

# **B Solutions as a Diagnostic Tool for Improving Cross-border Health Systems, Access to Patient Services and Population Health: Insights from Published Cases 2018-2023**

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## **Introduction: Health as a Human Right**

The practical field of cross-border healthcare is one in which it is possible to identify what are arguably empirical expressions of themes and debates associated with distributive and spatial justice (Silva et al. 2023), ethical discourse on the principle of proximity as a driver for community and organisation of communities of interest (Waldren, 2011), and access to fundamental rights. For EU Member States, and all countries globally, giving expression to the right to health is an ongoing imperative - a right underpinned in the 1948 Universal Declaration of Human Rights and revisited repeatedly in various treaties since, at least one of which every state in the U.N. has ratified (WHO/UNHCR). For States to discharge the most effective delivery of these commitments specifically where citizens of their border regions are concerned, tapping the reservoir of innovation which flows from cross-border co-operation can yield significant results in ways which in-country-only solutions cannot fully deliver in ways which are quite as commensurate with ensuring the highest attainable standard of health for border citizens.

Writing as an expert practitioner in governance and leadership for cross-border co-operation, with a specialist interest in the field of cross-border health co-operation, this chapter has been produced at the angle of incidence that lies between two areas of authorial awareness that, occasionally synthesised, may generate useful perspectives. The first is my awareness of a vast field of global scholarship relating to healthcare access and transformational service design, as well as hugely useful scholarly contributions towards establishing theoretical frameworks to assist with understanding cross-border healthcare in an EU context. The second is an awareness of the locus and significance of the *b-solutions* initiative for the practical work of European integration, drawn from my practice-based real-time experience of advising both the *b-solutions* initiative in implementation of cases, and in a cross-border healthcare policy context providing expert support to the European Commission on approaches to creating resilient cross-border healthcare systems through the alignment of qualitative measures and structural fund supports.

This chapter offers a reflection - at a single point in time - on the quantum insights that a synthesis of case findings from *b-solutions* may usefully reveal, for policy makers and healthcare system animators and stakeholders. This chapter is therefore a humble consideration of the kind of solution-focused thinking offered by *b-solutions* evidence bases, as policymakers and practitioners - alike - grapple across Europe with the challenges ahead and already upon us. These are quadruple at least- the challenges of meeting population healthcare needs, managing limited resources and the requirement for a rapid and just green transition, future-proofing (and shock-proofing) our health systems post-pandemic, and overall of creating a vision of European cohesion and integration which strives to extend the benefits of EU membership to as many citizens as possible regardless of location.

In considering these issues, I have also reflected on the fact that thirty per cent of the EU population lives in a border region, and that in this sense at least, consideration of access to services in border regions cannot - or at least ideally should not- be treated, either explicitly or implicitly, as a minority sport.

### ***b-solutions* as a source of learning in the wider journey towards resilient health systems**

Various health systems across the EU are beginning to consider cross-border collaborative approaches with

neighbouring health systems. Such activity may see exploration of shared investments and resources organised on and supported as feasible by being based on cross-border economies of scale.

We know from recent years that health systems need preparedness to respond and to absorb future shocks, not all of which can be foreseen, or where the precise nature and extent of which is hard to forecast. Resilience of our health systems within and on the external borders of the EU is a challenge which we must meet, to safeguard and optimise capacity to respond to future pandemics as well as handle the legacy of the Covid-19 Pandemic in population health terms. Health systems also need to be able to plan for and respond to the evolving health needs of populations which are living longer. In a Europe where we have spatial health inequalities which need to be addressed, health systems need to be able to interact in dynamic ways with wider social, cultural, civic and political systems in ways which can help to achieve a necessary whole-of-society approach to positively influencing the underlying determinants of health. Our future challenge, which an inclusive vision of Europe combined with technical innovation and determination is capable of driving, is to enable our greatest asset - our people - to be the experts in their own holistic physical, mental and emotional wellbeing. For this our populations need to be supported by well-managed, dynamic and effective

health systems at community level, and across the spectrum of intervention from primary care to secondary care and specialist care.

