veneto hub)** believes that the EU should not only listen but finally act to address the shortcomings identified so far, as reported by the Member States and their regions. On the other hand, the **International Lake Constance Conference hub** sees no need for any further action from the EU and finds the existing (and pending) legal acts to be sufficient.

The **Hauts-de-France hub** suggests that in order to think about building a real public health common policies in border region, the "cross-border health" (not just "cross-border healthcare") should be taken into consideration. Based on the cross-border health status of the local population, these policies would allow acting in a larger manner on prevention (smoking, alcohol, physical activity) and covering screening programs for example.

This ambitious proposal is not dissimilar to what the stakeholder from the **Autonomous Province of Bolzano/Bozen – South Tyrol hub** requested, namely a stronger pan-European health standard, swift adoption of the European Border Mechanism by the Council and removal of legal barriers between individual EU Member States. Coupled with establishment of interregional federations of patient associations, improved cooperation between medical specialists and interregional research, this could create European regional health areas in the true sense of the word.

Finally, a completely outstanding comment from Finland merits highlighting.

The **Helsinki-Uusimaa hub** draws attention to a different aspect which in the meantime has become highly topical across the continent – as well as globally. The hub calls for more cooperation in rare and infectious diseases. It wishes to have more EU involvement in controlling the spread of epidemics and in medicine supply and availability. The region highlights recent essential medicine shortages and advocates more investment and cooperation in research, development and innovation.

These recommendations – drafted in December 2019, before the news of the COVID-19 reached Europe – seem truly prophetic.

2. Expectations of the European Committee of the Regions

The European Committee of the Regions has taken an interest in the directive from the earliest stages. When it was consulted on the very first draft of the new law in 2008, the Committee provided its assessment and recommendations – including proposals for legislative amendments – to both co-legislators: the European Parliament and the Council.

After the publication of the first implementation report, three years after the new law entered into force, the Committee held a policy hearing with the EP rapporteur on the subject, the European Commission and the representatives of health providers and patients' associations to take stock of the limited progress, if any, in making cross-border healthcare a reality.

When drafting its second opinion on the implementation of the directive on the ground in 2020, the Committee also sought the views of the regional hubs as to how it could in future support the public authorities more in cross-border healthcare cooperation.

The regions felt that the key role of the CoR was to pass on to the other EU institutions the insights gathered on the implementation of the directive as well as highlighting the problems and areas for improvement.

Both **Umbria (as part of the Umbria/Veneto hub)** and the **Autonomous Province of Bolzano/Bozen – South Tyrol hub** list the above as the key priority for the CoR.

The hubs also felt that the CoR could take a more visible and active role in promoting cross-border initiatives, create a political momentum or giving impetus to new projects, as well as providing analyses of cross-border projects.

The **Autonomous region of Friuli Venezia Giulia hub** and **Veneto (as part of the Umbria/Veneto hub)**, for instance, see the CoR's role in awareness-raising and dissemination of best practices adopted by European regions or other public or private organisations. These hubs would like the CoR to facilitate political dialogue between its members, especially representatives of border regions, to help create mechanisms for cooperation in cross-border healthcare.

The **Brandenburg hub** would like the CoR to give political impetus to cross-border projects and lead discussions on how to further develop this policy area at EU level. The **Northern and Western Regional Assembly hub** sums it up with one word: "dialogue".

Not surprisingly, some regions called on the Committee to advocate allocation of adequate funding in general and optimal funding conditions within the Interreg programme in the upcoming programming period.

In addition, a more specific request was made to support lobbying efforts for more assistance to small-scale local initiatives. This is echoed in the comments of the **Dutch Provinces hub.**

Another suggestion is for the CoR to support the development of structured, systematic and mandatory coordination of cross-border healthcare projects. This could be done structurally through a platform, through cross-border conferences on healthcare where regions gather together and debate ideas and potential projects, or through other regional implementation structures. This request emerges from the comments made by the **Alentejo hub**, which similarly calls for regional cross-border conferences to popularise the topic and inject some dynamism into existing structures and contacts.

IX. CONCLUSIONS

This third report of the Network of Regional Hubs comes at a very difficult time. Designed to take stock of the regions' experience in sending and receiving patients from abroad, the report is published right in the midst of the greatest global health emergency since the Spanish influenza pandemic. Despite the fact that the survey was in no way intended to contribute to future reflections on post-crisis healthcare, it is impossible to ignore this dimension altogether.

But first, the findings in general. As expected by the European Committee of the Regions, most regions knew citizens were free to access care or purchase health products abroad. Still, some had not made a connection between this right and the directive. This is not surprising, given how low the **general awareness** of the EU population is with regards to the directive, and further reflection is needed on what else could be done to better anchor the law in people's minds.

Similarly, while in general the hubs reported knowing that the **National Contact Points** existed, in specific comments across various sections of the survey, they pointed to lack of knowledge and assistance and called for more dedicated training and support for regional health system managers. They also felt that regional administrations and health practitioners could do with more strategic advice, training and information-sharing.

To address this knowledge gap, almost a half of the hubs consulted have reported taking the matters into their own hands and **providing information** to either the administration, healthcare providers or patients themselves. Some do so when asked, whereas others actively target specific groups with information that may be of use to them. Not surprisingly, the border regions are more likely to have specific regional contact persons or structures to assist the public and professionals. This could in the future be further strengthened through a **network of border region contact points**.

Only a limited number of hubs can monitor and share **data on patient flows**. While this is a national and not a regional task under the directive, it still means that the hubs are largely left in the dark as to how many people cross borders to get medical help and how many choose to come to their area for treatment. This may ultimately have an impact on healthcare planning and may prevent regions, especially those on borders, to realise the full potential of their geographical location.

The next section of the survey sought the hubs' views on what the academic literature – and reports by the EU institutions themselves – defines as key obstacles to cross-border healthcare, namely the issue of **reimbursement** and **prior authorisation.**

With regard to **reimbursement**, the hubs reported no particular issues around charging foreign patients or reimbursing their own nationals for care received elsewhere. Not a single comment on possible discrimination on the basis of nationality was made, and neither was the question of private vs public healthcare an issue.

Interestingly, however, in another part of the questionnaire, several hubs complained of difficulties related to billing and reimbursement procedures. Many asked for greater involvement on the part of the EU in this field. Ranging from an exchange of information to a fully-fledged system of standard cross-

border medical bills, the recommendations from the hubs attest to the difficulties encountered not just by patients, but also by health providers and health insurers in the provision of cross-border health care.

The system of **prior authorisation**, regarded critically by many patient organisations, experts in the field and the European Parliament, does not seem to be an issue for the participating hubs. Most actually assess this safeguard as useful. They find it necessary to ensure sufficient and permanent access to a balanced range of high-quality treatments and helpful in controlling costs and resource use.

Most of the hubs also confirm that the list of treatments for which prior authorisation is required by law is publicly available.

Regarding another mechanism introduced by the directive, that of **prior notification**, the hubs express their support for it. They perceive it as an advantage for patients to have more clarity what they are entitled to and to be able to calculate the costs more accurately before embarking on the journey abroad, with two thirds of the hubs believing that it would be worth introducing such a system in their region.

Finally, the hubs shared their opinion on another specific arrangement under the directive: **financial compensation** between the competent institutions as provided for by Regulation (EC) No 883/2004. This mechanism, replacing upfront payment and reimbursement to patients by direct billing between competent bodies, is used in half of the participating hubs and only a couple of them found it to be burdensome. The prevailing view was that financial compensation leads to closer cross-border cooperation, improves financial management and facilitates access to care.

For the European Committee of the Regions, the hubs' assessment of **cooperation agreements**, especially in border regions, was particularly insightful. Border regions, home to more than 30% of Europeans, are typically disadvantaged in terms of economic opportunities, service coverage and access to care. Cooperation between health services, facilities, providers and authorities has the potential to transform proximity to a border from a common problem into a joint opportunity leading to better health outcomes, local innovation, jobs and growth.

Almost half of the participating hubs report on cooperation agreements on cross-border healthcare with neighbouring countries; alas, in most cases, regional authorities were not part of the negotiation teams when these were concluded.

All hubs, independently of whether or not they are involved in cross-border healthcare cooperation, were also invited to evaluate a range of several factors, identified in the literature and in reviews conducted by the European institutions, as **key to the success – or failure – of cross-border cooperation projects**.

Not surprisingly, the level of tariffs for medical services as well as education and skills requirements for medical staff were considered the two most important factors influencing cross-border cooperation.

When it comes to **awareness and support** to facilitate cross-border healthcare, regional hubs think that above all healthcare professionals and public administrations need to be better informed and assisted. Looking at **legal and administrative factors**, information on conditions for accessing healthcare abroad is deemed the most important factor in cross-border healthcare provision. It is followed by the presence of suitable regulatory frameworks enabling the seamless launch and running of cross-border projects.

