STUDY

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Cross-border cooperation in healthcare

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RESEARCH FOR REGI COMMITTEE

Cross-border cooperation in healthcare

Abstract

This study analyses the role of Cohesion Policy as regards cross-border cooperation in healthcare, with a particular focus on the 2014-2020 Interreg V-A programmes. It also reviews the issue of governance related to such projects and the impact of the COVID-19 pandemic. Finally, it identifies possible solutions and puts forward policy recommendations to facilitate patient and healthcare staff flows, to improve the cross-border supply of healthcare and to support cross-border mutual development.

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LIST OF ABBREVIATIONS

AEBR	Association of European Border Regions
CAWT	Cooperation And Working Together (Interreg project)
CB	Cross-Border
CBC	Cross-Border Cooperation
CBHC	Cross-Border HealthCare Directive
CoR	European Committee of the Regions
CRII	Coronavirus Response Investment Initiative
CRII+	Coronavirus Response Investment Initiative +
EC	European Commission
ECBM	European Cross-Border Monitoring Network
ECBM	European Cross-Border Mechanism
EEIG	European Economic Interest Grouping
EGTC	European Grouping of Territorial Cooperation
EMRIC	Euregio Meuse-Rhine Incident Control and Crisis Management
EPIRHINE	Epidemiology network for the cross-border exchange of information on epidemics mandates by the Upper Rhine Conference
ESF+	European Social Fund Plus
EU	European Union
EUREGHA	European Regional and Local Health Authorities
EWRS	Early Warning and Response System
IPA	Instrument for Pre-Accession Assistance
IZOM	Integratie Zog Op Maat (Interreg project)
MOT	Transfrontier Operational Mission

NGO	Non-Governmental Organisation
OFBS	Franco-Belgian Health Observatory
PandEMRIC	Pandemic Euregio Meuse-Rhine Incident Control and Crisis Management (Interreg project)
REACT-EU	Recovery Assistance for Cohesion and the Territories of Europe
TEIN	Transfrontier Euro-Institut Network
TFEU	Treaty on the Functioning of the European Union
TRISAN	Trinational competence centre for cross-border cooperation in the health sector
WHO	World Health Organisation
ZOAST	Organised Zone for Cross-Border Access to Healthcare

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EXECUTIVE SUMMARY

KEY FINDINGS

- Art. 168 of the Treaty on the Functioning of the European Union encourages the complementarity of health services in cross-border areas. The Directive on patients' rights in cross-border healthcare (2011/24/EU) ensures patient mobility and access to safe and high-quality healthcare in the EU.
- In the 2014-2020 programming period, the most frequent themes in cross-border cooperation (Interreg A) in healthcare were strengthening and improving institutional cooperation and increasing innovation. Projects covered actions such as training (38%), treatment and diagnosis (22%) and equipment (17%). Beneficiaries were first and foremost professionals and then patients.
- Cross-border cooperation faces persistent obstacles that hamper the crossing of borders and cross-border mutual development. Certain cases remain particularly difficult such as the long-term care of patients.
- As the health sector is highly regulated, cross-border cooperation requires the support and involvement of a wide range of partners and specific forms of multi-actor and multi-level governance.
- Intermediaries - such as organised zones for cross-border access to health, health observatories, or other instruments - can facilitate coordination with local and national authorities.
- The recent COVID-19 crisis has demonstrated the vulnerability of cross-border mechanisms and the structural intensity of cross-border flows. It has also highlighted cases of cross-border solidarity and the EU's response.
- Recommendations put forward in this study include simplified and disseminated information, a common cross-border language for healthcare operators, the collection and production of comparable data and mapping of healthcare institutions, the promotion of joint supply of healthcare, and the increased involvement of intermediaries.

"Everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality". This is one of the principles of the European Pillar of Social Rights Action Plan (European Commission, 2021d).

With the support of Cohesion Policy and, in particular, Interreg programmes, cross-border cooperation in healthcare has been the source of many fruitful initiatives over the last decades. These initiatives have focused on joint services, coordination of institutions or other kinds of collaboration between healthcare operators. They have improved the quality and affordability of healthcare for patients, enhanced the work of healthcare operators and lifted standards of well-being in cross-border areas despite the continued existence of obstacles limiting free circulation and cross-border cooperation in healthcare.

Objectives of the study

The main objective of this study is to analyse **the role of Cohesion Policy in cross-border cooperation in healthcare.** It outlines the issue of governance related to such projects as well as the persistent obstacles to crossing the border and to mutual development. It reviews the impact of the COVID-19 pandemic. The study also examines the EU's response to the pandemic. It identifies possible solutions and policy recommendations for improving cross-border cooperation in healthcare.

Methodology

The study is based on an analysis of Interreg programmes from the last 3 programming periods followed by a detailed analysis of 135 Interreg V-A projects related to cross-border cooperation in healthcare. It refers to previous surveys, comparative studies of cross-border governance as well as institutional, academic, and grey literature. It draws on information provided during different interviews with EU experts conducted between April and September 2021. It is also based on five case studies conducted specifically for the purpose of this study by five partners of the Transfrontier Euro-Institut Network (TEIN).

Main findings

Art. 168 of the Treaty on the Functioning of the European Union encourages complementarity of health services in cross-border areas. The Directive on patients' rights in cross-border healthcare (2011/24/EU) ensures patient mobility and access to safe and high-quality healthcare in the EU. National Contact Points, various agencies and measures facilitate access to cross-border healthcare. However, EU **Member States** are ultimately responsible for their own health policies and the organisation of their health and social security systems.

The comparison of **Interreg projects** shows that the number of projects related to healthcare has increased in all Interreg programmes (A, B and C). In the healthcare-related projects financed by the Interreg V-A programme, the most frequent themes are strengthening or improving institutional cooperation and fostering innovation, particularly with regard to products, processes, systems, and research. The analysis reveals that the beneficiaries are first and foremost professionals and then patients. The identified Interreg V-A projects mainly focus on training (38%), treatment and diagnosis (22%), equipment (17%), or information, communication, and networking.

As the health sector is highly regulated for **safety and budgetary reasons** and very often centralised, cross-border cooperation requires the support from and partnership between a wide-range of stakeholders and partners. They are not only hospitals and medico-social institutions but also public authorities, administrative systems, and insurers. Minimal coordination can be based on conventions and partnership, but additional guarantees are required when cooperation intensifies. Therefore, specific instruments or **intermediaries** can be established to act as coordinators and translators liaising local and national authorities and other stakeholders, in a complex **process of governance**.

In addition to the issue of governance, cross-border cooperation faces **obstacles** that hamper the crossing of borders and mutual development. The first type of obstacles concerns free movement; the flow of or access to information; the perception of patients and health staff; different taxation or social security systems; access to health professions and the recognition of qualifications. The second type concerns the required multi-actor and multi-level coordination; the need for a sustainable and win-win support; and the search for a common professional language. Certain cases remain particularly difficult such as the long-term care of patients.

The COVID-19 pandemic highlighted the absence of comparable appropriate and harmonised data, as well as the relatively low-level of awareness cross-border workers had of their rights. It revealed the intensity of cross-border patient and medical staff flows and the capacity for solidarity that European cross-border partners could demonstrate. The European Union Coronavirus Response Investment Initiative (CRII) and Coronavirus Response Investment Initiative Plus (CRII+) were two packages of customised measures to combat the impacts of the COVID-19 pandemic in the context of Cohesion Policy, including in the area of healthcare.

Recommendations

The study puts forward several key recommendations.

These include:

- **Improving and disseminating** simplified information for cross-border patients and healthcare staff (via a manual for patients and the establishment of cross-border regional contact points);
- **Adopting** a common cross-border language inside medical institutions and between all cross-border healthcare operators, including healthcare institutions, insurers, health and social security systems, administrative institutions, and local authorities. This not only requires the provision of documentation in several languages but also the explanation and the "translation" of routines, rules or procedures for the provision of cross-border care;
- **Developing** a sustainable and comparable cross-border database based on harmonised data collection methods as well as **mapping** border and cross-border healthcare operators in order to make cross-border realities more visible and create new opportunities for cross-border cooperation in healthcare;
- **Improving** the cross-border supply of healthcare by promoting e-medicine (with the appropriate supply of training and equipment) and joint public health services in a sustainable and win-win context for operators from both sides of the border;
- **Establishing** European standard protocols and regular meetings to develop integrated and efficient cross-border emergency services;
- **Promoting** the role of intermediaries (such as organising zones for cross-border access to healthcare, European Groupings of Territorial Cooperation, health observatories, networks, or other instruments) to help disseminate good practices and coordinate cross-border cooperation in healthcare in collaboration with local and national authorities.

1. INTRODUCTION

KEY FINDINGS

- *Healthcare of good quality* is one of the principles of the European Pillar of Social Rights and a *high level of human health protection* is stipulated in Article 168 (TFEU).
- The COVID-19 pandemic has highlighted the vulnerability of cross-border mechanisms as well as the structural intensity of cross-border flows.
- The study analyses the role of Cohesion Policy and its Interreg programmes as they relate to cross-border healthcare-related cooperation as well as the obstacles and the impacts of the COVID-19 pandemic on this cooperation.
- This study identifies possible solutions and policy recommendations to improve cross-border cooperation in healthcare.
- This study is based on a descriptive analysis of Interreg programmes; an institutional, academic, and grey literature review; qualitative interviews and five original case studies developed by TEIN partners.

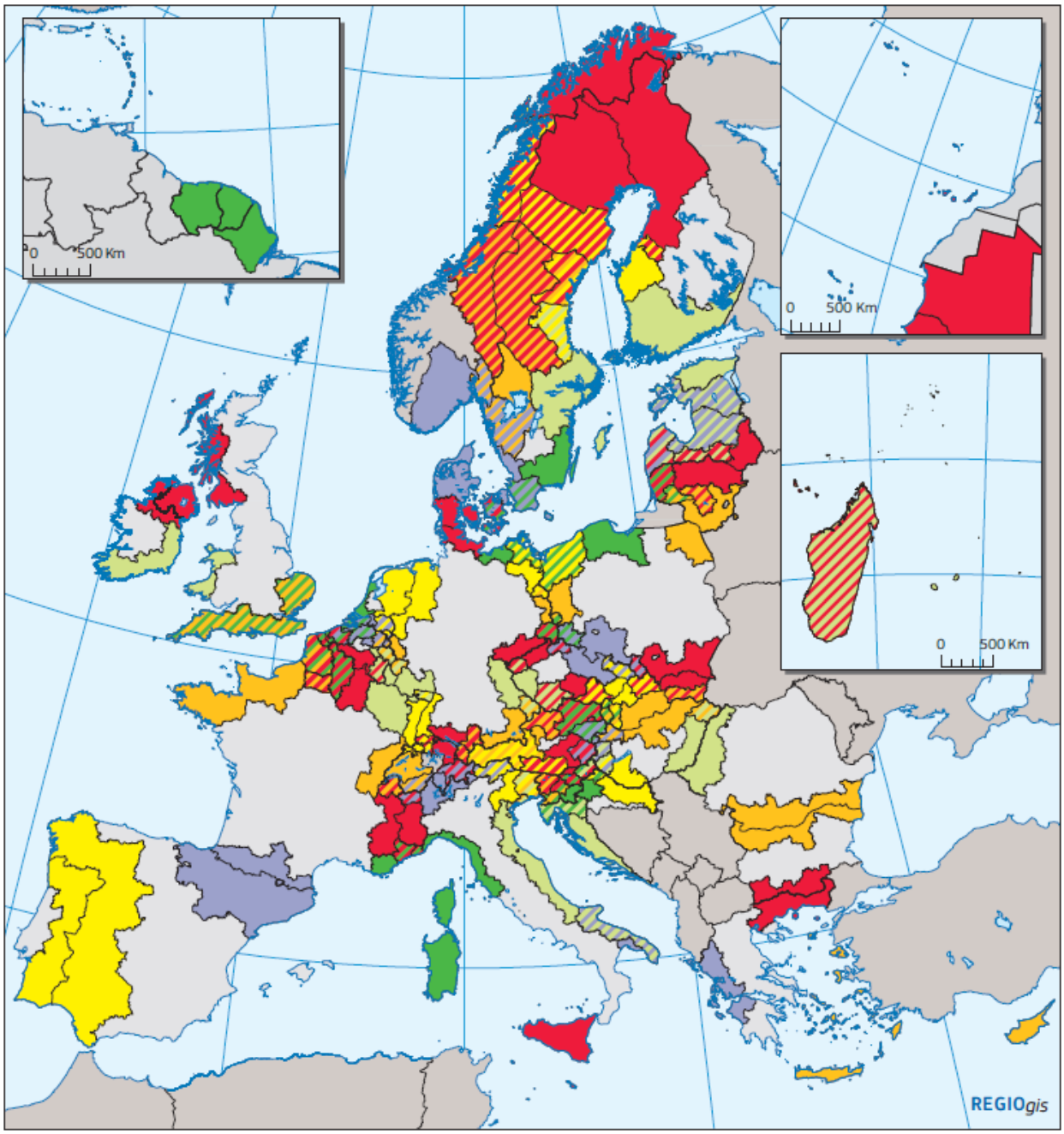
Cross-border territories represent 40% of the territory of the European Union, and more than one in three EU citizen lives in a cross-border region[1].

An integral part of Cohesion Policy since 1990, European Territorial Cooperation (ETC), better known as "Interreg"[2], has played a significant role in promoting cooperation across borders. Interreg-programmes cover a wide number of areas.

Cross-border cooperation in healthcare has gained increased prominence in the last years. It is aimed, first, at encouraging the mobility of patients and health professionals across borders and, second, at improving access to high-quality healthcare for citizens living in border regions through the use of common equipment, shared services and joint facilities.

[1] Boosting growth and cohesion in EU border regions - Regional Policy - European Commission (europa.eu)
[2] About Interreg | What is Interreg and how it works • Interreg.eu.

Figure 1: ERDF Cross-border cooperation programmes 2014-2020



This map shows the areas of the cross-border programmes co-financed by the ERDF.
Each programme area is shown with a specific colour.
Hatched areas are part of two or more programme areas simultaneously.

0 500 Km

Source: DG REGIO

1.1. Policy context

The fifth edition of the *"Health at a Glance: Europe 2018"* report described that the gains in life expectancy had slowed down since 2011 in Europe and that large disparities in life expectancy persisted depending on sex and socio-economic status. However, the authors also found that effective and resilient health systems could reduce premature mortality through the provision of timely healthcare (OECD/EU, 2018, p.13-16). In 2018, healthcare expenditure in the EU accounted for 9.9% of GDP with an overall growth between 2012 and 2018 of 13% [3]. In 2017, the **European Pillar of Social Rights** included healthcare in its 20 principles, proclaiming that "*everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality" (*EC, 2021d*)*.

A "European" public health policy had been developed in several domains such as legislation on medicines or medical and public health research programmes and pluriannual EU Public Health Programmes have been proposed since 2003: they have focused on "*fostering good health, protecting citizens from serious cross-border threats, supporting dynamic health systems and facilitating access to better and safer healthcare for EU citizens"* (EP, 2021, p. 2). More fundamentally, Article 168 of the Treaty on the Functioning of the European Union (TFEU) stipulates that "*a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities"* (Article 168 (1)), even if the EU has only a supporting competence in health and national governments are responsible for their health policy and the delivery of healthcare.

Article 168 of the TFEU also emphasises that "*the Union shall encourage cooperation between the Member States (…). It shall in particular encourage cooperation between the Member States to improve the complementary of their health services in cross-border areas"*. In a context of reduced public budgets and increasing demand for care, cross-border collaboration provides an adequate context to develop such opportunities.

With the support of Cohesion Policy and in particular Interreg programmes over several decades, cross-border cooperation in healthcare has evolved and been a source of many fruitful initiatives. These initiatives have included the provision of joint services, the coordination of institutions and other kinds of collaboration. They have improved the quality and affordability of healthcare for patients, enhanced the work of healthcare operators and lifted standards of citizens' well-being in cross-border areas in spite of the continued existence of obstacles limiting free circulation and cross-border cooperation in healthcare.

In February 2020, the COVID-19 pandemic severely affected the world. In the EU, 580 000 more deaths occurred between March and December 2020, compared with the same period in 2016-2019 [4]. The COVID-19 pandemic turned national borders into protective walls and challenged healthcare staff and institutions.

The crisis revealed the weaknesses and limits of national health systems but also highlighted the scale and need for cross-border flows and exchanges. In March and April 2020, the European Commission presented the Coronavirus Response Investment Initiative (CRII) and the Coronavirus Response Investment Initiative Plus (CRII+) to mobilise support from EU Cohesion Policy. Both packages, which were swiftly approved by Parliament and Council, did not offer any new funds; rather they provided for more flexibility to use existing, unspent resources and redirected them where they were needed most, including through transfers across Cohesion Policy funds and programmes[5].

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[3] Healthcare expenditure across the EU: 10% of GDP - Products Eurostat News - Eurostat (europa.eu).
[4] Eurostat, 12 March 2021, 580 000 excess deaths between March and December 2020 - Products Eurostat News - Eurostat (europa.eu).
[5] Cohesion policy action against coronavirus - Regional Policy - European Commission (europa.eu).

The Recovery Assistance for Cohesion and the Territories of Europe (REACT-EU)[6] extends the EU's crisis response but also provides a long-term recovery plan. The EU4Health programme 2021-2027[7], the fourth EU health programme since 2003, goes beyond crisis response and focuses on protecting people from serious cross-border health threats, making medicines and medical supplies available and affordable, strengthening health systems and healthcare workforce.

The border played a central role in the COVID-19 pandemic: it was seen first as a protective wall by Member States and, second, as a line that patients or healthcare staff had to cross to be cared or to care. As shown in previous Interreg programming periods, the border can also be a basis for organised zones for cross-border access to healthcare or for a cross-border hospital. Therefore, in the post-COVID19 context, cross-border cooperation in healthcare could be one of the flagships of a future "European Health Union".

1.2. Objectives

This study examines cross-border cooperation in healthcare. The healthcare sector follows an extremely hierarchical process of decision-making both for safety and budgetary reasons. Cross-border cooperation when related to healthcare requires the support and the involvement of a wide range of partners, healthcare institutions and staff, public authorities, health insurance entities and systems that finance healthcare and the patients themselves. Moreover, the primacy of EU Member States is restated since they are responsible for defining their national health policies, as well as organising and financing health services and medical practices.

The recent COVID-19 crisis has outlined the vulnerability of cross-border mechanisms and the structural intensity of cross-border flows but also the role of cross-border solidarity and of Cohesion Policy and its Interreg programmes.

The study pursues three main objectives. First, it analyses the role of cross-border cooperation in healthcare in the EU. More particularly, it reviews the role of Cohesion Policy and its Interreg programmes as regards cross-border cooperation in healthcare, with a predominant focus on the Interreg A programme during the 2014–2020 programming period. It analyses issues of governance surrounding healthcare-related projects and outlines main legal, administrative, financial, and organisational barriers to cross-border cooperation in healthcare in general terms. Second, it analyses the impacts of the COVID-19 crisis on this kind of cooperation. It assesses the consequences of the COVID-19 pandemic on cross-border cooperation in healthcare and it explores the response of the EU and cross-border operators to the pandemic, in particular the contribution of Interreg programmes. Third, the study identifies possible solutions and puts forwards policy recommendations on how to improve cross-border cooperation in healthcare.

The introduction presents the methodological and conceptual framework, as well as the limits of the study. Chapter 2 deals with the role of Cohesion Policy in cross-border cooperation in healthcare, the issue of governance and the barriers for such a cooperation. Chapter 3 focuses on the impact of the COVID-19 pandemic on cross-border cooperation in healthcare and Cohesion Policy action, the main problems, the arrangements and the EU response and initiatives. Chapter 4 identifies possible solutions and puts forward policy recommendations, as well as a critical analysis.

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6 Recovery assistance for cohesion and the territories of Europe (REACT-EU) | Fact Sheets on the European Union | European Parliament (europa.eu).

7 EU4Health 2021-2027 – a vision for a healthier European Union | Public Health (europa.eu).

1.3. Methodology

The methodological approaches differ according to the chapters and their sections.

Chapter 2 is based on a descriptive analysis of Interreg projects and EGCTs, secondary literature research and qualitative interviews.

For the first part of Chapter 2 (2.1), a set of Interreg projects was selected from the European database available on KEEP.EU. It is based on data related to the Interreg projects that include the term "healthcare" for the programming periods 2000–2006 (III), 2007–2013 (IV), 2014–2020 (V) and for the Interreg-programmes A, B and C. The set of 135 Interreg A-V projects was deeply analysed (e.g. via a lexical analysis of the titles and the summaries) and classified according to the lead-partner, the topics, the specific objectives, the beneficiaries or the proposed actions.

The second and the third part of Chapter 2 (2.2 and 2.3) are based on literature review (e.g. European Commission, 2016, 2017, 2018b; Mission Opérationnelle Transfrontalière, 2017; Working Group on Innovative Solutions to Cross-Border Obstacles, 2017; OFBS, 2018), on previous surveys and especially on Delecosse et al' s study (2017); they also refer to interviews conducted between April and September 2021 by Emilie Dutrieux and Fabienne Leloup and to five in-depth case studies (see Annex 1). The analysis of the EGTCs and other kinds of cross-border institutions is based on literature and previous studies such as Delecosse et al (2022). Some additional information comes from the surveys conducted by TEIN's partners (see below)[8].

Chapter 3 is based on literature research, interviews of experts (see Annex 1) and a collective contribution from five partners of TEIN. This contribution focuses on qualitative interviews and press or literature analyses at five European borders: the Czech-Polish-Slovak border, the Franco-Belgian border, the Franco-Spanish border, the Franco-German border and the border between the Netherlands, Germany and Belgium.

These original case studies all analyse two main elements. The first is a focus on the immediate effects of the COVID-19 pandemic on cross-border cooperation in healthcare, considering not only restraints and constraints but also examples of solidarity or positive effects. The second is the role of cross-border cooperation in healthcare and the EU's response to the COVID-19 pandemic at the border. Annex 2 provides the five original reports, including some clarifications about the method that was selected, and the detailed findings.

The cross-border cooperation in the Czech-Polish-Slovak border region was studied by prof. Joanna Kurowska-Pysz, from the Research Institute on Territorial and Inter-Organisational Cooperation, WSB University, Poland. The Franco-Belgian border was analysed by dr. Pauline Pupier, dr. François Moullé and prof. Fabienne Leloup, members of the Franco-Belgian Scientific Institute of Borders and Discontinuities. Prof. Martine Camiade (Institute of Catalan Studies) and prof. Jordi Cicres (University of Girona) investigated the Franco-Spanish border and the specific case of the Hospital of Cerdanya. The Franco-German border was studied by Lydia Kassa and Anne Dussap, from the Euro-Institut Kehl and TRISAN and the Euregio Meuse-Rhine, at the border between the Netherlands, Germany and Belgium by Martin Unfried, Hildegard Schneider (IR), Dorian Coppens and Mertens Pim, from the Institute for Transnational and Euregional Cross-border Cooperation and Mobility, University of Maastricht. Some verbatims coming from these interviewees are reported in the document, in italics, in order to give concrete testimonies; the detailed reference is given in footnotes.

[8] Transfrontier Euro-Institut Network.

Chapter 4 is based on the results of the previous chapters and the analysis of various reports, studies, public events, and webinars that discuss current situations and regulations related to cross-border cooperation in healthcare. It also includes the results of interviews with European and academic experts that were organised between April and September 2021. The list is given in Annex 1.

1.4. Conceptual framework

In border studies and the analysis of public policy, various schools of thought exist. There is no room here for a deep dive into a theoretical state of art, but it is nonetheless important to draw attention to the conceptual framework that underpins the current study.

When the question of governing cross-border operators arises, the concept of **governance** is frequently used. This concept accepts that there are many ways of dealing with public problems and suggests that new kinds of negotiations and arrangements be sought out (Rhodes, 1997). Governance may be undertaken by networks of operators of various types, including public authorities working at different scales, associations and private actors depending on the problem or the area concerned (Levi-Faur, 2012). Such a process of governance requires mutual trust and cooperation between operators since no coercive framework prevails. In cross-border cooperation, traditional government processes cannot be used as two or three systems of administration and jurisdiction need to work together. **Arrangements, negotiations** and organisational innovations are required to regulate collective actions and develop CBC projects (Saez et al., 1997; Anderson et al., 2002, Pupier, 2021). The process is multi-actor and multi-level as such coordination results in agreements between private and public partners, local, regional and national authorities. The mobilisation of a wide variety of operators is a direct result of the complexity of the issues at hand. The regulation of cross-border local projects is one example of such a complex issue. These processes of governance can be structured into cross-border networks or anchored in organised zones. In the latter case, the concept of place (or 'territory') arises. The territory is, to some extent, characterized by **homogeneity** (existence of the same rules and norms creating a feeling of belonging) and **continuity** (contiguity and networks of circulation and communication connecting the areas, which create a feeling of cohesion) (Guichonnet and Raffestin, 1974). Its perimeter can differ from traditional administrative divisions since this homogeneity can be based on collective skills, common historical or cultural perspectives or joint objectives. Another conceptual contribution in cross-border studies and administrative sciences has been developed by Joachim Beck (Wassenberg and Beck, 2011). Based on the cycle of public action, Beck's work sheds light on the **necessary conditions and the amplifying effects** a process of cooperation may generate. Initiated by meetings and exchanges of information, initial forms of coordination require joint partnerships, and some kinds of allocation of roles. Further steps in the cooperative relationship will lead to the establishment of a collective strategy, of proposals for a common process of decision-making – which requires binding strong commitments between partners and longer-term agreements – and to a joint implementation of projects and coordinated project management. Each step of cross-border cooperation requires a certain level of regulation and commitment.

The final conceptual framework underpinning this study relates to border realities and social and individual perceptions (Considère and Leloup, 2018). Even in the context of open borders between EU Member States – which means connected people, easy cross-border crossings and some common views about the neighbour living on the other side of the border -, a border remains **perceived** as necessary to protect national sovereignty, control population flows and guarantee security. Such protectionism is deeply anchored in both the minds of public officials and citizens, and it is quick to emerge in situations that are threatening or, at least, perceived to be so.

1.5. Limits

The study does not claim to be exhaustive. A first limit concerns the great number of reports, studies, statistical data and dashboards or opinion pieces published in 2020 and 2021 about the impacts of the COVID-19 pandemic on borders and cross-border cooperation and the numerous responses, regulations, and proposals the EU and its institutions have produced. It is clear that cross-border solidarity was much more advertised than obstacles or failures.

The case studies located at five borders reflect varied situations and common trends can be deduced, but additional cases (for instance in rural areas or at external borders) might provide important additional information.

The descriptive analysis of the Interreg projects is based on the KEEP-EU database. An updated analysis was done in September. The use of other key words (such as “health” or “health” + “social”) would have given another list of projects but we can induce that the trends would be similar.

The policy recommendations and proposed solutions are only briefly outlined; complementary information concerning operators, the legal context and the budget should be included in future studies.

