



**European Committee
of the Regions**

**Commission for
Natural Resources**

NAT

Implementation of the Cross-border Healthcare Directive in the European regions



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Summary

Eight years after the adoption of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, and six years after its transposition, cross-border healthcare mobility and cooperation is still a highly relevant policy issue for the European Union. Cross-border mobility of patients seeking care abroad remains scarce and this may be a consequence of a limited capacity of relevant authorities/entities and patients to engage in cross-border cooperation and healthcare, respectively.

In November 2019, the European Committee of the Regions launched a consultation through its Network of Regional Hubs to investigate the implementation of the Directive at the territorial level. The consultation was also an opportunity to enquire about expectations for future developments of cross-border healthcare as well as to collect experiences and suggestions for overcoming existing challenges to cooperation between border regions. Twenty-seven regional hubs participated in the survey, indicating a generally good awareness on cross-border healthcare, its funding mechanisms and respective National Contact Points. However, overall, the consultation provides evidence of a limited capacity to monitor patient flows at the regional level. Provision of information is rarely given proactively to patients and healthcare professionals and most of the times it is dealt with by a person who also has other responsibilities. Many regional hubs report that information on applicable fees for cross-border healthcare is not easily available. Systems of reimbursement vary widely and even if there is an overall positive perception about the system of prior authorisation it is actually only applied in half of the hubs. The number of hubs using the system of prior notification and mechanisms of financial compensation is even lower.

Almost half of the regional hubs report on the existence of cooperation agreements on cross-border healthcare with neighbouring countries, although regional authorities were usually not engaged in negotiating these agreements. Several hubs would consider having cooperation agreements in place and highlight which factors could facilitate, inspire, set up and sustain cross-border healthcare cooperation. Amongst the most influencing factors mentioned are education, skills and awareness of medical staff, the level of tariffs of medical services, and information on conditions to access care abroad. If inspiration comes primarily from listening to citizens' requests, the set-up of cross-border cooperation mainly aims at guaranteeing citizens' access to specialist care and care for rare diseases. Overall, EU funding is considered essential not only to pursue cross-border cooperation but also to keep it sustainable.

There is no consensus among regional hubs on the need to review the Directive and its implementing measures at the national and/or regional level. Therefore the suggestions given on how to improve the Directive are rather fragmented. In terms of regional hubs' expectations from European institutions, the European Committee of the Regions is expected to proactively communicate on the implementation of the Directive, give political impetus to cross-border initiatives, strengthen coordination, support continuous exchange and facilitate political dialogue between its members. At the EU level, expectations mainly relate to funding opportunities, to the improvement of information, communication and awareness activities, to the removal of legal and administrative barriers, including by strengthening European standards, and to the support of research, development and innovation.

Drawing on recent literature and on the most often quoted problems as well as the most promising solutions indicated by regional hubs, a set of recommendations on the future development of cross-border healthcare with respect to the functioning of the Directive is outlined in Part 2. Recommendations focus on five areas. The first area relates to the **existence of an excessive burden on patients**. Suggestions for improvement relate to increasing and disseminating the application of mechanisms of prior notification, simplifying and harmonising billing processes, and implementing specific measures for fragile categories of patients. The second area relates to a **general condition of low awareness and knowledge about the Directive**. Suggestions for improvement include revisiting the visibility and role of National Contact Points; promoting the establishment of regional cross-border information points; creating interregional federations of patients; calling for EU projects on communication and awareness-raising; and improving the provision of information to healthcare professionals. The third area concerns the existence of **limited cooperation activities on cross-border healthcare**. Suggestions for improvement call for proactively making information on EU funding and tools available to regional authorities; continuing to financially (and politically) support cross-border healthcare through EU projects/programmes; developing common European models for cooperation agreements; facilitating the development of cross-border structures/coordinated systems across the borders; setting up and/or arranging information exchange at all levels; and supporting the structural exchange of lessons learnt and best practices. The fourth area refers to the existence of **legal and administrative barriers between border regions**. Suggestions for improvement relate to carrying out a comparative study of legal rules applicable to healthcare services alongside EU borders, to advocating for the adoption of the European Cross-Border Mechanism, and to strengthening European standards. The last area relates to **improving data** to better understand the nature and scale of cross-border healthcare, for example by setting minimum data requirements at the EU level.

Introduction

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (hereafter referred to as "the Directive") codifies the conditions under which a patient may travel to another EU Member State for medical treatment. The Directive was designed to bring more clarity and coherence on the rights of citizens seeking care abroad, to clarify the conditions for patients to be reimbursed for healthcare received in other Member States, to give access to reliable information about 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 (EC-DG SANCO (2015); Footman *et al.*, 2014; Greer *et al.*, 2014).

Still, a limited number of patients are seeking care abroad (ECA, 2019; Callens *et al.*, 2018)). Several experts doubt if it is the role of the EU to actively promote the option of cross-border care (Palm *et al.*, 2011). They state that, instead, the EU task is to ensure that when care is sought abroad, patients are empowered to make an informed choice to receive safe, high-quality and efficient healthcare abroad, while enjoying the same rights and entitlements as they would domestically. In this case, it might not be relevant to assess the success of the Directive by analysing the numbers of patients seeking cross-border care. However, it remains highly relevant to measure whether public authorities and patients feel empowered to engage in cross-border cooperation and healthcare.

This report is commissioned by the European Committee of the Regions and is based on the results of the consultation on 'Cross-border healthcare' prepared and implemented by the Committee through its RegHub platform. The consultation took the form of an online questionnaire with 35 main questions several of which were articulated into sub-questions. The consultation was open from 8 November 2019 until 13 January 2020. Out of the 36 members of the Network of Regional Hubs, 27 hubs participated in the consultation. Each hub was free to consult relevant organisations/stakeholders within its region/s. Therefore, replies from regional hubs often reflect different and at times contradictory views since in several questions respondents could select multiple answers.

Part 1 of this report is based on the answers to the questionnaire. It is structured into five sections which reflect the sections of the questionnaire. Part 2 elaborates further on results and, also drawing on recent literature, outlines suggestions for the future development of cross-border healthcare with respect to the functioning of the Directive.

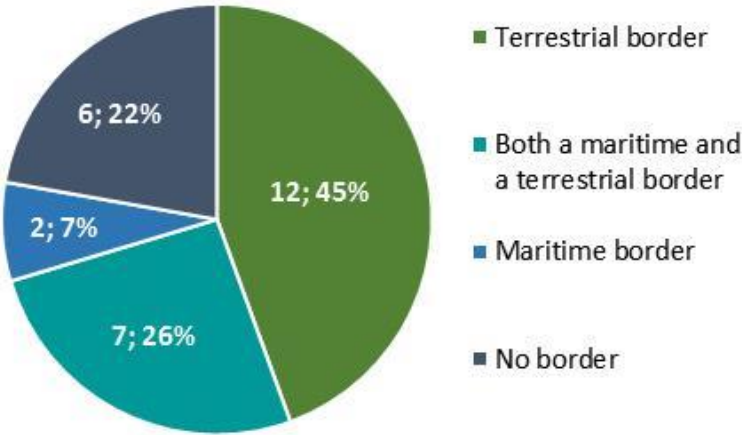
Part 1 Analysis of data submitted by the regional hubs

1.1 Description and awareness of respondents (Q1 to Q5)

Twenty-seven regional hubs participated in the consultation, out of which 21 border a neighbouring country. The participating regional hubs hold different responsibilities in terms of management of health systems and services and have different levels of awareness with respect to the Directive and the funding instruments aimed at supporting cross-border healthcare.

Out of the 36 members of the Network of Regional Hubs, 27 replies were received and validated by the European Committee of the Regions. The list of respondents is enclosed in Annex I. All but six of the participating hubs border a neighbouring country, over land and/or water (Figure 1).

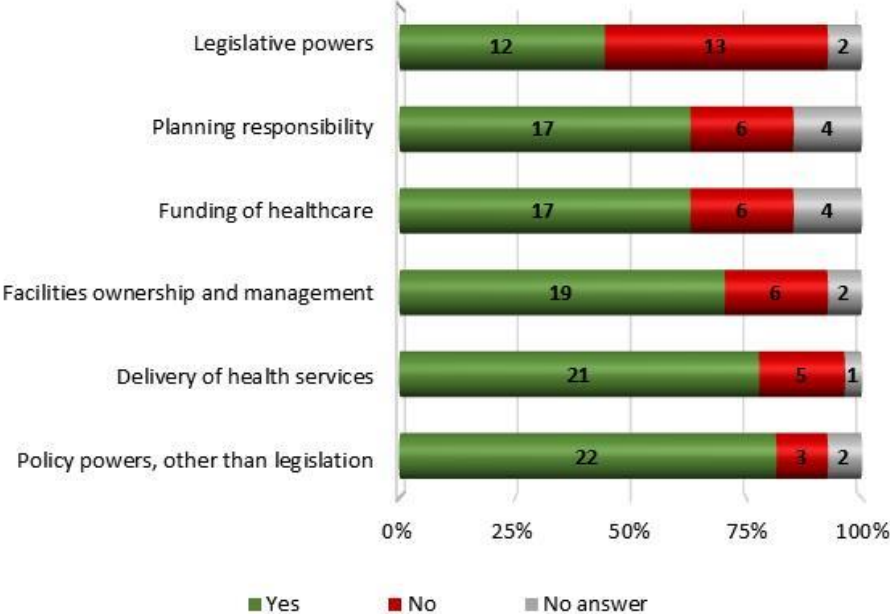
Figure 1. Does your region have a border with a neighbouring country (Q1)?
(multiple answers allowed)



Most of the participating hubs consulted with relevant stakeholders within their respective regions, including care providers (e.g. hospitals), regional and local administrations, regional health councils, patient associations, associations of healthcare professionals, management teams of EU-funded projects (e.g. Interreg projects), labour market and trade coordinators, and health and insurance funds. The highest involvement was accomplished by the region of Thessaly which consulted 28 distinct stakeholders on all the questions of the consultation. Overall, it is estimated that more than 150 stakeholders were involved to different degrees in the consultation.

In terms of the management of health systems and services, the majority (81%) of the participating regional hubs indicate having responsibilities in terms of policy powers – where in this context the term refers to health strategy, action plan, health promotion campaigns, etc. – and delivery of health services (78%). Facilities ownership and management (70%), planning responsibility and funding of healthcare are also relatively common (63% each). Less than half of the hubs (44%) report having legislative powers (Figure 2).

Figure 2. Does your region have responsibilities in terms of management of health systems and services (Q2)?



All 27 regional hubs are aware of the fact that patients can move freely across borders to obtain health treatment in other countries. Still, only 23 hubs report having been aware of the Directive on cross-border healthcare before participating in the consultation. The same number of hubs (23) is aware of the existence of funding instruments aimed at supporting cross-border healthcare. In particular, 17 are aware of the existence of Interreg, while six hubs indicate knowing of other funding instruments, among which are European structural and investment funds (ERDF, EAFRD and ESF), Horizon projects, the EU Health Programme, B-solutions pilot projects and National Strategic Reference Frameworks. Three of the four hubs that are not aware of ad-hoc funding instruments for cross-border healthcare have borders with a neighbouring country.