Concerning **language and sociocultural aspects**, trust and the ability to communicate freely with neighbours are highly rated by the majority of regions.

On a practical level, **physical access to healthcare across borders** is also highlighted as important, in particular the frequency of public transport connections.

Among the **economic factors** influencing cross-border healthcare cooperation, the level of tariffs for medical services, the basket of healthcare goods and services available to patients in cooperating regions and the type or amount of fees for medical professionals are also generally considered important.

Drawing on **experiences from the past and looking into the future**, the hubs also shared their views on where the inspiration to set up a cross-border project comes from, the rationale behind such a decision, which tool are key to setting it up and what helps to it stay alive.

Inspiration in most cases comes directly from the public and from listening to their wishes. This response – one of the most commonly selected - confirms that local and regional authorities are close to their population, engage meaningfully in dialogue and take to heart the wishes of their people.

Attending conferences on cross-border cooperation projects and simply talking to colleagues who have direct experience also sparks interest and boosts confidence in launching new projects.

The most popular **reason for setting up a new cross-border project** is to improve or guarantee access to specialist care. This includes treatment for rare diseases and emergency healthcare.

Looking at the **tools needed to launch and keep the projects going**, the hubs clearly identified "information on available EU funding" as the most helpful instrument. At the same time political support, long-term EU funding, and committed medical staff were also recognised as critical to keeping cooperation agreements alive and sustainable.

The least-chosen option (though still relevant for over 60% of respondents) was the European Cross-Border Mechanism. This is no surprise at this stage since the Mechanism has not been put in place, as it has not been approved yet by the Council.

When asked whether there was a need to **review either the directive** or its national or regional **implementing measures**, the hubs did not have a clear position. Their answers were split almost 50-50 on this matter. Nonetheless they shared some specific ideas on how to improve the directive by harmonising certain protocols and providing training on implementation, strengthening National Contact Points and linking them more closely to regional health authorities, cutting red tape and simplifying administrative procedures, and better informing the public and health professionals.

Despite all the barriers identified the majority of regional hubs would consider **setting up cross-border healthcare cooperation.** 22 would be ready to do so **in the near future**, preferably focusing on research and innovation, primary and specialised care and training and education.

Turning their attention to Brussels, the hubs formulated a **range of expectations and hopes** with regards to what the Union – and the CoR – could do to assist regions interested or active in cross-border healthcare cooperation.

As expected, most of the hubs saw a need to improve the flow of information between Brussels and the regions and called for better communication and awareness-raising activities. Many argued for the removal of legal and administrative barriers, requested support for research and development and made the case for sustainable and long-term funding of cross-border healthcare initiatives. Several regions used the question on the role of the EU to express their support, and outline their hopes, for the Interreg programme.

From the European Committee of the Regions, the regions would welcome **a more visible and active role in promoting cross-border initiatives**. They would like the CoR to create political momentum or give impetus to new projects, as well as providing analyses on cross-border projects.

Finally, they expect the CoR to pass on to the other EU institutions insights gathered on the implementation of the directive as well as to highlight the areas for improvement, while advocating the allocation of adequate funding in general and optimal funding conditions under the Interreg programme in the upcoming programming period.

Turning to the **coronavirus crisis**, the question of whether the opportunities under the directive have been used satisfactorily certainly merits reflection. The uncoordinated closure of national borders and the severing of ties with closest neighbours have left many cross-border patients and health professionals without access to their treatment or workplace. While this may not be essential for e.g. elective surgeries, it can certainly be life-threatening in areas where cross-border cooperation programmes ensure ambulance coverage on both sides of the border.

As widely reported by the international press, some German hospitals on the Oder-Neisse border employ up to 30% of Polish health professionals, who typically commute from their homes in Poland. Closure of the border and the quarantine imposed left many of them facing the dilemma of whether to stay with their families or continue attending to the needs of their patients.

Similarly, a tightly-sealed border between the French Grand-Est region and German Saarland has not been without (adverse) influence on cardiologic emergency care linking the Saarbrucken and Sarreguemines areas, putting heart patients effectively at higher risk.

The **potential of cross-border healthcare** workforce support and transfers has not been realised, and assistance between neighbouring hospitals also failed to materialise in the first critical weeks of the spread of the pandemic. Reacting to this, the European Commission issued specific guidelines on EU Emergency Assistance in Cross-Border Cooperation in Healthcare.

The **Guidelines** opened up the possibility for Member States:

- to request and offer intensive care beds and qualified teams through the Early Warning System;
- to access funds for the emergency transport of patients across the border;
- to use the reimbursement mechanism of the regulation (i.e. direct billing between health insurers, without charging patients);

- to be clear about the transfer of patient records and their continuity of care.

Finally, the Guidelines encouraged local, regional and national health authorities to use, where they existed, bilateral and regional agreements and contact points to relieve the burden of critical care units treating COVID-19 patients in the neighbouring region. Some regions – such as Lower Austria and the Maas-Rhine Euregio – were explicitly quoted as examples of good practice, maintaining their activities despite the crisis.

Both these suggestions from the Commission and the practice on the ground will merit another review once the acute phase of the COVID-19 crisis is over. The question of the recognition of professional qualifications highlighted by several hubs, reimbursement issues, the mutual recognition of prescriptions and the transfer of patient records are some of the areas that will need **more thorough examination** and commitment on the part of Member States.

Finally, as suggested by one of the hubs, more cross-border cooperation in infectious diseases and the supply and availability of medicine would also make a difference.

The benefit of the CoR's consultation of its RegHub network is clearly not limited to this report. The process itself incentivised the regions to look more closely into their regional health systems and generated an appetite for launching new projects with their neighbours. On the other hand, it also confirmed that while willingness is tangible, most regions would welcome more assistance, information, support and long-term funding commitment. The ball is now in the European Commission's court: both to address the shortcomings in the implementation of the directive and to further encourage the Member States to fine-tune this legal act in order to be more active in practical terms in normal and exceptional times.

X. ANNEXES

Annex 1: Statistics of RegHub survey on Cross-Border Healthcare

Statistics:

CoR RegHub Consultation on

Cross-Border Healthcare

1/ Does your region have a border with a neighbouring country? ***(You may select multiple answers)***

		Answers	Ratio
Yes, terrestrial		**19**	**70.37 %**
Yes, maritime		**9**	**33.33 %**
No		**7**	**25.93 %**
No Answer		**0**	**0 %**

2/ Does your region have responsibilities in terms of management of health systems and services? Funding of healthcare

		Answers	Ratio
Yes		**17**	**62.96 %**
No		**6**	**22.22 %**
No Answer		**4**	**14.81 %**

2/ Does your region have responsibilities in terms of management of health systems and services? Legislative powers

		Answers	Ratio
Yes		**12**	**44.44 %**
No		**13**	**48.15 %**
No Answer		**2**	**7.41 %**

2/ Does your region have responsibilities in terms of management of health systems and services? Policy powers, other than legislation (i.e., health strategy, action plan, health promotion campaigns, etc.)

		Answers	Ratio
Yes		22	81.48 %
No		3	11.11 %
No Answer		2	7.41 %

2/ Does your region have responsibilities in terms of management of health systems and services? Planning responsibility

		Answers	Ratio
Yes		17	62.96 %
No		6	22.22 %
No Answer		4	14.81 %

2/ Does your region have responsibilities in terms of management of health systems and services? Facilities ownership and management

		Answers	Ratio
Yes		19	70.37 %
No		6	22.22 %
No Answer		2	7.41 %

3/ Are you/is your regional authority aware of the fact that patients can move freely across borders to obtain health treatment in other countries?

		Answers	Ratio
Yes		**27**	**100 %**
No		**0**	**0 %**
No Answer		**0**	**0 %**

4/ Were you/was your regional authority aware of the EU directive on cross-border healthcare (https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ%3AL%3A2011%3A088%3A0045%3A0065%3AEN% 3APDF) before participating in this survey?

		Answers	Ratio
Yes		**23**	**85.19 %**
No		**4**	**14.81 %**
No Answer		**0**	**0 %**

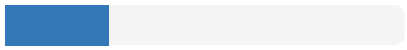
5/ Are you/is your regional authority aware of the opportunities provided by ETC/Interreg programmes (https://ec.europa.eu/regional_policy/en/atlas/programmes/) and/or other funding instruments to support cross-border healthcare?