2. THE ROLE OF COHESION POLICY IN CROSS-BORDER COOPERATION IN HEALTHCARE

KEY FINDINGS

- Health is a crucial element for growth and social cohesion; it is also an important economic sector. The evolution in the three last Interreg programmes shows a growing interest in healthcare and a diversification of partnerships.
- The number of healthcare-related projects increased in all Interreg programmes (A, B and C) during the last three programming periods. In the period 2014-2020, the most frequent themes in cross-border cooperation (Interreg A) were strengthening and improving institutional cooperation and increasing innovation.
- Art. 168 of the TFEU encourages complementarity of health services in cross-border areas. The Directive on patients' rights in cross-border healthcare (2011/24/EU) ensures patient mobility and access to safe and high-quality healthcare in the EU.
- Cross-border cooperation in healthcare requires coordination between a wide range of partners, from medical institutions to administrative systems, health insurance entities and local or national authorities. This coordination can be supported by cross-border intermediaries such as networks, observatories, organised zones for cross-border access to healthcare (ZOASTs) and European Groupings of Territorial Cooperation (EGTCs) or other instruments.
- Obstacles to crossing the border and to mutual development persist. Certain cases remain particularly difficult such as the long-term care of patients or the repatriation of the remains of people who died in a cross-border zone.

2.1. The role of Cohesion Policy in the 2014-2020 programming period

Health stands at the interface between social, economic, and fiscal systems (Palm, 2014). It is a crucial element for growth and social cohesion, as well as an important economic sector that overlaps with a number of other sectors. It also constitutes a critical budgetary item and plays a major role in sustainable lifestyles, particularly during a global health crisis such as the COVID-19 pandemic.

The diminishing public spending of the EU Member States as well as their financial difficulties have been a source of tension in the health sector for several decades, but there is a widespread and growing awareness – especially in the context of the current global pandemic – of the crucial importance of this sector. As President Ursula von Der Leyen said in her speech at the World Health Summit in October 2020 (President von der Leyen, 2020):

> *"We cannot wait for the end of the pandemic to repair and prepare for the future. We will build the foundations of a stronger European Health Union in which 27 countries work together to detect, prepare and respond collectively."*

The aim of this first section of Chapter 2 is to summarise the role of Cohesion Policy with regard to cross-border cooperation (CBC) in healthcare. It is divided into 3 subsections: (2.1.1) the role of Cohesion Policy in relation to cooperation in healthcare in general terms; (2.1.2) a comparative description of Interreg programmes and (2.1.3) an in-depth analysis of Interreg V-A programmes related to healthcare.

2.1.1. The role of Cohesion Policy in healthcare

Since 1992, cross-border cooperation in healthcare has been supported by European Territorial Cooperation (ETC), better known as "Interreg"[9]. The objective of ETC is to promote the harmonious economic, social, and territorial development of the EU as a whole. Funded by the European Fund for Regional Development (ERDF), Interreg comprises three strands of cooperation: cross-border cooperation (i.e. Interreg A), transnational cooperation (i.e. Interreg B) and interregional cooperation (i.e. Interreg C). There have been five previous programming periods: Interreg I (1990-1993), Interreg II (1994-1999), Interreg III (2000-2006), Interreg IV (2007-2013) and Interreg V (2014-2020). In the programming period 2014-2020, the fifth generation of Interreg-programmes, about 10.1 billion EUR have been invested in over 100 cooperation programmes, including healthcare.

Cross-border healthcare-related cooperation may involve the transfer or mobility of individuals such as staff, students and patients; exchanges of services or resources including information, equipment, expertise, know-how; and networking. Cooperation can generate mutual coordination or strategies between healthcare or social institutions, collective decision-making or even joint and integrated action and co-management of projects or institutions (Beck, 2017, Moullé et al, 2021). In the words of the former European Commissioner for Regional Policy, Corina Creţu, cross-border cooperation in healthcare *"aims to facilitate the mobility of patients and health professionals living and working in those regions, improving access to local care as well as developing joint facilities and services. This kind of cooperation is often necessary given the isolation of certain regions.*" (Delecosse et al 2017, p.4).

The European Cross-Border Cooperation on Health: Theory and Practice booklet not only outlines the European Union's role in public health and how it supports access to cross-border healthcare in the EU but also gives various examples of cross-border cooperation (Delecosse et al, 2017). As described in this study, a long-term approach to Franco-Belgian healthcare cooperation has been developed along different axes (Hainaut Développement, 2021): healthcare cooperation, emergency medical care and medico-social cooperation. This cooperative approach has been supported by European funding since Interreg I. It is worth highlighting three important outcomes used to support this long-term process: a simple form with conventions; a "cross-border" social security card; and, lastly, a shared healthcare zone. The first manifestation of Franco-Belgian healthcare cooperation was the establishment of **inter-hospital agreements**. It is interesting to note that the first hospitals that signed such agreements in the 1990s are still cooperating closely with each other today, as can be seen from the May 2021 interviews with the directors (see Annex 2). The **Transcard project** was tested in a rural and remote Franco-Belgian district, and it allowed health insurance beneficiaries to use their own social security cards to be admitted to a hospital on the other side of the border. As for the organised zones for cross-border access to healthcare (**ZOAST**), these were established thanks to a regulatory arrangement among institutions located within this cross-border area. These zones facilitate cross-border patient mobility, pool resources and techniques and coordinate social security systems for cross-border healthcare districts.

Seven particularly important cross-border cooperation projects are examined: Trisan, Intersyc, Cooperation and Working Together (CAWT), Telemedicine Euroregion Pomeranie, the Franco-German inter-hospital cardiology partnership project, Integratie Zog Op Maat (IZOM) and the Hospital of Cerdanya (Delecosse et al, 2017). All of these are **specific examples**, which have their own unique history, operators, and needs. They also reveal that projects in healthcare are confronted with the same initial difficulties and restrictions, but the existence of such projects also underlines a commitment in

[9] Interreg : European Territorial Co-operation - Regional Policy - European Commission (europa.eu).

search of mutual development. These projects have all received support from Interreg A in order to initiate or strengthen partnerships formed with them.

The Study on Cross-border Cooperation: Cross-border. Care (EC, 2018a) provided a generic analysis of the kinds of cooperation and partnerships that were formed as a result of cross-border cooperation in healthcare. The study conducted a general survey of 423 projects between 2007 and 2017 related to cross-border projects. It found that approximately a quarter of the 423 projects selected involved **patients** moving across borders, while a large majority of projects were focused on the cooperation between **healthcare providers, knowledge sharing or management** (50%); 23% of the projects aimed at improving treatment or diagnostics; 12% focused on staff exchange and training; and 6% were emergency care collaboration projects.

The top eight countries for lead partners were France, Hungary, Germany, Spain, Italy, Austria, Belgium, and the Netherlands. Romania and Hungary, Germany and the Netherlands and Norway and Sweden were among the most frequent country pairs in bilateral or multilateral collaboration initiatives. The European Commission's study (2018a) emphasised the complexity of cross-border healthcare collaboration as healthcare systems are conceived as historical and closed systems; it demonstrated that driving factors were geographical and related to cultural proximity and that policy makers from both sides of the border remained decisive in the establishment and maintenance of cross-border cooperation.

2.1.2. A comparative analysis of Interreg programmes

This section compares the Interreg programmes in the three programming periods, followed by a detailed description of the evolution of Interreg V-A.

The evolution of Interreg A, B, C

It is important to note that the mapping of cross-border comparison on which this research is based relied on the KEEP.EU database. Some data for the first two periods may be missing. The selection of the projects analysed below was based on Interreg A, B and C projects that included the term "healthcare".

Cross-border cooperation or Interreg A concerns adjacent regions; transnational cooperation; Interreg B covers larger areas of cooperation and focuses on transnational issues; interregional cooperation or Interreg C is based on global programmes between all Member States[10].

As can be seen in Table 1, the number of projects related to the theme of healthcare increased in all programmes, but the number of projects financed by Interreg A in healthcare more than doubled from one period to another. The percentage of Interreg A projects related to healthcare increased from less than 1% of the total Interreg A projects between 2000 and 2006 to nearly 3% between 2007 and 2013.

[10] Interreg : European Territorial Co-operation - Regional Policy - European Commission (europa.eu)

Table 1: Interreg projects including the term "healthcare"

Period	TOTAL	Interreg A	Interreg B	Interreg C
2000-2006	**29**	18	10	1
2007-2013	**60**	42	13	5
2014-2020	**169**	135	29	10

Source: P. Pupier and author, based on KEEP-EU database (April - September 2021)

Interest in healthcare is widespread and covers a broad range of themes, including diagnosis and treatment; digital health and telemedicine; the silver economy; networking and cooperation among healthcare staff or institutions; social services; and the development of thermal spa regions.

Table 2 is based on Interreg B. It identifies the number of healthcare-related projects per period and per region. The number of regions involved in healthcare projects fluctuated, with 6 out of 10 regions hosting such projects between 2000 and 2013, 5 out of 13 regions between 2007 and 2013, and 10 out of 29 regions between 2014 and 2020.

Table 2: Interreg B and healthcare projects

Programme	2000-2006	2007-2013	2014-2020
Adriatic Ionian			1
Alpine Space	1	4	2
Archimed	2		1
Baltic Sea Region	3	2	3
Cadses	1		
Central Europe		2	3
Danube			3
North Sea			3
North West Europe	2	3	6
Northern Periphery (and Artic)	1	2	6
South West Europe			1
Total	**10**	**13**	**29**

Source: author, based on KEEP-EU database (April 2021)

Table 2 shows that some regions had healthcare projects running throughout the three programming periods. This was the case for the Alpine Space, Baltic Sea Region, North West Europe and Northern Periphery programmes. North West Europe and Northern Periphery and Arctic, in Interreg V, hosted more than 3 Interreg B healthcare-related projects.

Table 3 lists healthcare-projects and interregional cooperation programmes, also known as Interreg C.

Table 3: Interreg C and healthcare projects

Period	Project
2000-2006	Interregional cooperation for a trans-European electronic health cards strategy
2007-2013	Consortium for assistive solutions adoption
	Declining, ageing and regional transformation
	Innovation for societal change
	Move on Green
	Regional telemedicine Forum
2014-2020	Delivery of innovative solutions for home care by strengthening quadruple-helix cooperation in regional innovation chains
	European Life Science Ecosystem
	Future Digital Health in the EU
	Health Innovation Experimental landscape through policy improvement
	Identification and implementation of regional policies to take advantage of the silver economy derived opportunities to engage SMEs in growth and entrepreneurship spirit
	Innovative health solutions for thermal spa regions
	Network for technology innovation and translation in ageing
	Open social innovation policies driven by co-creation regional innovation ecosystems
	Optimizing the impact of public policies in favour of research and innovative facilities in the field of medical technologies
	Urban links 2 landscape

Source: author, based on KEEP-EU database (April 2021)

As outlined in Table 3, Interreg C mainly supports **high tech and socially innovative projects**, such as a trans-European electronic health card strategy; regional telemedicine; future digital health; networks for technological innovation and translation in ageing; delivery of innovative solutions for home care and societal change and future digital health in the EU. These projects tend to identify, implement, or optimize public policies, especially in the field of medical technology or health innovation. They are focused on green **ecosystems** and the links between urban and rural landscapes, **aging territories, and population –** as defined in the silver economy and aging transformation projects – and **declining areas.**

Interreg A programmes

With regards to Interreg A programmes, Table 4 highlights the number of projects related to healthcare per programme. In the first period, between 2000 and 2006, Sweden-Norway, Italy-Slovenia, and France-Wallonia-Flanders had more than 2 projects related to healthcare. For the 2007–2013 period, three programmes had more than 5 healthcare-related projects: 2 SEAS (France, Belgium, the Netherlands, and England), France-Wallonia-Flanders, and Hungary-Romania. For the most recent period, Romania-Hungary, Lithuania-Poland, and Euregio Meuse Rhine had 10 or more healthcare-related projects. As outlined in Table 4, most countries developed healthcare projects at different borders, including maritime borders.

Table 4: Programmes concerning healthcare and the number of Interreg A projects per programme

Interreg period	Programme	Number of projects
2000-2006	France - Wallonia - Flanders	**4**
	Italy - Slovenia	**4**
	Sweden - Norway	**3**
	Euregio Karelia (FI-RU)	2
	Estonia Latvia Russia	1
	Finland Estonia	1
	Franco-British Program	1
	HU - RO - SCG	1
	Saxony Czech Republic	1
Total	*9*	*18*
2007-2013	2 SEAS	**9**
	France - Wallonia - Flanders	**8**
	Hungary - Romania	**7**
	Greece - Bulgaria	3
	Hungary - Croatia	2
	Hungary - Slovakia	2
	Romania - Bulgaria	2
	Syddanmark - Schleswig - K.E.R.N.	2
	France Channel England	1
	Greece - Italy	1
	Ireland - Wales	1
	Nord (SE - FI - NO)	1
	Slovenia - Austria	1
	South Baltic (PL - SE - DK - LT – DE)	1
Total	*14*	*41*

Interreg period	Programme	Number of projects
2014-2020	Romania - Hungary	**19**
	Lithuania - Poland	**17**
	Euregio Meuse Rhine (BE - DE - NL)	**13**
	2 SEAS	9
	Belgium - the Netherlands	8
	Germany - the Netherlands	8
	Greece - Bulgaria	7
	Germany - Denmark	6
	Italy - Slovenia	6
	United Kingdom - Ireland	6
	Romania - Bulgaria	4
	Belgium - France	3
	Central Baltic (Finland - Estonia - Latvia - Sweden)	3
	Austria - Hungary	2
	France - Italy	2
	France - United Kingdom	2
	Italy - Austria	2
	Italy - Malta	2
	Slovakia - Hungary	2
	Spain - France - Andorra	2
	Austria - Czech Republic	1
	Czech - Poland	1
	France - Germany - Switzerland	1
	Germany - Austria - Switzerland - Liechtenstein	1
	Greece – Cyprus	1
	Latvia – Lithuania	1
	Poland – Germany	1
	Poland – Slovakia	1
	Slovakia – Austria	1
	Slovenia – Austria	1
	Spain – Portugal	1
	Sweden – Norway	1
Total	*32*	*135*

Source: V. Duvivier, P. Pupier and author, based on KEEP.EU database (April – September 2021)

Table 5: Lead-partners in Interreg A healthcare projects

Country	2000-2006	2007-2013	2014-2020
Austria		1	5
Belgium		4	13
Bulgaria		3	4
Croatia			
Cyprus			
Czech Republic			1
Denmark		3	5
Estonia	1		1
Finland	3	2	2
France	5	12	8
Germany	1	5	9
Greece		3	5
Hungary	1	6	6
Ireland			2
Italy	4	4	9
Latvia			
Lithuania			3
Luxembourg			
Malta			
Netherlands		4	12
Norway	2		1
Poland			15
Portugal			
Romania		5	18
Slovakia			2
Slovenia			1
Spain		2	2
Sweden	1	2	1
United Kingdom		4	12

Note: two Interreg A-V projects have two lead-partners: Artifisiell Intelligens (AI) and IMODE.
Source: V. Duvivier, P. Pupier and author, based on KEEP.EU database (April – September 2021)

Table 5 covers the evolution of the lead-partnership in healthcare-related projects. During the first period (2000-2006), France, Italy, and Finland were the most frequent lead-partners in healthcare-related projects. For the 2007–2013 programming period, France, Germany, Hungary, and Romania were the leaders of 5 or more such projects. For the 2014–2020 period, Romania, Poland, Belgium, the Netherlands, and the United Kingdom were lead-partners in 10 or more such projects. This evolution shows the **growing interest in healthcare,** as well as a diversification in partners involved in healthcare-related projects. However, historical partnerships are still ongoing, as can be seen in the cases of the **2 SEAS** and the **Romania-Hungary** programmes.

2.1.3. An in-depth analysis of Interreg V-A projects related to healthcare

The following analysis provides a breakdown of the 135 projects identified with a link to healthcare. The information for this analysis was collected from the KEEP.EU database and classified according to themes, beneficiaries and actions.

The first comparison is based on **the themes of the specific objectives in relation to the 135 healthcare-related projects.** The specific objectives identify the priority that each Member-State assigns to healthcare. Table 6 arranges the specific objectives into nine themes (column 1) in relation to healthcare: institutional cooperation; innovation; deprived and disadvantaged groups; care; networking: capabilities; mobility and access; labour market and training. With regards to these themes, Table 6 highlights the different Interreg programmes that include these themes (column 2) and the number of projects in relation to the themes (column 3).

Table 6: Themes of the specific objectives per programme and the number of projects

Theme	Programme	Number of specific objectives	Number of projects
Strengthen institutional cooperation	AT - CZ	1	1
	AT - HU	1	1
	BE - DE - NL	1	4
	DE - NL	1	3
	FR - DE - CH	1	1
	IT - AT	1	1
	IT - SI	1	4
	LT - PO	1	6
	LV - LT	1	1
	RO - BU	1	2
	RO - HU	1	1
	SK - AT	1	2
	SK - HU	1	1
Total	*13*	*13*	*28*
Increase innovation	BE - DE - NL	1	1
	BE - FR	1	1
	DE - DK	1	6
	DE - NL	1	5
	FR - BE - NL - GB	**2**	19
	FR - GB	1	1
	SP - FR	1	1
Total	*7*	*8*	*34*

Theme	Programme	Number of specific objectives	Number of projects
Improve networking or cooperation among health operators	BE - DE - NL	1	3
	BE - FR	1	1
	BE - NL	**2**	5
	GR - CY	1	1
	IT - SI	1	2
	SI - AT	1	1
	SP - PO	1	1
Total	*7*	*8*	*14*
Increase the capabilities and capacities of health operators and institutions	BE - DE - NL	1	1
	BE - NL	**2**	5
	DE - AT - CH - LI	1	1
	GB - IE	1	4
	IT - SI	1	2
	SW - NO	1	1
Total	*6*	*7*	*14*
Improve social and care services for deprived or disadvantaged groups	AT - HU	1	1
	BE - DE - NL	1	2
	FR - GB	1	1
	GR - BU	1	7
	LT - PO	1	11
Total	*5*	*5*	*22*
Improve mobility and access to healthcare and services	FR - IT	1	2
	GR - BU	1	7
	PO - SK	1	1
	SP - FR	1	1
Total	*4*	*4*	*11*
Improve the balance between supply and demand in the labour market in healthcare and the global issue of depopulation	BE - DE - NL	1	2
	BE - NL	1	3
	CZ - PO	1	1
	FR - IT	1	2
Total	*4*	*4*	*8*
Improve the types of care	GB - IE	1	2
	RO - HU	1	18
Total	*2*	*2*	*20*
Improve education and training	BE - DE - NL	1	2
	FI - EE - LV - SW	1	3
Total	*2*	*2*	*5*

Note: When one specific objective was related to several themes, it was included several times.
Source: V. Duvivier, P. Pupier and author, based on KEEP.EU database (April-September 2021)

An analysis of the specific objectives indicates that providing **equitable and qualitative health care and services** for everyone remains a real need and that **facilitating institutional coordination** appeared to be one key vector for improving CBC in healthcare.

The most frequent theme in the specific objectives implemented in the 2014–2020 Interreg A programmes relates to **the strengthening or improvement of institutional cooperation**. This theme includes involving public authorities and key actors in the planning of joint solutions, increasing the efficiency of public institutions and services, strengthening institutional capacities, and reducing barrier effects for citizens or residents in cross-border regions. This theme was included in 13 specific objectives and was addressed in 28 projects.

The second theme is the **increase of innovation with regards to products, processes, systems, or research**. Cooperation based on this theme involves different operators and sectors from both sides of the border and encourages further exchanges and complementarity. It includes specific objectives, such as an increase in the delivery and the uptake of innovative products, processes, systems and services in smart specialization sectors or the development of social innovation applications. It featured in 7 programmes, corresponding to 8 specific objectives and 34 projects.

Seven programmes and 14 projects were implemented with the specific objectives of **improving networking and cooperation among healthcare operators in general terms**. This concerned not only healthcare providers but also enterprises, R&D centres or educational institutions. Two projects aimed at improving networking in order to better manage risks (programmes between Slovenia and Austria and between Greece and Cyprus).

Increasing the capabilities and capacities of healthcare operators and institutions was related to 7 specific objectives and 14 projects. It mainly concerned the R&D or innovation capabilities of healthcare institutions and enterprises, R&I centres, and other knowledge institutions.

The enhancement of social and care services for specific groups was included in 5 specific objectives and 22 projects. These programmes covered socially and economically disadvantaged people, such as the vulnerable, deprived, and communities in precarious situations. Eleven of the 22 projects involved CBC between Lithuania and Poland and 7 between Greece and Bulgaria.

Mobility and access to healthcare and services were addressed in 4 specific objectives and 11 projects, including those related to the access to emergency healthcare in mountainous and rural areas. Seven projects were funded by the Interreg V-A programme between Greece and Bulgaria.

The issue of **the labour market** featured in 4 specific objectives and 8 projects. The specific objectives related to the question of qualification, the balance between supply and demand and specific problems facing remote areas.

The following theme is **the improvement of care,** which appeared in 20 projects. It also referred to two specific objectives from two programmes: 18 of these 20 projects involved CBC between Romania and Hungary and aimed at improving preventive and curative healthcare services. The 2 other projects, which were run across the border between Ireland and Great Britain, were dedicated to people's health and well-being.

Finally, 2 programmes and 5 projects were dedicated **to better training and improved connections between educational systems**; these programmes and projects were based in the Central Baltic Region and in the Euregio Meuse-Rhine.

After analysing the specific objectives per theme, a lexical analysis of the summaries and titles of the 135 projects was carried out. The objective was to gain a better understanding of the 135 projects' beneficiaries (Table 7) and of the types of actions proposed by the projects (Table 8).

Table 7: Projects classified according to their beneficiaries

Beneficiary	% of the 135 projects
Professionals	45%
Patients	42%
Healthcare institutions	37%
Research centres	27%
Companies	17%
Disadvantaged people and areas	8%
Public authorities	4%

N.B.: The sum in the tables exceeds 100% as some projects had several beneficiaries.
Source: V. Duvivier, P. Pupier and author, based on KEEP.EU database (April -September 2021)

Regarding the beneficiaries, the main target group was professionals, as 45% of the projects focused on staff and the workforce: in most cases, they concerned healthcare professionals, but also cleaning staff, administrative or financial employees.

42%% of them focused on patients in general terms. It is interesting to note that there was no significant distinction according to age or gender. Nine of the 135 projects targeted children, 34 were aimed at older or elder people; 19 of the 135 projects related to COVID-19.

37% of the projects applied to healthcare institutions, mainly hospitals but also rehabilitation or specific disease centres such as cancer centres. This figure also includes 5 projects related to pharmacies.

In 27% of the projects, universities, knowledge and research institutions or laboratories were the beneficiaries. When universities were not included, 21 projects (or 15,5%) concerned research institutions.

Private companies and entrepreneurs were the target group of 17% of the projects and 4% of the projects focused on public authorities.

8%, that is 11 of the 135 projects, were dedicated to supporting disadvantaged and socially sensitive people and disadvantaged and poor areas.

Table 8: Projects classified according to their actions

Action	Number of projects	in % of the 135 projects
Training	51	38%
Treatment and diagnosis	29	21%
Equipment	23	17%
Information	22	16%
Campaign and publicity	19	14%
Networking	17	13%
Prevention	14	10%
Exchange and transfers	14	10%
Social action	11	8%
Capacity-building	9	7%
Telehealth	7	5%
Emergency	4	3%
Labour market	3	2%
Mobility	2	1%

Note: The sum in the tables exceeds 100% since some projects focused on several actions.
Source: V. Duvivier, P. Pupier and author, based on KEEP.EU database (April -September 2021)

Concerning the types of actions undertaken as part of these projects, 38% of them focused on developing different forms of training, including the organisation of workshops, conferences and seminars for health and social workers, as well as for administrative staff, managers and other partners and teachers. They also proposed curricula and traineeships for students.

Diagnosis and treatment, which is at the core of the healthcare mission, were the objects of 21% of the projects.

17% of the projects referred to the exchange or purchase of equipment. These mainly concerned medical equipment, but also covered equipment used for training, management, or measurement.

16% of the projects explicitly involved the sharing of information between medical professionals, trainers, managers, and the general population. 14% explicitly mentioned the development of campaigns with the aim of communicating a particular message or generating publicity.

13% of the projects were concerned with networking, in order to improve communication between research centres, hospitals, and enterprises or to improve diagnosis and teleconsulting.

10% of the projects, that is 14 projects, were aimed at prevention. This included one project that tackled the threat of epidemics.

Actions involving exchanges or transfers could be found in 10% of the projects; 10 of these projects concerned the transfer of data, information, experience, and knowledge.

8% of the projects involved social action or were aimed at social workers, while 7% were related to develop infrastructure and to improve the capacity of institutions, professionals, or managers. These focused on the development of new structures and tools such as online platforms, unified booking centres, cooperative frameworks, hubs, or governance networks.

Tele-medicine, telecare or e-health were the scope of 5% of the projects. Emergency was the main action of only 3% of the projects; 2% of the projects involved research on the development of a balanced labour market and 1% considered patient or labour mobility.

These statistics show that main beneficiaries of healthcare-related projects in Interreg V-A programmes were, first and foremost, professionals and then patients and few projects were aimed at specific subgroups, such as older, precarious, or deprived populations. More than a third of the projects focused on healthcare operators, and these were mainly healthcare or medical institutions. However, research centres (including universities) and private companies could also be beneficiaries.

The objectives of the projects can be divided into two main groups. In the first and largest group, the projects tended to aim at improving care (through training, networking, equipment, capacity-building) and were mainly directed at staff and institutions. The second group covered actions that directly aimed at the wider population, such as better, expanded or more innovative treatments, diagnosis, prevention, publicity and information campaigns.

Capacity building was the explicit objective in 7% of the projects, but the projects based on information, training, and networking can be seen as taking the first steps required for such a collective capacity building. It is worth noting that questions of mobility or exchange formed the basis of a small number of projects (11%) and these were more often related to data collection, information, equipment and even staff rather than patients.

The projects aimed to improve the current situation, through the purchase of equipment, the improvement of diagnoses or the emergency system, as well as plan for the future, as demonstrated by the role of research centres and the importance attributed to training, including the creation of curricula.

2.2. The issue of governance of healthcare-related projects

As discussed above, the issue of governance is one of the main themes addressed in the specific objectives of the Interreg V-A healthcare-related projects.

The second part of Chapter 2 considers the governance of healthcare-related cross-border projects, as healthcare is strictly regulated according to national laws. Member States are responsible for defining and implementing their health policies, as well as organising and delivering health services and medical care, while the European Union complements the Member States' actions, as set out in Article 168 of the TFEU. However, when cross-border cooperation occurs, common rules, standards and norms must be agreed upon, and a process of governance may be initiated. The following analysis of the Interreg V-A projects, which is based on interviews with CBC managers and literature research, sheds light on the various levels of coordination and the use of different support instruments for implementing such a process of governance.