1.2 Responsibilities on cross-border healthcare (Q6 to Q13)

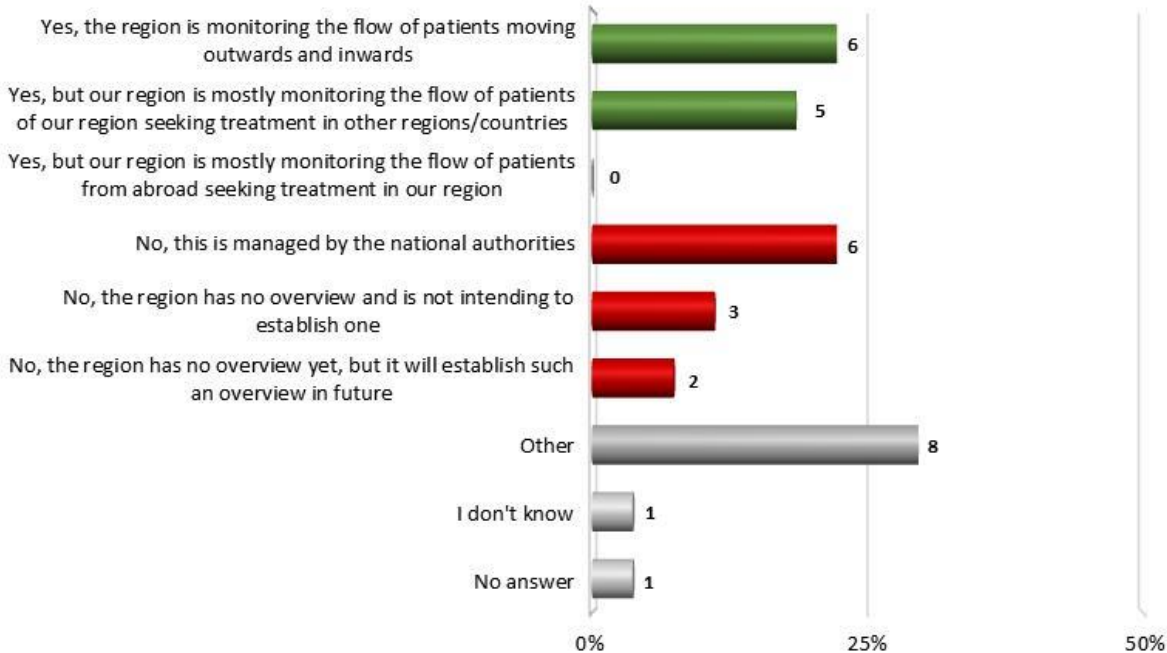
National and Regional Contact Points. Among participating hubs, there is a good awareness of their respective National Contact Points but these are not systematically given visibility on regional administrations' webpages.

Article 6(1) of the Directive requires the designation of at least one National Contact Point (NCP) for cross-border healthcare per Member State. It also requires that the existence and contact details of NCPs be made publicly available. The majority (93%) of participating regional hubs are aware of their respective NCPs. Seven of them even have a Regional Contact Point for cross-border healthcare. However, only nine hubs have links to the National Contact Point on their regional administration webpages.

Information gathering on patient flows. A limited number of regional hubs monitor patient flows across their borders.

Article 20 of the Directive sets obligations for Member States to gather information on patient mobility, including on patient flows. Only ten of the participating hubs undertake patient flows monitoring (Figure 3). Out of these, six indicate monitoring outward and inward patient flows while four focus on the flow of their regional patients seeking treatment in other regions/countries.

Figure 3. Do you keep track in your region of patients moving across borders for health treatment (Q9)? (multiple answers allowed)



Regional hubs monitoring outward and inward patient flows are Veneto, Bolzano, Emilia Romagna, Friuli Venezia Giulia, North Rhine-Westphalia and the IBK regional hub. All these hubs can separate the data on flows to/from the neighbouring region(s) from those to/from other countries or further away regions, except for North Rhine-Westphalia. There are ten hubs that do not perform monitoring. Among them, six specify that such monitoring is done at the national level and two (Valencia and Alentejo) indicate that they plan to establish such an overview of patient flows in the future. Notably, Valencia 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.

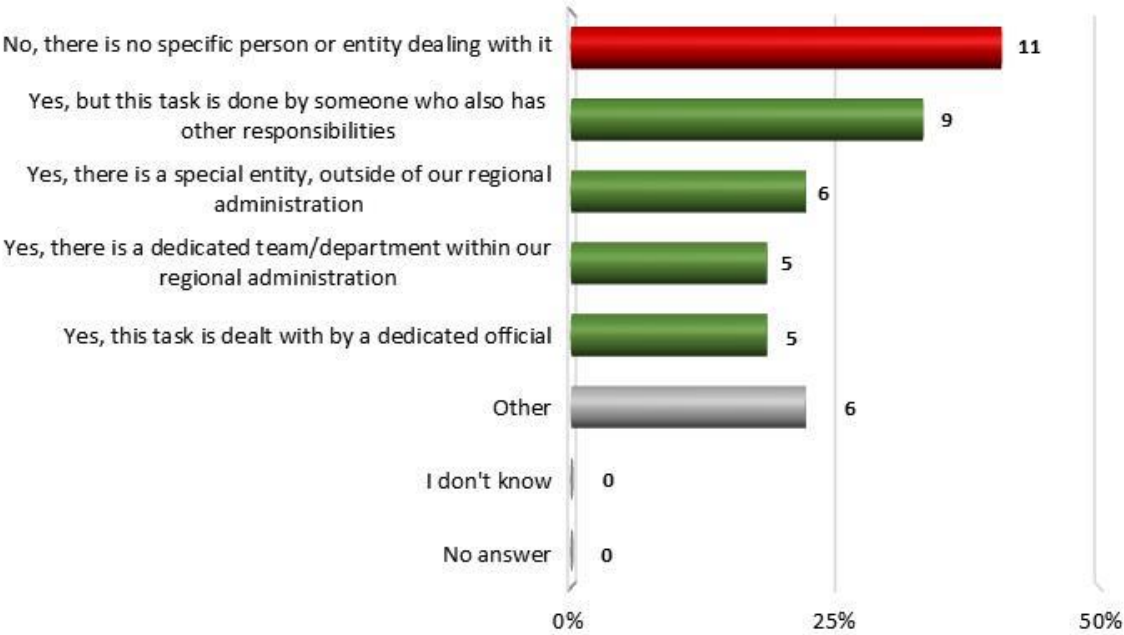
The ‘Other’ option is the most selected and points to different monitoring entities and arrangements. For example, Madrid receives this information from the National Social Security Institute while in the Netherlands the flow of patients is monitored by health insurers.

Provision of information to patients and healthcare providers. The most frequent situations reported by regional hubs are that there is no specific person or entity in charge of replying to queries and that information to patients and healthcare providers is provided upon request.

On modalities for dealing with questions regarding cross-border healthcare (Figure 4), the most selected (41%) option by regional hubs indicates that there is

no specific person or entity dealing with questions (11 selections). When the task is performed in the region, the most frequent situation (33%) is that it is attended to by someone who also holds other responsibilities (9 selections).

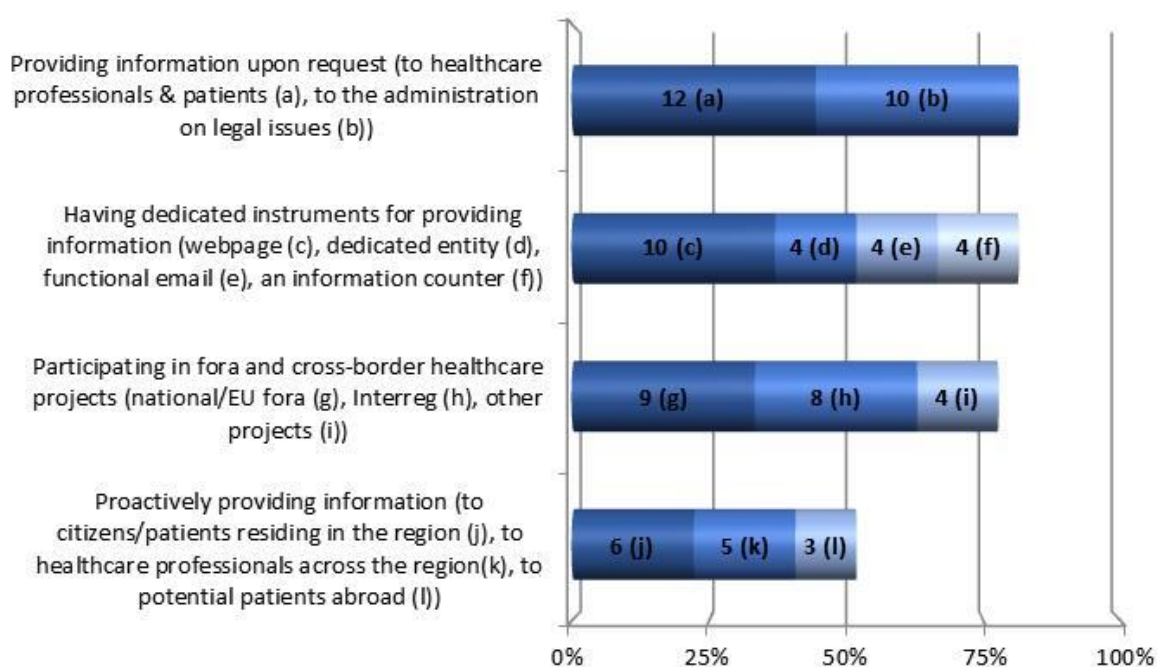
Figure 4. In your region, is there a specific administrative entity/department/person in charge of dealing with questions regarding cross-border healthcare? (Q10) (multiple answers allowed)



Six regional hubs illustrate a different set-up (the ‘Other’ option). For example, the Netherlands have indicated that in the province of Limburg there is a special foundation which deals exclusively with cross-border healthcare in the Maas-Rhine Euregio.

In line with Articles 4 (2).a-b and 5.b of the Directive, Member States must ensure that patients and healthcare providers receive relevant information on aspects of cross-border healthcare such as rights, reimbursements and costs. Regional hubs provide different types of information, in various ways and often combining different approaches within the same region (Figure 5).

Figure 5. Please indicate what type of information your region provides for cross-border healthcare (Q11) (multiple answers allowed)



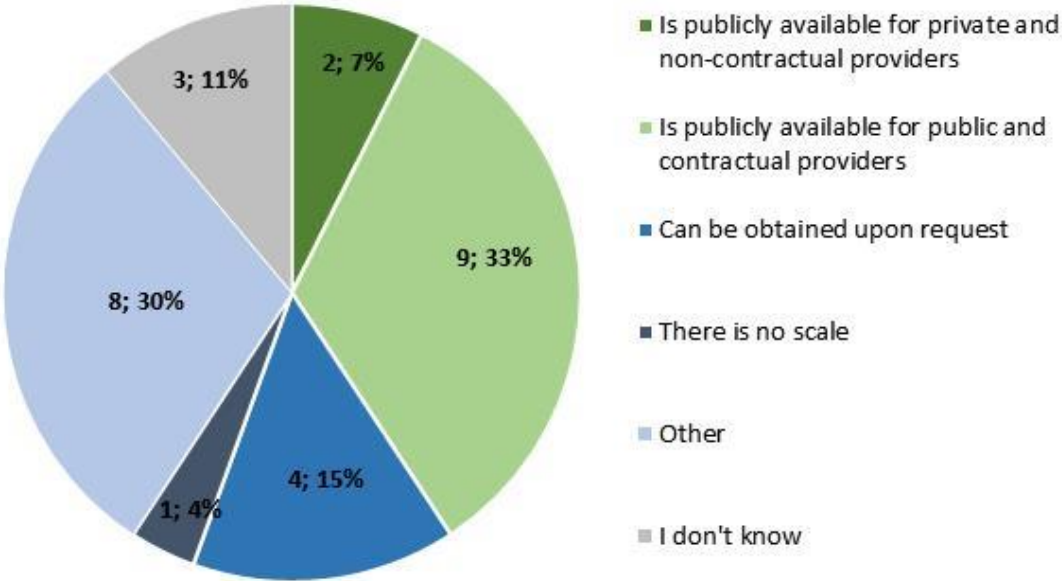
The most selected replies relate to the supply of information upon request, either to inform healthcare professionals and patients (12 selections) or to clarify legal issues to the administration (10 selections). Similarly common is the set-up of specific instruments (dedicated webpage, dedicated entity, functional email, information counter) to provide information about cross-border healthcare, or the sharing/provision of information through the participation in cooperation programmes, projects and/or fora related to cross-border healthcare. In 14 cases the information is provided proactively. Because of the multiple answer option, these 14 selections come from eight regional hubs, namely: Bolzano, Emilia Romagna, IBK-RegHub, North Rhine-Westphalia, Thessaly, Umbria, Veneto and West Pomerania. 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. The ‘Other’ replies point to specific situations or to the fact that the information is only made available at the national level.