		Answers	Ratio
Yes, aware of Interreg		**17**	**62.96 %**
Yes, aware of other funding instruments		**6**	**22.22 %**
No		**4**	**14.81 %**
No Answer		**0**	**0 %**

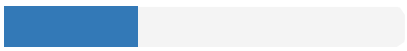
6/ Article 6(1) of the Directive requires each Member State to "*designate one or more national contact points for cross-border healthcare*" and to "*make this information publicly available*". Are you/is your regional authority aware of the existence of the National Contact Point created by the directive on cross- border healthcare under this article?

		Answers	Ratio
Yes		**25**	**92.59 %**
No		**2**	**7.41 %**
No Answer		**0**	**0 %**

7/ Does your region have its own Regional Contact Point?

		Answers	Ratio
Yes		**7**	**25.93 %**
No		**19**	**70.37 %**
No Answer		**1**	**3.7 %**

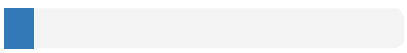
8/ Does your region have links to the National one on regional administration webpages?

		Answers	Ratio
Yes		**9**	**33.33 %**
No		**18**	**66.67 %**
No Answer		**0**	**0 %**

9/ Article 20 of the Directive spells out Member States' obligation to "*provide the Commission with assistance and all available information*" on patient flows, financial dimensions of patient mobility, on prior authorisation and on the functioning of national contact points. With regards to the patient flows, do you keep track in your region of patients moving across borders for health treatment? *(You may select multiple answers).*

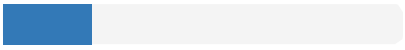
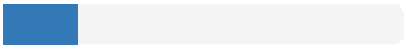
		Answers	Ratio
Yes, the region is monitoring the flow of patients moving outwards and inwards.		6	22.22 %
Yes, but our region is mostly monitoring the flow of patients from abroad seeking treatment in our region		0	0 %
Yes, but our region is mostly monitoring the flow of patients of our region seeking treatment in other regions/countries		5	18.52 %
No, the region has no overview yet, but it will establish such an overview in future		2	7.41 %
No, the region has no overview and is not intending to establish one		3	11.11 %
No, this is managed by the national authorities		6	22.22 %
I don't know		1	3.7 %
Other		8	29.63 %
No Answer		1	3.7 %

If patient flows are monitored, can you separate the data on flows to/from the neighbouring region(s) from those to/from other countries or further away regions?

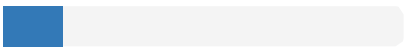
		Answers	Ratio
Yes		6	22.22 %
No		2	7.41 %
I don't know		2	7.41 %

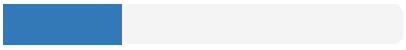
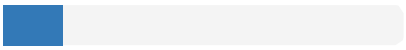
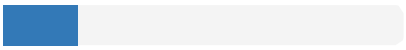
No Answer		**17**	**62.96 %**

10/ In your region, is there a specific administrative entity/department/person in charge of dealing with questions regarding cross-border healthcare? *(You may select multiple answers).*

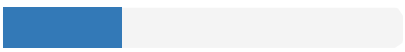
		Answers	Ratio
Yes, there is a dedicated team /department within our regional administration		**5**	**18.52 %**
Yes, there is a special entity, outside of our regional administration		**6**	**22.22 %**
Yes, this task is dealt with by a dedicated official		**5**	**18.52 %**
Yes, but this task is done by someone who also has other responsibilities		**9**	**33.33 %**
No, there is no specific person or entity dealing with it		**11**	**40.74 %**
I don't know		**0**	**0 %**
Other		**6**	**22.22 %**
No Answer		**0**	**0 %**

11/ In line with Articles 4 (2).a-b and 5.b, Member States must ensure that patients and healthcare providers receive relevant information on rights, entitlements, reimbursements, costs, standards and quality. Please indicate below what type of information your region provides for cross-border healthcare: *(You may select multiple answers)*.

		Answers	Ratio
The region provides, upon request, clarification on legal issues to the administration		10	37.04 %
The region provides, upon request, information to healthcare professionals and patients		12	44.44 %
The region is proactively giving out information to healthcare professionals across the region		5	18.52 %
The region is proactively informing citizens /patients residing in our region		6	22.22 %
The region is proactively providing information to potential patients abroad		3	11.11 %
The region has set up an information counter on cross-border healthcare accessible to citizens		4	14.81 %
The region has a dedicated webpage on cross-border healthcare		10	37.04 %
The region has set up a functional email address where interested citizens can send their questions on cross-border healthcare		4	14.81 %
There is a dedicated entity, set up with the support of the region, providing information		4	14.81 %

The region is participating in fora and information sessions at national and/or European level about cross-border healthcare		9	33.33 %
The region is involved in an Interreg funded cooperation programme/project to support cross- border healthcare		8	29.63 %
The region isinvolved incross-border healthcare projects funded through other funding instruments		4	14.81 %
I don't know		5	18.52 %
Other		9	33.33 %
No Answer		0	0 %

12/ In light of Article 4 (4), Member States must ensure that healthcare providers apply the same scale of fees to patients from other Member States as they do to domestic patients in a comparable medical situation. Any price, charged to both national and non-national patients must be calculated according to objective, non-discriminatory criteria. In your region, the scale of applicable fees...

		Answers	Ratio
Is publicly available for private and non-contractual providers		2	7.41 %
Is publicly available for public and contractual providers		9	33.33 %
Is available to healthcare professionals		0	0 %
Can be obtained upon request		4	14.81 %
There is no scale		1	3.7 %
I don't know		3	11.11 %
Other		8	29.63 %
No Answer		0	0 %

13/ The Member State of treatment must ensure, according to the Article 4(2)d., that "*systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory*". With regards to professional liability insurance, your national/regional healthcare system…

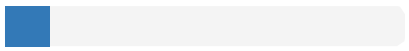
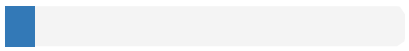
		Answers	Ratio
Requires healthcare providers (public and private) to have such an insurance policy		13	48.15 %
Requires public healthcare providers to have such an insurance policy and recommend to private healthcare providers to have such an insurance policy		3	11.11 %
Recommends to healthcare providers to have such an insurance policy		0	0 %
I don't know/ Not applicable		11	40.74 %
No Answer		0	0 %

14/ Your region's citizens traveling abroad for treatment are reimbursed or paid up to the level: *(You may select multiple answers).*

		Answers	Ratio
For healthcare received from private or non-contracted healthcare providers within the territory of their Member State of affiliation		4	14.81 %
For healthcare received from public or contracted healthcare providers within the territory of their Member State of affiliation		17	62.96 %
For healthcare received from any type of healthcare providers within the territory of their Member State of affiliation.		3	11.11 %
I don't know		3	11.11 %

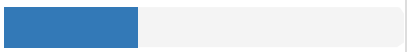
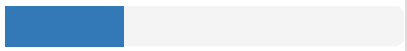
Other		**10**	**37.04 %**
No Answer		**1**	**3.7 %**

15/ In your region, patients from abroad seeking treatment are charged or pay up to the level that would have been billed to the regional/national insurance scheme of your country: ***(You may select multiple answers)***

		Answers	Ratio
For healthcare received from private or non-contracted healthcare providers within the territory of their Member State of affiliation		**3**	**11.11 %**
For healthcare received from public or contracted healthcare providers within the territory of their Member State of affiliation		**14**	**51.85 %**
For healthcare received from any type of healthcare providers within the territory of their Member State of affiliation		**2**	**7.41 %**
I don't know		**5**	**18.52 %**
Other		**9**	**33.33 %**
No Answer		**0**	**0 %**

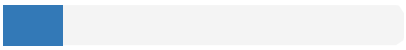
16/ The Directive [Article 8(2)] introduces the possibility for Member States to make reimbursement of costs for healthcare received in another Member State subject to prior authorisation. To date, seven Member States plus Norway decided not to have prior authorisation. In your territory, the prior authorisation: ***(You may select multiple answers)***

		Answers	Ratio
Is not applicable (for Czech Republic, Estonia, Finland, Latvia, Lithuania, The Dutch Provinces hub, Sweden and Norway)		**3**	**11.11 %**

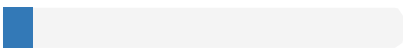
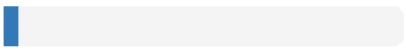
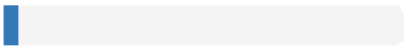
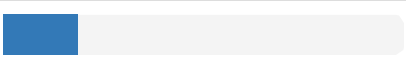
Is used for treatment involving overnight hospital accommodation of the patient in question for at least one night [art. 8 (2)a. i.]		11	40.74 %
Is used for treatment requiring use of highly specialised and cost-intensive medical infra- structure or medical equipment [art. 8 (2)a.ii.]		14	51.85 %
Is used for treatment presenting a particular risk for the patient or the population [art. 8 (2)b]		9	33.33 %
Is used for treatment provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare, which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union [art. 8 (2)c]		8	29.63 %
I don't know		3	11.11 %
Other		7	25.93 %
No Answer		3	11.11 %