2.2.1. Healthcare, the EU focus, and the permanent responsibility of the Member States

Initially, healthcare was not specifically addressed by the EU's founding treaties. From the 1990s onwards, however, the management of multiple health crises, growing tension between health systems and the close links between health and other policies required a more coordinated health policy at a European Union level. Art.129 of the Maastricht Treaty (1992) created a legal basis for EU

involvement in this area and **Art. 168** of the Lisbon Treaty ensured a high level of human health protection in EU policies and activities. It also encouraged "*cooperation between the Member States to improve the complementarity of their health services in cross-border areas.*" (Article 168. 2).

The **Directive on patients' rights in cross-border healthcare** of the European Parliament and of the Council of 9 March 2011 (2011/24/EU) largely resolved the issue of reimbursement of costs for healthcare provided outside the patient's Member State of affiliation and created a legal basis for the development of a healthcare coordination policy in the EU. This directive acknowledges that the patient can be reimbursed, without prior authorisation, for non-planned hospital treatment provided abroad at the rates applicable in the country of affiliation after having paid the costs in advance. Patients can also be reimbursed if they have received prior medical authorisation for a hospital stay that is more than one night and for specialised services; the amount reimbursed is equal to the current rate in the country of affiliation. This directive ensures patient mobility and access to safe and high-quality healthcare in the EU and it is not only directed at those citizens living in a cross-border area (Wassenberg and Reitel, 2020, p.520).

To facilitate the implementation of the directive, **National Contact Points** were created to provide information on access to healthcare and health systems to potential patients in other EU countries, as well as Iceland, Liechtenstein, Norway, and Switzerland. The directive is the subject of an annual report, and the directive's mechanism has been evaluated at 3-year intervals since 2015 (European Commission, 2015).

Various tools, committees, and expert groups have been created to support healthcare governance, such as the European Medicines Agency, the European Centre for Disease Prevention and Control, the European Chemicals Agency, the European Observatory on Health Systems and Policies, or the cross-border healthcare expert group (European Parliament, 2021). EU health programmes implement EU health policy, and the implementation of the European Pillar of Social Rights is related to EU actions on social security issues (European Parliament, 2019)[11]. Yet, **the primacy of Member States** in this area remains as they continue to define their national health policy, the organisation and the financing of health services and medical practices. National institutional systems define medical and social protocols, medical curricula and training, as well as the criteria for the conditions of reimbursement for social services and healthcare, all according to their own social security standards and budgetary concerns.

The regulation of the healthcare sector follows an extremely **hierarchical process of decision-making**. For several decades, the health sector in EU Member States has undergone major structural and organisational changes – as has been the case in a lot of public sectors – which have tended to reduce medical units in terms of budget, missions and staff, as well as having centralised the process of decision-making in some large centres (such as University Hospitals in major cities). In many cases, these centres are far from the border areas. As a consequence, cross-border cooperation in healthcare depends on institutions located far from the day-to-day realities that local hospitals or medical units face, and a hierarchical process of decision-making is added to any cross-border process.

2.2.2. Cross-Border cooperation and governance

When cross-border activities related to healthcare or any other sector are developed, such kind of cooperation requires the establishment of specific cross-border norms, rules, and agreements. The Interreg programmes serve to facilitate dialogue between the concerned parties and provide funds in

[11] Various reports are regularly published such as *State of Health in the EU* or the *Country Health Profiles,* a joint work of the OECD, the European Observatory of Health Systems and Policies, in cooperation with the European Commission.

support of cooperation, but the question of how to coordinate such efforts and how to govern such projects remains crucial.

The cross-border cooperation refers to a process of **governance. This means** the creation of networks of various operators, which may include different levels of public authorities, associations and private stakeholders, depending on the problem that requires resolution or on the place that needs to be organised (Levi-Faur, 2012).

In CBC, a traditional process of government cannot be used. Indeed, the linking of two or more administrative systems and jurisdictions requires transversal coordination. Arrangements, negotiations, complementary tools, and social and organisational innovations are all necessary for the regulation of collective actions and make permanent cooperation possible (Saez et al., 1997; Anderson et al., 2002). Hierarchy is replaced by a process of multi-level negotiation. Customised rules and mechanisms can be implemented to provide a flexible response, which must remain legally compatible with the relevant national systems. **Strong commitment from local stakeholders** is required to inform and negotiate such arrangements. For local elected representatives, this commitment requires tangible outcomes, such as access to closer hospitals, or the existence of a more effective emergency system.

The EU has developed **various tools for managing** similar processes of institutional innovation and governance, such as the European Grouping of Territorial Cooperation (EGTC). This legal entity enables public authorities to cooperate without requiring a prior international agreement to be signed by national authorities.

The question of governance in relation to CBC in healthcare is specific. As discussed above, the health sector is highly regulated both for safety and budgetary reasons and decision-making is very often centralised. CBC in healthcare requires the support and involvement of a wide range of partners: local but also national authorities; hospitals; health professionals; medico-social institution; health insurance entities and other systems that finance healthcare, administrative staff, and the patients themselves. Such a form of cooperation between so many stakeholders entails long processes of inter-sectorial and multi-level compromise and negotiation.

2.2.3. Healthcare: CBC governance

In the first part of this subsection, our analysis of CBC projects related to healthcare demonstrates the central role of bi- or trinational agreements in providing a sustainable framework and in emphasising the role of the European Union.

In the second part, we consider how the establishment of rules and regulations in this field often takes a specific form, which can vary according to the degree of cooperation expected by the stakeholders. On the one hand, the main objective may be to maintain flexibility, which is often achieved through the creation of a network or an associative framework with specific partnerships or conventions. On the other hand, when the aim is the recognition of a governance system, this can be achieved through the creation of some sort of governing framework, which informs, connects, or even manages and implements cross-border cooperation.

Need for bilateral or multilateral agreements and European coordination

As can be seen from the historical case of Franco-Belgian cross-border cooperation in healthcare, bilateral and multilateral agreements have been signed between local, regional, and national authorities to clearly identify relevant activities and institutions and to stabilise cross-border cooperation (Delecosse, et al 2017). The framework of the 2005 Franco-Belgian agreement and its

administrative arrangements took more than two years to establish; it defined the competent authorities and the aims of cross-border cooperation in healthcare, while delineating the areas covered by such a cooperation.

This kind of negotiation was replicated between France and Germany, Spain and France, and Luxembourg and France; similar cooperation agreements have been signed in the Northern regions of Finland and Sweden. To take one particular instance, the constitution of the Franco-German Cross-Border Cooperation Committee – one of the joint projects established by Germany and France in the Treaty of Aachen of 22 January 2019 – aims to support cooperation, particularly in relation to the daily issues of transport, employment, development, and health; this committee is made up of State representatives, local authorities, and members of Parliament[12].

Cooperation on medical emergency services may also be governed by binational agreement, as in the case of the Franco-Belgian agreement on emergency medical care, which was signed in 2007, or the agreements between Luxembourg, Belgium, and France and Germany.

This type of arrangements is in line with the spirit of **Article 168 of the TFEU as Member States are encouraged to develop strong forms of cooperation** and ensure that patients' rights are respected in cross-border healthcare. Arrangements encourage cooperation as they legitimise and stabilise it at the highest level. At the same time, they consist of a general framework and allow local authorities to negotiate and arrange additional agreements. European Union coordination on healthcare is becoming increasingly necessary. This is not only because it is a requirement of Article 168 of the TFEU and the Directive on patients' rights in cross-border healthcare. Such coordination is also required to face contemporary challenges in the health sector in cross-border areas and elsehwere. As discussed in further detail below, European Union coordination helps Member States to act while allowing for the collection of comparable data and the exchange of information, expertise, and equipment, as well as promoting the recognition of equivalent studies in educational curricula. CBC in healthcare is thus guaranteed or stabilised by Member States' agreements, but it also requires specific arrangements, or de-regulation to reach its long-term objectives.

Two forms of governance and various instruments

Healthcare cooperation in a cross-border context can follow two forms of governance. Certain cross-border activities or projects can fail to induce an integrated process of governing and, in these cases, cooperation is only regulated in a **local and pragmatic way** with a minimum of functional arrangements. Alternatively, some kinds of formalised institutionalisation are adopted as cooperation is reinforced. This is the case, for instance, when cooperation shifts from exchanging information to pooling resources or expertise. In the first case, the main objective is to retain flexibility, which is achieved through the creation of regular networking or the maintenance of associative frameworks with specific partnerships or conventions. In the other case and in addition to the usual conventions, **a learning process** based on a cross-border process of co-decision emerges, which tends to use European instruments in order to develop original institutional arrangements and recognise the basis for a system of cross-border governance.

[12] https://www.diplomatie.gouv.fr/en/country-files/germany/events/article/germany-franco-german-cross-border-cooperation-committee-23-dec-20 .

Minimal coordination: the need for a convention or a partnership

An analysis of cross-border cooperation in healthcare demonstrates the need for inter-hospitals partnerships or inter-centres conventions that not only guarantee the quality of patient care but also handle questions of reimbursement and personnel commitment.

A first example is the Franco-German inter-hospital partnership, which was signed between the cardiology units in the hospitals in Forbach (France) and Völklingen (Germany) on 19 March 2013 (Delecosse et al 2017). Limited in scope, the agreement only concerns the diagnosis of specific cases. This inter-hospital partnership has reinforced the medical teams - thanks to the presence of bilingual cardiologists -, as well as strengthened the links between the hospitals at the administrative and managerial levels. Such an agreement could play an important role during a pandemic (for example, by permitting patients with acute myocardial infarction to continue crossing the border to receive care). A similar case can be found in the conventions signed between the hospitals of Mouscron (Belgium) and Tourcoing (France) since 2005. Both institutions have developed formal and informal forms of cooperation, including the pooling of medical staff and equipment. Both are also members of the same ZOAST (see below), which is a large network of medical institutions located in the same zone sharing information and experiences (this cooperation has continued throughout the COVID-19 crisis).

In the Interreg V-A programmes, several projects include **comparable arrangements**. These include the CBC-HOSPEQUIP project, which was signed between the Dr. Gavril Curteanu Hospital in Oradea (Romania) and the Békés County Central Hospital in Hungary[13]; NEX-AID, which implemented 3 cross-border protocols for the transfer of patients or for the emergency systems in place between certain medical and research centres in Italy and Slovenia[14]; and REMOTE CARE which is based on joint health and social integration protocols among public institutions in Bulgaria and Greece[15].

Collective rulemaking

When cooperation intensifies, operators and authorities may look for additional guarantees, especially when agreements include more than two partners, a variety of medical collaborations or expanded care access for patients. Such guarantees may be provided by the European Union in the form of assistance from a European Grouping of Territorial Cooperation, for example, or specifically put in place, by the establishment of a particular healthcare network, centre, observatory, organised zone, or other instrument.

A European Grouping of Territorial Cooperation (EGTC) is a European legal instrument for facilitating territorial cooperation. EGTCs are governed by Regulation (EC) No 1082/2006 amended by Regulation (EC) No 1302/2013 (Wassenberg and Reitel, 2020, p.366-367). This entity is a flexible and principally multi-sectoral structure that does not involve a transfer of power between members. It mainly covers municipalities (currently ranging as few as 2 to as many as 85 in the *Bànàt-Triplex Confinium* EGTC), as well as regional and national public authorities and non-governmental organisations, private enterprises, and universities (Delecosse et al, 2022). EGTCs are seen as instituted forums that are useful for inspiring Interreg projects, facilitating information exchange and networking among partners from various sectors, and acting on scales ranging from local to national levels.

EGTCs play various roles in CBC in healthcare. As partners in European Union Cohesion Policy, EGTCs can act as managing authorities for operational programmes, as is the case of the *Greater Region* EGTC (FR, DE, LU, BE). They may also be leaders of or partners in specific Interreg projects, such as the EGTC

13 Telemedicine is the future – Interreg (interreg-rohu.eu).
14 NEX AID | Italia Slovenia (ita-slo.eu).
15 Remote Care (remotecare2020.eu).

West Vlaanderen/Flandres – Dunkerque – Côte d'Opale (FR-BE), the *Bànàt-Triplex Confinium* (HU-RO), *Muraba* (HU-SI), *Saar Moselle* (FR-DE) and *Via Carpatia* (SK-HU). The cross-border Hospital of Cerdanya is a special case: opened in September 2014, this EGTC manages a medical institution; the hospital offers a limited portfolio of services and receives support from reference hospitals in France (Perpignan, Toulouse, Montpellier) and Spain (Manresa and several other hospitals); it coordinates French and Catalan public health systems and recognises a patient's right to care if they hold a French or Spanish insurance card or are covered by the European Health Insurance system.

CBC in healthcare also tends to create **specific instruments**: formalised networks, coordination centres, observatories, or organised zones for cross-border access to healthcare.

Formalised networks serve to bring partners together within a flexible structure that is easy to expand to other operators, as the case of the *Telemedicine Euroregion Pomerania* network (DE-PO) which offers access to health services and communication technologies (Delecosse and al 2017). Another example is the *Euroregio Meuse-Rhine incident control and crisis management* (EMRIC) cross-border network, which is based on collaboration between public services responsible for public safety – including fire, technical assistance, and emergency medical care service – in the Euroregio Meuse-Rhine.

In Interreg V-A, several projects have involved the creation of these types of networks, such as *I SAID*, which is developing practical cross-border communities and a collaborative platform to promote cross-border health (FR-BE)[16], or *MOBI*, which is setting up a network platform (Sharepoint)[17]. In the case of the latter, the development of such a platform must be supported by training courses, seminars, or other face-to-face meetings in order to create sustainable linkage and confidence.

TRISAN (FR-DE-CH) is an interesting example of formalised network as it has been created to identify, coordinate, and amplify synergies among cross-border partners. Some of the partners involved in TRISAN have already been working together since Interreg I (1990-1993), but the creation of the tri-national centre in 2016 has helped to consolidate their long-standing history of cooperation. This has been achieved by creating a cooperative platform to help healthcare stakeholders, set joint planning goals, or create synergies between new and existing networks.

Another instrument is the establishment of a **cross-border health observatory.** The observatory is dedicated to the collection of data, but it can also serve to bring hospitals, medical professionals, and institutions together in order to keep them informed of various developments and induce collective capacity-building. Moreover, it helps the coordination of cross-border activities in a flexible and permanent way. The Franco-Belgian Health Observatory (OFBS) is run as a European Economic Interest Grouping (EEIG), which is a European legal instrument formed by individuals, companies, and other entities that cooperate across borders; it leads or takes part in Interreg projects and plays an intermediary role between medical staff, patients, and public authorities.

The last example of a specific instrument that stimulates cross-border healthcare cooperation are the **organised zones for cross-border access to healthcare** (ZOASTs) (OFBS, 2019). The objective of these zones is to define a cross-border living space where hospitals and other medical or social centres agree to collaborate and to establish partnerships. They facilitate patient mobility by reducing administrative or financial barriers. The seven Franco-Belgian ZOASTs are regulated by the Franco-Belgian framework agreement. The success of the ZOASTs is not automatic; it depends on software development work, as well as mutual arrangements and reciprocal needs. This instrument tends to be used at the Dutch-Belgian and Franco-German borders.

[16] I SAID | Interreg (interreg-fwvl.eu).
[17] MOBI | Interreg Euregio Meuse-Rhine (interregemr.eu).

Treaties, successive European Union agreements and health and social security directives have aimed to gradually moderate the impact of Member State borders on healthcare for the benefit of European citizens. However, the primacy of Member States in health remains and a hierarchical and strict process of decision-making is part of any sustainable CBC in healthcare.

A minimum of conventions or formal rules is required for the successful implementation of cross-border healthcare-related cooperation, and these must remain legally compatible with the national systems in place. The use of binational or trinational agreements serves to stabilise such cooperation. This analysis shows the importance of flexible instruments that can be adapted to the field, as well as the need for a process that involves many actors as the outcomes of CBC concern public health authorities, health insurers and health institutions.

Various instruments are available to help strengthen CBC, and these can assist with the exchange and collection of information, the development of common databases, the pooling of equipment or staff, the transfer of patients, and lobbying. Virtual platforms alone are not sufficient as confidence and sustainable links are required. As the case of the ZOASTs demonstrates, a key strength of CBC in healthcare is its potential to take advantage of geographical proximity: these organised zones provide an open system that favours coordination in a flexible way, while institutionalising such a coordination.

2.3. The legal, administrative, financial and organisational barriers

Given the length of this report, the analysis of the legal, administrative, financial, and organisational barriers to CBC in healthcare cannot be exhaustive. This study is based on literature, on interviews and on five in-depth case studies. It outlines the existing barriers according to two possible objectives of healthcare-related cooperation: (2.3.1) crossing the border and (2.3.2) improving mutual activities and promoting cross-border development. It examines issues surrounding coordination and governance, as highlighted by existing cases of cross-border cooperation.

2.3.1. Barriers to crossing the border

The integration of the European market promotes the free movement of goods, capital, and people. This fundamental element of European integration should be especially apparent for those who live close to the borders. It ensures the free passage of patients, medical staff, and students across borders so they may receive care, can work or study in the neighbouring country.

Patients

- *People are not sure about how much they will be reimbursed and how long this reimbursement will take (a Belgian extract from an interview, May 2021[18])*

The first barrier that limits cross-border healthcare is a **lack of information**. This ties in with a lack of awareness concerning the availability or quality of treatments across the border. Inhabitants and workers are not aware of the opportunities that exist beyond national boundaries.

This lack of information also concerns the existing European legal framework surrounding patient mobility. As mentioned above, two different categories of patient mobility can be identified: patients who receive medical treatment while already abroad (seeking unplanned healthcare) and patients who travel to receive medical treatment in a different country (seeking planned healthcare). Unplanned healthcare is regulated by the European Health Insurance Card, whereas planned healthcare is regulated by the form S2. As for specific populations, Regulation (EC) No 883/2004 and Regulation (EC)

[18] Reported by the Franco-Belgian Scientific Institute of Borders and Discontinuities, Annex 2.

No 987/2009 outline the rules that exist for pensioners who reside in a country that differs from the one where they had worked or for cross-border workers who work in one country and reside in another. As explained above, Directive 2005/36/EC has established National Contact Points which provide information for citizens who wish to receive healthcare in other EU countries. This information covers, among others, the types of treatment for which potential patients can be reimbursed, and the categories of costs covered. Each Member State publishes the conditions of its prior authorisation system on this platform. Directive 2011/24/EU lets Member States define the conditions of its prior authorisation system; for instance, such authorisation is required when the treatment sought requires the patient to spend at least one night in hospital or involves the use of highly specialised and/or cost-intensive medical equipment or infrastructure.

Since 2015, studies on Directive 2011/24/EU have been published every three years in order to evaluate this process. The 2015 evaluative study on the directive found **a relatively low level of patient awareness** with regards to cross-border healthcare-related cooperation; National Contact Points provided quite limited information, especially on undue delays or waiting times estimated by national authorities or health insurance providers. Member States' data on cross-border patient healthcare following Directive 2011/24/EU (European Commission, 2019) showed that the total number of requests for information received across the National Contact Points remained stable. Only four Member States, as well as Iceland, put in place mechanisms that could be used to limit a citizen's access to healthcare from another Member State and only one (Denmark) applied these measures. Nine countries reported that they had not introduced a prior authorisation system. 7171 requests were reported – slightly down from the 7297 requests received in 2018 – and only 16% were reported as having been refused, whereas 28% were refused in 2018.

In addition to the limits set out in the directives and legal documents, a patient's mobility could also be hampered by perceptions. Even when patients are informed and willing to cross the border in order to receive care in another country, the real or perceived complexity of administrative procedures, uncertainty surrounding the amount they may be reimbursed, and a risk of delay or other bureaucratic procedures can serve to limit mobility. Language barriers can further amplify a patient's reluctance to travel beyond their national borders in search of medical treatment (for instance, when all documents are not translated or when nobody in the medical institution is bilingual).

As outlined below, this complexity limiting patient mobility is further reinforced by the wide range of parties required for complete coordination. These parties can include administrative staff from medical institutions or the relevant social security system or insurers, or other related services. All or some of these parties may be unfamiliar with cross-border situations and legislation and, therefore, unable or simply unwilling to help.

Certain cases related to patient mobility remain particularly difficult, such as those related to the long-term care of elderly or disabled people or the repatriation of the remains of people who died in the cross-border zone.

Healthcare staff

- *A Greek doctor can practice in France, but it is incredibly difficult for a French doctor to receive official permission to practice just across the border in Belgium (a French extract from an interview, May 2021[19])*

For cross-border workers, including medical staff, different taxation and social security systems are still significant obstacles as these differ from one country to another and no specific information is easily available. Similar obstacles also restrain the cross-border **mobility of medical trainees and students** working in the field of healthcare as well as their teachers. Some progress has been made in this domain; Directive 2005/36/EC and Regulation (EC) No 883/2004 have ensured the mutual **recognition of professional qualifications** in the EU. However, a lack of knowledge and automaticity concerning questions of equivalence and the recognition of education and qualifications persists.

2.3.2. Barriers to mutual development

EU Cohesion Policy contributes to the promotion of the economic, social, and territorial development of European regions. It aims to bring border regions and their inhabitants closer together by "*exploiting the untapped growth potential in such areas where cross-border interaction may effectively take place or in which functional areas can be identified*" as stated in Regulation (EU) No 2021/1059 of 24 June 2021 on specific provisions for the European territorial cooperation goal (Interreg)[20]. When such a cross-border interaction is developed, the question of patient or staff mobility quickly emerges and has to be addressed: a process of reimbursement, equivalence, or a coherent administrative procedure has to be established and it will require transversal or multi-actor coordination or similar arrangements.

Medical organisations

- *As a cross-border partner of a German hospital, a French nursing school had to organise language courses (a French extract from an interview, May 2021[21])*
- *The Franco-Catalan Hospital of Cerdanya had to form binational nursing teams to manage linguistic as well as cultural differences (a Spanish extract from an interview, June 2021[22])*

When inter-hospital conventions are signed, some of the services and units of the organisation must be informed about the cross-border specificities. These services and units include reception personnel, social workers, and administrative staff, as well as the medical staff who work specifically on the project. This degree of cooperation can require a good level of proficiency in the languages used in both contiguous countries as well as time in order to explain the project and its consequences.

Apart from **linguistic barriers**, difficulties can also arise from **differences in regulation, terminology, or routines**. These differences are particularly visible when cross-border cooperation is developed for emergency medical services. Such difficulties can stem from divergences between domestic systems for civil protection, different qualification requirements for staff, asymmetries in emergency call systems – even the colour of the cross on the emergency vehicles or the sound of their alarms may differ.

Cultural misunderstandings can also arise, and frequent meetings and exchanges may be required to limit or address these.

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19 Reported by the Franco-Belgian Scientific Institute of Borders and Discontinuities, Annex 2.
20 Publications Office (europa.eu).
21 Reported by Euro-Institut of Kehl and TRISAN, Annex 2.
22 Reported by prof. Martine Camiade and Jordi Cicres, Annex 2.

Healthcare systems

- *The French regional healthcare agency negotiates only with its equivalent; local institutions located within the cross-border region need to receive regional permission to run cross-border projects (a French extract from an interview, May 2021[23])*
- *At the border between Poland and the Czech Republic, hospitals are managed either by the local government or national authorities: this leads to a lack of compatibility among procedures, protocols, and healthcare systems (a Polish extract from an interview, June 2021[24]).*

Healthcare is a highly regulated sector and is dependent on various stakeholders. Therefore, when cross-border cooperation is initiated, it requires **the support and partnership of a wide range of stakeholders, working within hospitals** and medico-social institutions as well as **from people working for public authorities, administrative systems, and insurers.**

Societal and cultural differences may crop up and time is required to create a favourable cross-border "atmosphere" among healthcare operators. The mobility, or lack thereof, of institutional management teams or changes in locally elected representatives can erode collective trust or undermine mutual understanding and prevent the establishment of a stable cross-border process.

In order to improve cooperation, the interconnection of different administrative systems requires **multi-level coordination**. This is produced by the fact that authorities or institutions competent in the domain of a particular project may not necessarily be at the same hierarchical level in both countries; they may not benefit from the same legal powers, budgets, or legitimacies. Nor may they have a cross-border region's concerns on their agenda. An imbalance in the quality of information, hierarchy, legitimacy, funding, and other elements can create tensions among the healthcare authorities and insurance bodies responsible for the reimbursement of treatments as they need to keep control over their expenses and are not necessarily aware of the mutual interest of such a complex cooperation. Inertia or even obstacles – such as additional checks or limits - can emerge and hamper or prevent the establishment of long and fruitful cooperative projects.

The **contemporary trend of centralised decision-making** in the health sector further increases the complexity of such cooperation when it is based on local coordination. The analysis above demonstrates how closely legal, administrative, financial, and organisational barriers are entangled. The Interreg programmes create incentives, facilitate and encourage voluntary innovation, the objective of which is to establish a long-lasting cooperation. However, even the most basic convention signed by two hospital managers requires collective awareness and generates multiple consequences and additional arrangements. When legal or administrative guarantees exist, such as those ensured by the CBHC directive (2011/24/EU), people still need to be informed and to understand how to implement them. A major obstacle to crossing a border or running cross-border projects relates to feelings or beliefs. An inclusive process is required for the diffusion of information and of interests linked to cross-border opportunities beyond well-informed stakeholders.

In all cases, CBC takes a long time: it involves the collection of information, the provision of assistance for operators so they may understand it, translation – not only in linguistic terms – and negotiation with all parties associated with a particular project. It also requires adequate coordination in order to strengthen mutual trust that favours a cross-border cooperation. In this context, public and healthcare authorities may point to financial or administrative obstacles in order to avoid facing the complex issues posed by CBC.

[23] Reported by the Franco-Belgian Scientific Institute of Borders and Discontinuities, Annex 2.
[24] Reported by Joanna Kurowska Pysz, Annex 2.

3. THE IMPACT OF THE COVID-19 PANDEMIC ON CROSS-BORDER COOPERATION IN HEALTHCARE

KEY FINDINGS

- The COVID-19 pandemic resulted in border closures and controls, shortage of appropriate information and data, asymmetric decisions, and a lack of tailor-made solutions. It also sowed confusion and distrust.
- Cross-border medico-social professionals could continue working. Cross-border partners established virtual help desks and cross-border local task forces. Cross-border intermediaries, such as EGTCs, health observatories, ZOASTs, and other instruments played an important role by providing informing, networking, lobbying or leading new Interreg projects.
- The Coronavirus Response Investment Initiative (CRII), the Coronavirus Response Investment Initiative Plus (CRII+) and the Recovery Assistance for Cohesion and the Territories of Europe (REACT-EU) were three major packages of measures adopted by the EU to combat the impacts of the COVID-19 pandemic. They were partly related to cross-border cooperation in healthcare.

This chapter is based on literature research, the analysis of webinars, interviews with experts and representatives, and an in-depth analysis conducted by five members of the Transfrontier Euro-Institut Network (TEIN) in different EU border regions. Full reports of the five original case studies are given in Annex 2. The analysis has been limited to the impacts of the COVID-19 pandemic on cross-border cooperation in healthcare and does not take into account other issues such as cross-border residents or workers' rights.