Fees for cross-border healthcare. In most of the participating regional hubs, a scale of applicable medical fees is not easily available. If it is available, the list is for the most part only shared with public and contractual healthcare providers or available upon request.

Member States are required to apply the same scale of fees to patients from other Member States as to domestic patients in a comparable medical situation

(Article 4(4)). These fees, charged to both domestic and foreign EU patients, must be calculated in an objective and non-discriminatory way. Regional hubs were asked about the existence and/or availability of a scale of applicable fees. In nine hubs, the scale of applicable fees is publicly available for public and contractual providers (Figure 6). Only in Helsinki Uusimaa and West Pomerania is the scale reported to be also available for private and non-contractual providers. In four regional hubs, it can be obtained upon request. In four regional hubs, it can be obtained upon request.

Figure 6. In your region, the scale of applicable fees... (Q12)

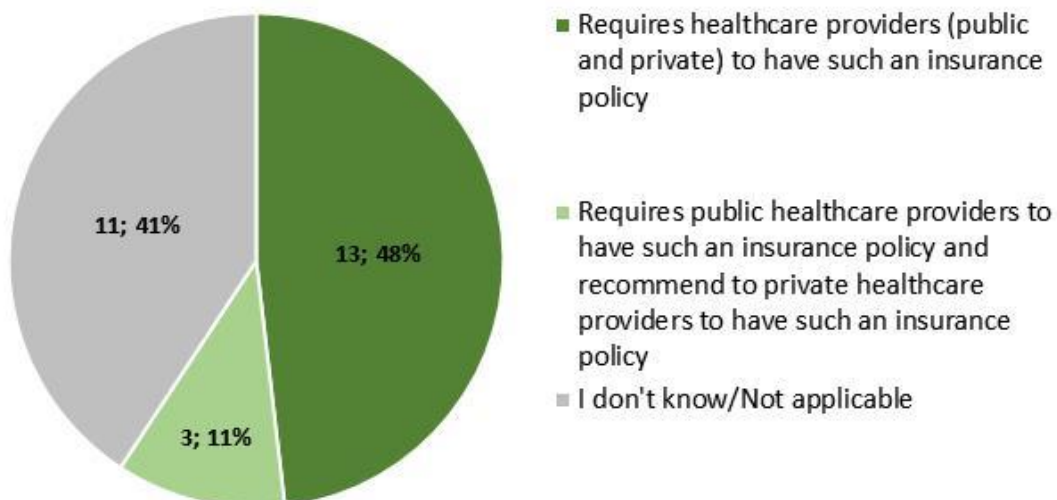


None of the hubs indicate that the scale of fees is available to healthcare professionals (0; 0%). However, the high share of ‘Other’ selections (30%) indicates that the topic of chargeable fees is handled in very diverse ways across regions. Thessaly and Mazovia specify that the healthcare providers give information on prices. The EGTC Tritia reports that the Polish National Health Fund publishes a list of approximate rates (i.e. not an exact price list) which are used to reimburse the costs of cross-border care. In Brandenburg, the scales of fees are publicly available for all service providers but it is possible to diverge from the agreed fees. In the Flanders, pricing is managed at the national level.

Professional liability insurance. In the majority of the participating regional hubs, professional liability insurance is required for public healthcare providers. To a slightly lesser extent, it is also required or recommended for private providers. However, in several regional hubs such insurance is not applicable or the respondents are not aware of obligations.

Article 4(2)d of the Directive specifies that Member States shall put systems of professional liability insurance or similar arrangements in place for treatment provided on their territory. Regional hubs were asked about the requirements of their national/regional healthcare system with regard to this aspect (Figure 7). In 16 hubs, public healthcare providers are required to have professional liability insurance. In 13 hubs, private healthcare providers are also required to have such insurance while in three hubs this insurance is only recommended for private providers. However, 41% of the hubs report that professional liability insurance is not applicable or that they are not aware of obligations in this sense.

Figure 7. With regards to professional liability insurance, your national/regional healthcare system... (Q13)

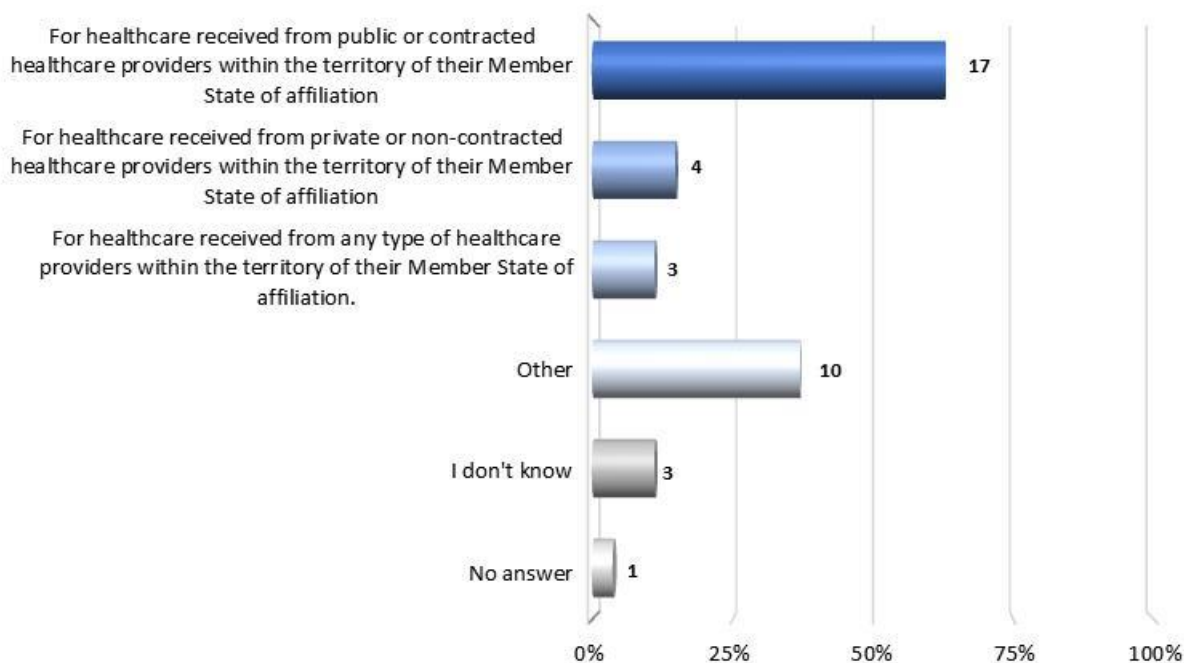


1.3 Reimbursement of costs of cross-border healthcare (Q14 to Q20)

Systems of reimbursement. 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 the regional or national insurance scheme of the country for healthcare received from public or contracted healthcare providers.

Eighteen regional hubs reimburse their own citizens in one way or another (Figure 8). 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. Only three regional hubs indicate that they reimburse their citizens up to the level of healthcare received from any type of healthcare providers. The ‘Other’ selection includes the cases of national competency (i.e. Flanders and Thessaly) or the application of national rules for reimbursement (i.e. Brandenburg and Helsinki Uusimaa).

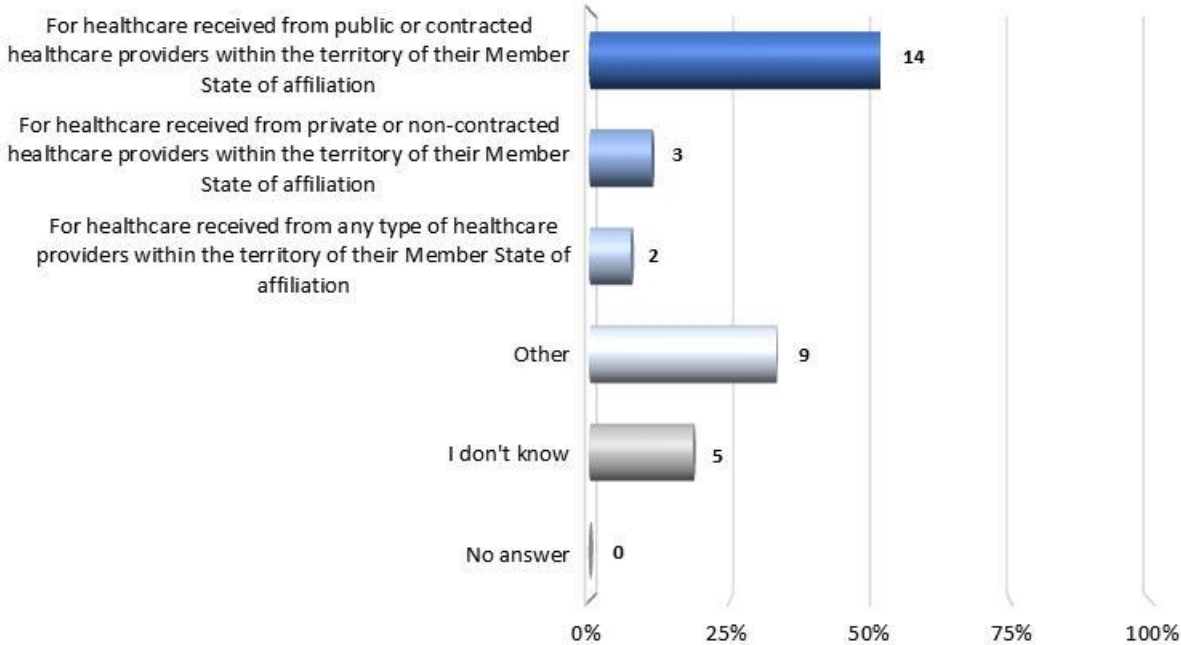
Figure 8. Your region's citizens traveling abroad for treatment are reimbursed or paid up to the level... (Q14) (multiple answers allowed)



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

Among the ‘Other’ replies Catalonia highlights that at the Cross-border Hospital of Cerdanya (an EGTC resulting from a partnership between France and Catalonia, Spain) “patients of both nationalities do not have to pay anything for their healthcare”, a situation that, indeed, goes a step ahead in the interest of patients.