17/ Do you consider the system of prior authorisation, such as introduced by your national government, in line with the article 8(2) to be: *(You may select multiple answers)*

		Answers	Ratio
Necessary to ensure sufficient and permanent access to a balanced range of high-quality treatment in my region		17	62.96 %
Necessary to control costs for my regional authority		12	44.44 %

Necessary to avoid, as far as possible, any waste of financial, technical and human resources in my region		13	48.15 %
Non-discriminatory, justified and proportionate		9	33.33 %
An obstacle to the free movement of patients		5	18.52 %
I don't know		4	14.81 %
Other		4	14.81 %
No Answer		0	0 %

18/ Article 8(7) of the Directive requires Member States to '*make publicly available which healthcare is subject to prior authorisation*'. In your region a list of these treatments: *(You may select multiple answers).*

		Answers	Ratio
Is publicly available, detailed and sufficiently defined		12	44.44 %
Is publicly available, somewhat detailed and defined		8	29.63 %
Is publicly available, without any details		2	7.41 %
Is not publicly available but can be obtained upon request		1	3.7 %
There is no list		1	3.7 %
I don't know		5	18.52 %
Other		8	29.63 %
No Answer		0	0 %

19/ Article 9(5) of the Directive offers a possibility to "operate a voluntary system of prior notification whereby, in return for such notification, the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate" (taking into account the patient's clinical case and specifying the medical procedures likely to apply). Is prior notification: : …applied in your region?

		Answers	Ratio
Yes		12	44.44 %
No		10	37.04 %
No Answer		5	18.52 %

19/ Article 9(5) of the Directive offers a possibility to "operate a voluntary system of prior notification whereby, in return for such notification, the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate" (taking into account the patient's clinical case and specifying the medical procedures likely to apply). Is prior notification: : …a useful tool to provide patients with clarity?

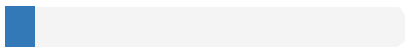
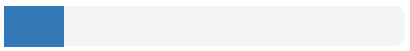
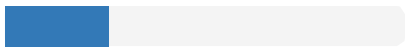
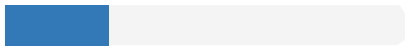
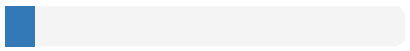
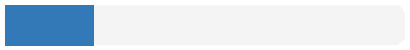
		Answers	Ratio
Yes		19	70.37 %
No		3	11.11 %
No Answer		5	18.52 %

19/ Article 9(5) of the Directive offers a possibility to "operate a voluntary system of prior notification whereby, in return for such notification, the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate" (taking into account the patient's clinical case and specifying the medical procedures likely to apply). Is prior notification: : …a useful tool to support the national or regional authorities to comply with their obligations?

		Answers	Ratio
Yes		17	62.96 %
No		5	18.52 %

No Answer		**5**	**18.52 %**

20/ Member States may choose to apply under article 9(5) of the Directive "*the mechanisms of financial compensation between the competent institutions as provided for by Regulation (EC) No 883/2004* [2]". Such mechanisms, replacing upfront payment and reimbursement to patients by direct billing between competent bodies: *(You may select multiple answers)*

		Answers	Ratio
Are applied in my region		**4**	**14.81 %**
Are applied in my region but induce administrative and/or financial burden		**2**	**7.41 %**
Are applied in my region but are managed at the national level		**4**	**14.81 %**
Are applied in my region but are managed by healthcare insurances/social security		**7**	**25.93 %**
Could facilitate the access to care for patients, especially low-income ones		**11**	**40.74 %**
Could facilitate the accounting and improve financial oversight and management		**7**	**25.93 %**
Could enable a closer cross-border healthcare cooperation		**11**	**40.74 %**
I don't know		**2**	**7.41 %**
Other		**6**	**22.22 %**
No Answer		**0**	**0 %**

21/ In line with Article 10(3), "*the Commission shall encourage Member States, particularly neighbouring countries, to conclude agreements among themselves*" in view of a cooperation in healthcare across the borders. Do these agreements exist in your region?

		Answers	Ratio
Yes		13	48.15 %
No		13	48.15 %
No Answer		1	3.7 %

a) Was your regional authority involved in these negotiations?

		Answers	Ratio
Yes		7	25.93 %
No		13	48.15 %
I don't know		5	18.52 %
No Answer		2	7.41 %

b) Are there new cooperation agreements currently being discussed?

		Answers	Ratio
Yes		3	11.11 %
No		12	44.44 %
I don't know		8	29.63 %
No Answer		4	14.81 %

c) If there is no agreement in place, would you consider it relevant for your regional authority to have one?

		Answers	Ratio

Yes		11	40.74 %
No		5	18.52 %
I don't know		3	11.11 %
No Answer		8	29.63 %

22/ Awareness and support: : a) At the political level nationally

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		4	14.81 %
Important/relevant		9	33.33 %
Highly important/relevant		12	44.44 %
Not applicable		0	0 %
No Answer		1	3.7 %

22/ Awareness and support: : b) At the political level within the region

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		7	25.93 %
Important/relevant		7	25.93 %
Highly important/relevant		11	40.74 %
Not applicable		0	0 %

No Answer		1	3.7 %

22/ Awareness and support: : c) At the public administration level

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		5	18.52 %
Important/relevant		7	25.93 %
Highly important/relevant		13	48.15 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

22/ Awareness and support: : d) Among healthcare professionals

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		8	29.63 %
Highly important/relevant		14	51.85 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

22/ Awareness and support: : e) Among citizens

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		4	14.81 %
Important/relevant		12	44.44 %
Highly important/relevant		10	37.04 %
Not applicable		0	0 %
No Answer		1	3.7 %

23/ Legal and administrative: : a) Information on conditions for accessing healthcare abroad

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		11	40.74 %
Highly important/relevant		14	51.85 %
Not applicable		0	0 %
No Answer		1	3.7 %

23/ Legal and administrative: : b) Communication between social security schemes across the border

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		9	33.33 %
Highly important/relevant		12	44.44 %
Not applicable		3	11.11 %
No Answer		1	3.7 %

23/ Legal and administrative: : c) Infrastructure (legal, physical, IT) to transfer information between systems

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		10	37.04 %
Highly important/relevant		13	48.15 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

23/ Legal and administrative: : d) Symmetric administrative structures on all sides of the border

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		3	11.11 %
Neutral		5	18.52 %
Important/relevant		11	40.74 %
Highly important/relevant		5	18.52 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

23/ Legal and administrative: : e) Regulatory framework suited to cross-border situation

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		9	33.33 %
Highly important/relevant		13	48.15 %
Not applicable		3	11.11 %
No Answer		1	3.7 %

23/ Legal and administrative: : f) Recognition of e-prescriptions

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		14	51.85 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

24/ Language and sociocultural: : a) Ability to communicate freely with neighbours

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		2	7.41 %
Important/relevant		9	33.33 %
Highly important/relevant		12	44.44 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

24/ Language and sociocultural: : b) Interest and awareness about neighbours' culture

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		2	7.41 %
Neutral		6	22.22 %
Important/relevant		9	33.33 %
Highly important/relevant		7	25.93 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

24/ Language and sociocultural: : c) Socio-medical traditions and preferences

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		6	22.22 %
Important/relevant		14	51.85 %
Highly important/relevant		4	14.81 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

24/ Language and sociocultural: : d) Trust

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		12	44.44 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

25/ Physical access to healthcare across the border: : a) Road infrastructure

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		4	14.81 %
Important/relevant		9	33.33 %
Highly important/relevant		10	37.04 %
Not applicable		3	11.11 %
No Answer		1	3.7 %

25/ Physical access to healthcare across the border: : b) Number and frequency of public transport connections

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		5	18.52 %
Important/relevant		10	37.04 %
Highly important/relevant		9	33.33 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

26/ Economic: : a) Level of tariffs for medical services

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		8	29.63 %
Highly important/relevant		15	55.56 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

26/ Economic: : b) Type or height of honoraria for medical professionals

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		2	7.41 %
Important/relevant		11	40.74 %
Highly important/relevant		10	37.04 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

26/ Economic: : c) Provisions for telemedicine reimbursement

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		4	14.81 %
Important/relevant		16	59.26 %
Highly important/relevant		5	18.52 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

26/ Economic: : d) Consumer purchasing power

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		8	29.63 %
Important/relevant		8	29.63 %
Highly important/relevant		8	29.63 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

26/ Economic: : e) Basket of healthcare goods and services available to patients in the cooperating regions