The first section of this chapter outlines the major problems and constraints the pandemic has placed on border regions between February 2020 and June 2021. The second section considers how cross-border partners could take advantage of European proposals and how they proposed specific changes, arrangements, or other innovations. As shown by the surveys, such initiatives were related to the transfer of equipment or patients as well as the exchange of information among professionals and institutions or lobbying. These initiatives were not only put forward by historical or local partners, but also by new operators and they were partly dedicated to cross-border inhabitants. The last section summarises EU initiatives to overcome the constraints created by the COVID-19 pandemic with regard to cross-border cooperation in healthcare.

3.1. Main problems

The constraints created by the COVID-19 pandemic are numerous[25]. This analysis is limited to the impacts on cross-border cooperation in healthcare identified during the surveys and the literature research. The first type of problems concerns the difficulties in crossing the border; a second type is related to incomplete or missing information. Other problems linked to these issues are asymmetric decision-making processes established by public authorities on each side of the border and a lack of coordination at a local level. Two additional difficulties can be emphasised: a slowing-down of cross-border cooperation and cases of inter-cultural hostility.

[25] Arcitores, 2020 ; De la Mata, 2020 ; Gate to Europe EGTC, 2020 ; Mission Opérationnelle Transfrontalière, 2020.

3.1.1. The closure of the borders

The first negative impact of the COVID-19 pandemic and the subsequent nation-specific anti-pandemic measures quickly became visible on the borders. In a very short time, EU borders were closed, concrete blocks were placed on roads and border controls were re-introduced.

As a result, the movements of cross-border workers were restricted. In most cases, even for **healthcare staff**, specific administrative papers were required and checked by officials working at the border; repeatedly, COVID-19 tests had to be performed – as reported at the Polish border. Healthcare workers suffered from the implementation of non-compatible decisions (such as school closures for their children and curfews). Traffic jams were created by border controls – as seen at the Franco-Belgian or Franco-German borders. The surveys reveal that some cross-border **workers who were confined** at home were unable to access to the healthcare social security system from which they normally benefit from. As a result, they had to buy additional insurance in the country where they were staying to receive care. This was the case when they were not registered with the health insurance fund of their country of residence as stipulated in Article 17 of Regulation (EC) No 883/2004 on the coordination of social security systems and Article 24 of Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004.

Patients faced similar impediments. They could **no longer cross borders to receive care**; they were separated from their doctors and found it difficult to stay in contact with them. An admission to an hospital was only organised within the country, even if medical services in a close cross-border hospital were available. Difficulties were also identified when ambulances had to cross a border and the movement of goods, especially medical equipment, was hampered as well, notably on the border between Poland and the Czech Republic.

3.1.2. Missing information

The absence of **appropriate and harmonised data** prevented local or regional authorities from drawing a cross-border map or publishing infection data on cross-border regions for a long time. For instance, Belgian figures were not comparable with German or Dutch ones as the former included assumed COVID19 -related cases in retirement homes. Moreover, Germany reported its infection rates on a weekly basis, whereas the Netherlands and Belgium reported daily or fortnightly rates.

The customisation and diffusion of cross-border information mainly depended on single initiatives such as those run by Euregio Meuse-Rhine, TRISAN or certain EGTCs (as discussed in further detail below).

When **patient transfers** occurred – with the exception of where historical agreements or cooperation networks were already in place – hospitals and healthcare institutions experienced problems related to required documents, procedures, or the compatibility of the healthcare systems concerned. Uncertainties about reimbursement or other administrative constraints also remained important obstacles for patients. Formulated protocols or agreements that would have defined cross-border coordination were not available. Additional difficulties emerged for the patients and their families in terms of linguistic barriers, delays for translating documents or the communication of required papers. Even the information on the hospital where the transfer of the patient occurred could sometimes go missing.

Another problem was identified in relation to **vaccination**. When cross-border workers or inhabitants were vaccinated on the other side of the border, the validity of the vaccination was always taken into account in their home country and its inclusion in the national vaccination system called into question.

A lack of information was also stressed when exchanges of equipment occurred. For instance, some ventilators provided by a German clinic to a French hospital did not have suitable connections.

3.1.3. Asymmetric decisions

In Spring 2020, every European Union Member State established **its own set of measures** in order to combat the COVID-19 pandemic. The supply of protective equipment, information flows and data production, the availability of hospitals and of intensive care units were evaluated within national boundaries. The decisions made in terms of curfews, masks, hygiene and preventive measures, mobility, testing, conditions of lockdown and quarantine were national in scope and differed from one side of the border to the other. All these decisions were regularly modified based on national infection figures. Opening or closing borders depended on decision made by foreign affairs Ministers and some borders could be **crossed in one direction but not the other** (Berrod, 2020).

This situation not only made it difficult for staff, authorities, and inhabitants in border regions to keep informed but it also generated **misunderstandings and mistrust**. This was particularly evident in cross-border institutions where people coming from both sides of the border had to work together or when treatments differed depending on the referral hospital, as was the case in the Hospital of Cerdanya (the cross-border hospital located in Spain at the French border), where the treatment differed depending on whether the patients arrived from a Spanish or French hospital. It also led to instances of discriminations, such as when Polish cross-border workers had to choose between staying in the Czech Republic and keeping their job or returning home and losing their job. The national speeches that justified such decisions reinforced feelings of protectionism and isolation.

When solidarity among partners was developed and transfers of patients coordinated across the border, it was mainly organised at a national level and patients had sometimes to be transferred at a hospital located far from the border.

3.1.4. Absence of local coordination

During the first lockdown, a large portion of the decision-making process was centralised. The closure of the borders was decided **without consultation with local authorities**: this did not reflect how important daily cross-border flows are and how entangled living spaces may be in some cross-border regions.

Therefore, even when some hospitals were ready to welcome patients coming from the other side of the border, the establishment of agreements was first required. The absence of historical local cooperation or bilateral national agreements on health emergency or healthcare prevented the establishment of a cross-border solidarity mechanism.

3.1.5. A slowdown in cross-border cooperation

Official cross-border cooperation was drastically restrained due to the closure of the borders and shifts in national or local priorities. Although some **Interreg projects were altered** and tailored to tackle the COVID-19 pandemic (as explained above), some other projects were stopped. The establishment of cross-border agreements or protocols did not always guarantee coordination. **Informal cross-border activities** were also limited since commuting across borders was restrained.

3.1.6. Resentment and hostility

The closure of the national borders suggested that crossing the border became synonymous with diffusing the COVID-19 pandemic. This type of feeling was amplified by classic and social media. There

was a marked increase in hostility shown toward cross-border **workers and foreigners**. Some resentment was also felt towards local and national authorities, as the closed borders impacted the daily life.

3.2. Arrangements

This second part of this Chapter reveals how partners cooperating across the border on healthcare responded to the crisis and took advantage of the various opportunities proposed by the EU or even created their own specific arrangements. The first subsection below outlines the types of arrangements: it discusses ways of facilitating mobility and information flows, mechanisms of solidarity and lobbying, coordination, and governance. The second subsection highlights how European Union measures, institutions and arrangements could be capitalised on by cross-border parties in order to handle the negative consequences of the crisis.

3.2.1. A plurality of arrangements

The surveys, reports, and online platforms reveal the massive constraints created by the COVID-19 crisis. They also highlight the capacity for innovation that European cross-border partners can demonstrate. Based on case studies and literature research, this section arranges the practices into five themes: helping cross the border, staying informed, developing mechanisms of solidarity (in terms of equipment, transfer of patients or professionals), lobbying national authorities, facilitating local public coordination, or testing processes of governance. As highlighted at the border between Poland, the Czech Republic and Slovakia, both historical and spontaneous cooperation arose.

In terms of mobility, even during the first lockdown, **medical and social professionals could cross** the border, under certain conditions such as the possession of a particular certificate or proof of a negative COVID-19 test. When it was possible, the necessary documents were made available by medical institutions and border control was usually quite lenient. Patients could also cross the border to receive care (as illustrated in the surveys at the Franco-Belgian border or in the Hospital of Cerdanya). However, the blocked roads, the curfews or the controls reduced the flows and some institutions decided to provide housing for their staff to avoid any inconveniences caused by crossing a border.

Staying informed was and remains a major challenge in cross-border regions since each Member State has established its own protocols relating to, for example, equipment for the medical staff and treatments. In a number of cases, managers or medical professionals were informed by their own staff and colleagues or by bilateral contacts with counterparts on the other side of the border. The media were used to publicise conditions for crossing borders and the availability of healthcare services. The need for information pushed public authorities from both sides of the border to organise **regular meetings** and establish task forces (as discussed in further detail below). In order to inform cross-border patients and inhabitants, tables comparing regulations and protocols in both countries were published on the websites of Eurodistricts and EGTCs as well as through traditional or social media. **Virtual "help-desks"** were also created. Comparable COVID-19 dashboards were established by healthcare professionals before harmonised cross-border figures were published officially.

The reality of **cross-border solidarity** was diversified: it could concern the exchange of equipment as well as that of medical staff and transfers of COVID-19 patients. The latter have continued well into 2021 (in March 2021, 17 French COVID-19 patients were transferred from the region of Hauts-de-France to Belgian hospitals[26]. Such a show of solidarity made it possible for cross-border workers to be tested or

[26] Actualités | OFBS.

vaccinated where they worked. A portion of these cross-border flows occurred thanks to interpersonal or local interinstitutional relations. **Protection and medical equipment** was delivered across the border, as was the case between German and Belgian hospitals, between Austrian and Italian institutions, in the Euroregio Glacensis (CZ - PO) and Euregio Meuse-Rhine (BE - NL - DE). Regarding the Hospital of Cerdanya, during the first weeks of lockdown, even if Spanish hospitals suffered from a lack of personal protective equipment (masks, gloves, scrubs, etc.), it was able to receive materials from France, especially from the hospital of Perpignan.

The **transfer of COVID-19 patients** resulted either from *ad hoc* decisions or from national and centralised decision-making processes. On the one hand, institutions themselves organised the exchanges. There are numerous examples of this happening: Dutch and Belgian patients were treated in German intensive care units; Slovak patients were admitted to Polish hospitals; French patients ended up in German hospitals and French and Belgian hospitals transferred patients between one another. As early as March 2020, transfers of COVID-19 patients from Alsace to Germany were organised thanks to coordination between the German "Länder" involved and the region of Grand Est; these flows anticipated more systematic transfers. On the other hand, official protocols were established and organised for the transfer of COVID-19 patients on a larger scale. Czech patients were transferred to Polish hospitals after the activation of the Early Warning and Response System of the European Union. After a national appeal from the Czech Republic and Slovakia, the Polish government provided beds for Slovak and Czech COVID-19 patients; Dutch and German authorities organised transfers towards the Land of Nordrhein-Westfalen, and regional initiatives of hospital cooperation from German Länder and Luxembourg provided intensive care beds for Italian and French patients. Cross-border help for **testing or vaccination** was also developed, either in terms of flows of medical staff or equipment. This **transfer of medical staff** from one side of the border to the other can be illustrated by the transfer of 200 doctors from Poland to Slovakia: cross-border medical staff provided uninterrupted services, despite the obstacles they faced.

Another way of handling the impacts of the COVID-19 pandemic on cross-border healthcare-related cooperation was to **lobby** local cross-border authorities, healthcare institutions, and European bodies and networks. Cross-border citizens **carried out demonstrations and applied pressure** to make visible the cross-border difficulties and specificities and to persuade local and national authorities to handle those specificities and to adopt the appropriate measures. They aimed to highlight specific obstacles generated by the national management of the crisis, the inadequacy of the information provided and the asymmetry of the rules; they pushed public authorities and operators to adopt more coordinated solutions to address the specific situations and issues encountered by cross-border residents, workers, and institutions.

Another type of arrangements related to specific **local public collaboration**. The Hospital of Cerdanya (FR - ES) is a good example of such collaboration. In order to maintain its activities, French and Spanish regional health agencies had to collaborate with local municipalities and these had to coordinate with their police forces to ensure that the roads connecting the cities of Puigcerda and Ur were always open. Other examples are the opening of a Franco-German COVID-19 testing centre at the border post of Saarbrücken or the networking between the emergency control centres of Lower Austria, South Bohemia and South Moravia – these were included in agreements previously signed by Austrian and Czech authorities – which were activated and could dispatch ambulances.

Finally, the need for such arrangements pushed authorities to establish an original **process of governance,** as multi-sector and multi-level authorities and operators had to coordinate their decisions and to implement them. This was not only done to share or produce information but also to encourage cooperation. The creation of **Pandemic or Corona Task Forces** that brought together

regional and local authorities, public services related to public safety, insurance providers and regional European institutions and networks illustrates this process. Such task forces were created, for instance, in the Greater Region (LU - FR - DE - BE), the Euregio Meuse Rhine (BE - NL - DE) and on the Franco-Belgian border - including the organised zones for cross-border access to healthcare. Some details can be provided for the **meetings** organised by the Council of Upper Rhine Conference (FR - DE - CH). From spring 2020, a meeting was organised every two days between the French, German and Swiss local and regional authorities, the administrative institutions managing various aspects of the response to the COVID-19 pandemic (health, transport, home affairs) and representatives of cross-border institutions, such as Infobest, TRISAN, the four Eurodistricts, the cross-border council of politicians and the cross-border task force. The **working group** "Health Policies", a member of the Upper Rhine Conference, focused its agenda on contact tracing, vaccination campaigns and testing strategies. It reported the difficulties it identified to the respective regional and national authorities.

National arrangements were also established. For instance, the Polish, Czech and Slovak governments coordinated the transport and the admission of patients by linking all the required services including border controls, social security systems, and their respective diplomatic corps. In other cases, an intergovernmental agreement of cooperation was signed between Italy and France and the French also signed a specific agreement with Luxembourg that aimed to manage cross-border cooperation more effectively.

3.2.2. Arrangements based or supported by EU measures, projects, or institutions

This section describes the arrangements initiated for handling the specific issues created by the COVID-19 crisis. The specific practices have been revealed in our surveys and interviewees. As noted above, this study analyses cross-border cooperation in healthcare, therefore a great number of initiatives taken by European bodies such EGTCs are not outlined when they are not strongly connected with patients, hospitals, or healthcare[27].

Tools such as the **European Health Insurance Card** or **National Contact Points** were key forms of support. In addition to customised measures or European Union agencies, existing European cross-border institutions and networks and cooperation initiated during previous Interreg projects played a positive role in **inspiring or generating solutions** to the impacts of the crisis. In some cases, official cooperation was dramatically reduced or even came to a complete halt. Notably during the first lockdown, the established cooperation of three hospitals on the border between Poland and the Czech Republic was recentralised within the national territories and the European Centre for Disease Prevention and Control (ECDC) was not systematically used although Polish hospitals were members of it. Some Interreg projects on healthcare were also reframed or restrained; while other continued despite the COVID-19 pandemic as illustrated by Interreg V-A KIDHEARTS project where children with heart infections continued to be transferred from Lille to Brussels during the period of lockdowns.

The surveys carried out at the border between the Czech Republic, Poland, and Slovakia refer to the activation of the **Early Warning and Response System of the EU.** This system established transport cooperation between Czech and Polish hospitals. The **capacity of Interreg partners** to transform existing projects when faced with the COVID-19 crisis and generate concrete results is clear from the surveys conducted in the framework of this study and a variety of testimonies (Acitores, 2020; European Commission, 2021c). For instance, an Interreg project called "Your health matters!" (RO - BG) ensured the purchase of life-saving equipment for Romanian hospitals. With the support of the projects

[27] Such as the specific funding of EUR 700,000 provided by EGTC Pyrenees-Mediterranean (FR-ES) for enterprises and economic development.

"SANTRANSFOR" and "COSAN" (FR - DE), the German "SHG Kliniken Völklingen" hospital admitted French patients, and provided equipment to French institutions, while it continued cooperating with the French nursing school IFSI Sarregueminnes by providing online language courses for the students. FILA, an Interreg cooperation project between Italy, Albania, and Montenegro funded by the Instrument for Pre-Accession Assistance, produced medical equipment with its 3D-printers (instead of products related to agriculture as initially foreseen). Another example is the group of experts created in the framework of the Northern Periphery and Artic Programme (FI - IE - SE - GB – in cooperation with the Faroe Islands, Iceland, Greenland, and Norway).

The "Pandemic Euregio Meuse-Rhine Incident Control and Crisis Management" project (PandEMRIC) (BE - NL - DE) focused on implementing the lessons learned during the first lockdown and on promoting long-term cooperation in the event of a pandemic or a large-scale outbreak of an infectious disease. Other examples include cooperation between Slovak and Polish hospitals in order to care for Slovak patients, and the GeKo SaarMoselle project (FR - DE)[28] which coordinated the actions of healthcare institutions and was involved in the dematerialisation of administrative exchanges between French and German social security systems. GeKo also provided information to the public. In several cases, technical teams from Interreg programmes did not even wait for European Union incentives and, from February or the beginning of March 2020, they began identifying existing projects that were likely to generate direct support and contacted the relevant partners.

Cross-border institutions or networks such as the Eurodistricts, the EGTCs, the Franco-Belgian Observatory of Health, the ZOASTs, or the trinational competence centre for cross-border cooperation in the health sector in the Upper Rhine Region, TRISAN, have also played a specific role by informing inhabitants, institutions, or health operators, and by networking with or lobbying regional and national authorities. Such bodies and networks were often **members or initiators of Pandemic Task Forces** such as EGCT *Greater Region* (LU - BE - DE - FR) or the *Eurometropolis Lille-Kortrijk-Tournai* and the *West Vlaanderen/Flandre-Dunkerque Côte d'Opale* which covered the border between France and Belgium. Such Task Forces exchanged information, compared situations, handled specific cross-border problems, and even solved problems such as monitoring the availability of intensive care beds on both sides of the border. EGTC *Bànàt Triplex Confinium* (HU - RO - SCG) helped Romania purchase urgently needed medical and safety equipment and pushed Hungarian, Serbian, and Romanian local authorities to cooperate. The *Eurometropolis Lille-Tournai-Kortrijk* (FR - BE) provided systematic comparative information on its website and through media channels. These institutions were also leaders or partners of new Interreg projects as was the case of EGTC *SaarMoselle* (DE - FR), the lead-partner of the GeKo SaarMoselle project.

It is worth highlighting the case of the *Euregio Meuse Rhine* (NL - DE - BE). Within it, the **Euregio Meuse Rhine Incident Control and Crisis Management** (EMRIC) was established a long time ago, a CB collaborative network that includes public services responsible for public safety, such as fire departments and emergency medical care departments. During the COVID-19 crisis, EMRIC, in the collaboration with the EGTC and institute ITEM, produced **regularly updated tables**. Initiated by North Rhine Westphalia, a **Cross-border Task Force Corona** was established between NRW, the Netherlands and Germany to exchange information. The EMR together with **cross-border contact points** provided information to inhabitants and private companies; it provided the forms required on the other side of the border on its website. The Euregio secretariat and EMRIC helped coordinate patients' transfers even if they did not have a specific mandate in the field of health. The Interreg EMR programme also launched a COVID-19 call in May 2020 with a duration of 12 months.

[28] Eurodistrict SaarMoselle.

In addition to networking, the **Franco-Belgian Observatory of Health** produced a summarised comparison of the Belgian and French rules and, as of January 2021, led the **Interreg project InTerESanT** (Innovation Territoriale en Santé Transfrontalière)[29]. The ZOASTs and the emergency medical services reactivated their own protocols.

TRISAN (FR - DE - CH) is another interesting example. The Upper Rhine Conference coordinated regular consultations, exchanges of information and lobbying; TRISAN was involved and requested to coordinate the exchange of comparative information, collected experiences and questions from citizens in collaboration with the **Infobest network** (including the Infobests of the 4 Rhineland Eurodistricts). The Interreg project "Trinational Framework for Cross-Border Healthcare in the Upper Rhine Region" led by TRISAN produced informative material to assist healthcare operators and, with the support of Infobest, helped reinforce cross-border coordination and **the dissemination of information** related to vaccination or testing; it published flyers and proposed to develop a platform that would be implemented by the EPI-RHINE network. This network supports cross-border exchange of information on infectious diseases and health reporting and is in charge of the regional epidemiologic alert system, as mandated by the Upper Rhine Conference. Moreover, TRISAN established new protocols on cooperation between health insurance funds in order to handle specific issues such as the use of the form S1 or sick leave for cross-border workers.

The **Hospital of Cerdanya** has also played a specific role during the COVID-19 pandemic. It was the only hospital to transfer patients between Spain and France. In particular it transferred patients who required intensive care to referral hospitals in Manresa (ES) or Perpignan (FR) as well as Foix (FR) or other Spanish or French hospitals. The hospital staff, no matter of their nationality, received vaccination between January and February 2021. Despite the COVID-19 pandemic, cooperation continued as per usual, with new arrangements readily drawn up in response to different specificities of France and Spain and their two social security systems.

Other examples of specific arrangements were produced by institutions that **used to be partners** of Interreg projects in previous programmes and remained highly connected. For instance, the hospital of Nowy Targ (PO) welcomed Slovak COVID-19 patients while the hospitals of Tourcoing (FR) and Mouscron (BE) continued their mutual cooperation.

The guidelines on EU Emergency Assistance on Cross-Border Cooperation in Healthcare related to the COVID-19 crisis (2020/C 111 I/01) listed the diverse types of institutions and measures that Member States or healthcare institutions could use to assist themselves, and the European Commission encouraged authorities to cooperate, especially in border regions. Cross-border institutions or networks helped collect and diffuse information, lobby and sometimes solve specific problems. Their roles depended on the resources available (e.g. human resources) and their degree of connection with healthcare institutions or public authorities.

Surveys and interviews outline that, when a crisis such as the COVID-19 pandemic happens, the existence of previous cross-border cooperation helps healthcare operators to organise and find arrangements, but the existence of such a historical cooperation does not create automatic solidarity and is far from being sufficient.

[29] InTerESanT (projet-interesant.eu).

3.3. EU response and initiatives

This section summarises the European Commission's initiatives related to cross-border cooperation and healthcare in relation to the COVID-19 pandemic. It does not cover major decisions such as the recovery plans, the vaccine rollouts, testing and tracing systems, or the digital green certificates which were created to facilitate safe and free movement in the EU during the pandemic. Nor does it outline the role played by specific agencies during the pandemic such as the European Centre for Disease Prevention and Control (ECDC).

In the **Guidelines** on EU Emergency Assistance on Cross-Border Cooperation in Healthcare related to the COVID-19 crisis (2020/C 111 I/01), the European Commission highlighted the existing structures, mechanisms, and process available to assist health national authorities, especially during such a crisis. The **Health Security Committee** and the **Early Warning and Response System** (EWRS) have helped "*coordinate requested and offered intensive care beds or qualified medical staff*": The **EU Civil Protection Mechanism** could assist Member States *in "the coordination of emergency transport of patients or qualified teams of medical staff across borders"*. The **Social Security Coordination Regulations** have allowed for "*the reimbursement of healthcare costs when organised in another Member State*"; the **Cross-Border Healthcare Directive** has organised the "*transfer of patient records, continuity of care or mutual recognition of prescription*". The **Emergency Response Coordination Centre** could coordinate and co-finance the medical transport; in accordance with COVID-19 Guidelines for Border Management, emergency transport services should have priority via cross-border green lanes.

In those guidelines, local, regional, and national authorities were urged to use National Contact Points or existing cross-border protocols. They were also encouraged to be flexible with regard to Interreg programmes and to propose projects under the Coronavirus Response Investment Initiative (CRII), the Coronavirus Response Investment Initiative Plus (CRII+) and the Recovery Assistance for Cohesion and the Territories of Europe (REACT-EU)[30]. These packages proposed by the European Commission were swiftly endorsed by the European Parliament and the European Council.

The first package of measures, the **Coronavirus Response Investment Initiative** (CRII)[31], targeted the most exposed sectors such as healthcare or the labour market and SMEs. Expenditure related to the COVID-19 pandemic became eligible under the Cohesion Policy funds and the use of unused funds was also authorised. Funding from the European Regional Development Fund and the European Social Funds were reprogrammed for health-related investments, including purchasing medical and protective equipment; disease prevention; e-health; purchasing medical devices including respirators and masks; medicines; testing; and treatment facilities; securing working environments in the healthcare sector; training and supplementary wage support for health staff; hiring additional staff and providing support for vulnerable groups including home care services.

The second package of measures, the **Coronavirus Response Investment Initiative Plus** (CRII+)[32] complemented CRII and allowed for the mobilisation of non-utilised support from the European Structural and Investment Funds. Additional flexibility was provided for instance through transfer possibilities across the three Cohesion Policy funds, i.e. the European Regional Development Fund

[30] This package aims to help to bridge the gap between crisis response and long-term recovery. It continues to support emergency situations in the health sector. Parliament confirmed the agreement during its plenary session of the 15 December 2020 and the REACT-EU Regulation came into force on 24 December 2020.

[31] Coronavirus Response Investment Initiative (CRII).

[32] Coronavirus Response Investment Initiative Plus (CRII+).

(ERDF), the European Social Fund (ESF) and the Cohesion Fund (CF) and between different types of regions. The possibility of EU financing up to 100% was introduced to address liquidity shortages and relieve pressure on public finances. The transfers of resources across funds and programmes have led to a net increase in support to health actions in general[33].

In addition, under the "Recovery Assistance for Cohesion and the Territories of Europe" (REACT-EU), an additional EUR 4.3 billion has been allocated in support of healthcare systems from the ERDF so far. All these initiatives partly relate to cross-border cooperation in healthcare as well.

The European Parliament played a key role as co-legislator and budgetary authority. The measures to fight the COVID-19 pandemic were given priority and swiftly adopted. Within Parliament, the Committee on Regional Development (REGI) took the lead on the CRII and CRII+ measures and strengthened the REACT-EU package. The European Parliament insisted that resources reach the most affected regions and people and highlighted the need for structural investments in the health and social sectors, including in cross-border areas[34].

Institutions such as the **European Committee of the Regions** and the **Association of European Border Regions** have also played a role in collecting experiences, organising debates and webinars, in association with cross-border networks, and lobbied European and national authorities in order to enable cross-border cooperation and ensure a rapid and coordinated re-opening of borders.

[33] Coronavirus Dashboard: Cohesion Policy Response | Data | European Structural and Investment Funds (europa.eu).
[34] The EU's response to the coronavirus | News | European Parliament (europa.eu).