Figure 9. 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... (Q15) (multiple answers allowed)

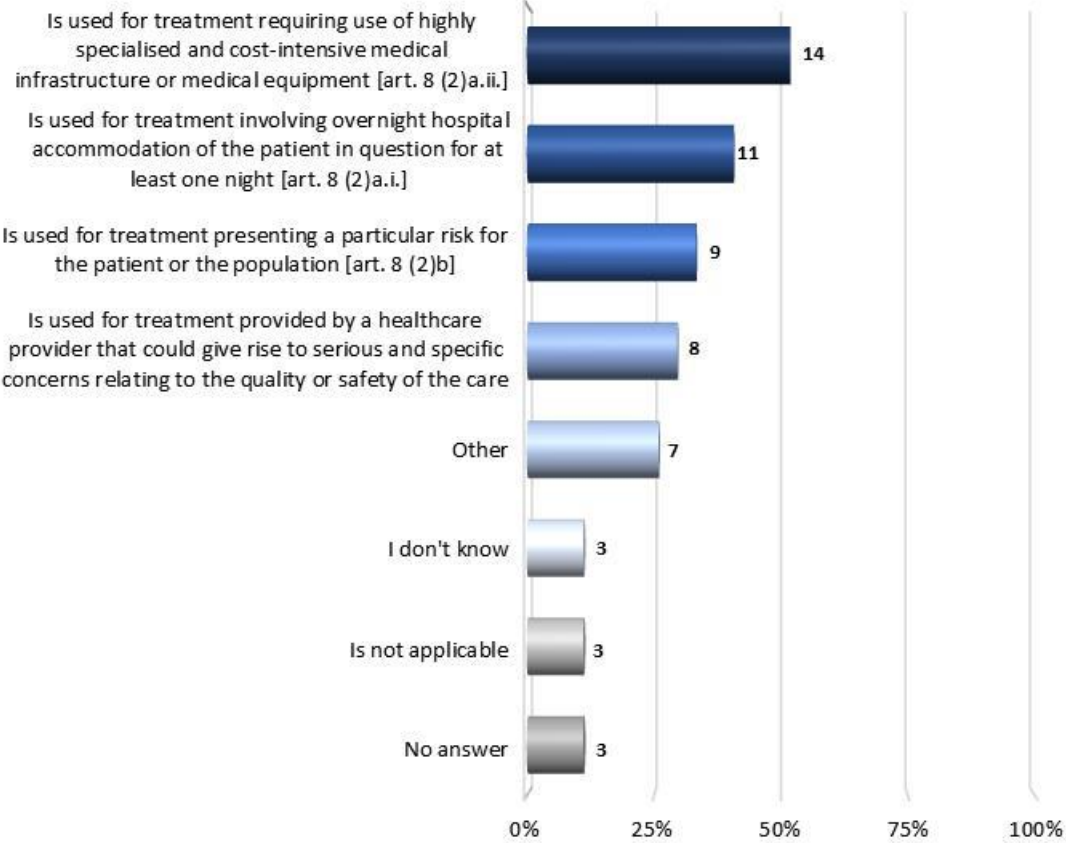


System of prior authorisation for reimbursement of costs. About half of the participating hubs apply systems of prior authorisation, often for care requiring highly specialised and cost-intensive medical infrastructure /equipment or overnight stay. Most hubs perceive prior authorisation necessary to ensure sufficient and permanent access to a balanced range of high-quality treatments, and to some extent, to avoid wasting resources and to control costs. A list of treatments that are subject to prior authorisation is publicly available in most of the hubs that apply this system.

According to the Directive (Article 8(2)), Member States can make reimbursement of costs (for healthcare abroad) subject to prior authorisation. Fourteen of the participating hubs indicate using a system of prior authorisation (Figure 10). In these hubs, its use is most often related to treatment requiring highly specialised and cost-intensive medical infrastructure/equipment (14 selections) or to treatment involving at least one overnight hospital accommodation (11 selections). Alentejo 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.

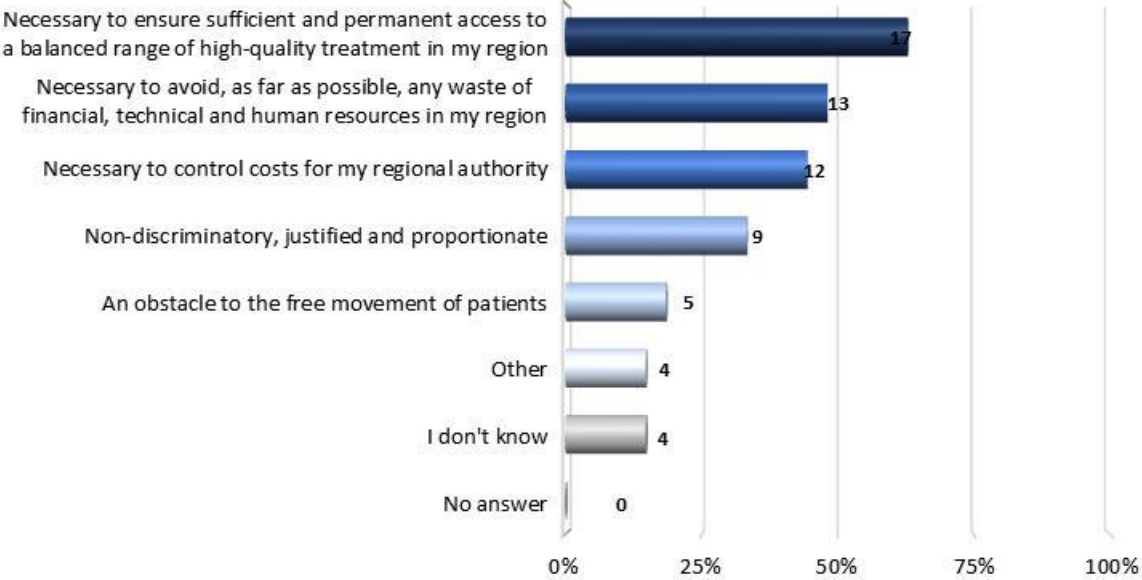
The three ‘not applicable’ selections are from the hubs belonging to the seven Member States that have decided not to apply prior authorisation.

Figure 10. In your territory, the prior authorisation... (Q16)
(multiple answers allowed)



There is an overall positive opinion among hubs of the system of prior authorisation introduced by their national governments (Figure 11).

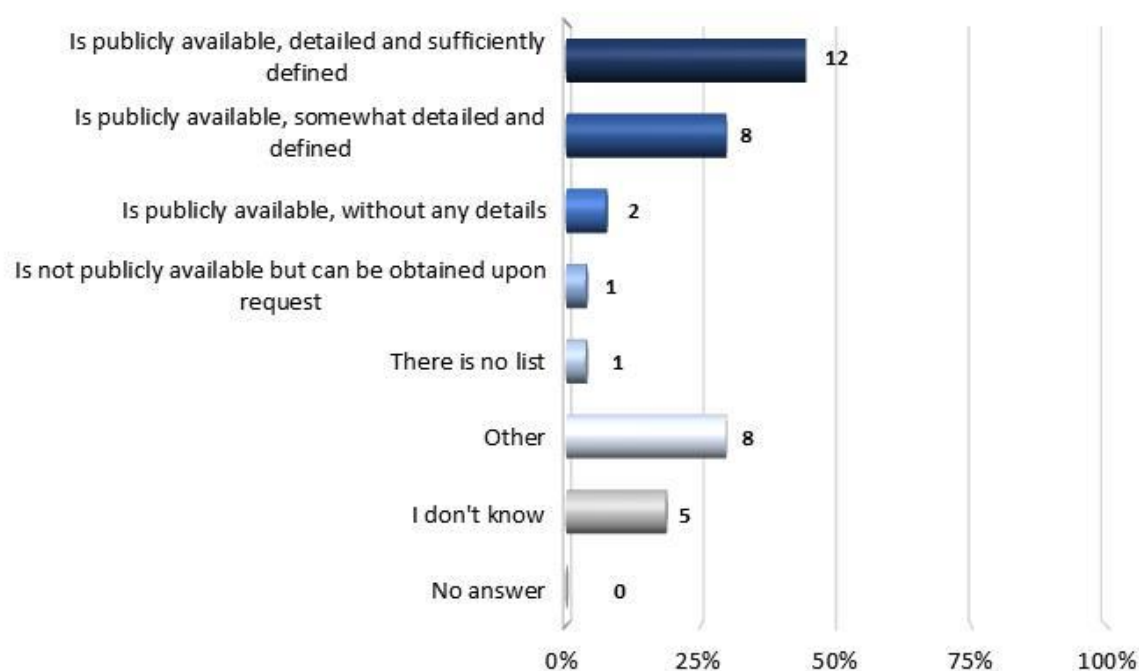
Figure 11. Do you consider the system of prior authorisation, such as introduced by your national government, in line with the article 8(2) to be...(Q17)
(multiple answers allowed)



The majority of them (63%) believe that such a system is necessary to ensure access to quality healthcare. Several hubs also believe that prior authorisation is necessary to avoid wasting resources (48%) and to control costs at the regional level (44%). Hauts-de-France considers prior authorisation to be an additional security measure that allows patients to access care, irrespective of their financial means. Nevertheless, in the opinion of five hubs the system represents an obstacle to the free movement of patients.

According to Article 8(7) of the Directive a list of the treatments which are subject to prior authorisation shall be publicly available. Nineteen regional hubs indicate that a list of these treatments is publicly available (Figure 12). Out of these hubs, 12 believe that the list is detailed and sufficiently defined while the other hubs are less convinced about the detail of their lists. In one hub there is no such a list while five hubs are not aware of its existence. Among the ‘Other’ replies the reference to national sources is common (i.e. Spanish respondents and the Flanders).

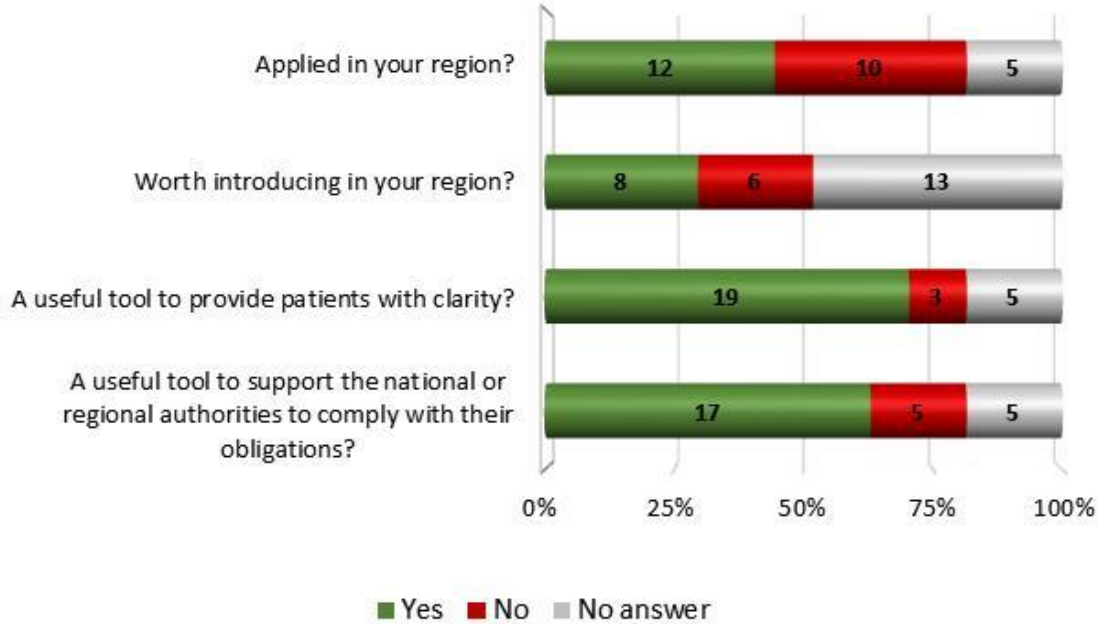
Figure 12. In your region a list of these treatments... (Q18) (multiple answers allowed)



System of prior notification for determining the amount of reimbursement. Prior notification is applied by less than half of the hubs but it is largely perceived to be a useful tool to provide patients with clarity and to support authorities in complying with their obligations.

Under the Directive (Article 9(5)), Member States can operate a voluntary system of prior notification, in which a patient can obtain a written confirmation of the (estimated) amount to be reimbursed. Only 12 regional hubs implement such a system but eight other hubs believe that it would be worth introducing this system in their region (Figure 13). The majority of the hubs have a positive view on this system. Nineteen hubs indicate that prior notification is a useful tool to provide patients with more clarity and 17 hubs indicate that it is useful to support national or regional authorities in complying with their obligations.