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		4	14.81 %
Important/relevant		10	37.04 %
Highly important/relevant		11	40.74 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

27/ Inherent to health systems: : a) Education and skills requirement for medical staff

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		9	33.33 %
Highly important/relevant		15	55.56 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

27/ Inherent to health systems: : b) Scope of medical services

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		13	48.15 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

27/ Inherent to health systems: : c) Medical protocols

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		11	40.74 %
Highly important/relevant		11	40.74 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

28/ Inspiration : a) Talking to colleagues from other regions in your Member State who run such projects

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		13	48.15 %
Highly important/relevant		9	33.33 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

28/ Inspiration : b) Talking to colleagues from other EU and/or non-EU regions involved in such cooperation

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		12	44.44 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

28/ Inspiration : c) Reading about such projects

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		3	11.11 %
Important/relevant		17	62.96 %
Highly important/relevant		4	14.81 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

28/ Inspiration : d) Attending conferences where such projects are discussed

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		19	70.37 %
Highly important/relevant		5	18.52 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

28/ Inspiration : e) Listening to citizens' requests

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		2	7.41 %
Important/relevant		10	37.04 %
Highly important/relevant		12	44.44 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : a) Guaranteeing access to emergency healthcare

		Answers	Ratio
Absolutely not important/relevant		1	3.7 %
Not important/relevant		1	3.7 %
Neutral		1	3.7 %
Important/relevant		7	25.93 %
Highly important/relevant		12	44.44 %
Not applicable		2	7.41 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : b) Guaranteeing access to specialist care lacking/insufficient in the region

		Answers	Ratio
Absolutely not important/relevant		1	3.7 %
Not important/relevant		2	7.41 %
Neutral		1	3.7 %
Important/relevant		4	14.81 %
Highly important/relevant		15	55.56 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : c) Improving cost-efficiency of care services

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		2	7.41 %
Neutral		4	14.81 %
Important/relevant		9	33.33 %
Highly important/relevant		8	29.63 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : d) Reducing waiting time for medical procedures

		Answers	Ratio
Absolutely not important/relevant		1	3.7 %
Not important/relevant		1	3.7 %
Neutral		2	7.41 %
Important/relevant		9	33.33 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : e) Complementing the region's health service provision

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		5	18.52 %
Important/relevant		8	29.63 %
Highly important/relevant		9	33.33 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : f) Reacting to citizens' wishes

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		4	14.81 %
Important/relevant		9	33.33 %
Highly important/relevant		10	37.04 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : g) Restoring previously existing links and collaboration schemes

		Answers	Ratio
Absolutely not important/relevant		1	3.7 %
Not important/relevant		2	7.41 %
Neutral		5	18.52 %
Important/relevant		9	33.33 %
Highly important/relevant		4	14.81 %
Not applicable		2	7.41 %
No Answer		4	14.81 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : h) Acting to improve regions' attractiveness for medical professionals and citizens

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		8	29.63 %
Important/relevant		6	22.22 %
Highly important/relevant		9	33.33 %
Not applicable		1	3.7 %
No Answer		3	11.11 %

29/ What was/is the main reason for setting up a cross-border healthcare cooperation? : i) Guaranteeing patients' access to adequate care in relation to rare diseases

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		7	25.93 %
Highly important/relevant		13	48.15 %
Not applicable		2	7.41 %
No Answer		3	11.11 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : a) Information on available EU funding to support cross-border cooperation

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		9	33.33 %
Highly important/ relevant		14	51.85 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : b) European Cross-Border Mechanism [3]

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		5	18.52 %
Important/relevant		7	25.93 %
Highly important/ relevant		11	40.74 %
Not applicable		3	11.11 %
No Answer		1	3.7 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : c) Regional cross-border information point

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		9	33.33 %
Highly important/ relevant		13	48.15 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : d) Contact person at the national contact point set up under the Directive

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		12	44.44 %
Highly important/ relevant		11	40.74 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : e) Compendium of successfully set- up projects across the EU

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		5	18.52 %
Important/relevant		19	70.37 %
Highly important/ relevant		2	7.41 %
Not applicable		1	3.7 %
No Answer		0	0 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : f) Comparative study of legal rules applicable to healthcare services alongside the EU borders

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		4	14.81 %
Important/relevant		13	48.15 %
Highly important/ relevant		6	22.22 %
Not applicable		1	3.7 %
No Answer		2	7.41 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : g) Detailed information on medical protocols

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		1	3.7 %
Neutral		3	11.11 %
Important/relevant		14	51.85 %
Highly important/ relevant		7	25.93 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

30/ What were/are/would be the useful tools to set up a cross-border healthcare cooperation? : h) Information on reimbursement mechanisms (directive, regulation, negotiated tariff)

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		11	40.74 %
Highly important/ relevant		12	44.44 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : a) Ongoing political support

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		10	37.04 %
Highly important/relevant		14	51.85 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : b) Long-term EU funding

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		5	18.52 %
Highly important/relevant		16	59.26 %
Not applicable		2	7.41 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : c) Motivated public administration employees

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		10	37.04 %
Highly important/relevant		12	44.44 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : d) Committed medical staff

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		10	37.04 %
Highly important/relevant		14	51.85 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : e) Quantifiable benefits to local population

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		1	3.7 %
Important/relevant		11	40.74 %
Highly important/relevant		13	48.15 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : f) Discernible cost-efficiency for regional budget

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		13	48.15 %
Highly important/relevant		9	33.33 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : g) Communication and awareness raising activities

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		2	7.41 %
Important/relevant		14	51.85 %
Highly important/relevant		9	33.33 %
Not applicable		1	3.7 %
No Answer		1	3.7 %

31/ What helps to keep the cross-border healthcare cooperation alive and sustainable? : h) Regular meetings between all partners

		Answers	Ratio
Absolutely not important/relevant		0	0 %
Not important/relevant		0	0 %
Neutral		3	11.11 %
Important/relevant		11	40.74 %
Highly important/relevant		9	33.33 %
Not applicable		2	7.41 %
No Answer		2	7.41 %

32/ Reflecting on your experience to date, do you think there is a need to:

(You may select multiple answers)

		Answers	Ratio
Review the Directive		10	37.04 %
Review the national implementing measures that transposed the Directive		10	37.04 %
Review the regional implementing measures		6	22.22 %
No changes are needed		11	40.74 %
Other		3	11.11 %
No Answer		1	3.7 %

33/ Would your organisation/institution consider setting up a cross-border healthcare cooperation in the near future?

		Answers	Ratio
Yes		**22**	**81.48 %**
No		**4**	**14.81 %**
No Answer		**1**	**3.7 %**

If yes, what would be the focus of the cooperation? *You may select multiple answers.*

		Answers	Ratio
Primary care		**14**	**51.85 %**
Specialised care		**13**	**48.15 %**
Emergency services		**12**	**44.44 %**
Shared infrastructure		**6**	**22.22 %**
Research and innovation		**16**	**59.26 %**
Training and education		**13**	**48.15 %**
Care for selected groups (based on age, gender, ethnicity or socio-economic status)		**9**	**33.33 %**
Other		**5**	**18.52 %**
No Answer		**6**	**22.22 %**

Annex 2: Regional Hubs Survey Sample

Welcome to the Reg Hub consultation on cross-border healthcare!

European regions have a long history of engaging with their neighbours, running projects together, developing infrastructure and services that benefit local population on both sides of the border. With this survey on cross-border healthcare, we seek to learn more about your region's experience in working on health matters with partners abroad.

What is this survey for?

With this survey we want to gauge your level of awareness and involvement in health cooperation with regions abroad and to find out what works, what doesn't and what can be done to make it better and easier for your regional authority to either consider a new one or to deepen an existing collaboration.

We will use the results in our political work, sharing them with the CoR Rapporteur who at the request of the European Commission will outline the new vision of the European cities and regions for cross-border healthcare cooperation. We will also share the findings with the European institutions and health stakeholders to reflect jointly on ways forward.

What is the European legal background?

Eight years ago, the Member States accepted the European Commission proposal for a Directive on the application of patients' rights in cross border healthcare. This Directive foresees that "*the Commission shall encourage Member States, particularly neighbouring countries, to conclude agreements among themselves (and) to cooperate in cross-border healthcare provision in border regions*".

Why is the Directive important?

The Directive - the first and only health directive to date - translated the rulings of the European Court of Justice into the law applicable everywhere in the Union. It made it legal for Europeans to access medical care - using both public and private care providers - in another Member State, not just when

they were on holidays and had an emergency, but because they preferred to. It also clarified when it is necessary to have a permission ("prior authorisation") before starting a procedure or treatment and when it was not required.