4. SOLUTIONS AND POLICY RECOMMENDATIONS FOR IMPROVING CROSS-BORDER COOPERATION IN HEALTHCARE

KEY FINDINGS

- Supporting healthcare requires the provision of a sufficiently large health workforce, healthcare infrastructure and equipment in order to provide equal access to quality healthcare even in remote cross-border areas. Interreg programmes can supply joint public health services, and initiate cross-border experiences.
- Promoting cross-border healthcare reduces the carbon footprint, which is highly compatible with the European objective of green sustainability. Tailor-made solutions and a local approach developed in agreement with national and European strategies are needed due to the diversity of cross-border regions.
- Facilitating cross-border flows of patients and healthcare staff requires the availability of appropriate and simple information provided to all healthcare stakeholders. The EU-wide recognition of diplomas, linguistic ability and training for cross-border healthcare operators should be facilitated in order to promote the adoption of a common "healthcare" language and to strengthen trust between stakeholders.
- The EU should support the development of e-medicine, the creation of a cross-border emergency services structure and the supply of joint public services in order to guarantee win-win results. Social security systems and public administrations should be encouraged to find common arrangements.
- The collection of cross-border qualitative and quantitative data and the production of original cross-border healthcare-related information need to be promoted. This includes mapping cross-border and border health operators and partners to emphasize the importance of cross-border flows and to help cross-border initiatives.
- Establishing adequate forms of governance, from flexible networks to more structural processes such as territorial zonings like the ZOASTs and other cross-border institutions will remain important, according to the degree of cooperation sought. They are necessary not only for the initiation but also for the implementation of sustainable cross-border partnerships.
- The increased involvement of intermediaries, such as health observatories, health networks or EGTCs, should be promoted.

The COVID-19 pandemic has demonstrated how deeply integrated some cross-border regions are and that some of these regions can be compared to homogenous living spaces. The pandemic has also revealed the need for sustainable health systems, a quality and reinforced health workforce and a guaranteed provision of services and equipment. In other words, the crisis has not only highlighted the strength of cross-border relations, but it has also laid bare the threats to cross-border cooperation. The solutions and recommendations presented in this study go beyond the pandemic as EU Cohesion Policy needs to guarantee equal, affordable, and qualitative healthcare in all cross-border regions, whether they are "hot spots of intense cross-border interaction" (European Commission 2021b) or remote and unpopulated areas.

The objective of this Chapter is to propose possible solutions on how to address the barriers and challenges identified as well as to provide policy recommendations on how to improve cross-border cooperation in healthcare in the 2021–2027 programming period. The proposals and recommendations presented below are based on surveys, case studies and interviews conducted for this study and on recent reports and studies (i.e. CoR, 2021a and b; European Court of Auditors, 2021). They are limited to healthcare-related cooperation in a cross-border context even though there are significant overlaps with other fields, such as mobility, labour, or economic development.

The first section (4.1) outlines some principles and guidelines, particularly with regards to Cohesion Policy and synergies with other European programmes and funds. The second section (4.2) on proposed solutions considers the obstacles discussed in the previous chapters. The improvement of CBC in healthcare requires solutions based on greater freedom of circulation for both patients and medical staff and a diversified and complementary supply of healthcare. More innovative processes of cross-border governance need to be considered, which can improve the collection and dissemination of information and can assist in the establishment of new protocols and the creation of institutions and networks. Specific recommendations are proposed in section (4.3). The last section of this chapter (4.4) critically examines the limits of such proposals.

4.1. Principles

Three questions can be used as a basis : Why support healthcare in Cohesion Policy? Why support cross-border cooperation in healthcare? Why support bottom-up and local approaches?

4.1.1. Why support healthcare in Cohesion Policy?

Ensuring healthy lives and, generally speaking, promoting well-being are among the key objectives imposed by the World Health Organisation. Achieving these goals means providing healthcare to all, with specific attention being paid to precarious populations and minorities. Most populations throughout the world are not only **living longer but living healthier**, which has brought major gains in life expectancy (Smith et al, 2020). Furthermore, healthcare is an important social and economic sector that employs a large number of direct and indirect workers. Supporting healthcare requires the provision of a sufficiently large and well-trained health workforce, healthcare infrastructure and equipment in order to ensure basic service delivery and equal access to quality services. Healthcare is closely linked to other fields, such as diseases prevention, rehabilitation, nutrition, mobility, technology, and employment.

As highlighted in the CoR Report (2021b, p.29), the staff of many institutions who gave interviews insisted on the importance of an EU-wide insurance coverage that was not limited by national borders and on a European healthcare system that is fully interoperable and guaranteed **to every EU citizen**. Financial protection is a key dimension of universal health coverage and, therefore, guarantees of healthcare reimbursement need to be generalised and simplified even when such care is supplied in another Member State.

4.1.2. Why support cross-border cooperation in healthcare?

In the priorities for the 2021–2027 Interreg programmes, two of the five policy objectives are directly linked to healthcare. These objectives are: "a more social and inclusive Europe" and "a Europe closer to citizens by fostering the sustainable and integrated development of all types of territories". Open borders and free circulation of patients and medical staff are not sufficient to achieve these objectives; EU Cohesion Policy is required to assist the social and economic development of cross-border regions and to limit a core-periphery phenomenon, which could considerably weaken the development of

those same cross-border areas. Diseases such as cancer, diabetes, hypertension, obesity, as well as those affecting mental health not only require long-term care but also multi-sectoral policies aimed at disease prevention, nutrition, and living habits. As a consequence, CBC in healthcare requires specific forms of support. The high costs of healthcare – due to, for example, the use of cutting-edge technology and the care of ageing populations – as well as the lack of health personnel in some cross-border areas can prevent regions from providing good-quality public services along internal borders. This trend can be amplified by the current propensity of some of the European governments to rationalise and (re)centralise public services.

Cross-border cooperation in healthcare can guarantee quality and equality in the supply of **joint public health services**: This type of cooperation decreases fixed costs, increases the number of patients that can receive treatments and improves efficiency. Public and private cross-border operators are free to take part in cross-border projects. The financing provided by Interreg programmes motivates and initiates cross-border experiences; it provides an ideal starting point for experimentation. CBC means that public authorities and other institutions tend to look at the cross-border region as a single, integrated territory, instead of two or three separate parts. **When faced with a crisis**, as outlined during the surveys conducted in the framework of this study, public authorities should make cross-border cooperation in healthcare a priority in order to, for instance, resolve shortages of essential or strategic equipment or products. As the examples have shown, such an integrated view has already been endorsed by citizens, and, as described in the CoR report (2021, p.26), emergency services should be able to operate on both sides of the border if Europe was again confronted with an international crisis like the COVID-19 pandemic.

Another argument for promoting cross-border healthcare is a geographical one based on **green sustainability**. A new generation of inhabitants - and this includes cross-border residents - are seeking to reduce their carbon footprint. Cross-border healthcare provided in a local area is highly compatible with this objective of sustainability.

A final argument in favour of CBC in healthcare concerns cross-border citizens. Being a cross border patient and receiving healthcare services in an institution that is geographically close but abroad can help the recipient feel like and become a **real European citizen**.

4.1.3. Why support a bottom-up and local approach to Interreg programmes?

Cross-border cooperation is mainly based on day-to-day life. As demonstrated during the COVID-19 pandemic, the closure of borders rendered the intensity of medical staff and patients flows particularly visible.

The diversity of cross-border regions requires the maintenance of policies based on **a bottom-up approach**. Cross-border regions can be "laboratories of European integration" (European Commission, 2021b), they may have close-knit communities with a common identity or a collective strategy, or they may be under-developed, sparsely populated areas (European Court of Auditors, 2021, p.5). This diversity can be seen as a real strength, particularly when experiences are shared and disseminated throughout Member States (European Parliament, 2020, p.54). Tailor-made solutions and some forms of decentralisation are thus required to fit such a diversity. This is the reason why "b-solution projects" dedicated to solving specific cross-border problems have been successful (Medeiros et al, 2021).[35].

Such a bottom-up approach needs to be developed in agreement with national and European strategies (as outlined below).

[35] Home | b-solutionsproject.

4.2. Proposed solutions

4.2.1. How can cross-border patient and medical staff flows be facilitated?

As discussed earlier, the Directive 2011/24/EU protects **patients' rights in cross-border healthcare**, National Contact Points provide information, and the Administrative Commission for the Coordination of Social Security Systems provides guidance to find pragmatic solutions when inhabitants commute across borders. Yet a certain number of problems persist: the system of healthcare reimbursement remains complex, prior authorisation for planned treatment is often sought when it is not necessary, there are numerous administrative obstacles, uncertainty exists surrounding financial coverage and there is a general lack of information. The COVID-19 pandemic amplified these issues when national borders were suddenly closed to limit the spread of the virus. The Stakeholder Consultation organised by the European Commission from May to July 2021 explained how the Directive 2011/24/EU works in practice. In addition to a report published every 3 years, various studies – such as the Association of European Border Regions study funded by DG SANTE or the Transfrontier Operational Mission for the European Commission (European Commission 2021c), collect data on patient mobility and conditions.

One of the suggestions emerging from interviews and reports is to propose an easily available European **Manual for Patients** that would be systematically provided to medical institutions or insurance providers located at the border as well as cross-border institutions and pharmacies. Examples of such manuals for local requirements have been produced by TRISAN or by the Hospital of Cerdanya. As demonstrated by the TRISAN project, people are not aware of their rights or the required administrative procedures. Therefore, a first step would be to provide them with summaries of the necessary information in their own language.

A **new design for the National Contact Points** and the creation of **cross-border regional contact points** could help disseminate this information. The establishment of cross-border contact points in each Member State should not only be the responsibility of cross-border operators (as described in CoR, 2021b, p.21); it should also be the responsibility of **all healthcare stakeholders**, including insurance providers, social security institutions, embassies, and consulates.

Another obstacle concerns the perception of patients and medical staff (Considère and Leloup, 2018). People living close to the border are not all "natural" cross-border patients or commuters. Steps must be taken to gain **trust and adopt a common language** that suits all parties: This common language is based on linguistic ability, but it is also related to the administrative and medical fields where intercultural obstacles exist.

An additional issue concerns staff and student mobility, the lack of recognition of some medical diplomas and the conditions of admission to medical professions. This was addressed in a b-solution project. This has led so far to a bilateral agreement between France and Spain. A second case is also currently under review in a project led by the Franco-Belgian Health Observatory. Recognising the equivalence of degrees and diplomas awarded in one Member State by the others should be accelerated and, at the level of the Interreg programmes, cross-border medical **networking could help with the sharing of experiences and the dissemination of agreement models** and other protocols.

4.2.2. How can the supply of healthcare in cross-border regions be improved?

One set of possible solutions relates to crossing the border virtually or, in other words, the development of **e-medicine** in a cross-border context. This not only concerns the provision of compatible digital equipment, technical and medical training and ensuring conditions for sustainable use. It can also cover strategies to improve **patients' computer skills and ensure the provision of home**

equipment. This proposal can be linked to the European Commission's report on EU regions as living labs of European Integration (European Commission, 2021b) which outlines various tailor-made solutions, such as "a cluster of European digital innovation hubs" and a "reinforced interoperability policy to provide support for digital innovation of public services to improve e-medicine".

Another solution relates to medical emergency systems. A **cross-border emergency services structure** should be available to provide healthcare irrespective of the state of the borders and citizenship status, including some European minimum standards.

Moreover, the supply of **joint public or private services in healthcare** should be extended. This is related to prevention, care and rehabilitation. This would encompass financial support – to guarantee, in particular, win-win results for all operators – but also assistance for social security systems and public administration on both sides of the border to encourage them to work together and find common solutions, protocols, or other arrangements. This implies taking into account cross-border healthcare for long-term care.

4.2.3. How can cross-border cooperation in healthcare be visible and reinforced?

As detailed in the surveys, missing information prevents healthcare operators, staff and patients from using cross-border opportunities and local authorities or administrative institutions from being aware of the importance of such flows. Collecting cross-border data and producing original data or mapping health operators available could be a solution.

Collecting, spreading or producing appropriate data to inform cross-border healthcare-related stakeholders

The COVID-19 crisis has revealed the importance of cross-border flows and interdependencies in some regions. It has shown that local and national authorities have **to be aware** of such exchanges and cooperation in order to make adequate decisions, not only during a crisis but also in an everyday context.

Accurate information on these cross-border flows and interdependencies does not yet exist. Measures have to be taken in order **to collect and to disseminate** this information. The systematic collection of a broader range of data and of knowledge for an improved understanding of cross-border territories is recommended. The regional statistics department at Eurostat has established a working group to develop cross-border statistics on cross-border cities and functional urban areas. The data are currently focused on cross-border commuting but could be **extended to cross-border healthcare** and public service demands (as listed by European Court of Auditors, 2021 p.18), in connection with the European Union's yearly report on the state of health. At the cross-border level, it is important to collect the data not only of active cross-border regions but also of **less dynamic cross-border areas** (such as less populated regions). Furthermore, **quantitative and qualitative** data should be collected in order to analyse issues of trust and perception. Such cross-border knowledge requires the use of **homogeneous methods of collection and the development of a sustainable comparable database**.

This work can be developed in parallel with existing cross-border networks. The European Cross-Border Monitoring Network (a network made up of 16 institutions including statistical institutes, local and regional authorities and universities), or other networks such as EMRIC, TRISAN, TEIN and Health Observatories can help to initiate or improve data collection. It could be important to link all these institutions and networks together in order to improve the quality and the comparability of the data they collect.

Mapping border and cross-border healthcare operators

Various cross-border networks or institutions exist to help cross-border cooperation in general or specifically in the field of healthcare. For instance, the European Union encourages the establishment of cross-border health observatories. It seems therefore important **to map such institutions and networks** and to link them together.

A regularly updated **mapping of healthcare institutions and services** established at the border – even if they do not engage in cross-border cooperation – could also be useful in order to highlight potential joint services for local decision-makers. This specific **mapping of all border and cross-border healthcare institutions**, networks or operators established at the different borders could be useful for local as well as national authorities in order to create awareness of such cross-border resources and encourage close interaction between them. It can also be useful to promote the diffusion of good practices and the exchange of experiences at a European level.

Such cross-border data and mapping will allow local and national authorities to consider cross-border dimensions in their decision-making processes and could help make them aware of the existing potential of cross-border cooperation and, therefore, act as an incentive to engage in such cross-border cooperation.

4.2.4. How can governance in cross-border healthcare be established?

The objective of "A better cooperation governance" is introduced in the new Interreg regulation for the 2021-2027 programming period[36]. The solutions proposed in terms of governance cover the adoption of a multi-operator and multi-level approach, various cross-border initiatives such as a suitable delineation for managing the healthcare-related cooperation or adequate forms of governance .

Coordinating and governing: a multi-operator and multi-level approach:

Cross-border cooperation in healthcare is related to a large set of stakeholders, including healthcare operators but also national authorities or central administrative institutions.

The experiences of those interviewed in the surveys and by TEIN's partners highlight the **interdependency of healthcare operators** when it comes to cross-border cooperation in the field of healthcare. Insurance providers, local and national administrative institutions, and medical and social institutions should be contacted as they are potential cross-border healthcare-related partners. As explained below, specific intermediaries (such as EGCTs, observatories, networks, or other instruments) can be established to play the roles of coordinator and translator in such situations.

Sharing experiences and organising meetings with staff from both sides of the border can help identify misunderstandings and contribute to an intercultural atmosphere (as demonstrated by the case of the Hospital of Cerdanya). This not only requires the involvement of medical staff but also healthcare and social security systems operators and insurance providers.

Some national coordination can also be required to prevent exceptional border closure cases or at least limit their impact. Several cases were described above where pre-existing coordination could help manage border checks and controls during the COVID-19 pandemic.

[36] Regulation (EU) 2021/1059 of the European Parliament and of the Council of 24 June 2021 on specific provisions for the European territorial cooperation goal (Interreg) supported by the European Regional Development Fund and external financing instruments; also see European territorial cooperation (Interreg) 2021-2027 (europa.eu); Home | Interreg Europe.

Identifying a suitable delineation to manage cross-border coordination

Cross-border cooperation transcends the territorial boundaries of two or three states. As became abundantly clear during the COVID-19 pandemic, national borders are far from convenient limits for appropriate decision-making. As illustrated in the Euregio Meuse-Rhine, restrictions were applied to cross-border commuters whereas real data showed that the situation was not as severe in this cross-border region as it was in the rest of the countries. Appropriate delineation would have been useful in ensuring the implementation of better decisions. This can be the case when epidemics occur but also when considerable funds need to be mobilised. For example, the decision to open a maternity centre located close to a border or ensure that it continues its activities can be changed if the estimations are based on the potential of the national territory and of the cross-border region. This philosophy explains the opening of cross-border hospitals at the borders between France and Spain and the Czech Republic and Austria.

Defining new perimeters for public actions encourages coordination between additional operators who are brought together by a common project. The **ZOASTs** are made up of such newly delineated areas: the zones covered are defined by the local healthcare operators, as well as by local authorities, and this creates a functional space for bringing together stakeholders who wish to achieve the same goals.

The perimeter is defined by the local situation and its delineation should be based on an endogenous process.

Identifying an adequate form of governance

Governance means bringing together operators from various institutions, scales, or sectors, to achieve a common goal – such as cross-border cooperation in healthcare. Two main models of governance can take shape: either networks based on fluid coordination are established or more structured processes of governance are implemented.

Different examples of active **networks** exist. The **Border Focal Point Network** is an EU-wide professional network that brings together experts on cross-border issues; its online platform, which was relaunched in January 2021 (CoR, 2021b), allows users to share information on best practices and events as well as useful documentation. This platform could be a useful orum for exchanging best practices as well as to make visible various cross-border problems and constraints. A portion of these cross-border activities could be easily opened up to a larger audience, especially when focused on specific domains such as healthcare.

Another example is given by **EUREGHA**[37], the reference network for European Regional and Local Health Authorities, which brings together knowledge and expertise in health systems. Such a network can promote the European Reference Network model in cross-border healthcare for rare diseases (EPRS, 2019) and can be useful for other tasks, such as collecting and diffusing cross-border data or good practices.

New networks connecting expertise in cross-border cooperation in healthcare could also be created. These models of coordination are extremely flexible. They are mainly used to disseminate information and capitalise on best practices provided by members. Some networks may propose and implement projects, but the links among the partners remain relatively non-binding.

More sophisticated forms of governance can be required, for example when cross-border institutions are established. ZOASTs delineate a specific perimeter within which stakeholders come together to

[37] EUREGHA - Bringing regions together for better health.

achieve collective objectives and implement common projects, but there is no transfer of competence or resources. In the case of the Hospital of Cerdanya, a specific EGTC has been created in order to manage the hospital: it ensures collective decision-making in partnership with Spanish and French healthcare stakeholders and authorities.

4.2.5. How can cross-border healthcare-related governance be supported?

The issues related to language, misunderstanding, and perception when cross-border operators work together and when patients receive care on the other side of the border were outlined previously. Operators can also encounter difficulties due to the amount of information and regulations they have to sift through from various sources, which include diverse national administrative institutions, social security systems and Europe. The **establishment of intermediaries**, therefore, appears to be necessary for the initiation and implementation of CBC, especially in the healthcare sector.

Some intermediaries can be sectoral institutions, such as the health observatories (e.g. OFBS) or health networks (e.g. TRISAN).

The status of the **EGTC** (Delecosse et al, 2022) can be used either to create networks or delineated governance; its flexible legal framework can help local operators define their specific goals in a collective way in concert with local and national authorities and implement joint initiatives. The interest of such groupings is their multi-level approach. As shown in this study, EGTCs such as Euregio Meuse-Rhine, the Greater Region and the Eurometropolis Lille-Kortrijk-Tournai have played significant roles in supporting cross-border cooperation during the COVID-19 pandemic.

All of them act as points of contact, coordinators, and translators, in addition to collecting and diffusing cross-border information.

4.2.6. How to improve synergies between European, national policies and programmes?

Cross-border cooperation has important synergies with mainstream programmes. **Synergies with CBC and other European funds exist**, which helps vulnerable groups access instruments, and the "Digital Europe and Connecting Europe Facility", which create the digital infrastructure needed for e-medicine and emergency support instruments. On the other hand, Cohesion Policy has to address social imbalances and contribute to improving ties between different social groups, minorities, and communities. The publication of the Guidelines (2020/C 111 I/01) (European Commission, 2020) has shown the variety of instruments and policies available. The publication of **such inventories** could become more systematic in order to provide easy guides for public decision-makers.

As outlined during the study, the improvement of CBC in healthcare is related to additional coherence in social security systems and fiscal systems existing in the Member States.

Various other European plans and tools, such as the European Interoperability Framework – the EU's eGovernment action plan for digitalisation and interoperability in cross-border regions – can be used to address some of the obstacles hindering cross-border cooperation in healthcare. The cross-border dimension could be usefully examined in numerous policies and proposals. The existing Border Focal Point Network, a EU-wide online professional network of experts on cross-border issues, can help to promote cross-border interaction and encourage the pooling of cross-border services.

As developed in previous chapters, even if cross-border healthcare-related cooperation is established principally by local operators, **national agreements or protocols continue to play a major role** with regards to the specificities of the sector. When established between Member States, such operational agreements provide a generic framework, facilitate cross-border exemptions, and establish the conditions of cooperation. This would appear to be the best way to frame CBC, particularly in a domain

that is as regulated as healthcare. Such official agreements remain important as long as the European Cross-Border Mechanism[38] or similar mechanisms remain unapproved.

4.3. Recommendations

Ensuring healthy lives means providing healthcare to all, guaranteeing a sufficiently large and well-trained health workforce, health infrastructure and equipment, an equal access to quality health services and a European wide-insurance coverage. Cohesion Policy and especially Interreg programmes can supply joint public health equipment or services and initiate cross-border initiatives. Tailor-made solutions and a local approach are needed due to the existing diversity existing between cross-border regions; the maintenance and the development of such initiatives require strong connections with national and European regulations. To promote cross-border cooperation means to promote proximity, which is highly compatible with the objective of green sustainability.

The study puts forward the following recommendations to strengthen cross-border cooperation in healthcare:

- **Promoting and spreading** simplified information for cross-border patients and healthcare staff via, for instance, a manual for patients and the establishment of cross-border regional contact points;
- **Helping adopt** a cross-border language inside the medical institutions and between all cross-border healthcare operators, such as healthcare institutions, insurers, health and social security systems administrative institutions or local authorities (i.e. not only translating in several languages but also translating routines, rules, procedures or other conditions for providing cross-border care);
- **Developing** a sustainable comparable cross-border database based on harmonised methods and **mapping** border and cross-border healthcare operators to make cross-border realities more visible and to create new opportunities of CBC;
- **Improving** cross-border supply of healthcare by promoting cross-border e-medicine with the appropriate supply of training and equipment and by supporting joint public health and social services in a sustainable and win-win context for operators from both sides of the border;
- **Establishing** European standard protocols and regular meetings for developing integrated and efficient cross-border emergency services;
- **Promoting** the role of specific intermediaries such as organising zones for cross-border access to healthcare, EGCTs, Health Observatories or other instruments in order to help to diffuse good practices and to coordinate cross-border cooperation in healthcare in collaboration with local and national authorities.

[38] The ECBM is a legal tool that was proposed by the European Commission in 2018 (European Commission 2018b); it proposes a mechanism "to allow the application in one Member State, with regard to a cross-border region, of the legal provisions from another Member State, where the application of the legal provisions of the former would constitute a legal obstacle hampering the implementation of a joint project".(CHAPTER I General provisions Article 1 Subject matter 1).

4.4. Critical analysis

Five limits to the recommendations outlined above need to be highlighted: the diversity of cross-border realities; the question of sustainable and balanced funding; the learning process related to new technologies; the ideal conditions for a multi-actor and multi-level process of governance in cross-border cooperation; and the constant risk of protectionism.

First of all, even if cross-border regions can be defined as "living laboratories of European integration" (European Commission, 2021b), some of them are already fully integrated living spaces with well-organised sustainable healthcare institutions or networks, whereas others have very little medical coverage. Therefore, a tailor-made approach is always required.

The question of funding is crucial. Interreg programmes help initiate projects, but long-term funding is needed to stabilise cooperation. Win-win cooperation has to be defined since healthcare depends on the equilibrium of national social security systems; the risk of imbalance is highly visible when the question of healthcare of cross-border commuters is analysed. It is crucial to consider differential benefits that may exist in one country and not in the other one. National labour laws, diplomas, and curricula and fiscal policies may explain the attractiveness of working on one side of the border as opposed to the other; cross-border healthcare operators need to consider these asymmetries and avoid amplifying such discrepancies.

The COVID-19 pandemic has highlighted the importance of advances in e-health, e-medicine, and other forms of digitalisation. As already discussed in the case of the Telepom project (2007-2013 Interreg IV-A) (Delecosse et al, 2017), the evolution in digital technology is a source of new opportunities, but also requires adequate equipment for each specific situation as well as training for users and patients.

The process of governance in CBC in healthcare can be supported by the existence of intermediaries. Such intermediaries are required since healthcare professionals may be interested in cooperating with others in their sector, but they may not necessarily have the time or information to deal with complex cross-border processes.

Another point related to the process of governance is that national authorities remain key-players; bi-national agreements or protocols are essential if CBC in healthcare and in other fields is to be sustained. Asymmetries or differential benefits can be amplified, and public authorities should be cautious and cooperate step by step in order to avoid growing imbalances.

The final limit concerns the constant risk of national protectionism, which was underscored by the COVID-19 crisis. Cross-border solidarity has existed, but asymmetric and unilateral processes of decision-making have also occurred. In such cases, the border was transformed from a resource into a protective barrier against a perceived foreign enemy. Such feelings and resentments remain and have to be taken into consideration.

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ANNEX 1: LIST OF INTERVIEWEES

Conducted from April to September 2021 by Emilie Dutrieux and prof. Fabienne Leloup, UCLouvain

European Union Experts

(conducted by prof Fabienne Leloup)

Berrod Frédérique, professor in European Laws, UNISTRA.

Delecosse Eric, Director of Interreg France-Wallonie-Vlaanderen Programme - Technical Team - Antennae Wallonia.

Ferreira Ricardo, Programme Manager, DG REGIO, European Commission.

Hager Caroline, Team Leader Cross-Border Healthcare, DG for Health and Food Safety, European Commission.

Lambertz Karl-Keinz, President of the European Committee of the Regions from 2017 to 2020, President of the Parliament of the German-speaking Community of Belgium.

Thevenet Anne, Deputy Director, Euro-Institut/TEIN

Tomalak Dorota, Deputy Head of Unit, European Committee of the Regions.

Wassenberg Birte, professor in European History, UNISTRA.

Interviewees

(Conducted by Emilie Dutrieux (MSc, UCLouvain) and prof Fabienne Leloup)

Danjon Marie-Charlotte, Employee of the Franco-Belgian Health Observatory (FR – BE)

Delhuvenne Loïc, Director of the Eurometropolis Lille-Kortrik Tournai EGTC (BE – FR)

Iro Louka, Partner of the Intersyc project (BU – GR)

Laforsch Céline, Director of SaarMoselle EGCT (DE - FR)

Lewalle Henri, Coordinator of the COSAN Interreg project (BE - LU –DE – FR)

O'Doherty Edel, Deputy Chief Officer of the CAWT Interreg project (IE – GB)

ANNEX 2: FIVE CASE STUDIES BY TEIN'S PARTNERS

1. CBC in healthcare in the Czech-Polish-Slovak borderland

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Methodology

The research was conducted in the period between April and June 2021 in the Czech-Polish-Slovak borderland using qualitative and quantitative methods and the following technics:

- in-depth interviews (12) with Polish, Czech and Slovak representatives of the borderland selected according to their professional and social functions related to the topic of the study,

- **case studies (4)** which present good and bad practices in cross-border cooperation (CBC) relating to healthcare on the Czech-Polish-Slovak borderland, supported by the INTERREG Czech Republic – Poland Programme and INTERREG Poland – Slovakia Programme. Two case studies cover hospitals in Poland, Slovakia and the Czech Republic that benefited from the INTERREG Programme before and during the pandemic. The third case study presents the relations between partner cities Cieszyn (PL) and Český Těšín (CZ) and does not include any formal healthcare issues. The last case study is aimed at the assessment of the situation when the pandemic led to the spontaneous cooperation of Polish, Czech and Slovak state, regional and local government administration units, as well as the armed forces, healthcare facilities and centres coordinating the fight against the pandemic at the level of countries,

- **desk research** including reports and analysis, statistical data, legal acts, etc.,

- **media analysis** covers social media publications on the broadly understood conditions in the healthcare service, CBC between hospitals and local governments, and information on the situation of border residents in terms of using healthcare services or employment in the healthcare service.