Figure 13. Is prior notification... (Q19)?



Mechanisms of financial compensation. Almost half of the participating hubs apply mechanisms of direct financial compensation between competent bodies. Financial compensation is generally looked upon favourably as a way to enable closer cross-border cooperation, improve financial management and facilitate access to care.

Member States may implement mechanisms of financial compensation to directly bill between competent institutions and replace upfront payment and reimbursement to patients (Article 9(5)). A total of 13 regional hubs indicate applying mechanisms of financial compensation (Figure 14). In seven of these hubs, the mechanism is managed by healthcare insurance or social security. In four other hubs, it is managed at the national level. Two hubs indicate that the mechanism induces an administrative or financial burden. However, on the perception of these mechanisms, several regional hubs believe that they enable closer cross-border healthcare cooperation and that could facilitate patients’ access to care (11 selections each).

Among the hubs selecting ‘Other’, Alentejo notes that the coordination between involved entities can be challenging.

Figure 14. Such mechanisms (of financial compensation)...(Q20)
(multiple answers allowed)

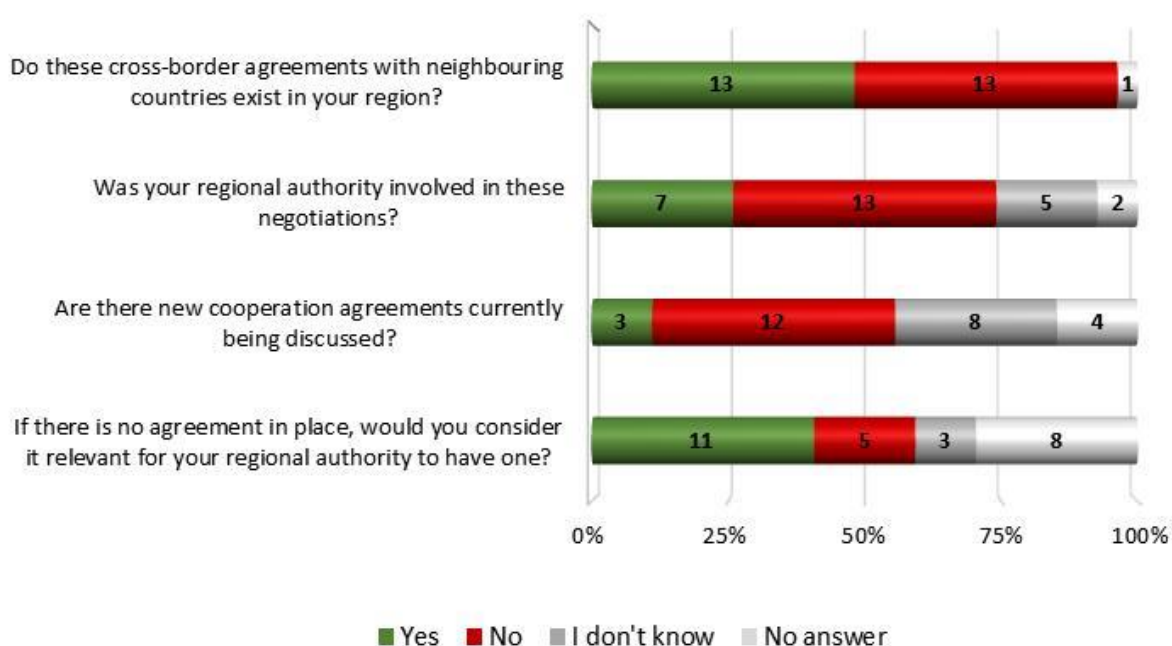


1.4 Cooperation in healthcare (Q21 to Q27)

Cooperation agreements. Almost half of the participating hubs report on cooperation agreements on cross-border healthcare with neighbouring countries. Often, the regional authorities were not involved in the negotiation process of these agreements. Few new cross-border cooperation agreements are reported to be under discussion but a significant number of hubs would consider it relevant to have one in place.

In 13 of the participating regional hubs, cooperation agreements on cross-border healthcare with neighbouring countries exist (Figure 15). In seven of these regional hubs, regional authorities were not involved in negotiations leading to the agreement. Several of the agreements are between hospitals (e.g. in Košice Self-Governing Region). In the Netherlands, agreements exist between hospitals and health insurers across borders. Dubrovnik-Neretva reports on cross-border cooperation agreements in the field of healthcare service provision between Croatian's hospitals/medical centres and the Republic of Montenegro's Clinical Centre as well as with Bosnia and Herzegovina's Federal Ministry of Health.

Figure 15. Agreements (Q21)



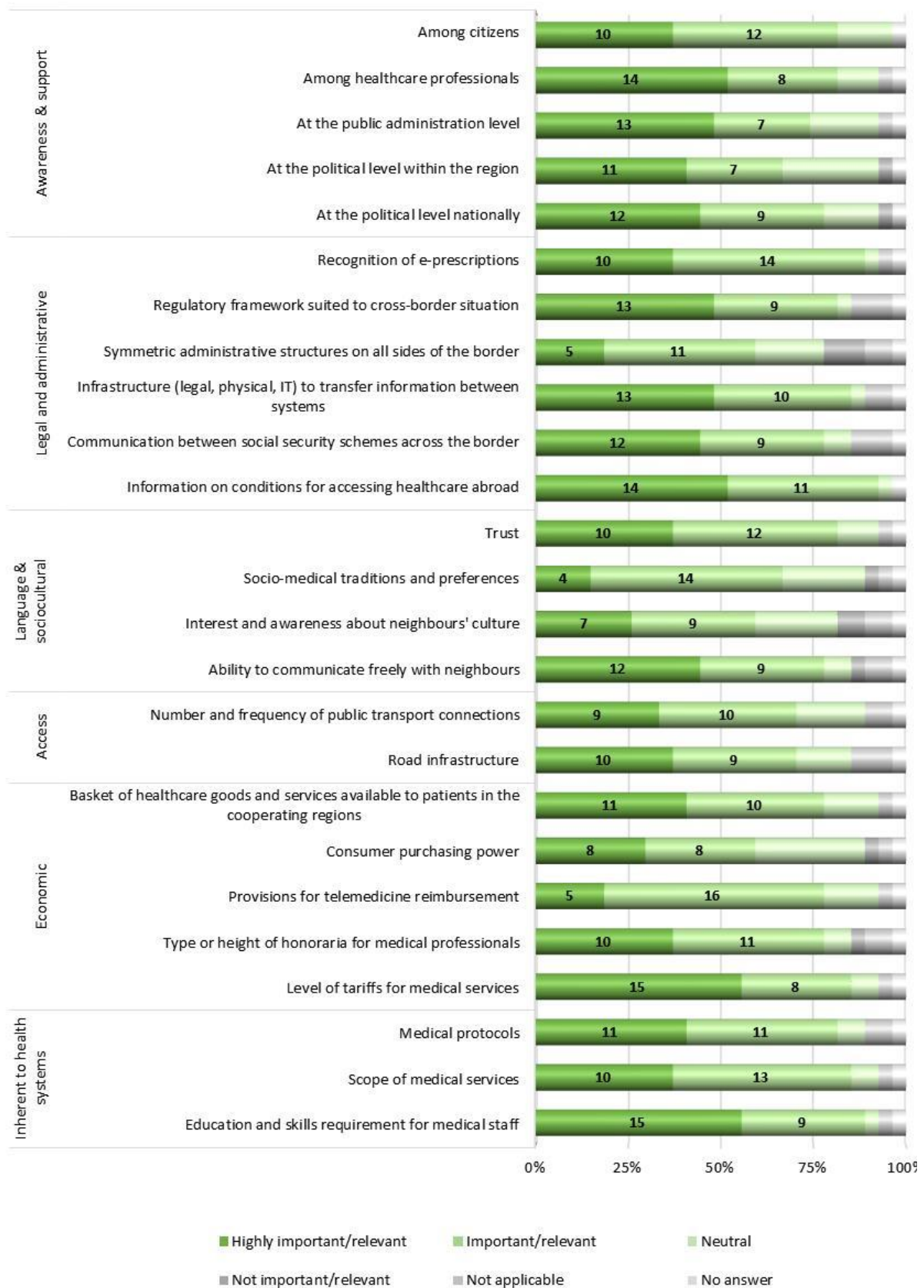
Only three hubs indicate that new cooperation agreements are currently being discussed but 11 hubs indicate it would be relevant for their regional authority to have a cooperation agreement with a bordering country in place.

Among the comments provided by respondents, Alentejo highlights that new agreements can be considered when there is potential for leverage on both sides of the border. Umbria underlines that for regions not having a border with other countries, it is more important to make agreements with neighbouring regions, as that is where the majority of patient mobility is concentrated.

Factors influencing cross-border cooperation. Cooperation in cross-border healthcare provision is facilitated by different factors, among which education, skills and awareness of medical staff, the level of tariffs of medical services, information on conditions to access care abroad, and legal, physical and IT infrastructure for information exchange are believed to be major ones.

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 (Figure 16). Awareness among citizens is also generally deemed important.

Figure 16. Factors influencing cross-border cooperation (Q22 to Q27)



Among the *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 the existence of appropriate infrastructure for the transfer of information. Catalonia 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/referral systems and medical records will also be important.

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.

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, Kosice underlines that these factors, although important, fall only partially within the remit of regional councils at a general and planning level.

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 type/height of honoraria for medical professionals are also generally considered important. Economic factors appear to constrain both healthcare professionals and patients. Still in the Hospital of Cerdanya, the recruitment of professionals across borders is reported to be a serious problem as there are important differences in salaries and social security conditions between France and Spain. These differences create inequalities and difficulties in establishing cross-border cooperation. From the perspective of patients, Hauts-de-France underlines that the Directive creates a barrier for patients with limited financial means and increases the risk of unpaid invoices for healthcare providers.

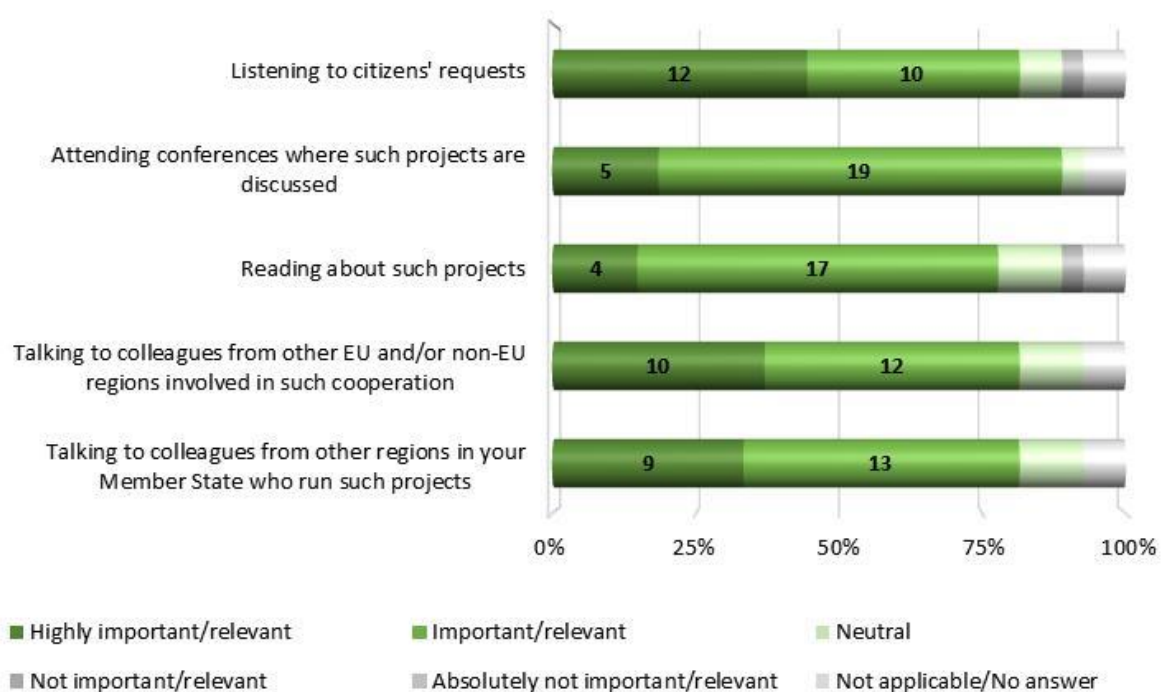
Finally, on factors inherent to *health systems*, most hubs believe that education and skills requirements for medical staff are highly important. Actually, this factor and the previously mentioned level of tariffs for medical services are considered the two most important factors influencing cross-border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

1.5 Lessons from the past and plans for the future (Q28 to Q35)

Drivers and tools to set up cross-border healthcare cooperation and keep it alive. Various factors are deemed to be important to inspire cross-border cooperation in healthcare while among the most important reasons for setting up a cross-border healthcare cooperation is the capacity for guaranteeing access to specialist care. Information on available EU funding is a highly relevant tool to set up cross-border cooperation projects in healthcare while political support, long-term EU funding, and committed medical staff help keeping cooperation agreements alive and sustainable.