The Directive codifies European patients' rights to obtain repayment for planned non-hospital treatment provided abroad without prior authorisation at the rates applicable in the country of affiliation after paying the cost in advance.

For other treatments, both requiring overnight stay or being highly specialised and cost-intensive, prior medical authorisation remains mandatory in most EU Member States.

The Directive also required the Member States to create the so-called "National Contact Points" to provide citizens, public authorities and medical professionals with information on these procedures, reimbursement limits, waiting times and quality assurances.

Furthermore, the Directive provides for a recognition of prescriptions issued in another Member State and enables a closer cooperation in the field of rare diseases, health technology assessment and eHealth. These however are not subject of our survey.

What is the bigger picture?

The European Union has been investing in cross-border cooperation for 25 years via Interreg, funded under the European Territorial Cooperation goal of the ESIF. Interreg projects have achieved much to enhance cooperation and alleviate border obstacles.

Two years ago, a communication "Boosting Growth and Cohesion in EU Border regions" took stock of the situation and put forward actions to dismantle existing barriers and to improve accessibility of services, including in the cross-border healthcare sector. As part of this work, an impressive catalogue of 200 well-documented border obstacles affecting the daily life of cross-border citizens and businesses has been created.

Why are we launching this survey now?

The reason to seek your views now is the 10th anniversary of the Lisbon Treaty and its new provision giving the Union the possibility to "*encourage cooperation between the Member Stated to improve the complementarity of their health services in cross-border areas*"[11]. Likewise, it has now been six years since the Directive has been transposed. This gives enough time to look back and reflect whether the expectations have been met and the regions empowered enough to engage in cross-border healthcare cooperation.

The new legislative term starting late this autumn, as well as the new programming period 2021-2027, create also a window of opportunity to make suggestions how to improve or fine-tune the existing policy and funding framework.

My region in landlocked, it does not concern me?

[11] TFEU, article 168.2

If your region does not have border with neighbouring country, please do not think your views are not interesting. We recognise that you may not have this everyday movement of people crossing the border to see a doctor and going back; still you may have people coming to your place by ferry, plane, car or train to access your health services because of their excellent reputation. You may have digital health projects with other regions or specific collaboration agreements between your centre of medical excellence and universities abroad.

Practical information

The survey will be open until Monday 13 January 2020 midnight For more information, please contact RegHub@cor.europa.eu

Details of the Contact Point

* First name

* Last name

* Email

* Contact point of (name of your hub):

* Function/Position

Details of the Stakeholders

* Please mention here:
1/ the **name and contact information** of all of the stakeholders that you have consulted, and 2/ **the question(s)** on which they were consulted

How is this survey structured?

The questionnaire is divided into 5 parts. First, we ask some general questions about your region and your awareness about the Directive. In the second part, we focus on the Chapter 2 of the Directive and the responsibilities of Member States. The third part covers Chapter 3 of the Directive looking specifically at questions of reimbursement and prior notification. The fourth part relates to Chapter 4 of the Directive and focuses specifically on cross-border healthcare cooperation. In the last part, we ask for your feedback on concrete cooperation projects, your experiences and plans.

Preliminary and general questions:

Does your region have a border with a neighbouring country?

☐ Yes
☐ No

Does your region have responsibilities in terms of management of health systems and services?

Funding of healthcare

☐ Yes
☐ No

Legislative powers

☐ Yes
☐ No

Policy power

☐ Yes
☐ No

Planning responsibility

☐ Yes
☐ No

Delivery responsibility

☐ Yes
☐ No

Facilities ownership and management

☐ Yes
☐ No

A. Awareness

1) Are you/is your regional authority aware of the fact that patients can move freely across borders to obtain health treatment in other countries?
   ☐ Yes
   ☐ No

2) Are you/is your regional authority aware of the EU directive on cross-border healthcare?
   ☐ Yes
   ☐ No

3) Are you/is your regional authority aware of the existence of the National Contact Point created by the directive on cross-border healthcare?
   ☐ Yes
   ☐ No

4) Does your region have its own Regional Contact Point or links to the National one on regional administration webpages?
   ☐ Yes
   ☐ No

5) Are you/is your regional authority aware of the opportunities provided by ETC/Interreg programmes to support cross-border healthcare?
   ☐ Yes
   ☐ No

B. Involvement

6) In your region, do you keep track of patients moving across borders for health treatment?
   ☐ Yes, the region is monitoring the flow of patients moving outwards and inwards
   ☐ Yes, but our region is mostly monitoring the flow of patients from abroad seeking treatment in our region
   ☐ Yes, but our region is mostly monitoring the flow of patients of our region seeking treatment in other regions/countries

For the monitored flows, can you separate the data on flows to/from the neighbouring regions (s) from those to/from other countries or further away regions?

- ☐ Yes
- ☐ No
- ☐ No, the region has no overview yet, but it will establish such an overview in future

7) In your region, is there a specific administrative entity/department/person in charge of cross-border healthcare?

- ☐ Yes, there is a dedicated team/department in our region
- ☐ Yes, this task is dealt with by a dedicated official
- ☐ Yes, but this task is done by someone who also has other responsibilities
- ☐ No, there is no specific person or entity dealing with it

8) Please indicate below the involvement of your region in cross-border healthcare (multiple answers possible)

- ☐ The region provides upon request clarification on legal issues to the administration
- ☐ The region provides upon request information to health professionals and patients
- ☐ The region is proactively giving out information to health professionals across the region
- ☐ The region is proactively informing citizens/patients residing in our region
- ☐ The region is proactively providing information to potential patients abroad
- ☐ The region has set up an information counter on cross-border healthcare accessible to citizens
- ☐ The region has a dedicated webpage on cross-border healthcare
- ☐ The region has set up a functional email address where interested citizens can send their questions on cross-border healthcare
- ☐ The region is participating in fora and information sessions at national and/or European level about cross-border health care
- ☐ The region is involved in an Interreg funded cooperation programme/project to support cross-border healthcare
- ☐ Other, please specify:

C. Enablers for cross-border healthcare cooperation in your region

When looking at how well your region is working with cross-border healthcare, what do you consider are the driving factors to enable the involvement of your region?

Answers on a scale from 0 to 10
0: not important at all/not relevant at all for our region
10: absolutely important/most relevant for our region

9) **Awareness and support**

Choose an item At the political level nationally
Choose an item At the political level within the region
Choose an item At the public administration level

Choose an item Among healthcare professionals
Choose an item Among the citizens

10) **Legal and administrative factors**
Choose an item Detailed information on conditions for accessing health care abroad
Choose an item Communication between social security schemes across the border
Choose an item Infrastructure (legal, physical, IT) to transfer information between systems
Choose an item Symmetric administrative structures on all sides of the border
Choose an item Flexible regulatory framework suited to cross-border situation

11) **Language and sociocultural similarity**
Choose an item Ability to communicate freely with neighbours
Choose an item Interest and awareness about neighbours' culture
Choose an item Similar socio-medical traditions and preferences
Choose an item Trust

12) **Appropriate physical access to healthcare across the border**
Choose an item Sufficiently developed road infrastructure
Choose an item Sufficient number and frequency of public transport connections

13) **Economic factors**
Choose an item Comparable level of tariffs for medical services
Choose an item Similar type or height of honoraria for medical professionals
Choose an item Compatible provisions for telemedicine reimbursement
Choose an item Similar consumer purchasing power
Choose an item Comparable basket of healthcare goods and services available to patients in the country of origin

14) **Issues inherent to health systems**
Choose an item Similar education and skills requirement for medical staff
Choose an item Similar scope of medical services
Choose an item Similar medical protocols

D. Barriers to cross-border healthcare cooperation in your region

When looking at how your region is working with cross-border healthcare, what do you consider are still some barriers in relation to the involvement of your region?

Answers on a scale from 0 to 10
0: not important at all/not relevant at all for our region
10: absolutely important/most relevant for our region

15) **Lack of awareness or willingness:**
Choose an item At the political level nationally
Choose an item At the political level within the region
Choose an item At the public administration level

Choose an item Among healthcare professionals
Choose an item Among the citizens

16) **Legal and administrative hurdles**

Choose an item Absence of information on conditions for accessing health care abroad
Choose an item Lack of coordination between social security schemes across the border
Choose an item Difficulties in transferring information between systems
Choose an item Asymmetries between administrative structures on different sides of the border
Choose an item Inflexible regulatory framework unsuited to border region situation

17) **Language barrier and sociocultural differences**

Choose an item Inability to communicate freely with neighbours
Choose an item Lack of interest of awareness about neighbours' culture
Choose an item Different socio-medical traditions and preferences
Choose an item Lack of trust

18) **Difficult physical access to healthcare across the border**

Choose an item Lack of road infrastructure
Choose an item Lack of connections and the low frequency of public transport connections

19) **Economic disparities**

Choose an item Varying level of tariffs for medical services
Choose an item Disparities in types and heights of honoraria of medical professionals
Choose an item Different / missing provisions for telemedicine reimbursement
Choose an item Consumer purchasing power
Choose an item Basket of healthcare goods and services available to patients in the country of origin

20) **Differences inherent to health systems**

Choose an item Different education and skills requirement for medical staff
Choose an item Different scope of medical services
Choose an item Different medical protocols

E. Details of your regions' cross-border healthcare initiatives and involvement

When looking at your region's activities in cross-border healthcare and the cooperation with other regions, what have been or what are the success factors for implementing the activities?