Targets of the specific research:

- The identification of the immediate effects of the COVID-19 pandemic on the CBC in healthcare, especially for the partners and beneficiaries of INTERREG Programmes as well as for society and entities operating on the borderland.

- The assessment of the role of CBC in facilitating the EU response to the pandemic, especially the contribution of INTERREG Programmes to support the fight of cross-border regions against the pandemic.

Specific results

The identification of the immediate effects of the COVID-19 pandemic on CBC in healthcare

Before the pandemic, the cross-border movement of employees flowing from Poland to the Czech Republic and Slovakia reflected the movement related to the demand for health services (Slovakia – health and rehabilitation tourism, the Czech Republic – healthcare, rehabilitation and pharmacies). Czechs and Slovaks used to visit Poland mainly for shopping and personal services. So far, no one has collected detailed data on the number of people employed on the other side of the border (e.g. in the healthcare sector), or people using trade or other services (e.g. in health services).

The Polish border with the Czech Republic and Slovakia was closed on 15.03.2020 (entry only with the preservation of quarantine). On 27.03.2020 the Czech border was closed for cross-border employees and they were given the option of transferring to the Czech Republic or undergoing quarantine upon each return to Poland. It wasn't until 04.05.2020 that the Polish government waived the obligation of a quarantine for cross-border employees and their families. The Czech authorities, in contrast, still demanded a negative COVID-19 test result every 30 days. This provision did not apply to medical professionals or employees at social aid centres. The Slovakian government, on the other hand, did not create any significant problems for cross-border employees. For persons living and working up to 30 km on either side of the border, the so-called "local border traffic" was introduced, releasing them from the obligation of undergoing a quarantine. As of 01.05.2020 cross-border employees working in Slovakia had to have a negative COVID-19 test result conducted not later than 30 days before. It also applied to cross-border employees working in healthcare. During the peaks of the subsequent waves of the pandemic (autumn 2020 and spring 2021) the borders were closed and entry to the Czech Republic and Slovakia was possible only upon presentation of a negative test result. Cross-border employees were treated more leniently but full freedom of movement for persons providing or benefiting from healthcare services was not introduced.

Polish-Czech and Polish-Slovak cooperation in healthcare was performed as:

- institutional cooperation e.g. local government authorities or public institutions also covering the cooperation of their subsidiaries (e.g. hospitals), executed on the basis of intergovernmental agreements or bilateral agreements between partners (agreements on cooperation in the area of healthcare between authorities of Polish, Czech and Slovak border regions were not identified, even in the statute of the Czech-Polish-Slovak EGTC TRITIA) as well as the informal relations. Very few cooperation agreements were concluded in this regard, this cooperation developed far more spontaneously during the pandemic, when for example, Polish hospitals admitted patients from the Czech Republic and Slovakia. This process was steered by the state authorities of Poland, the Czech Republic and Slovakia, but was not a result of the bottom-up need to strengthen cooperation.

- cross-border micro-projects funded by the Czech Republic-Poland INTERREG Programme and the Poland-Slovakia INTERREG Programme, concerning healthcare and social welfare, which in the years 2004-2020 constituted 1.5% of all micro-projects (34,320). Their beneficiaries were local governments, NGOs and public institutions. In both programmemes, applying for support for the CBC concerning healthcare within the so-called large projects was possible only with regard to education, cooperation of institutions, or fighting threats and only a few of such projects were implemented.

The immediate negative impacts of the COVID-19 pandemic on CBC in healthcare:

1. Becoming aware of the lack of durable mechanisms that built the borderland resilience against such crises, the weaknesses of cross-border relations between entities responsible for crisis management as well as a large gap in the CBC of hospitals in a crisis situation were revealed.

2. Placing national interest above the interest of the borderland (none of the countries consulted each other on the dates of opening and closing common borders, which led to many misunderstandings for the entire duration of pandemic, and the lack of a united approach to treating people crossing these borders for various purposes).

3. Withholding a few cross-border initiatives in the area of healthcare or reducing them to a symbolic dimension.

4. The lack of cooperation in the area of healthcare, especially noticeable in border cities which should have cooperated most closely.

There is a lack of joint measures in the area of healthcare as a result of the following aspects:

- the low level of maturity of CBC aimed at removing mental barriers, integration of citizens and elimination of antagonisms and resentments,

- differences in the approach to CBC in so-called "niche areas" (e.g. healthcare), where joint measures are more complicated than in culture or sports,

- differences in the level of motivation for CBC i.e. putting national interests above the international interests (the interests of the borderland as an integrated region),

- a lack of compatibility of healthcare systems (Poland and the Czech Republic are characterized by diverse administrative subordination of healthcare facilities and different systems of managing them, counterparts of local governments managing hospitals on one side of the border are e.g. management authorities at the central level on the other side of the border).

5. The protection of the national state system as a priority to the coordination of processes of combating the pandemic by central offices (during the pandemic cross-border contacts at the regional/local level were not really initiated/maintained by local governments on both sides of the border as the national governments recommended them to focus on national issues).

6. The discrepancies between healthcare systems in Poland, the Czech Republic and Slovakia and the weakness of the healthcare system in each country.

7. The atmosphere of institutional helplessness in entities operating on borderland e.g. euro regions.

8. The increase of information chaos in the cross-border medical environment

9. Stopping cooperation between facilities producing disinfectants and protective equipment.
10. The feeling of a loss of security

11. The increase in mental and emotional problems among the borderland residents, who had put a lot of effort into the cross-border integration in recent years.

The immediate positive impacts of the COVID-19 pandemic on CBC in healthcare:

1. Aid initiatives related to the declaration of readiness to transport Czech and Slovakian patients to selected hospitals on the Polish side of the border and provide treatment for them.

During the epidemic the Polish healthcare system worked better then Czech and Slovak systems and thus, could provide support (transferring Polish medical services to the Czech Republic and Slovakia, admitting patients, assisting in testing and vaccinating citizens).

National rather than regional authorities initiated measures such as the cross-border transport of patients with COVID-19 who needed hospitalisation in the neighbouring country. This revealed new, previously undeveloped fields for CBC at the Polish-Czech-Slovak border (Slovaks were transported to hospitals in Nowy Targ, Gorlice, and Czechs – to Racibórz). Other examples of Polish government support for the Czech Republic and Slovakia (mainly on the borderlands) during the pandemic confirm that it was cooperation coordinated at government level, and not CBC.

2. The increase of CBC related to the supply, by Polish entrepreneurs, of disinfectants and face masks to the Czech side (both commercially and voluntary).

3. Gestures of solidarity as a new cross-border activity (e.g. inhabitants in Cieszyn and Český Těšín organised social protests against the closing of the border and restrictions for cross-border employees).

4. The increase in openness to new acquaintances and readiness to provide small, human help, and to share information, especially via social media (social networks provided a creative for people in a difficult time).

5. The increase of online communication in cross-border relations (it was not able to replace direct contact, but at least it facilitated the implementation of joint projects).

6. The increase in the need for sharing cross-border experiences in healthcare (the increase of the awareness of mutual problems related to healthcare and the labour market in health services).

7. The increase of the awareness of the needs and specific requirements concerning the situation of cross-border employees as well as the increase of awareness of the importance of the mutual ties within local economic ecosystems on both sides of the border.

Assessment of the role of CBC in facilitating the EU response to the pandemic, especially the contribution of INTERREG Programmes to the fight of cross-border regions against the pandemic

The assessment of CBC as a tool facilitating the European and national response to the pandemic

The Polish-Czech and the Polish-Slovak CBC hasn't dealt with this crisis situation well in three aspects:

- the disappearance of CBC between institutions. In the face of the pandemic many declarations of deep integration turned out to be superficial (each country focused on their own problems),

- a lack of many important communication procedures (e.g. online) and cooperation mechanisms e.g. in crisis situations, which have not been developed over the course of many years spent establishing CBC,

- a lack of CBC in strategic areas such as healthcare, the labor market and the assurance of cross-border mobility, which should have been developed to provide borderland cohesion and resilience to crises.

The pandemic revealed that the neighbouring country's healthcare often has significant potential which has previously failed to be used e.g. patients from Český Těšín (CZ) underwent treatment in Ostrava, although there is a very good hospital in the immediate neighbourhood, in Cieszyn (PL). Only a few cases of hospitals that maintained continuity of CBC during the pandemic have been stated. In

compliance with valid provisions, the process of transporting and treating the ill in the neighbouring country requires a lot of effort. Unclear procedures, as well as language and legal barriers (e.g. an ambulance has to leave the patient at the border, where he or she is picked up by an ambulance from the neighbouring country) constitute a problem. Mental barriers are still visible (e.g. Polish healthcare personnel taking care of Czech and Slovak patients faced a wave of hate on the Internet claiming that they do not focus on to Polish people), whereas Polish cross-border employees were accused in the Czech Republic of spreading the virus across border.

The reasons for such a low level of interest in CBC in healthcare may be as follows:

- the centralization of healthcare systems in Poland, in the Czech Republic and in Slovakia,

- a small number of entities that can develop this cooperation (mainly local governments),

- the changes in the strategies of the hospitals caused by the changes in boards of directors and supervisors,

a different ownership structure and divergent management procedures, administrative barriers),

- a lack of sufficient and effective promotion of good practice examples in the area of healthcare and other "niche" areas of CBC, e.g. crisis management;

- complicated procedures related to the preparation and implementation of cross-border projects,

- a lack of personnel prepared for CBC and servicing projects,

- a lack of funds for contributions for entities that implement valuable projects.

Potential opportunities that occurred at the European level on the basis of experiences from the pandemic at the Polish-Czech-Slovak border indicate new challenges for EU institutions:

1. The EU should have a voice on leaving borders open, at least for the citizens of the borderlands employed or using services on the other side of the border. Such solutions can be established within cross-border functional areas.

2. The pandemic demonstrated the need to establish solutions ensuring open borders in the border regions and the unification of procedures for crossing them - at least at the level of neighbouring countries. It should be the expected reaction for the possible repetition of a crisis situation.

3. Top down regulation of issues concerning assurance of mobility of the healthcare personnel and treatment on both sides of the border both in a crisis and a standard situation are necessary.

4. Using opportunities that arose from the development of new relations between institutions of various levels during the pandemic should lead to the exchange of experiences related to various aspects of healthcare during the pandemic, joint projects between hospitals and healthcare facilities, interchangeable internships of healthcare employees, etc. The pandemic demonstrated the necessity of implementing of a larger number of micro-projects on this topic, e.g. activation of a bilingual medical school in the border regions.

5. Assurance of an analogous flow of information and standardisation of statistical data collected in all cross-border regions.

6. The selection of strategic institutions and entities operating in border regions which should obligatorily develop CBC strategies and information exchange models (e.g. sanitary-epidemiological stations, hospital chains etc.).

7. The regulation of the issue of vaccinations in border regions (e.g. on the Polish side the decision to vaccinate citizens aged 12-14 has already been made while on the Czech and Slovak side, it has not).

8. Higher levels of activity and faster reactions of European institutions in crisis situations concerning the whole European Union as a response to bureaucratic barriers which are still visible (e.g. the slow decision making process, the low level of flexibility of actions during the pandemic).

9. The reaction of the European Union to the pandemic will be effective in the area of healthcare only in the situation of a simultaneous strengthening of CBC (e.g. Polish, Czech and Slovak institutions).

The following should also be taken into account when seeking solutions for the facilitating European and national responses to the pandemic:

- the necessity of revising conditions and procedures for treating patients in border regions in the whole EU (e.g. bilingual medical documentation, facilitations for the transport of patients),

- recognising the potential of using the EWRS in order to ensure its obligatory use in crisis situations on all border regions in the European Union and recommend this procedure,

- making CBC more realistic, measurable and responding to real challenges and needs,

- placing greater emphasis on the subject and quality of implemented cross-border projects and supporting only those that are related to the current situation (such as crisis management),

- creating the obligatory system of responding to threats adapted to specificity of the region (natural disasters, pandemics, etc.) in all borderlands as well as creating appropriate procedures for cross-border communication, standardised throughout the European Union.

The contribution of existing INTERREG Programmes covering the Czech-Polish-Slovak borderland in the fight of cross-border regions against the pandemic

Before the pandemic the INTERREG Programmes were a potential catalyst for the development of CBC in many areas (including healthcare, indirectly), since:

- it allowed entities which have not had a lot of cross-border contacts (e.g. hospitals) to obtain funds for cooperation,

- it ensured continuity of cooperation during the project (despite personal changes in partner institutions),

- it inspired innovative projects exceeding standard activities, including in healthcare entities,

- it put pressure on interpersonal contacts which, aside from financial support, proved to be key to ensuring continuity of CBC during the pandemic.

The insufficient availability of support from the INTERREG Programme and weak relations between partners (or weakening of strong relations) constitute important reasons for insufficient CBC in the area of healthcare before the pandemic. Both factors restricted CBC in the area of healthcare during the pandemic even more, because:

- at the beginning of 2020 the majority of funds from the INTERREG Programme had already been used up, thus there were not enough funds to support cooperation in healthcare; closing borders hindered the maintenance of direct cross-border contacts which partners had already become used to, while the online communication was being introduced gradually,

- the tasks of the medical service were coordinated by national authorities, in principle without any agreements with neighbouring countries, preventing neighbouring regions and towns from undertaking cross-border initiatives,

- the activity of the Polish-Czech working party consisting of the representatives of healthcare facilities whose aim was to develop solutions ensuring continuity of CBC in the area of healthcare, turned out to be ineffective (at the Polish-Slovak border such a group was not even established),

- the only area where the Managing Authorities of the INTERREG Programme supported entities implementing CBC in the field of healthcare, was the management of implemented projects, where many facilitations were introduced regarding the manner of project implementation.

The pandemic revealed weakness in cross-border relations in areas strategic for the borderland (e.g. crisis management, healthcare). The input on cross-border projects (e.g. in the INTERREG Programme) at the Polish-Czech-Slovak border did not ensure as strong CBC as had been expected (after closing borders the cross-border contacts ceased, online communications were rarely initiated, demonstrating that these relations were of a secondary character for many institutions). There is a need to revise the direction of CBC support under the INTERREG Programme for 2021-2027.

Healthcare protection in the conditions of epidemic threats and other catastrophes is a new area for activity of the European Union, especially institutions responsible for shaping regional policy. In 2020 a declaration to provide financial support to states and regions which suffered the most as a result of the pandemic was made. It is difficult therefore, to understand why drafts of Programme documents on cross-border programme for 2021–2027 do not include direct references in this scope:

- the Programme document of the INTERREG Czech Republic - Poland Programme for 2021–2017, where only the priority axis "Supporting measures in the scope of the climate change adaptation, risk prevention and resilience to natural disasters" was included,

- the Programme document of the INTERREG Poland – Slovakia Programme for 2021–2017, where only the priority axis "A nature-friendly and safe borderland" was included.

Both programmes also include the axis related to the cooperation of institutions and inhabitants of the borderland, but this is only an indirect possibility to support projects focused on healthcare and they will have to compete with other proposals focused on a wide variety of activities. Such measures do not provide sufficient support for the development of CBC in healthcare.

The borderland situation caused by the COVID-19 pandemic shows both programmes should clearly include the possibility to support healthcare in the key dimensions at least: procedures for institutional cooperation especially in an emergency; procedures for institutional cooperation between medical services and entities responsible for crisis management, bilingual education for the medical services, medical services quality improvement, equipment which could be used jointly by hospitals on the borderland.

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2. CBC in healthcare at the Franco-Belgian border

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Research methodology

Our survey is based on 7 in-depth interviews of executive managers in healthcare facilities, plus 4 interviews of cross-border institutions (the EGTCs, the Franco-Belgian Observatory on Healthcare and one member of the Interreg V A team).

The facilities have been chosen according to the kind of location (rural and urban areas) and the services provided (hospital, retirement homes, care homes for people with physical or psychological disabilities). The one-hour in-depth interview grid included first questions on the immediate effects of the pandemic on (cross-)border healthcare in concrete terms, including on activities, patients, organisation or cooperation, on the process of information and regulation, and on the adjustments. A second part of the survey was concerned with the CBC, the potential help coming from cross-border institutions, and the EU adjustments and support.

Contents

Healthcare & Covid-19 in Cross-Border Cooperation. The Franco-Belgian border

Introduction

For several decades, the Franco-Belgian border region has developed a large number of projects for cross-border cooperation, including the healthcare sector. Our research has been based on two hypotheses: first, the Covid-19 pandemic has led to border closures in various ways and, second, the long tradition of cross-border cooperation in healthcare has contributed to a better response to the pandemic.

The immediate effects of the Covid-19 pandemic on CBC

The Covid-19 epidemic hit the French and Belgian sides of the border strongly, rapidly and concomitantly on three occasions: in April 2020, in October 2020 and in February-April 2021. In the French Grand Est region, the initial outbreak around Mulhouse was stronger along the Franco-German border. The second wave was earlier and more brutal in Belgium than in France. Generally speaking, however, the temporalities of the crisis was the same on both sides of the border. The national measures to combat the epidemic and the reorganisation of health establishments were broadly symmetrical.

Closing the border: no major functional consequences

The French and Belgian national authorities took measures to close the border, without this really affecting the operation of health establishments. The many cross-border workers were able to cross the border either in the context of:

- cross-border cooperation (the SMUR mobile emergency services have adapted within the ZOAST perimeters)
- inter-hospital collaboration (15 Belgian doctors and 5 French doctors between the neighbouring hospitals of Tourcoing and Mouscron)
- commuting (one third of the nurses at the Centre de santé des Fagnes in Chimay live in France)
- supply delivery (the medicines for the disabled residents of a Belgian reception centre are provided by a French pharmacy).

Therefore, the closure of the border had no major functional effects for health professionals. It has, however, triggered numerous reorganisations and uncertainties. Employers provided ambulances and staff with derogatory cross-border travel permits, but these were not always in line with national standards, as it was quite difficult to keep up-to-date with changing requirements.

Few controls actually took place on this 620-km-long border with numerous crossing points. Checks were occasionally carried out by law enforcement officers from other regions, who had no understanding of the reality of cross-border living areas. Employees had to adapt by avoiding the roadblocks, taking detours and anticipating traffic jams.

On the other hand, the border was closed to the families and relatives of hospitalized patients or residents of reception centres for the disabled and retirement homes. In general and regardless of the border situation, visits were stopped. One Belgian nursing home has systematised video-conferencing to maintain the link with relatives. This practice already existed before, as many residents are neither national nor cross-border, but transnational, with relatives in the Paris region or in Brittany. The Covid-19 crisis thus made more common some cross-border practices which were previously considered exceptional.

Tinkering with the asymmetry of national decisions

In some cases, information on national regulations was circulated through official channels: the ARS in France and the AVIQ in Belgium had their role reinforced. National and regional authorities failed to provide clear instructions in a timely manner, especially when national regulations were divergent or contradictory between France and Belgium.

As a result, information on the rules of the neighbouring country and sometimes on one's own country followed a more informal path. The local and national press was a major source of direct information for health professionals. Border worker staff also informed the management of their establishment about the rules in force in the neighbouring country. Citizens and border workers played a very important communication role, sometimes criticizing the discrepancies between countries.

Faced with cross-border problems, the management of health care institutions had to adapt in a hurry and to resort to "tinkering". In interviews, they endorse this responsibility and autonomy in the decision-making process, while emphasising how difficult it is to make new procedures credible when they exist only on one side of the border.

For example, a rest and care home in Tournai, where one third of the elderly residents are French, aligned itself with the French recommendations on personal protective equipment, judging the initial AVIQ recommendations too loose. It then used the French prevention posters.

The closure of schools did not follow the same schedule in both countries, but it hindered the activity of health professionals and cross-border mobility. This affected mothers more often than fathers, and nurses, care assistants, cleaning staff, etc., are mainly women. The staff available in a country where schools remained open accepted an extra workload to compensate for the absence of colleagues from the neighbouring country.

Exchanges of Covid patients started as early as 2020 between hospitals that were used to working together. Without referring to the supervisory authorities, hospital directors contacted each other spontaneously to gain efficiency and speed. These exceptional cross-border agreements are based on the quality of long-term interpersonal relations.

National frameworks were later established for the transfer of patients through Europe, validating the specific steps already taken and increasing the number of exchanges. With the agreement of the families, the Lille University Hospital sent 17 patients to intensive care units in Belgium. Most of them were hospitalised in Wallonia, and some Dutch-speaking patients were treated in Flanders.

The national health response: a centrifugal effect, a new border effect

Following similar national rules and timetables, hospitals implemented an exceptional health response and underwent profound reorganisation, on the borders as well as in all European areas. On several occasions, interventions were postponed, focusing on emergency reception, and services were transformed for Covid patients. Reception centres and nursing homes isolated residents and banned visits from families and relatives.

Thus, except during epidemic peaks, emergency departments have experienced a downward trend in activity. The number of patients received fell and the decrease was particularly strong concerning cross-border patients. Almost no patients spontaneously presented themselves to the emergency room of a neighbouring country. Only the hospitals in Tourcoing and Mouscron, three kilometres apart, in the middle of an urban area, continued to receive cross-border patients. One hospital even posted on its website a pre-filled authorization to allow potential patients to cross the border on medical grounds.

According to its management, the Tourcoing hospital has managed to attract Belgian patients who had heard of its academic division of infectious diseases, with an emergency reception and 42 full hospitalization beds in infectiology. In February 2020, this service was also requested by the French authorities to treat the very first French patients in the Oise cluster. The Covid-19 pandemic has made it customary to dispatch patients according to their territory and nationality. Overall, the border has been reintroduced between hospitals.

While the SMUR agreements were functioning, the French Ministry of Health reintroduced border crossing controls and made the passage of certain ambulances conditional on its authorisation.

Faced with a crisis, health services reorganised themselves to deal with the emergency and therefore focused internally on their Covid activities. This reduced cross-border exchanges and cooperation. Later on, the response to the crisis became national, with regulations from the Belgian and French

authorities. These top-down approaches distracted the cross-border cooperation actors; they were used to working in a horizontal governance approach, which now depended on the approval of the supervisory authorities. Even before the Covid-19 pandemic, a national centrifugal effect was felt in the health services. The Groupements Hospitaliers de Territoire in France and the Réseaux d'Hôpitaux in Belgium reflect a reorganisation of the national healthcare systems, following hierarchical national territorial logics. They are part of a centralising movement aimed at rationalising and reducing public expenses. The health crisis has highlighted a lack of resources and reinforced the takeover by the regional and national administrative hierarchy. These two factors hinder cross-border cooperation in healthcare. This top-down structuring through the institutional imposition of a national reference framework reintroduces the separative effects of the border.

The asymmetry of decisions has acted as a brake on cross-border management in some cases, but it has also led to a certain loss of legitimacy of decisions (if the pandemic hit both countries, why should there be only one vaccination shot in France and two in Belgium?)

In spite of cross-border health and medico-social cooperation, and beyond the Covid-19 epidemic, there are still no truly integrated health territories on the Franco-Belgian border. The main obstacles concern

- persistent administrative difficulties in reimbursing care despite the ZOASTs,
- the mobility of health professionals hampered by national registration procedures with the professional associations, and
- the repatriation of corpses with compulsory arrest and sealing of coffins.

The role of CBC in facilitating the EU response to the pandemic

Our response is subdivided into three stages. First, we contend that cross-border cooperation, established before the pandemic, facilitated the management of the pandemic. Secondly, we present how European decisions were implemented to support the management of the pandemic and, thirdly, we advance proposals for better management of a possible future crisis.

the role of cross-border cooperation

Globally speaking, in view of the urgency and scale of the crisis, all actors have concentrated their resources on their specific activities. This trend was strongly reinforced by the national systems, which refocused the rules within national borders during the pandemic; it should also be noted that this refocusing in favour of the larger entities is a long-term trend on both the Belgian and French sides (a hospital situated close to the border now has to follow the regulation issued by a higher-level hospital centre, without necessarily taking advantage of cross-border opportunities): indeed, this long-term hospital management trend is centrifugal with respect to the border.

However, long-standing cooperation persists between operators and their projects:

Thus, the hospitals of Tourcoing and Mouscron continue to exchange patients and share common equipment, even if national refocusing tends to restrict collaborations.

The ZOAST and SMUR agreements leading to cross-border hospitalisations were reactivated after the first wave of the pandemic.

SMUR interventions between French and Belgian teams have been modified, discussions have lead to adaptations of the equipment when necessary, but the ambulances continue to cross the border.

The *Kids-Heart* Interreg project, enabling French children to be treated in Belgium and the transfer of knowledge, is being resumed.

Some Interreg project leaders (e.g. the Resaliance project), have adapted their activities in order to continue to act in accordance with the strictest rules, making it easier to establish new rules in spite of differences between France and Belgium)

Resources were pooled, for example in the Franco-Belgian Health Observatory which draws up a comparative table of the measures in force in the two countries, its operational office meeting from time to time, as it is regularly called upon. Unfortunately, because of its limited size, it cannot handle crisis management.

During the third wave of lockdown, patients were transferred between the Lille University Hospital and Belgian establishments.

The authorities validated common procedures according to actual problems: for example, in the case of tests, French people went to Belgium to be tested, so a common orientation was quickly validated on the French side and for the three Franco-Walloon provinces. The results of the tests performed in Belgium were to be transmitted to the ARS.

EGTCs can disseminate information. The Côte d'Opale EGTC and the Lille-Kortrijk-Tournai Eurometropolis (LKT) took part in the meetings of the cross-border pandemic management committee organised jointly by the Prefecture of the Hauts-de-France Region and the Belgian Embassy in France, in the presence of the territory's public authorities, including the police services. The two EGTCs were thus able to relay the specific difficulties encountered by citizens.

The LKT Eurometropolis posts on its website an updated comparative table of national rules; the EGTC publishes testimonies from citizens and local elected representatives, and relays citizens' difficulties to the authorities of the three sides (Flanders, Wallonia, France) via its information channels but also the local and national press.

Implementation of European decisions

Even before the Commission's call, the technical teams of the Interreg France-Walloon-Flanders programmes drew up an inventory of projects that could be linked to the resolution of the crisis. As early as March 2020, REACT-EU led the managers to consider direct aid, fully financed by European funds. This involved support for nursing homes, based on the collaboration between the Belgian AVIQ and the French ARS, currently underway.