Regional hubs consider listening to citizens' requests the most important inspiration factor to cooperate across borders in healthcare (Figure 17). Talking to colleagues from other EU and/or non-EU regions already involved in such cooperation is also deemed a highly important inspiring factor. In any case, it is noted that all given options were selected as 'important' or 'highly important' by about 80% of the hubs.

Figure 17. Factors inspiring cross-border cooperation in healthcare (Q28)

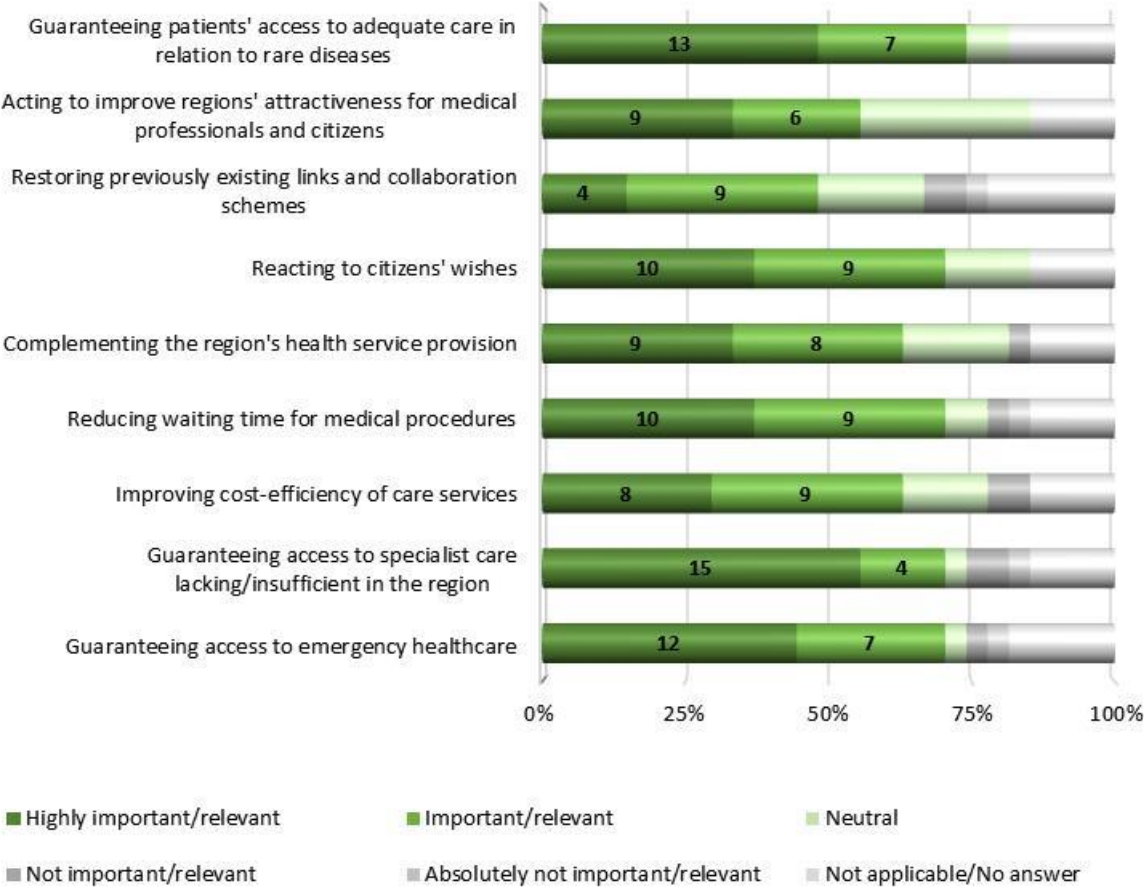


Among the most important reasons for setting up a cross-border healthcare cooperation is the capacity for guaranteeing access to specialist care that is lacking or insufficient in the region (Figure 18). Guaranteeing access to adequate care for

rare diseases and to emergency healthcare are also considered very important reasons. Similarly, cooperation is sought to reduce waiting time for medical procedures and to react to citizens' requests. Also in this question, all given options are selected as 'important' or 'highly important' by about 80% of the hubs.

On complementing the region's health service provision, Hauts-de-France envisions the creation of innovative forms of organisation which take action on the specific determinants of a cross-border region and respond to local needs as well as to global health challenges such as population ageing and health technology developments.

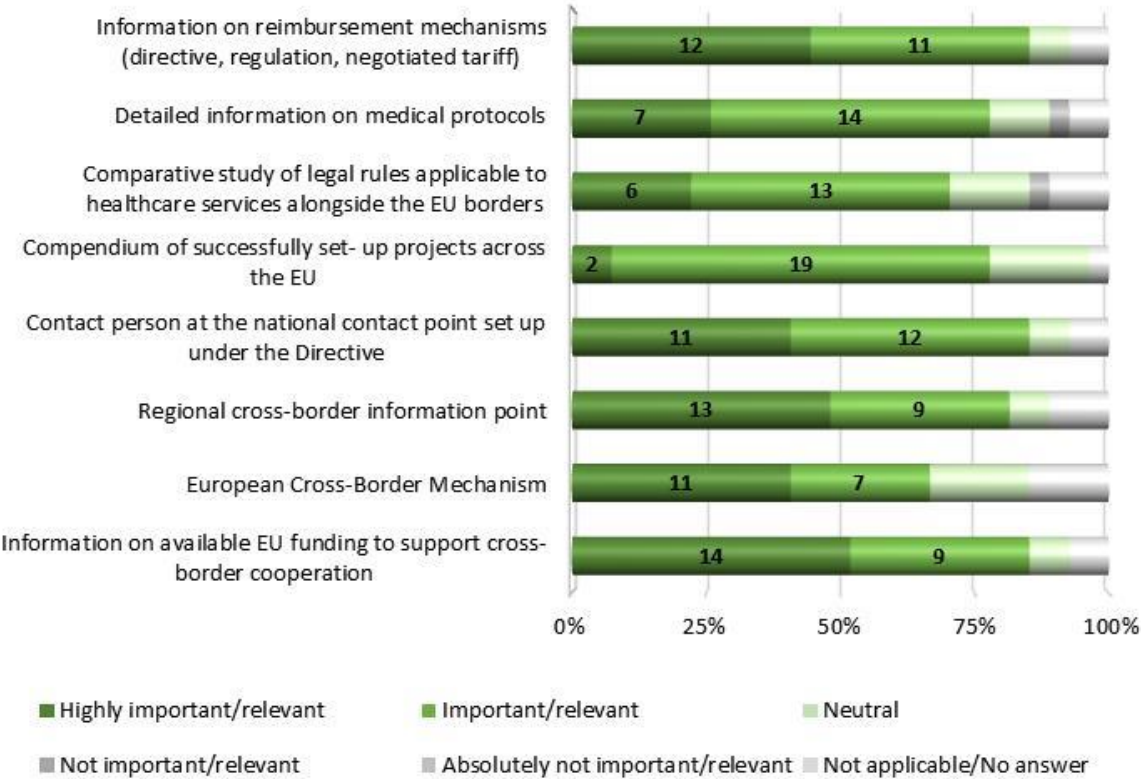
Figure 18. What was/is the main reason for setting up a cross-border healthcare cooperation? (Q29)



Information on available EU funding is considered by regional hubs to be the most important tool to set up cross-border healthcare cooperation (Figure 19). This is followed in importance by the presence of a regional cross-border information point and by the availability of information on reimbursement mechanisms.

Among the provided comments, Hauts-de-France underlines the importance of having the possibility to create cross-border structures which bring together public, private and not-for-profit partners, and mentions the French-Belgian Health Observatory (OFBS), which is a European Economic Interest Grouping. Valencia 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. North Rhine-Westphalia points out the importance of a comparative study of national laws to be able to implement meaningful healthcare provision in border regions.

Figure 19. What were/are/would be the useful tools to set up a cross-border healthcare cooperation? (Q30)

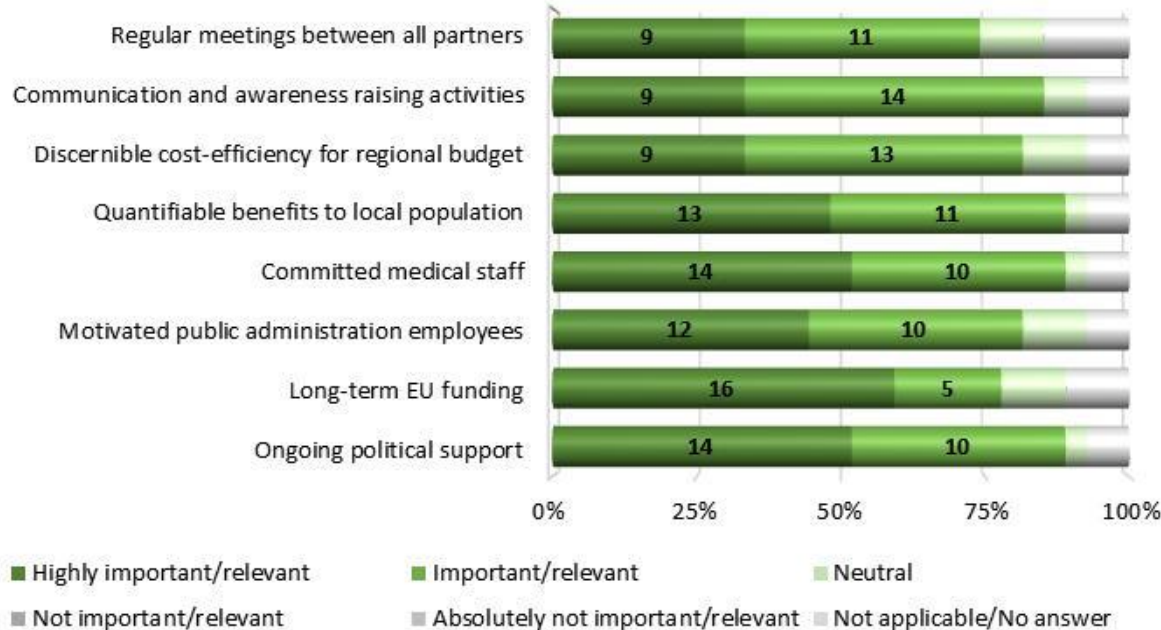


On ways to keep cross-border healthcare cooperation alive and sustainable, almost 60% of the hubs indicate that long-term EU funding is highly important (Figure 20).