Answers on a scale from 0 to 10
0: this was/is not important at all/not relevant at all for our region
10: this was/is absolutely important/most relevant for our region

21) **Where do you draw experience from?**

Choose an item talking to colleagues from other regions in our country who run such projects

Choose an item talking to colleagues from other EU regions involved in such cooperation
Choose an item reading about such projects
Choose an item attending conferences where such projects are discussed
Choose an item listening to citizens' requests
Other, please specify:

22) **What was/is the main reason for setting up a cross-border healthcare cooperation?**
Choose an item guarantying access to emergency healthcare
Choose an item guarantying access to specialist care lacking/insufficient in the region
Choose an item improving cost-efficiency of care services
Choose an item reducing waiting time for medical procedures
Choose an item complementing region's health service provision
Choose an item reacting to citizens' wishes
Choose an item restoring previously existing links and collaboration schemes
Choose an item acting to improve regions' attractiveness for medical professionals and citizens

23) **What were/are/would be the useful tools to set up a cross-border healthcare cooperation?**
Choose an item Information on available EU funding to support cross-border cooperation
Choose an item European Cross-Border Mechanism[12]
Choose an item Regional cross-border information point
Choose an item Contact person at the National Contact Point set up under the Directive
Choose an item Compendium of successfully set-up projects across the EU
Choose an item Comparative study of legal rules applicable to healthcare services alongside the EU borders
Choose an item Detailed information on medical protocols
Choose an item Information on reimbursement mechanisms (directive, regulation, negotiated tariff)
Other, please specify

24) **What helps to keep the cross-border healthcare cooperation alive and sustainable?**
Choose an item Ongoing political support
Choose an item Long-term EU funding
Choose an item Long-term regional funding
Choose an item Motivated public administration employees
Choose an item Committed medical staff
Choose an item Quantifiable benefits to local population
Choose an item Discernible cost-efficiency for regional budget
Choose an item Communication and awareness raising activities
Choose an item Regular meetings between all partners
Other, please specify:

[12] European Cross Border Mechanism is a voluntary mechanism to resolve legal obstacles in border regions, focusing on neighbouring EU land borders at NUTS 3 level and covering joint projects for any item of infrastructure or service of general economic interest operating in a cross-border region. The mechanism would enable the application, in a given Member State and in relation to a common cross-border region, of the laws of a neighbouring Member State if the laws of the former are a legal obstacle to the delivery of a joint project. Proposed by the European Commission in May 2018, this draft regulation is currently under discussion between the European Parliament and the Member States

F. Would your region consider setting up a cross-border healthcare cooperation in near future?

☐ Yes

What would be the focus of the cooperation?

- ☐ Primary care
- ☐ Specialised care (please specify the area):
- ☐ Emergency services
- ☐ Shared infrastructure
- ☐ Research and innovation
- ☐ Training and education
- ☐ Care for targeted groups (e.g. age, gender, ethnicity, special need related) (please specify):
- ☐ Other, please specify :

☐ No

Tell us why

G. What would your region expect from the European Committee of the Regions (CoR) to assist regions interested or active in cross-border healthcare cooperation?

H. What could the European Union do to support further cross-border healthcare cooperation between regions?

Annex 3: List of regional hubs and consulted stakeholders

1. Alentejo (Portugal)

- The health center cluster of Alentejo Central.
- The health unit of Norte Alentejo.
- The health unit of Baixo Alentejo.
- Members of the regional health administration of Alentejo.

2. Autonomous Province of Bolzano/Bozen – South Tyrol (Italy)

- Health division of the provincial administration. Office for healthcare: Ursula Vigl (administrative Inspector).
- South Tyrol health authority. Services and community care: Martin Matscher (director).
- EGTC Euregio Tyrol-Alto Adige-Trentino: Christof von Ach (director).
- Office of the ombudsman (mediator between public administration and the public); Provincial Council of Bolzano/Bozen) Tiziana De Villa (expert in administrative sector, responsible for health matters).
- Federation of social and healthcare associations (umbrella organisation for non-profit social and healthcare organisations). Paola Zimmermann (staff member).
- South Tyrol rheumatism association. Andreas Varesco (legal representative).
- Association of parents of people with disability, Angelika Stampfl (president).

3. Autonomous region of Friuli Venezia Giulia (Italy)

- Autonomous Region of Friuli-Venezia Giulia, Central Directorate for Health, Social Policies and Disabilities, Gianna Zamaro.
- European Grouping of Territorial Cooperation, EGTC Gorizia, Nova Gorica, Sempeter Vrtojba, Sandra Sodini.

4. Brandenburg (Germany)

- Walter Kuhn, (head of labour market), German Trade Union Confederation.
- Maria Czarkowska-Borek (management of Interreg projects); Märkisch-Oderland rescue service; Rolf Nowak (coordinator); Bad Saarow tumour centre.
- Gabriele Meißner (project management), Berufsbildungsverein e.V. (vocational training association), Eberswalde.
- Carsten Jacob (managing director), Euroregion Spree-Neiße-Bober, Guben.

5. Brittany (France)

- URPS Liberal Dental Surgeons.
- ID5Santé (Biotech Santé Bretagne) - Competition hub in the health sector, active at European level.
- Regional Council of Bretagne, services to society department.

6. Brod-Posavina County (Croatia)

- Klara Ščuka, head of the administrative department for health and social care of Brod-Posavina County.

7. Calabria (Italy)

- Didn't reply to the survey.

8. Catalonia (Spain)

- Government of Catalonia Department of Health (Departament de Salut de la Generalitat de Catalunya), Cross-border Hospital of Cerdanya.
- The whole of the questionnaire was sent to the Department of Health. Part IV of the questionnaire was sent to the Hospital of Cerdanya.

9. Community of Madrid (Spain)

- Community of Madrid Department of Health (Servicio Madrileño de Salud. Dirección General del Proceso Integrado de Salud)
- Spanish Private Healthcare Alliance (ASPE)
- Contact must be made with these parties through Madrid's Directorate General for Cooperation with the State and the European Union

10. Community of Valencia (Spain)

- María Gracia-Baquero Urbiola, Head of the Department for Patient Care and Communication with Patients.
- Burgos Muñoz, General Director of Healthcare Research and Inspections.
- María José Zaragozá, Head of the Budget Management Department
- Juan Carlos Albiach, Head of the Inspectorate.

11. Crete (Greece)

- Didn't reply to the survey.

12. Dubrovnik-Neretva County (Croatia)

- Dubrovnik-Neretva County, Nikoleta Borković Ljubić.
- Dubrovnik General Hospital, Marijo Bekić.
- Dubrovnik Medical Centre, Branko Bazdan
- Metković Medical Centre, Mihovil Štimac.
- Dubrovnik-Neretva County Institute of Emergency Medicine, Luka Lulić.
- Dunea Regional Development Agency, Melanija Milić.

13. Eastern Slovenia Cohesion Region (Slovenia)

- Didn't reply to the survey.

14. Flanders (Belgium)

- Data on stakeholders not available.

15. Harghita / Ialomita (Romania)

Harghita:

- Hargita County Emergency Hospital, Csíkszereda/Miercurea Ciuc.
- Psychiatric Hospital of Tölgyes/Tulghies.
- County Directorate for Public Health, Csíkszereda/Miercurea Ciuc.
- County Health Insurance Fund, Csíkszereda/Miercurea Ciuc.
- Hargita County Medical Chamber, Csíkszereda/Miercurea Ciuc.
- Order of Nursing, Csíkszereda/Miercurea Ciuc.
- Hargita County Ambulance Service, Csíkszereda/Miercurea Ciuc.
- City Hospital of Székelyudvarhely/Odorheiu Secuiesc.
- City Hospital of Gyergyószentmiklós/Gheorgheni.
- City Hospital of Maroshévíz/Toplita.

Ialomita

- Didn't reply to the survey.