The "re-open Europe" website has made it possible to centralise the measures taken in the countries, but its contents could have been much clearer and more easily available to the whole population.

Proposals

The cross-border health observatories could be focal points because of their multi-faceted structure, in relation with the actors on the ground, and provided they are granted more resources. A flexible structure, with contacts at state level and at European level, would provide an efficient link.

Covid notwithstanding, there is still a lack of information about the possibility of cross-border care. Further awareness-raising work is needed.

The ZOASTs are another promising institution: pooling their resources, they could implement harmonised measures. This would allow national structures to build on their experience and legitimacy at local and cross-border level.

Emergency agreements should be facilitated, in the form of conventions, for example, with common rules in the event of a crisis.

At European level, a better harmonisation in the event of a crisis would avoid transforming borders into become barriers to cross-border life. This could involve

- common rules for the movement of persons, with European, non-national documents
- common curfew rules
- the uniform application of European health care policies (vaccinations, etc.)
- common instructions and sign systems

Generally speaking, the crisis has highlighted the need for a truly European integrated health care policy, so as not to marginalise the border territories.

To conclude, and after cross-referencing various reports and interviews, the withdrawal observed during the pandemic, combining with a political trend towards recentralisation and savings (of beds, sites, staff, equipment), might lead to less investment in cross-border development.

The List of interviewees

Frank Cappiello, director ff, Centre d'accueil La Pilerie, Mons and its région, 26 April 2021.

Sandrine Delamaere, responsible for the Franco-Belgian cooperation, CHU, Lille, 26 April, 2021

Vincent Kauffmann, director of the Hospital Centre of Tourcoing, 29 April 2021.

Grégoire Lefebvre, director of the Hospital Centre of Mouscron, 6 May 2021.

Manager of the Home Centre 'Belle Rive' of Tournai, 11 May 2021.

Thierry Boxus, recently director, Health Centre of the Fagnes, Chimay, 19 May 2021.

Jaroslaw Rysinski, adjoint director of the hospital of Fourmies, 11 May 2021.

The interview guide

Covid 19 à la frontière
Établissement (MRS, Maison d'accueil, hôpital…) dans un contexte franco-belge ? Travailleurs ou patients étrangers ou frontaliers ? En temps normal ?

Affronter le Covid, qui plus est dans une perspective transfrontalière ? Depuis mars 2020, concrètement

Personnels,

- Professionnels de santé (administratif, personnel d'entretien)
- Étudiants stagiaires
- Fournisseurs

Résidents, usagers ou patients

- Accueil et hospitalisation, suivi médical, urgence
- Familles et visites
- Décès et rapatriement des corps

Comment vous êtes-vous informés sur les règlementations nationales ?
Comment vous êtes-vous adaptés notamment vis-à-vis des injonctions contradictoires des deux États ?
Réorganisations et stratégies adoptées : mesures d'urgence, nouvelles procédures ? pérennisations / aussi améliorations ?

Coopération transfrontalière et réponse européenne
Comment la coopération transfrontalière en matière de santé a-t-elle été impactée par la pandémie ? A-t-elle su réagir ?

- Présente /absente ?
- *ad hoc* / encadrée ?
- Positif / négatif ?

Quel peut être le rôle de la coopération transfrontalière ? Quels projets pourraient émerger ? Qu'est-ce que l'on peut améliorer ? En lien avec :

- ZOAST
- GECT
- Observatoire franco-belge de la santé
- Accords transfrontaliers
- INTERREG
- Autres

Adaptation et assouplissements des règles INTERREG pour vos projets en période Covid : pertinent, efficace ?

Attendez-vous une réponse européenne à la pandémie ? Comment le niveau européen pourrait vous aider dans cette crise ?

3. CBC in healthcare at the Franco-Spanish border. The case of the cross-border hospital of Cerdanya

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Research methodology

The methodological approach is qualitative. On the one hand, a series of in-depth semi-structured interviews with a number of relevant people from the hospital are used; on the other, a thorough analysis of the information on the HC and COVID-19 which appeared in the media is carried out.

Regarding the interviews, the methodology proposed by Schmidt (2004: 254–258) was followed, so open-ended questions were posed in order to obtain information relevant to the objectives of the study. First of all, the topics on which information was to be obtained were defined (day-to-day management of the hospital, extraordinary management of the hospital due to the pandemic, communication policy, medical treatments, effects of the border closure, and cross-border cooperation); then, specific questions were prepared on each of these topics; thirdly, once the interviews had been conducted and transcribed, categories for analysis were established; finally, the interviews were analysed according to these categories and generalisations were extracted. The interviews, lasting between 60 and 120 minutes, were conducted with a member of the hospital management (Dr Xavier Conill, deputy director general), two members of the medical community (Dr José María David, head of the emergency department, and Dr Maria Arenas, medical director), and the communications officer (Ms Cristina Ferrer).

In terms of the media analysis, the qualitative content analysis framework (QCA) was used, a methodology derived from communication sciences which is used for the systematic study of communicative material from different media outlets (Mayring, 2004). QCA consists in thoroughly tracking the documents which deal with the issue under study over a given period of time and duly registering them (by means of the creation of a repository) for a posteriori analysis. An array of regional and national newspapers was selected, and the systematic searches were carried out using their digital versions. Therefore, restricted searches were performed for each of the selected media outlets using the option *site:* (for instance, *site:*lavanguardia.com) with the following search string on Google (in the language of the media outlet: Catalan, Spanish, or French): "(covid OR covid-19 OR coronavirus) AND "hospital of Cerdanya"". The results were filtered by date of publication (between March 13 2020, the moment when the lockdown is decreed, and May 31 2021). The data obtained from this analysis served to complement and document the information extracted from the interviews.

Contents

Context and Research Question

Located in the eastern part of the French–Spanish border, within the Catalan Cross-border Area,[39] is the Cerdanya region, a plateau in the midst of the Pyrenees at an altitude of 1,200 metres. Since the 17th century, the region is divided between the "Upper Cerdanya" (under the administration of the French state) and the "Lower Cerdanya" (which forms part of the Spanish state). Despite this division, close personal and family, economic, social, and cultural relations have always been maintained, to the point where the border is referred to by the inhabitants of the area as *la ratlla* ("the line"). Thus, despite the administrative border, a large part of the common identity traits (including the Catalan language) have been preserved. Currently, the area has around 35,000 inhabitants (55% on the Spanish side and 45% on the French side). The availability of facilities on the northern side of the border is very poor, as it is a sparsely populated area. This lack of facilities has traditionally been an important inconvenience mainly in terms of medical attention, since beyond primary health care (which in France is generally provided via a general practitioner) the nearest French state hospital facilities are about 85-100 km away (Foix and Perpignan), with adverse weather conditions during winter and a mountain road network which hinders mobility. The capital of the Catalan region is Puigcerdà, a village of approximately 9,500 inhabitants, which is the de facto capital of the "Upper" as well as the "Lower Cerdanya". Puigcerdà, then, groups together most of the services (trade, tourism) and is also where the reference hospital is located (the Hospital of Cerdanya). Both in the north and in the south, the economy is mainly based on services (with a 65% GDP, mainly for tourism) and construction (21%), while industry (9%) and agriculture and livestock (5%) have much less economic weight.

The Cross-border Hospital of Cerdanya (Hospital de Cerdanya-Hôpital de Cerdagne, according to its official name; henceforth HC) opened in September 2014, although planning started during the 1990s. During those years, the need was felt for cross-border cooperation in health care as the restructuring of the French and Spanish health systems coincided (Oliveras, 2013). In the case of the former, the French state began the recentralisation of medical facilities in urban areas, and so rural areas were left particularly underserved. On the Spanish side, the Servei Català de la Salut (Catalan Health Service) assigned the entire "Lower Cerdanya" to the reference hospital in La Seu d'Urgell (about 50 km away with a deficient transport connection). In any case, despite the fact that the population on either side of the border was too small to justify quality hospital facilities in the territory, with the sum of both populations the demand for a hospital in the area was legitimised.

Due to its cross-border nature, the HC entailed an important and unprecedented legal and administrative challenge, which was resolved by means of a European Grouping of Territorial Cooperation (EGTC). The HC is a facility which combines two different health care models: the Catalan one and the French one. Despite some difficulties (which were resolved over time, such as, for instance, legal procedures related to births and deaths), this model allows for the integration of the health care services from both sides of the border, taking advantage of the best characteristics of each system while, at the same time, also receiving support from reference hospitals of both regions (Perpignan, Toulouse, and Montpellier on the north side, and Manresa and several hospitals from the Barcelona area on the Spanish side) for the treatment of more serious illnesses. The hospital has 56 conventional hospital beds, 5 observation beds for critically ill patients, and 10 day hospital and major ambulatory surgery places.

Despite being a cross-border centre, the hospital has a regional and local character. Thus, the HC has a limited portfolio of services (for instance, it does not have any intensive care units), although it does have conventional and outpatient surgery, outpatient care, diagnostic imaging, pharmaceutical and

[39] The Catalan Cross-border Area consists of the province of Girona, six municipalities of the province of Lleida (in Spain), and the Pyrénées-Orientales (in France). It comprises a population of 1.2 million inhabitants.

laboratory facilities, haemodialysis, hospitalisation, inpatient functional rehabilitation, an emergency room, etc. It is the reference hospital for the inhabitants of 53 municipalities (17 Spanish and 36 French) and it is sized to tend to a population of 35,000 people. Nevertheless, at specific times (when it is peak tourist season, which coincides mainly with the skiing season, summer, and spring vacation) the resident population in this area can increase to a total of 150,000 people (since, apart from seasonal tourists, second-home owners also factor into this number). Finally, its geographical location and its proximity to the ski resorts makes the HC an international reference centre on mountain sports medicine.

This report is focused on the HC. It is a unique hospital in Europe because it was conceived from the beginning in order to serve the citizens of a territory divided between two states. Because of this unique cross-border character, we believe that it is of relevance to analyse which effects the COVID-19 pandemic has had on this territory, and how health care was managed by the hospital. Specifically, we consider the following questions:

a) How has the pandemic been managed by the HC? Which advantages and drawbacks has the fact of being a cross-border centre entailed for them compared to national hospitals in terms of hospital management, medical practice, and communication policy?

b) How has the hospital been affected by the border closure and mobility constraints?

c) How has cross-border cooperation in the region been affected by COVID-19?

THE MANAGEMENT OF THE PANDEMIC AT THE HOSPITAL OF CERDANYA

The hospital management

The HC is a unique cross-border hospital project in Europe. It is the first of its kind to be conceived since its inception as cross-border: from the idea to the construction and launch. The cross-border nature of the hospital implies, on a daily basis, the need to adapt to two different languages and medical cultures. The hospital has been adopting different strategies in order to offer the best service to its users from both countries. For instance, by opting to form bi-national nursing teams they were able to solve the linguistic issue and better adapt to the customs of each country when communicating with patients and families. The hospital has also had to find strategies to coordinate the French and Catalan medical attention and public health systems on the one hand, and facilitate access and recognise the right to aid by means of the *carte vitale* (in France), *targeta sanitària* (TSI) (in Catalonia, Spain), and the European Health Insurance Card (EHIC), on the other.

The COVID-19 outbreak did not, at any point, result in an overburdening of the hospital (unlike other Spanish and French medical centres). This was possible because, similar to other hospitals, all non-urgent surgeries and treatments had been postponed during the height of the pandemic. Due to the HC's characteristics, the most seriously ill patients (those who required intensive care units) were transferred to referral hospitals in Manresa and Perpignan. Moreover, this exceptional situation has made it possible to expand the network of hospital collaboration with the hospital of Foix (a small hospital with which there had not been any prior contact) and with other large French and Spanish hospitals, as the referral hospitals were overburdened. Fortunately, during the construction of the HC enough space was provided for further growth, so that no additional wards had to be set up to accommodate COVID-19 patients either. The HC has had a maximum of 21 patients admitted for COVID-19 at the same time at the peak of contagion.

Due to the fact that it is a cross-border hospital (and that it is, thus, an integral part of the health care models of two different countries), there have been some significant differences in hospital management during the pandemic compared to the other national hospitals, both Spanish and French. First of all, it is worth mentioning the **vaccination of the hospital staff** who, irrespective of their

nationality, were able to be vaccinated between the months of January and February of 2021, at which point there were still some reservations in the French state and they were not administered there to medical personnel (in Catalonia, on the other hand, vaccines were already authorised and were being administered to all essential health personnel). Additionally, during the first weeks of lockdown (which were tougher on the southern side of the border) Spanish hospitals suffered **serious problems with the supply of personal protective equipment** (masks, gloves, scrubs, etc.); the HC, however, could receive the material from the French state, since the peak of cases in France happened a few weeks later than in Spain[40] and the hospital of Perpignan had sufficient stocks.

Secondly, the HC's cross-border nature allowed for the **transfer of patients** from one country to the other. During the second wave of the coronavirus (which was at first more severe in Spain than it was in France), Catalan hospitals found themselves in a situation of near collapse and could not take on any new patients with intensive care needs. At the HC they found themselves with a case of a Spanish patient in serious condition (and who needed a respirator which the hospital did not have at their disposal); since the hospital of Manresa did not have any critical care beds available, the patient was referred to the hospital of Foix, in France.[41] In fact, the HC has been the only hospital to transfer patients between Spain and France. Along the same lines, when the hospitals of Toulouse and Perpignan found themselves overburdened they, too, sent patients to Puigcerdà (and Foix), which operated in network.

Lastly, and in relation to the previous point, both the incidence of the pandemic and the preventive measures which were put in place by the states (lockdowns, curfews, business closures, etc.) were noted to not always coincide at exactly the same time (just as holiday periods or school calendars do not coincide exactly), so that the HC—in addition to treating patients from its region of reference—was able to **reinforce health care of the Catalan or French systems** when they needed it most. In this sense, even though the majority of COVID-19 patients have been from the Spanish side, the percentage of French patients increased (since in some cases they opted to directly visit the hospital when experiencing symptoms rather than visiting their general practitioner, who usually ends up referring their patients to the hospital of Perpignan if necessary). The number of births by French women also increased, in such a way that during the pandemic the percentage almost equalled that of women from Spain (before the pandemic, the percentages of pregnant French women tended to at the HC was very low).

Medical practice

At the beginning of the pandemic, a study[42] carried out on 46 patients—and, thus, preliminary—led by Dr Raoult on the potential beneficial effects of hydroxychloroquine on combating COVID-19 was published. At that moment, scientific evidence on effective treatments for COVID-19 was still scarce and preliminary, but medical teams had to make decisions on the treatments they administered.[43] In the case of the HC (which, due to its characteristics, is not a hospital where research is done), the doctors assumed that patients had to receive different treatments depending on their referral hospital and, more specifically, where they had to be transferred once they left the HC. Thus, the patients that were referred from the hospital of Perpignan were not administered hydroxylchloroquine, but those that were referred from the hospital of Manresa were, as well as those French patients who were following their general practitioner's recommendations.[44]

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40 https://elpais.com/internacional/2020-06-04/el-hospital-que-borro-la-frontera-durante-la-pandemia.html

41 This case was widely reported by the Spanish press and some international European media outlets: Diari Ara (https://www.ara.cat/societat/lluitar-contra-coronavirus-enimg-frontera-hospital-cerdanya-puigcerda-coronavirus-covid-19_1_1006457.html), Diari de Girona (https://www.diaridegirona.cat/comarques/2020/04/01/els-casos-coronavirus-detectats-l-48727932.html), La Vanguardia (https://www.lavanguardia.com/politica/20201222/6141393/salud-fronteras-hospital-hispano-frances-puigcerda.html), among others.

42 https://www.sciencedirect.com/science/article/pii/S0924857920300820?via%3Dihub

43 Hydroxychloroquine has subsequently been shown to be ineffective in combating the SARS-CoV-2 virus.

44 French general practitioners (who perform primary care) were allowed to prescribe hydroxychloroquine, but the primary health care centres in Catalonia were prohibited from doing so.

Communication policy

The information provided by the health authorities of the two countries did not always match. For instance, the population protection protocols (lockdowns, curfews, hygiene and preventive measures) did not coincide at any point in time, which caused confusion. There has also been a saturation of information (and of *fake news*) on both sides of the border, which has led to confusion, fear, and anxiety (particularly in relation to the AstraZeneca vaccine). This excess of information occurred to a greater extent on the southern side due to the Spanish administrative structure (which has a centralised ministry of health in Madrid while, at the same time, health competences are transferred to the autonomous communities). This led to a multitude of messages and recommendations (often deviating or contradictory). In France, on the other hand, the information was mainly conveyed through appearances by the president of the Republic, Emmanuel Macron, or the prime minister, so the messages were more coherent. From the point of view of the HC's communication policy, they opted to reinforce the common messages from the French and Catalan health authorities.

THE CLOSURE OF THE BORDERS

Large part of the secondary roads crossing the border between Spain and France in Cerdanya were blocked off with concrete blocks so as to prevent traffic, except for the road connecting Puigcerdà and Ur, as it is the road which leads to the HC from France. This fact is significant, since authorities had to guarantee the possibility for French citizens to access the hospital. Cross-border mobility was prohibited for several months,[45] but in no way did this prohibition affect the HC's staff (who were able to cross the border for the trajectories between their homes and the hospital) or the patients (as the Spanish and French police forces had instructions to let citizens of the villages served by the hospital cross the border in order to access the HC).[46] Thus, it was noted that major cross-border infrastructures ensured mobility.

The medical teams, however, noted that it made no sense to close the borders, and that what was needed was to simply limit mobility. During the pandemic, absurd situations arose in which mobility within the region (between the "Upper" and "Lower Cerdanya") was prohibited, and yet accessing the "Lower Cerdanya" from Barcelona was allowed.

CROSS-BORDER COOPERATION BEYOND COVID-19

It is when extraordinary events occur that cross-border cooperation becomes more evident. In the case of health cooperation, throughout history the hospital of Puigcerdà (now converted into the new HC) has tended to patients from the French side of Cerdanya, despite the lack of trust French citizens had towards Spanish health care (a mistrust which, over the years, has been decreasing). For instance, in 1996, due to landslides the N116 road (which connects Cerdanya with Prades and Perpignan) became impassable for weeks and the citizens of the "Upper Cerdanya" were forced to go to the hospital of Puigcerdà (that year 15 French women gave birth there); in 2001, due to heavy snowfall the situation repeated itself. Once the HC had been built in 2014, with the intention of being a cross-border service, new crises arose which forced part of the still reluctant French population to use the hospital: in early 2020, due to Storm Gloria (which once again made the N116 road impassable) and, two months later, COVID-19. The hospital was able to continue operating as normal and has benefited from its cross-border nature, for instance, with the supply of personal protective equipment (masks, gloves, scrubs) and reagents or medication by the French side when there were stock-outs in Spain; with the possibility of transferring patients to and receiving patients from other health care centres from both sides of the

[45] Despite the "official" closing of the borders, in practice many citizens continued to pass through to the other country in order to access services or shops. A curious case is the presence of French citizens in bars and restaurants in the Spanish enclave of Llívia during the period in which French catering establishments had to remain closed. (https://www.lindependant.fr/2021/03/04/pyrenees-a-llivia-enclave-espagnole-au-beau-milieu-de-la-cerdagne-terrasses-et-tables-ouvertes-font-le-bonheur-des-francais-9408366.php).

[46] https://www.larazon.es/sociedad/20201205/4popnm3wrncq7l3mr75tudi45i.html

border, according to the needs (networking); or with the possibility of vaccinating the personnel from both countries sooner.

From the HC, however, they are asking for the reinforcement of day-to-day operations of the hospital, as an optimal operation in ordinary periods (which in the case of the HC does not imply more funding, but rather administrative and legal changes that would allow it to operate with more autonomy and flexibility) is the best guarantee that it will be able to successfully overcome extraordinary situations. The underlying idea is that the patients are European citizens and that they, therefore, need to be guaranteed the best possible health care, regardless of the idiosyncrasies of the health care systems in the various countries.

4. CBC in healthcare at the Franco-German border

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Methodology

We sent a written survey to cross-border structures and networks working on healthcare-related issues – whether they are related to the pandemic or not- established on the Franco-German border in recent months.

By doing so, we could analyse the stakeholders' different experiences during the crisis in order to analyse the immediate effects of the Covid-19 crisis on cross-border cooperation in healthcare.

Spring 2020 – the crisis as an obstacle for the cross-border cooperation in healthcare

First, the Covid-19 crisis was a major obstacle for cross-border cooperation. The closure of the border forced the existing cross-border organisations to adjust their presence meeting habits. Furthermore, the decisions were made at national levels – especially those concerned with the closure of the border - without consultation at local level. More generally, there has been a shift of decision taking processes: from the regional to the national level in France, and from the health sector to security services in all countries. New arrangements had to be made for cross-border workers and users. The crisis has had a real negative impact in this respect; the existing cross-border structures could not participate in management of the crisis.

The usual institutional networks were not prepared and were proven adequate when confronted with such a crisis; new problems occurred related with cross-border mobility on a daily basis. During the outbreak of the crisis, a coordination meeting was arranged every two days, chaired by the French state representation in the Region Grand Est (*Préfecture*) in order to fix all issues related to cross-border workers (social security, cross-border worker status, mobility of cross-border workers related to home-office, home-schooling, quarantine measures, etc.), international transportation and the control of the epidemiological situation in the different countries of the Upper-Rhine. These regular telephone conferences gathered representatives of different administrations (health services, transport services, interior affairs) at local, regional and national levels and from local and regional authorities from France, Germany and Switzerland respectively, as well as representatives of cross-border organisations (Infobest, TRISAN, Eurodistricts, Cross-border Task Force) and of the cross-border council of politicians from the Upper-Rhine. These telephone conferences were aimed at exchanging information about respective regulations, identifying problems arising at the borders and, as far as possible, finding solutions. They were taking place as an open forum to deliver and get information, structured by the French regional state government.

During this first period politicians strongly reiterated the need for more cross-border cooperation (i.e. in the resolutions of the cross-border council of politicians from the Upper-Rhine).

Autumn 2020 – a new dynamic

Nevertheless, after a couple of months, by summer 2020, a new dynamic revitalised cross-border mobility and cross-border cooperation. The regular coordination telephone conferences settled during the spring from the French state administration changed into a weekly cross-border telephone conference attended by representatives of the French-German-Swiss Upper-Rhine conference. In addition to that, the working group "Health Policies" of the Upper-Rhine Conference arranged a weekly telephone conference open to a wider audience, contributing to discussions related to cross-border issues. These additional coordination meetings focused on issues dealing, among others, with contact tracing, cross-border workers, closure (or not) of the border and respective vaccination campaigns and testing strategies. The meetings aimed at coordinating the French-German-Swiss approaches to deal with the pandemic, identifying possible problems arising in the border area and reporting them to regional authorities (a bottom-up approach) in order to find appropriate solutions for the cross-border area. These telephone conferences gathered a broad audience including the four Eurodistricts and the INFOBEST-Network, local authorities but also regional and national state authorities from the Grand Est region, and from the three German Länder (Baden-Württemberg, Rhineland-Palatinate and Saarland), from the cantons and federal authorities. This coordination represented the possibility to forward information and problems to decision making-bodies at regional level (in Germany) and national/ federal level, and to transmit decisions taken back to local level.

Furthermore, political declarations of intent have been signed pledging mutual support in case of an emergency, such as the mutual assistance pact signed in November 2020 between Baden-Württemberg, Rhineland-Palatinate, Saarland and the Grand Est region.

The traffic jams at the borders in spring 2020 revealed the extent of cross-border daily mobility and cross-border routines of many people – for work, school, health care, family networks or just consumer purposes. It showed that the cross-border areas cannot simply be viewed as neighbouring areas, but are becoming more and more integrated living environments. It raised awareness on the need for greater cooperation and coordination and showed the importance of collaboration between local, regional but also national and federal authorities, the need for multilevel governance and the challenges of asymmetrical competences.

The crisis proved that cross-border cooperation on health issues was essential to the protection of the population's health. Thus, the cross-border cooperation in health has inspired renewed support from local, regional and national actors, to underline the importance of multi-level governance and the resilience of formal and informal actors' networks.

The local structures adapted their work

In order to face the crisis, the local structures had to adapt their way of working, as well as their activities.

Regular meetings

The working group "Health Policies" of the German-French-Swiss Upper Rhine Conference for instance multiplied their meetings and organised meetings every week to ensure regular exchange between the countries. Moreover, and as mentioned before, coordination meetings were arranged every two days, chaired by the French regional state government (*Préfecture*) in order to fix all issues related to cross-border workers.

New issues raised by citizens and relaying of those issues

The INFOBEST-Network is made up of four public bodies located in the Upper Rhine region along the French-German border. It handles about 20.000 requests of citizens per year, mainly concerning the taxation of cross-border workers based at home, social security, family benefits, the status of frontier workers, moving to the neighbouring country and labour law. The Network noticed since the beginning of the crisis in March 2020 that the citizens had to deal with new issues, hindering their way of life in a borderless space. The closure of the border from March to June 2020 between France and Germany increased, for instance, difficulties in accessing health care in the neighbouring country. Indeed, many people living at the border work in one country, in which they also have their health insurance, while living in the neighbouring country. The pandemic and the restrictions put in place therefore had a significant impact on people who have their health care habits in the neighbouring country and who have not registered with the health insurance fund of their country of residence, as foreseen by article 17 of the European regulation 883/2004 and article 24 of the implementing regulation 987/2009.

New challenges also emerged for the institutions at the border. They needed more information about the measures taken in the neighbouring country to guarantee health security, and to ensure minimum operation at the border. This was for example the case for the vaccination process.

The INFOBEST-Network had to report these new obstacles to the political and administrative bodies, so that solutions could been found. It had to adapt its work to these new questions of the citizens and to the rise of identified problems.

Transmission of information and awareness raising

The Eurodistricts, some of which have already worked on health issues, noticed that the issue of health and the need for cross-border coordination has become even more prominent during the pandemic, and accordingly, shortcomings have been highlighted. In the context of the Covid-19 pandemic, the Eurodistricts played an important role as both coordinator and facilitator, and have taken on two new roles in this context: communicator of information to citizens and coordinator between the different actors and crisis teams. They provided political lobbying towards the institutions. Moreover, they could raise the awareness of the importance of mobility at the border though their presence in the Media.

Adaptation of the working plans of projects

TRISAN, the trinational competence centre for cross-border cooperation in the health sector coordinates the INTERREG-Project "Trinational Framework for Cross-border Health Care in the Upper Rhine Region" since December 2019. The centre is co-financed by the regional health authorities as well as by the territorial entities, and was therefore also required to reconsider its working plan. The INTERREG Upper-Rhine-Secretariat and DG Regio of the European Commission asked the coordinators about its activities related to the crisis management. After consultation with the project partners, it was decided that the project must adapt the planned activities according to the effect of the pandemic on cross-border cooperation. The project started counselling and producing information material to help stakeholders to coordinate their crisis management at the border in order to reinforce the coordination of the measures in the cross-border area. Furthermore, TRISAN elaborates cooperation protocols dealing with new issues, which have emerged during the crisis for citizens living in border regions, in collaboration with the INFOBEST-Network. TRISAN also develops information material about the vaccination and the testing strategies in the neighbouring countries as well as a concept for a cross-border platform for contact tracing to be implemented by the *EPI-Rhine*-Network. *EPI-Rhine* is a cross-

border network of physicians in charge of the regional epidemiologic alert system, coordinated by the Upper Rhine Conference.