Ongoing political support, committed medical staff and quantifiable benefits to local population are also deemed highly important by about half of the hubs. Factors generally found to be important to keep cross-border healthcare cooperation alive and sustainable include communication and awareness-raising activities and discernible cost-efficiency for the regional budget.

On employment, Catalonia comments that remaining attractive to professionals is important and this would imply an ad-hoc agreement that builds on the most relevant aspects of employment in both border countries (France and Spain in the specific case mentioned by the hub).

Figure 20. What helps to keep the cross-border healthcare cooperation alive and sustainable? (Q31)



Opinions on the need to review the Directive and its implementation measures. Regional hubs are divided on the need to review the Directive as well as regional and national implementing measures.

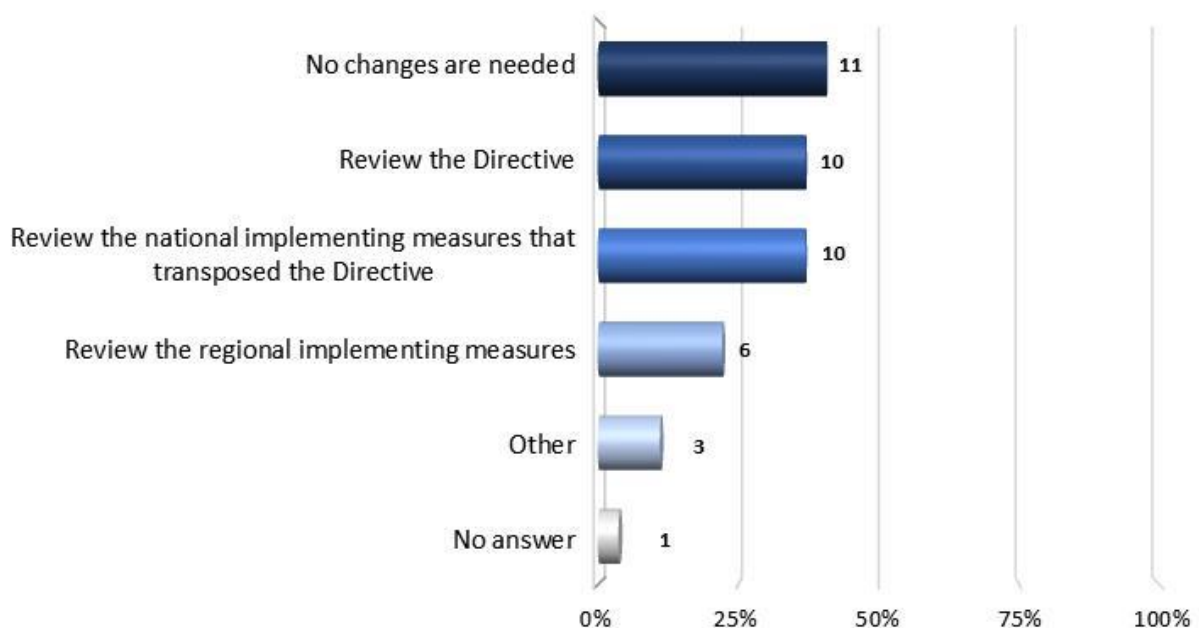
Only ten regional hubs believe that the Directive needs to be reviewed (Figure 21). In fact, the number of selections of the ‘no changes are needed’ reply is higher (11 selections). Similarly, only ten regional hubs indicate that implementing measures need to be reviewed at the national (10 selections) and/or regional (6 selections) level.

Some of the regional hubs provide individual suggestions on the way the Directive may be improved:

- Give the Directive its own European character and autonomous management and make it less optional (someone notes that the Directive might currently be too optional to be truly effective) thereby relying less on sub-national authorities, for example by making implementing protocols and training on implementation available.

- Review the competences of 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 the 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 citizens (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 about their rights or by publishing EU tenders for projects on communication and awareness-raising.

Figure 21. Reflecting on your experience to date, do you think there is a need to...?
(Q32) (*multiple answers allowed*)

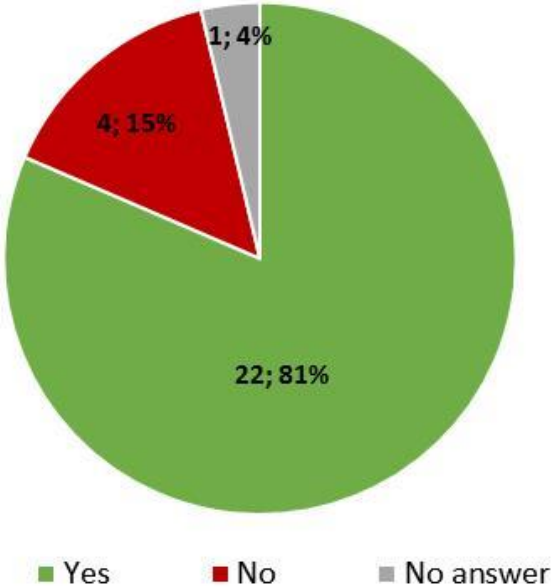


As the need to review the Directive is perceived differently among regional hubs, there are also comments reiterating that the Directive does not require changes. In particular, it is noted that the Directive has a limited scope of application and that both planned and unplanned treatment in other EU countries are mainly covered by Regulation (EC) No 883/2004. In addition, if patients can freely choose where to be treated throughout the EU, especially for treatment in hospitals, public healthcare would no longer be manageable in terms of organisation and financing.

Future plans to set-up a cross-border healthcare cooperation. The majority of regional hubs would consider setting up a cross-border healthcare cooperation. The focus of cooperation would mainly be on research and innovation. Primary and specialised care is also prioritised by a good number of hubs.

Twenty-two regional hubs would consider setting up a cross-border healthcare cooperation in the near future (Figure 22). 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).

Figure 22. Would your organisation/institution consider setting up a cross-border healthcare cooperation in the near future? (Q33)



Areas of specialised care which are most mentioned are ophthalmology, oncology, dialysis and rare diseases. Among the reasons for prioritising these types of specialised care in setting up a cross-border healthcare cooperation are the level of patient demand; availability of specialist staff; cost, safety and quality considerations; the possibility to provide care for specific target groups such as

vulnerable persons and irregular foreign nationals/asylum seekers; and the opportunity to learn from one's neighbours.

Expectations of regional hubs from the European Committee of the Regions. The European Committee of the Regions is expected to communicate proactively on the implementation of the Directive, give political impetus to cross-border initiatives, strengthen coordination, support continuous exchange and facilitate political dialogue between its members.

Several requests are put forward by regional hubs for the European Committee of the Regions (COR) in order to assist those regions interested or active in cross-border cooperation.

The COR is expected to **communicate proactively to the other European institutions** on the information gathered on the implementation of the Directive as well as on problems faced and areas for improvement as perceived and/or identified at the regional level. In the opinion of few hubs, still at the policy level, the COR is expected to **give political impetus** to cross-border initiatives such as projects on cross-border healthcare provision and cross-border analyses. This also includes **advocating for the allocation of adequate funding and for adequate funding conditions** (e.g. co-funding rate) for the Interreg programme in the upcoming new programming period. There is also a specific request to give support for lobbying EU institutions to help more small-scale local initiatives.

Another suggestion is that the COR **supports the development of structured, systematic and mandatory coordination of cross-border healthcare**. 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.

Another recommendation to the COR is to **support continuous exchange and encourage and facilitate political dialogue between its members**, and especially the representatives of border regions, to help create mechanisms (or a strategy) for cooperation. Some regional hubs also suggest that the COR **raises awareness on the importance of cross-border healthcare cooperation, including through the dissemination of best practices** implemented by regions or by other public/private organisations.

Individually, regional hubs voice other needs which may not fall directly under the mandate of the COR but that are or may be considered as potential recommendations to be made to the European Commission. These needs are: breaking down administrative and legal barriers, for example by providing

European legal coverage to overcome national legal restrictions and by encouraging cross-border recognition of medical qualifications and specialisations; enabling the creation of a standardised compensation system for payments between countries; making the transferral of information on citizens for whom cross-border care is relevant mandatory; encouraging the integration of data with social security systems; organising workshops for managers who are involved in transposing/implementing the Directive on cross-border healthcare; strengthening National Contact Points by providing training, promoting their mutual cooperation and connecting them to Interreg; creating a database with standardised information on the healthcare systems of the EU/EEA Member States; providing funding for multilingual information tools; and organising training sessions based on best practices.

Expectations of regional hubs from the European Union. At the EU level, several of the expectations relate to the funding of cross-border healthcare, to the improvement of information, communication and awareness activities, to the removal of legal and administrative barriers, and to the support of research and development.

Most of the needs highlighted with respect to the European Committee of the Regions are reiterated by regional hubs when specifying what could be done by the European Union to support further cross-border healthcare cooperation. Overall, regional hubs' expectations at the EU level may be grouped around four main areas: funding requirements; need for information, communication and awareness; standardisation and simplification requirements; and requests for supporting research, development and innovation activities.

Although there are differing opinions among regional hubs on the need to review the Directive, one regional hub expects that the EU not only listen to needs but also respond to encountered and previously reported shortcomings of the Directive. Still at the policy level, the EU is expected to develop a cross-border health vision. This would, for example, imply more comprehensive prevention efforts and a health state analysis on a cross-border level, as well as the establishment of interregional federations of patient organisations.

As mentioned above, several regional hubs refer to the financial costs implied by the implementation of cross-border healthcare cooperation. Their **expectations in terms of funding are therefore substantial** and relate to having long term EU financing ensured, to the creation of a separate or priority funding for healthcare, to the supply of more and tailored information on funding for health and on existing support mechanisms at the regional level. Several hubs also call for the continuation of support to cross-border healthcare through EU programmes and

projects. The Interreg programme in particular is expected to be made more accessible and open to healthcare activities. Apart from supporting existing projects, the EU is also asked to support new pilot projects in cross-border healthcare with the provision of start-up funding where appropriate. Notably, there is also a request to provide better information on what has been achieved by ongoing and completed projects.

In fact, several regional hubs expect that the EU **promotes cross-border healthcare cooperation by raising awareness, informing and communicating on it**. The target groups would not only be citizens but also healthcare professionals and policymakers. This could be done by disseminating and sharing best practices in cross-border cooperation, by launching tenders for projects focussed on communication and awareness activities, and by inviting regular meetings, or working groups, of stakeholders and managers involved in cross-border healthcare cooperation.

Standardization and simplification requirements put forward by regional hubs range widely, from the creation of models to be used to finalise bilateral agreements to the removal of legal barriers and the establishment of stronger European standards. Some regional hubs would expect the EU to optimise and simplify billing structures and procedures for cross-border projects. Another suggestion for lifting (administrative) barriers to healthcare is to create a solidarity fund for citizens without a right to public care, and to waive the need for prior authorisation for patients with rare diseases. One regional hub also mentions the necessity to approve the proposed European cross-border mechanism whose aim is to solve legal and administrative obstacles in a cross-border context.

Expectations at the EU level also relate to the **support of research, development and innovation activities**. Proposals refer to investing in research which is inter-regionally relevant such as research on rare and infectious diseases. Examples of relevant developments relate to the improvement on responses to emerging infection threats, including those of a global nature, the supply of vital drugs in particular, and the availability of medicines in general. The encouragement and facilitation of cross-border development of telemedicine is also expected at the EU level.

Part 2 Recommendations for the future

This part highlights recommendations for the future development of cross-border healthcare with respect to the functioning of the Directive. It draws on recent literature and on the most often quoted problems as well as the most promising solutions shared by regional hubs through the consultation.