16. Hauts-de-France (France)

- Laurent Peyrodie, HEI (Advanced Engineering Institute) - YNCREA Hauts-de-France / Research lecturer INTERREG / 2 SEAS MOTION project.
- Guillaume Alsac, Soignons Humain, President INTERREG / 2 SEAS SEAS2Grow or AGE'IN projects.
- Isabelle Lengagne, Centre Socioculturel Audrey Bartier (CSC) / Director INTERREG / 2 SEAS AGE'IN.
- Pierre Vasseur, La Vie Active (LVA) / EU Projects Coordinator, Development Unit INTERREG / 2 SEAS SEAS2Grow.
- Nicola Villenet, Franco-Belgian Health Observatory (OFBS) / President.
- Jennifer Rodriguez Nunez, l'Assurance Maladie, Head of International Relations for the Hauts de France (migrants, pensioners, cross-border workers, students studying abroad, bilateral agreements, care abroad (together with the CNSE (National Centre for Care Abroad), planned medical treatment (together with the ELSM (local medical service)), handling of level 2 claims - Médialog / Eptica, operation of CNSE disputes, statistical reports for CLEISS (Centre of European and International Liaisons for Social Security).
- David Pasquier, INTERREG / 2 seas CoBra Centre Oscar Lambret, Lille / MCU-PH, Oncologist and radiotherapist.
- Cecile Bogucki, Hauts de France Regional Council / Head of Healthcare Sector.

17. Helsinki-Uusimaa (Finland)

- Heikki Kallasvaara, Senior Advisor, Helsinki-Uusimaa regional Council.
- The Contact Point for Cross-Border Health Care at the Social Insurance Institution of Finland (KELA) (Section 3).
- The Association of Finnish Municipalities.

18. Košice Self-governing Region (Slovak Republic)

- Department of Health of the Košice Self-governing Region.
- Regional Development Department.

19. Dutch Provinces (The Netherlands)

- Central Brabant: Sander Linssen.
- Province of Limburg: Eric Lemmens.

20. Marche (Italy)

- Didn't reply to the survey.

21. Mazovia (Poland)

- Mazovia Specialist Hospital, Dr. Józef Psarski in Ostrołęka.
- Specialist Provincial Hospital in Ciechanów.
- Mazovia Centrum Rehabilitacji "STOCER" Sp. z o.o.
- Children's Hospital Prof. Dr. Med. Jan Bogdanowicz, Independent Public Care Institution health.
- National Health Fund.

22. Molise (Italy)

- Didn't reply to the survey.

23. North Rhine-Westphalia (Germany)

- North Rhine-Westphalia's health ministry.
- EU representatives for municipalities.
- North Rhine and Westphalia-Lippe Medical Association.
- North Rhine and Westphalia-Lippe Pharmacists' Association.
- AOK health insurance fund for Rhineland and the North-West.
- TK health insurance fund, North Rhine-Westphalia office.
- BARMER health insurance fund.
- KNAPPSCHAFT health insurance fund.
- University hospitals (Cologne, Düsseldorf, Bonn, Aachen, Essen, Münster).
- Patients' associations.

24. Northern and Western Regional Assembly (Ireland)

- The questionnaire was put forward to a number of Healthcare officials working in cross border health care.

25. Piedmont (Italy)

- Didn't reply to the survey.

26. Primorje-Gorski Kotar County (Croatia)

- Administrative department for Health.

27. Region of Emilia Romagna (Italy)

- Large Area of Emilia Nord.
- Large Area of Emilia Centro.
- Large Area of Romagna.

28. Šibenik-Knin County (Croatia)

- Didn't reply to the survey.

29. EGTC TRITIA (Slovak Republic, Czech Republic, Poland)

- Marshal's Office of the Śląskie Voivodeship, Department of Health.

30. Thessaly (Greece)

- Chrysoula Kolimitra, head of the department of public health and social care of the regional units of Magnisia and the Sporades in the region of Thessaly.
- Sotirios Nikolakakos, head of the department of health and social care of Trikala.
- Fotini Peroni, head of the department of health and social care of Larissa.
- George Zigras, department of public health of the region of Thessaly.
- Dimitrios Platogiannis, head of medical services - acting head of Trikala hospital.
- Fotios Seretis, head of 5th regional health authority.
- Administrative office of the general hospital of Volos "Achilopoulio".
- Anastasios Grigoropoulos, head of Evangelismos general hospital.
- Andriana Ponirakou, deputy head coordinator for Agia Sofia medical centre - 2nd regional health authority of Pireaus.
- Skopelos medical centre.
- Farkadona medical centre, Farkadona, Trikala.
- Maria Petriniti Theodorou, head of general medical practice - coordinator of scientific operations.
- Gonnos medical centre.
- Ioannis Mantzios, general practitioner / coordinator of scientific operations for the medical centre of Kalambaka.
- Evangelos Grantzis, head of scientific operations for the medical centre of Larissa.
- Limnos medical centre.
- Mouzaki health centre, Karditsa.
- Vasilios Delezos, deputy director of the Sofades medical centre.
- Panagiotis Mousafiris, deputy director.
- Georgios Bakoulas, research director of Volos health centre.
- Athanasios Giannoukas, head of the department of medicine, school of health sciences, university of Thessaly.
- Anthousa Karamvasi, head of general medicine, coordinator of Plomari health centre, Lesvos.
- Dimitrios Anastasiou, head of the pharmaceutical association of Trikala.
- Fotini Vrina, deputy head of the general hospital of Nikea "Agios Panteleimon", west Attica's prefecture general hospital Agia “Varvara".
- Athanasios Koutsoukis, head of the pharmaceutical association of Larissa
- Mixali Dandoulakis, hospital director general practitioner, coordinator of the medical centre of Vari.
- Dr. G. Feretzakis, head of the department for quality control, research and continuous education (Sismanogleio general hospital).
- Kostantinos Matsiolis, head of the pharmaceutical association of Magnesia.

- Vasiliki Koukou, directorate for international insurance relations, department of cross-border care, national contact point, national organisation for the provision of health services (eoypp).

31. Tolna (Hungary)

- Didn't reply to the survey.

32. Umbria and Veneto (Italy)

Umbria

- Paola Casucci and Ombretta Checconi, Office for "Health mobility, Management of the health and social care information system. Regional Epidemiological Observatory".
- Francesca Breccolotti, Office for "Community programming".
- Alessandro Montedori, "Hospital care. Research and innovation".
- Simona Guzzo, Office for "Economic and financial planning, investment and management oversight of health authorities".

Veneto

- Veneto Region, Committee for Health and Social - Health Relations unit, Antonio Maritati.
- Francesco Bortolan, Healthcare and Social - Health Analysis Unit - Azienda Zero (entity aimed at streamlining, integrating and increasing the efficiency of the health, social-health, and technical-administrative services of the region's health service).
- Antonio Maritati, Progetto Mattone Internazionale Salute (PROMIS, international health project).

33. Austrian Länder (Vorarlberg chairing the joint country expert conference "Subsidiarity monitoring") (Austria)

- Didn't reply to the survey.

34. The International Lake Constance Conference (chaired by Vorarlberg, in collaboration with Baden-Württemberg and Bayern) (Austria, Germany, Switzerland, Liechtenstein)

Baden-Württemberg:

- AOK Baden-Württemberg health insurance fund.
- BKK Linde company health insurance fund.
- Ministry for Social Affairs and Integration.
- TRISAN Trinational Competency Centre for Health Projects.
- Heidelberg University Hospital.
- Tübingen University Hospital.
- Ulm University Hospital.

Liechtenstein:

- Office of Public Health.

Switzerland:

- All IBK cantons; the canton of Zurich's Department of Health.

Vorarlberg:

- Office of the State Government (AdL), Department of Health and Sport.

- Austrian Health Insurance Fund (ÖGK), Vorarlberg.
- Vorarlberg patient advocate.
- Vorarlberger Krankenhaus-Betriebsgesellschaft mbH (the company operating Vorarlberg's hospitals).

35. West Pomerania (Poland)

- All the questions were proposed to consult for the National Health Fund Regional Board in Szczecin and the Health Department of the West Pomeranian Marshall Office. However the NHF did not response for any question, the HD explained its position in all subjects.

36. Zasavje Development Region (Slovenia)

- Didn't reply to the survey.

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European Committee of the Regions

Created in 1994 following the signing of the Maastricht Treaty, the European Committee of the Regions is the EU's assembly of 329 regional and local representatives from all 27 Member States, representing over 447 million Europeans. Its mission is to involve regional and local authorities and the communities they represent in the EU's decision-making process and to inform them about EU policies. The European Commission, the European Parliament and the Council are obliged to consult the Committee in policy areas affecting regions and cities. It can appeal to the Court of Justice of the European Union if its rights are infringed or it believes that EU law infringes the subsidiarity principle or fails to respect regional or local powers.

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