The INTERREG-project GEKO, coordinated by the Eurodistrict *Saarmoselle*, reports on the adaptations to the new conditions in terms of meetings and exchanges, but above all in terms of fluctuating and uncertain scheduling.

Local cooperation between hospitals or health schools also adapted their working procedures. The cooperation between the hospital *SHG-Kliniken Völklingen* in Germany and the nursing school *IFSI Sarreguemines* in France, for example, had to cancel all internships abroad, because the nursing students were urgently needed as reinforcement in the French institutions. The language courses provided by the nursing school, however, continued to be held online. Simulations of everyday situations could also be carried out and analysed with the students via video link.

The importance of networks

The crisis reinforced the need to cooperate at cross-border level, in order to ensure sanitary security and to guarantee the possibility to maintain a continuity of the cross-border task force. Furthermore, the crisis has shown that cooperation and solidarity are essential to guarantee the resilience of health systems in case of emergency, and showed in the meantime the challenges of deepening cooperation. Another lesson is the extent of the need for multi-level governance, including the very local level to the national/federal levels or even the European level, as well as the capacity (and competence) for actors to build and take decisions and act in such a multi-level cross-border governance.

The INFOBEST-Network experienced an adapted and intensified collaboration with health insurance funds in order to respond as well as possible to the concrete requests of users facing new obstacles.

In their responses to the survey, the actors underline the importance of partnership and the resilience of networks and informal personal contacts, and the need for even greater coordination of cross-border cooperation bodies in the context of a pandemic. The crisis led the actors to a reinforced cooperation and they had to build a better understanding and knowledge of the functioning of other cross-border institutions. The networks have thereby been strengthened. All actors are now therefore better able to fill gaps and to present a unified front to Paris, Berlin or Brussels.

Nevertheless, while the crisis accelerated some exchanges, it also negatively affected the exchanges in other fields of action. It is too early to identify the effects on the cooperation in health other than on issues specifically related to Covid-19.

A local response to the crisis

Although the crisis had an impact on the cross-border cooperation in health, the actors on the local level could contribute to the crisis management.

Spread of information to citizens

An important contribution was the spread of information, which had to be made available as quickly as possible for the public. A regular exchange between the local health actors, like the competent funds, has been crucial. The new activities of the cross-border actors, especially the Eurodistricts, the INFOBEST-Network and the INTERREG-projects, aim to provide new solutions to new problems. New information tools were prepared for the citizens of the Upper Rhine, including for example an

information flyer about the vaccination and the testing in the neighbouring country developed by the INTERREG-Project "Trinational Framework for a Cross-border Health Care in the Upper Rhine Region" and the INFOBEST-Network. As mentioned before, the project also develops cooperation protocols dealing with the new issues. The insurance funds of the Upper Rhine Region are involved in the elaboration of these protocols and are thus committed to work together on new solutions.

Moreover, to provide information, the Eurodistrict Strasbourg-Ortenau summarised the national regulations into the necessary languages, created a clear overview and made the information accessible via social media. In April 2020 the Eurodistrict Council adopted in a resolution for an "enhanced Franco-German cooperation", in which it appealed to the respective authorities in Germany and France to continuously review the measures taken, in order to restore the fundamental freedom of movement as soon as possible. The Council called for *"an exanimation in what form structures can be created for future crises that can be established quickly, if necessary, in order to keep cross-border cooperation functioning at the local level and in cooperation with the respective state authorities in accordance with the situation, even in the event of a crisis*".

In addition, the Eurodistrict has participated in the networking of various actors, as cooperation between the various institutions is extremely important, especially in times of crisis.

Facilitation of hospital cooperation

Hospital cooperation contributed to the sanitary response to the crisis. At the north of the Upper Rhine Region, the Eurodistrict PAMINA aims to sign a partnership agreement on the hospital cooperation scale in order to intensify the cooperation in health and to assure a communication at the local level and the integration of actors in cross-border territories. The Eurodistrict *Saarmoselle* established a cross-border testing centre in March 2021.

Local cooperation between hospitals, like the cardiology agreement between the *SHG-Kliniken* in Völklingen, Germany, and the *Centre Hospitalier InterCommunal UNISANTE* + in Forbach, France, enabled to admit French Covid-19 patients in Germany in the first, second and third wave. Furthermore, three doctors of the *SHG-Kliniken*, who regularly complete services at the hospital in Forbach within the framework of the cardiology agreement and know the procedures there, could second their colleagues to the hospital there. They also provided ventilators to the French hospital, although the connections of the ventilators were not suitable. In addition, even with the borders closed in spring 2020, patients with acute myocardial infarction could continue to cross the border within the framework of this cooperation.

It is important to highlight that local politicians could organise cross-border patient transfers on the base of informal contact.

Political lobbying

As mentioned before, the Eurodistricts provided political lobbying to enhance the administrative cooperation at the French-German border. The political council of the upper Rhine played also in important role in political lobbying.

Administrative coordination

The meetings of the working group "Health policies" and the regional state in France promoted the administrative coordination of crisis management strategies in the cross-border area. This exchange about the strategies, the regular meetings and the commitment of those local actors has helped to prevent the border from being closed again during the second and third wave.

A response at European level?

While there is a consensus about the local initiatives, not all the interviewees perceived the European-level response to the crisis to have been successful, but instead emphasizing the lack of competences. The unilateral decisions, the closure of the borders and the differences by the implementation of crisis management measures represented a huge obstacle to the visibility of the European-level response – for actors as well as people living in cross-border regions.

Nevertheless, there have been coordinated decisions, which facilitated the work of local actors. All actors welcomed the decision by European states to ensure that the increased levels of working from home should not have any impact on social security coverage, and that the employees concerned should continue being covered by the social security system of their country of employment. Article 13 of Regulation (EC) 883/2004 normally sets a ceiling of 25%, above which the competent country for social security purposes changes. If this decision between these different border countries would not have been taken and the European regulation had been applied, the pandemic would have had an even greater impact on the Upper Rhine Region, which has more than 90,000 border workers, even if not all of them had or could have had recourse to work from home.

The current European coordination on the purchase of vaccines and the distribution of doses between European States has been given greater visibility.

Another measure has been the transfer of patients from one member state to another. These transfers proved a strong European solidarity. However, as seen before, in the Upper-Rhine it is still recorded as a result of a local political initiative, coordinated by the national level.

In response the crisis, the EU has accepted that the Member States propose some amendments to their existing Cohesion Policy programmes and European Funds.

The support of the INTERREG Program in questioning health INTERREG Projects about their concrete role in the crisis management has remind regional health authorities and local partners about the involvement in seeking together for solutions. For example, the both INTERREG-projects "Trinational Framework for a Cross-border Health Care at the Upper Rhine Region" and "PAMINA health services" are co-financed by the INTERREG-Programme Upper Rhine and thus by the EU. In the context of the pandemic, the project partners decided to extend the projects by six additional months, which means in case of the "trinational framework for cross-border health care" a higher financial contribution from the partners and the INTERREG-programme. This also made possible the relaunching of a dialogue between the actors about the main missions of the project.

However, the real impact of this measure on cross-border cooperation in health and as a real response to the crisis cannot be analysed yet. The existing cross-border projects need first to implement these new possibilities. In addition, the measures taken by the EU Commission are often integrated directly into national measures and are not recognized explicitly as European measures.

A future Europe of health?

The crisis has raised the question of whether, and to what extent, the EU should deepen its actions and competences in the health sector. The question of a "Europe of health" refers not only to the management of future pandemics, but also more generally to the mobility of patients and health professionals.

For the interviewed structures, a better coordination of the EU Member States seems to be a key factor for the management of future health crisis. The EU should provide a strong legal framework in order to encourage national health stakeholders to work with their peers on the other side of the border.

Moreover, the measures should be adapted to border regions and consider their specificities and the living and mobility habits of their inhabitants. In fact, cross-border regions have a real cross-border dynamic of an integrated living environment that should not be impacted by unilateral decisions taken at national level.

A greater autonomy of the Eurodistricts, as well as a transfer of competences for local actions, could facilitate the direct exchange between stakeholders and a faster implementation of measures. According to the Eurodistricts, the regulation on the European Grouping of Territorial Cooperation (EGTC) seems to not be appropriate, as the question of the transfer of competences has not been clearly clarified so far.

A concrete mission for a "Europe of health" could be the development of a cross-border contact-tracing tool.

The EU should also provide a funding dedicated to the coordination of health measure of the Member States. Such funding could contribute to a cross-border crisis management, but also to the development of cross-border health care in general.

A future vision of cooperation could also be to promote existing cross-border cooperation agreements within the EU in order to facilitate mutual support for hospitals. The EU could promote that process along the border, for instance through the exchange of equipment, or by allowing patient mobility without prior authorisation from the health insurers and thus ensure better care for patients in cross-border living areas in the event of a new health crisis. This would lead to a stronger cooperation of hospitals, which can save lives in a crisis. In fact, if hospitals near the border were used to work together in cross-border patient care, future health crises would be easier to manage. Regular cooperation promotes a common understanding and increases the level of knowledge, so that in the event of an emergency the hospitals could help each other out more easily.

5. CBC in healthcare in the Euregio Meuse-Rhine

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Methodology

During the COVID-19 crisis, ITEM participated in an INTERREG project called Pandemric. In the course of this project, three different studies on cross-border health cooperation have been conducted. These projects look at the cross-border crisis management, the question of public procurement of relevant material and equipment during the crisis, and the cooperation with respect to cross-border emergency ambulance transport. The results of the research will allow for the situation in our border region to be described. From a methodological point of view, we made use of qualitative interviews with practitioners from the health sector and public bodies involved in crisis management. The expert perspectives are complimented by desk research on the particular regulatory background: made up of cross-border agreements or other relevant legislation. In addition, the situation is analysed with respect to cross-border cooperation capacities and cross-border governance structures. This will include looking at the role of cross-border stakeholders, such as the EGTC Euregion Meuse-Rhine and Cross-border Information Points, among others.

Based on our analysis of cross-border cooperation (CBC) in the health sector we will discuss the immediate negative effects (1.1) on cross-border cooperation due to the constraints of the COVID-19 pandemic on the mobility of medical staff, and in particular for the mobility of ambulance services and patients. Focus will be shown to what type of solidarity mechanisms still worked during the crisis, and what type of solidarity did not work because of restrictions and national steering.
On the other hand, we will discuss (1.2) positive effects on CBC with the stronger role for cross-border organisations, as a source of expertise and support for cross-border decision making, as in our case. This will include looking at the different bilateral agreements and instruments used. These include employers statements for cross-border workers, exemptions from quarantine rules, or adaptations with respect to taxes and social security to ensure the contractual situation of cross-border workers.

In a second step, the role of cross-border cooperation will be analysed in general. How it facilitated a European (or a national) response to the pandemic (e.g. innovation, good practices, cross-border exception). In this case, we will discuss the political role of a trilateral Covid taskforce set up by NRW, NL and BE. The role of the cross-border task force will be analysed to examine its competence and to identify where limitations existed. In this case, there are indications that the Taskforce could have helped to support general recommendations made by the Council to minimise border restrictions and guarantee free movement of people. With respect to different crisis management instruments (quarantine rules, travel recommendations, test obligations, data collection) we will discuss the

[47] This contribution is based on the INTERREG Project PANDEMRIC, ITEM Cross-border Impact Assessment & EU-Citizen report, with the authors: Buiskool, B., Kortese, L., Lakerveld, J. van, Mertens, P., Schneider, H., Schoenmakers, S., Sivonen, S. & Unfried, M.

question: to what extent have national measures been streamlined in order to avoid problems in border regions. Though this is closely related to answering the question: to what extent could other problems not be avoided or tackled with the existing tool box of CBC.
We will in addition analyse the question, whether and how cross-border cooperation during the crisis added or reduced the complexity of European (or a national) responses to the pandemic. And finally make recommendations how the complementarity of cross-border crisis management could be improved with respect to the recent EU, national or regional responses.

Contents:

Introduction

As part of the Cross-border Impact Assessment of 2020, ITEM (Maastricht University), together with three other border institutes, assessed the impacts of the first wave of Covid during the spring and summer of 2020. ITEM was responsible for the Euregion Meuse-Rhine (EMR), located at the Dutch-Belgian-German border with cities such as Maastricht, Aachen and Liège. For this study, a first analysis of measures and the cross-border effects was conducted through desk research and interviews.[48]
In addition, ITEM was a partner in the INTERREG project PANDEMRIC, focusing on the Euregional effects of the pandemic. Among other things the cooperation between hospitals across the border was examined. This was in part to identify possible improvements for the cooperation during the existing and future crises, and to more generally support a cross-border approach to crisis management. In this respect, ITEM was actively involved in providing information and analyses on the pandemic situation and the respective measures in the Euregion. As part of the INTERREG project, three studies are conducted on Euregional crisis management, public procurement and ambulance services during the pandemic situation, finalised in August 2021.[49] ITEM also monitored the COVID crisis, with respect to border questions, for the Dutch Ministry of Interior during 2020 and 2021 and gave advice with respect to certain Dutch measures.
Furthermore, as part of the EU-Citizen project financed by the EU Commission/DG-JUST, ITEM finished a report in the summer of 2021[50] concerning various measures taken by EU Member States in light of COVID-19, which have influenced the right of free movement of EU citizens and their families. Special attention is given in this study to the consequences of national measures for the people living selected border regions including the EMR.
Finally, during the COVID crisis, ITEM performed several case studies in an EU context via B-Solutions and an EU Academic Network, focusing on the legal aspects and cross-border effects of national and EU measures. The results presented here are the combination of these different activities related to the COVID crisis.

Subject of the research

The immediate effects of the COVID-19 pandemic on cross-border cooperation in the healthcare sector

We detected disruptions of cross-border cooperation even in a relatively well-established border regions such as the Euregion Meuse-Rhine. This was related to the fact, that at the beginning of the crisis the Member States NL and BE centralised their approach at the national level (in Germany this was true for the land Nordrhein-Westfalen). This meant that solidarity was initially focused upon within

[48] The reports can be found on https://www.maastrichtuniversity.nl/research/item/research/item-cross-border-impact-assessment.
[49] Written by Schoenmakers, S., Lakerveld, J. Van, Buiskool, B., Unfried, M., Kortese, L. Sivonen, S.
[50] Mertens, P., Sivonen, S., Kortese, L., & Schneider, H. (2021). *Cross-border mobility in times of COVID-19: Assessing COVID-19 Measures and their Effects on Cross-border Regions within the EU*. EU-CITZEN: Academic Network on European Citizenship Rights.

national boundaries. Existing, regional, structures of cross-border solidarity where not part of the national strategy to tackle COVID-19. This was true with respect to the procurement of protective equipment, the information flow and data production, and the preparation of hospitals and the capacities of intensive care units. National (or regional) governments wanted to safeguard their own national health system and capacities. This was the result of a lack of formulated protocols or agreements that would have defined the role of cross-border coordination in the case of a pandemic situation. In the case of industrial accidents where cross-border cooperation of police and fire brigades are laid down, this type of cross-border emergency planning was missing for a pandemic outbreak. In particular, the allocation of COVID patients to different hospitals and intensive care units was organised from a central coordination body. Meaning that patients were transported larger distances within, for instance, the Netherlands without benefiting from existing capacities just across the border. This meant, that well established cross-border networks were to some extent hindered from effectively managing patient exchange. Only when the capacities of intensive care beds were critical in BE and NL, were transports across the border organised; this was a result of direct contact between the government of NL and NRW.[51] Even where this cooperation occurred it was the result of centralised coordination. Meaning that in the case of NRW one hospital (Universitätsklinik Münster) was responsible for the coordination of Dutch patients, instead for example the one in Aachen for the EMR. Practitioners from the hospitals in the Euregion Meuse-Rhine repeatedly regretted the fact that the coordination was centralised.[52] Also in this case, the direct coordination between the local hospitals (Maastricht, Aachen, Liége) was only the exemption to the rule. In October 2020, when the intensive care capacities in the Belgian province of Liège where overstretched, patients were taken to nearby hospitals in Aachen, though not in first instance in line with the national approach.[53]

Another critical aspect for the cross-border situation was the question of appropriate data in order to assess the situation across the border for the territory of the Euregion Meuse-Rhine. As was discovered in ITEM's impact assessment on the first wave, there was initially no cross-border map in order to assess the spread of the pandemic. For a long time, there was a limited ability to publish infection data on cross-border territories: this data could have informed on the necessity of the closure of national borders from a cross-border pandemic point of view. There was a big difference with respect to the national registration of infections and death rates. This led to a situation where Belgian numbers could not be properly understood in comparison to the Dutch or German, without knowing that they also counted assumed Covid-related cases in old people's homes. This was not the case in the Netherlands.[54] This means that a proper monitoring of a cross-border situation was already hindered by a non-harmonisation of national statistics. This has to some extend changed during the second wave in the autumn and winter of 2020, the flow of information and the comparability between figures has improved. Practitioners from the Landkreis Heinsberg (NRW) for instance reported that they could use particular external internet sites where the German methodology (reporting the incidence per week and 100 000 inhabitants) was also applied to the Dutch regions and municipalities.[55] Apart from this site, run by private individuals, German figures reported the infection rate per week, whereas NL and BE reported figures daily or for a two week period. During the end of 2020 and in 2021, experts finally had charts with harmonised figures for the cross-border territory, but for the general public, it was still

[51] During the first wave until summer 2020, around 50 Dutch patients were treated in German hospitals.

[52] In the course of the Pandemric Project, two workshops were held, on the 5th of February and on the 18th of June 2021.

[53] See: Steigende Coronazahlen in Belgien: Patienten aus der Provinz Lüttich nach Aachen verlegt - Bald Phase 2A in den Krankenhäusern, Belgian Public Broadcasting VRT, https://www.vrt.be/vrtnws/de/2020/10/22/weiter-steigende-corona-zahlen-in-belgien-erste-patienten-aus-d/

[54] See for instance: Tans, Ruben, Drie landen, drie manieren van tellen? ITEM Blog, 24. April 2020, https://www.maastrichtuniversity.nl/nl/blog/2020/04/drie-landen-drie-manieren-van-tellen (last retrieved, 21.6. 2021)

[55] The particular site provides a COVID dashboard with one special site applying the German counting to the Dutch figures. See: COVID-19 Uitbraakmonitor volgens Duits model, https://www.coviddashboard.nl/covid-19-uitbraakmonitor-volgens-duits-model/

difficult to get a grip on the situation in the neighbouring region. The observation for the first wave was that health systems operating with national monitoring systems could not meet the challenge of a cross-border crisis. Let alone the question of a structured and defined possibility to share capacities of hospitals in a pandemic crisis.

Another phenomena was that national measures with respect to quarantine or testing rules where based on national figures. This led to measures that did not correspond to the actual infection rate in a particular region. There were long periods during spring 2020 and spring 2021 when the infections rates in the German city of Aachen were much lower than in most of the regions in the Netherlands. Nevertheless, since the Dutch government defined the whole of Germany as a high risk country (orange), people returning from Aachen to Maastricht were given the advice to stay at home in quarantine for at least 10 days. Very often, the infection rates were much higher for instance in Rotterdam then in Aachen. People coming back from Rotterdam to Maastricht did not fall under the quarantine advice. This meant, it was not the actual risk due to the infection rate but the nationally defined rule determined the assessment on quarantine. On the other hand, Germany and the Land NRW defined their rules on testing and quarantine obligations purely on a national definition of risk for the Netherland. The lack of regionalised risk assessments was one of the most problematic elements for the border regions. A regionalised risk assessment could have been the precondition for the regionalisation of measures also across borders. In this respect we also concluded that using a uniform conceptualisation and reporting of the term 'region' would benefit the cross-border region, where some reported at the level of a province and another State at the level of a Land.

The role of cross-border cooperation in facilitating the EU response

Without strong networks, institutions and cross-border governance structures, these disruptions would have been worse, especially for hospitals. The secretariat of the EGTC Euregion Meuse-Rhine, together with the recently established cross-border information points (help desks for citizens and companies) were able to influence national policy makers by signalling the most urgent problems at the border. In this respect, the crisis even helped to bring official stakeholders (not the citizens) of the border regions closer together. According to practitioners the secretariat of the Euregion played a role in crisis management, even without having a clear mandate in this field.[56] Many stakeholders also pointed out (in interviews conducted for the ITEM research on outbreak management) that the information flow and coordination capacities was very much facilitated by the Euregion's secretariat. It could for instance bring stakeholders together with respect to the lack of protective equipment, the coordination of patient transfers or the correction of national COVID rules that did not fit into the reality of the border region.

In addition, the unique cross-border network EMRIC played a very positive role, who closely collaborated with the Euregion.[57] EMRIC is the cross-border network of public services, that are responsible for public safety, including fire services, technical assistance and emergency medical care in their respective territories in the Euregion Meuse-Rhine. The EMRIC secretariat acted as a quasi-coordination and information "headquarter". EMRIC for instance provides (still in Autumn 2021) cross-border information to all different stakeholders in the field of crisis management and health.[58] On 21 June 2021, EMRIC disseminated the 103rd edition of the table presenting the latest situation. This illustrates how often national measures did change with respect to certain rules. Together with the

[56] This was for instance said in the second symposium of the INTERREG project Pandemric on 18 June 2021. See: One Year Corona crisis: lessions learned? https://www.maastrichtuniversity.nl/events/pandemric-symposium-18june-item

[57] EMRIC is an abbreviation for Euregion Meuse-Rhine Incident control and Crisis management. EMRIC is the collaboration of public services, that are responsible for public safety, including fire services, technical assistance and emergency medical care in their respective territories. See: https://www.emric.info/en/citizens/what-is-emric.

[58] EMRIC produce a table with the current measures and the specific situation for the different territories of the Euregion Meuse-Rhine.

Euregion and also ITEM, EMRIC also provided input to a special application on its homepage for citizens, translating the rules in the different Member States and regions into a tool, where citizens could easily check the rules when crossing the border. [59] In the course of the project Pandemric[60], ITEM also analysed different information platforms of the Dutch, Belgian and German authorities. Especially in the spring 2021, it was very often extremely difficult for citizens to find up-dated information on travel recommendations, quarantine or testing rules for crossing the border between BE, NL and DE. In this respect, the EMRIC/Euregion Meuse-Rhine site was an exemption to the rule: it updated in real time the many changes coming from the national or regional governments.

In conclusion, existing cross-border institutions and networks played a very important and positive role. Especially, established relations and personal contacts were essential for the cross-border exchange of information despite the national or regional top-down steering. Practitioners from all partner regions formulated it in the same way: "Knowing the right persons across the borders was essential". This also indicated one weakness: the proper functioning of cross-border information and cooperation was very much dependent on individuals at the working level.

Specific results

In hindsight, cooperation across the border was very difficult during the first wave, even in a cross-border territory that is, in comparison to other EU border regions, relatively well integrated. The Netherlands and Belgium are both members of the Benelux Union. Meaning that next to the broader governance elements of cross-border networks and Euregions, they could have joined forces at the level of national ministers under the umbrella of the Benelux. However, the health sector has not been a major cross-border cooperation issue at the EU level, nor at the level of the Benelux Union or bilaterally between Belgium and the Netherlands. Also, with the German neighbours, in this case the German Länder of North-Rhine Westphalia, Lower Saxony and Rhineland-Palatinate, there were no broader agreements with respect to the health emergency situation and cross-border solidarity. For instance, according to practitioners, during the first wave, only in exceptional cases was it possible to coordinate the procurement of protective equipment for health workers across the border. This was also concluded in the ITEM study on procurement questions for the following phases of the crisis in 2020/2021. There was also no wider cooperation with respect to testing material, where for instance on the Belgian and Dutch side shortages were registered in hospitals and old people's homes. There were exceptional cases when hospitals in Liége were helped by German partners with respect to protective material. This has been an exemption to the rule.

As already mentioned, Dutch and Belgian COVID patients were incidentally treated in German intensive care units, however this was rather the result of *ad hoc* decisions rather than well-prepared exchange structures and cross-border protocols. Thus it still reflects a lack of structured cooperation and exchange of capacities in a nationally oriented health sector and of a well-defined system of mutual assistance and solidarity in crisis situations. The deficiencies were not a result of unwillingness of the partners (hospitals, emergency services) and their cross-border networks, but of an actual lack of "solidarity mechanisms" in place when it comes to hospital cooperation.

During the second wave, it was still obvious that national quarantine rules lack consistency when applied to border regions that also led to a sort of discrimination. For example: according to Dutch rules (set at the beginning of December 2020), a self-employed plumber who has done a job for a couple of hours and is returning from Aachen (Germany) to his place of residence in Maastricht (Netherlands),

[59] The Euregion Meuse-Rhine provides a particular form for citizens on their homepage: https://euregio-mr.info/de/ueber-uns/formular-zu-ein-und-ausreise-fragen/index.php

[60] PANDEMRIC is an INTERREG Project (Programme INTERREG Euregion Meuse-Rhine) that focuses on promoting Euregional cooperation in the event of a pandemic or large-scale outbreak of an infectious disease. See: https://pandemric.info/

has to stay at home for the following 10 days since Germany was at the time, from the Dutch perspective, defined as a risk area. The same self-employed person could have stayed for a couple of weeks in the Dutch city of Amsterdam where the infection numbers had been for many weeks much higher than in Aachen. When returning from the real high-risk Dutch area no quarantine was required in Maastricht since national quarantine rules only apply for territories abroad. This illustrates that in this case, the national rules did not reflect regional or Euregional health risks and discriminated against citizens living and working in border regions. For people living in Dutch border cities like Kerkrade, where in some places the German territory is just on the other side of the street, a trip to the supermarket across the border is not travelling to a foreign country, but a normal daily routine. Quarantine examples showed that even during the second wave, it was difficult for national governments to understand the reality in border regions. This could have been tackled in the shorter-term by pragmatic solutions. For instance, the German Land North-Rhine Westphalia formulated a 24-hour rule for the so-called "small border traffic": meaning that if German citizens in border regions cross the border to Belgian or Dutch territory but return on the same day, the quarantine and other rules (registration at certain health institutions) did not apply. Unfortunately, the Netherlands and Belgium did not operate with a 24 rules but implemented other exemptions based on 48 hours in Belgium and, relatively late implemented in Spring 2021, 12 hours in the Netherlands.

This study analyses the role of Cohesion Policy as regards cross-border cooperation in healthcare, with a particular focus on the 2014-2020 Interreg V-A programmes. It also reviews the issue of governance related to such projects and the impact of the COVID-19 pandemic. Finally, it identifies possible solutions and puts forward policy recommendations to facilitate patient and healthcare staff flows, to improve the cross-border supply of healthcare and to support cross-border mutual development.

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