Reducing burden on patients

When designing the Directive, a much-quoted concern in focus groups was that the Directive imposes or leaves a large burden on patients (Baeten and Jelfs, 2012). Recent studies find that areas that obstruct patients in seeking care are the use of prior authorisation, administrative requirements and the system of reimbursement (EP, 2019). In fact, the current reimbursement system, in which patients have to pay upfront, can be a major barrier for consumption of healthcare abroad (Frischut and Levaggi, 2015).

In the consultation, the theme of cross-border healthcare as a burden to patients comes up often. Several mechanisms or measures are mentioned which are believed to be promising for reducing such a burden in the future. These include:

- Increasing and disseminating the application of mechanisms of prior notification. Prior notification is considered a very promising way to reduce patients' burden as it gives them more certainty while seeking cross-border healthcare.
- Optimising, simplifying and harmonising billing processes and administrative structures for cross-border healthcare in order to lighten patients' burden of arranging payment and paying upfront.
- Linking of cross-border health with social security systems and increasing the application of mechanisms of direct reimbursement or financial compensation between competent authorities/entities are other promising options in the area of financial burden reduction which may facilitate the access to care especially for those patients with a lower income.
- Paying particular attention to certain categories of patients. This may be tackled by integrating social reasons in prior authorisation criteria, by creating a solidarity fund for citizens without a right to public care, and/or by waiving the need for prior authorisation for patients with, for example, rare diseases.

Enhancing awareness and knowledge of patients, healthcare professionals and regional authorities

Literature provides ample evidence of a lack of awareness about the Directive among citizens, which may partially explain the scarcity of patients seeking care abroad (Callens *et al.*, 2018). The low profile of cross-border healthcare and the lack of transparency on patient rights and reimbursement conditions are indeed major obstacles to cross-border healthcare consumption (Leloup *et al.*, 2017). Likewise, a recent report by the European Commission echoes that knowledge of the (existence of) the Directive remains scarce among surveyed citizens (EC, 2018). In the majority of cases, they have not even heard of National Contact Points. The report finds that the slight increase in cross-border mobility recorded from 2015 to 2018 is probably due to better information and awareness or to increased collaboration on the implementation on the Directive, but, overall, patient mobility remains low. The National Contact Points designed to provide information on patient rights and on procedures, vary greatly in organisation, funding, staff and type of host institution. Although improvements to these contacts points have been made since the Directive was implemented, in recent literature it has been suggested that the online communication and visibility of NCPs be improved and that a discussion be initiated to review their competences in order to streamline the information provision approach, which could aid in increasing awareness (Callens *et al.*, 2018; EC- DG SANTE, 2018; ECA, 2019).

The consultation provides evidence that information and awareness at the regional level on areas related to the implementation of the Directive is not up to the required standards. This adds to the call by regional hubs to improve awareness and information provision for patients and healthcare providers. The most promising solutions include:

- Improving the visibility of National Contact Points as well as their role and effectiveness in passing on information to patients and in linking to health authorities, to other relevant public and private stakeholders as well as to other National Contact Points.
- Providing training and tools to National Contact Points within the framework of an evaluation of their competences.
- Promoting the establishment of regional cross-border information points.
- Developing implementation protocols for the different aspects covered by the Directive.

- Creating interregional federations of patients as a way to empower patients in their rights on cross-border healthcare provision, including the right to receive complete and adequate information. The creation of interregional patient federations could also facilitate, overall, a bottom-up approach to cross-border healthcare cooperation.
- Publishing tenders at the EU level for projects on communication and awareness-raising which target not only citizens but also healthcare professionals and policymakers.
- Improving the provision of information to healthcare professionals. As patients are most likely to search information about cross-border care through their health insurer, national health services, or their doctor or general practitioner (EC-DG SANTE, 2015), this would seem a logical step to improve patient awareness. This may be achieved, for example, by inviting regular meetings, or working groups, at the EU level of health professionals and managers involved in cross-border healthcare cooperation.

Facilitating cross-border cooperation on a regional and local level

Implementing cross-border cooperation, including on a regional and local level, is at the core of the functioning of the Directive. Strengthening cooperation and enhancing cohesion between border regions is also recommended by the European Parliament (EP, 2019). Its report emphasises the importance of funds in supporting cohesion and development, of the intensification of cooperation between NCPs, but also outside of NCPs, and of the structural exchange of best practices (EP, 2019). Other literature underlines that the effectiveness of cross-border healthcare initiatives depends on the ease of cooperation, relating to, for example, geographical proximity, the similarity of welfare traditions and historical ties (EC-DG SANTE, 2018). Most identified cross-border collaboration projects have a regional focus (between local entities or border regions) and are developed around the areas of knowledge sharing and management, or treatment and diagnostics, across the scope of different diseases (most often cancer, rare diseases, chronic diseases and dementia). Nevertheless, evidence is often lacking on the sustainability and effectiveness of these cooperation projects which is, in fact, a necessary condition to share practices and experiences (EC-DG SANTE, 2018).

Many of the recommendations made in literature to enhance cross-border cooperation are echoed by regional hubs in the consultation. In addition, results of the consultation provide evidence that there is ample room for improvement in the area of setting up cross-border healthcare agreements. Most promising solutions include:

- Proactively making information on EU funding and tools to develop cross-border healthcare cooperation available at the regional level.
- Providing adequate and long-term EU funding in the next programming period, especially but not exclusively through Interreg, including for the implementation of cross-border studies/projects aimed at removing specific barriers and at smoothing differences that affect cooperation (for example, differences in salaries and social security conditions of healthcare professionals across borders).
- Developing common European models for cooperation agreements.
- Facilitating the development of cross-border structures and infrastructures as well as of coordinated systems across the borders (e.g. patient record system, billing systems).
- Setting up and/or arranging information exchange and opportunities at the EU, national and regional level for stakeholder involvement and knowledge sharing, especially among key actors and on topics which are essential to the implementation of cross-border cooperation (e.g. ways to reduce the costs of cross-border healthcare). A recent study by DG SANTE (2018) confirms that support to key players such as regional policy makers or hospital managers is important to reduce costs of cross-border care.
- Collecting evidence on the efficiency, effectiveness, impact and sustainability of pilot/cooperation projects on cross-border healthcare in order to draw useful lessons and identify best practices.
- Supporting the structural exchange among border regions of lessons learnt and best practices not only to facilitate exchange of information and raise awareness but also to give cross-border healthcare a higher profile (Leloup *et al.*, 2017).

Easing legal and administrative barriers for Member States and regions

The Directive was put in place to provide a clear legal mechanism for cross-border cooperation in healthcare (Greer *et al.*, 2014). The European Parliament acknowledges that border regions face legal and administrative barriers in cross-border cooperation in healthcare and that the sustainability of such cooperation depends, among other factors, on the (similarity of) administrative systems in place on both sides of the border (EP, 2019). In this critical area, suggestions include:

- Carrying out a comparative study of legal rules applicable to healthcare services alongside EU borders.
- Advocating for the adoption of a European Cross-Border Mechanism which is deemed an important or highly important factor for setting up cross-border cooperation in healthcare by the majority of the regional hubs participating in the consultation. This is irrespective of the fact that the process of adoption of such a mechanism is expected to take several years and that the proposal by the European Commission is likely to be softened significantly before being adopted (Sielker, 2018).
- Strengthening of European standards, for example in terms of a compensation system for payments between countries.

Improving data collection on patient mobility

Data on patient mobility is rather limited and there are national differences in what data are collected by which organisation (Footman *et al.*, 2014; ECA, 2019). This is confirmed by a recent report by the European Commission where data provided by Member States differ widely, including year by year, and in some cases it is not even possible to differentiate among patient groups or categories of reimbursement (EC, 2018). This consultation confirms that a limited number of regional hubs are monitoring patient flows and that within this limited number different strategies to collect data and maintain an overview of cross-border healthcare consumption are adopted. Furthermore, different organisations are responsible and not all hubs measure detail to the same extent, or know how or by whom this information is measured. The European Commission is planning on making more use of patient data in the future (EC, 2018). This is important to better grasp the nature and scale of cross-border care in order to ensure the quality of it. Recommendations include:

- Enhancing regional authorities' familiarity on who collects what data in which way with regard to cross-border healthcare in the territory of their competence in order to increase awareness and understanding of the situation.
- Setting minimum content requirements at the EU level on what needs to be monitored while working with common definitions of the different aspects of cross-border mobility.

Annex I – List of respondents

Name of the member of Reg-Hub	Country
Alentejo	Portugal
Autonomous Province of Bolzano	Italy
Brandenburg	Germany
Brittany	France
Brod-Posavina County	Croatia
Catalonia	Spain
Community of Madrid	Spain
Community of Valencia	Spain
Dubrovnik-Neretva County	Croatia
EGTC - TRITIA Ltd.	Poland, Slovakia, Czech Republic
Emilia Romagna	Italy
Flanders	Belgium
Friuli Venezia Giulia	Italy
Harghita	Romania
Hauts-de-France	France
Helsinki Uusimaa	Finland
Košice Self-Governing Region	Slovakia
Mazovia	Poland
Netherlands	The Netherlands
Northern & Western Region of Ireland	Ireland
North Rhine-Westphalia	Germany
Primorje-Gorski Kotar County	Croatia
Thessaly	Greece
Umbria	Italy
Veneto	Italy
Vorarlberg, chairing the IBK-RegHub	Austria, Germany, Liechtenstein, Switzerland
West Pomerania	Poland

Annex II – List of references

Baeten, R. and Jelfs, E. (2012), Simulation on the EU Cross-Border Care Directive, *Eurohealth*, 18(3):18–20.

Callens, S., van Gompel, N., van de Steeg, L., Weistra, K., Klein, P., Invernizzi, S. and Thieme-Groen, E. (2018), Study on cross-border health services: enhancing information to patients: Final report.

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, OJ L 88, 4.4.2011, p. 45–65.

European Commission (2018), Report from the Commission to the European Parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM/2018/651 final.

European Commission, Directorate-General for Health and Consumers (2015), Patients' rights in cross-border healthcare in the European Union, Special Eurobarometer 425, prepared by TNS Opinion & Social, doi: 10.2875/606830.

European Commission, Directorate-General for Health and Food Safety (2018), Study on Cross-Border Cooperation: Capitalising on existing initiatives for cooperation in cross-border regions, Final report prepared by Gesundheit Österreich Forschungs und Planungs GmbH.

European Court of Auditors (2019), EU actions for cross-border healthcare: significant ambitions but improved management required, Special report no 07/2019.

European Parliament (2019), Report on the implementation of the Cross-Border Healthcare Directive, Committee on the Environment, Public Health and Food Safety.

Footman, K., Knai, C., Baeten, R., Glonti, K. and McKee, M. (2014), Policy Summary: Cross-border health care in Europe, World Health Organization Regional Office for Europe.

Frischhut, M. and Levaggi, R. (2015), Patient mobility in the context of austerity and an enlarged EU: The European Court of Justice's ruling in the Petru Case, *Health Policy*, 119(10), 1293-1297.

Greer, S. L., Fahy, N., Elliott, H., Wismar, M., Jarman, H. and Palm, W. (2014), Everything you always wanted to know about European Union health policies but were afraid to ask, World Health Organization Regional Office for Europe.

Leloup, F., Delecasse, E. and Lewalle, H. (2017), European Crossborder Cooperation on Health: theory and practice.

Palm, W., Wismar, M., Van Ginneken, E., Busse, R., Ernst, K. and Figueras, J. (2011), Towards a renewed community framework for safe, high-quality and efficient cross-border health care within the European Union, in book: Cross-border health care in the European Union: mapping and analysing practices and policies, Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 23-46.

Sielker, F. (2018), The European Commission's proposal for a cross-border mechanism (ECBM), *Journal of Property, Planning and Environmental Law*, 10(3), 219–239. doi:10.1108/jppel-08-2018-0024.

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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.

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