Health systems which optimise equality of access and opportunity, across the widest possible portions of our territories, are the key to future workforces and ongoing European competitiveness in a wider sense. In terms of how health systems can facilitate best practice in clinical care and preventative health interventions, the global emergence of integrated care as a set of principles informing systems models is one which also provides a fruitful field for exploration of transboundary patient pathways and the organisation of resources and clinical workforces<sup>1</sup> in cross-border areas.

Some of the cases relate specifically to patient mobility and the systems which are necessary to enable these - such as bilateral arrangements for reimbursement of care costs, in order to complement and give full effect to EU enabling frameworks such as Directive 2011/24/EU on the rights of patients in the EU in cross-border healthcare. Other obstacles featured relate to challenges of inter-institutional cooperation, where the solutions may lie in the development of the required capacities, culture and relationships

to underpin innovative models of collaborative governance required in order to deliver effective services and access to healthcare in border regions.

It is important also to recognise that a technical obstacle in relation to a healthcare access issue may also have a wider knock-on effect within a territory: other obstacles, unresolved, contribute to barriers in other areas such as the development of cross-border labour markets; solving such obstacles often relates to co-ordinated approaches to the arrangements by which frontier workers can access their entitlements to health and social insurance across borders.

This chapter draws on a selection of the 131 cases and analyses which have been formally published by AEBR in the official project compendia and associated smaller publications published by *b-solutions* at the time of going to print with this edition of the journal. In doing so, its purpose is also to point to the integral relationship of health, resilient health systems, and healthcare access across borders to not only an improved EU population health profile, but to indicate its relevance within other important EU policy priorities related to cohesion, enlargement, and deepening the impact of existing EU enabling frameworks for these.

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1 The International Foundation for Integrated Care's Nine Pillars of Integrated Care are useful guiding principles in this regard. These are: 1. Shared values and vision; 2. Population health and local context; 3. People as partners in care; 4. Resilient communities and new alliances; 5. Workforce capacity and capability; 6. System wide governance and leadership; 7. Digital solutions; 8. Aligned payment systems; 9. Transparency of progress, results and impact.

## The relevance of good qualitative conditions for cross-border healthcare cooperation

In preparation for its evaluation of the Directive 2011/24/EU, the European Commission commissioned and published a report carried out by AEHR (2022) which dealt with cross-border patient mobility in a number of EU border regions. Based on a study carried out during the height of the Covid-19 Pandemic, the report looked primarily at data and examined the underlying narratives derived from data on cross-border patient mobility in selected cross-border regions, as indicators of a broader picture of conditions for cross-border patient access to healthcare. The report's key recommendations focused on improved approaches to data collection on cross-border patient mobility and access, but also emphasised the relevance for such practical efficacy, of having multilevel collaborative healthcare ecosystems approaches in border regions as a key to improving the qualitative conditions for cross-border patient mobility and delivery of the rights of patients in the EU in cross-border healthcare.

The report made a number of recommendations relating to the wider qualitative conditions for cross-border healthcare, a revisiting of which can also inform how *b-solutions* learning can be applied to a wider applied Lebenswelt context in which health systems struggle

to meet evolving challenges in-country and on their borders. In this chapter I attempt to highlight the illustrative value of *b-solutions* for those interested in further developing healthcare systems across borders as a strand of future European healthcare system recovery, resilience and sustainability. Healthcare systems are also close to the daily lives of citizens and in this sense, cross-border healthcare co-operation is increasingly understood by cross-border practitioners as being a highly relevant field for realizing European integration and cohesion in a way which brings Europe closer to citizens.

### ***b-solutions* cases, 2018-2023**

This section deals with cases supported in the broad category of health in the successive rounds of *b-solutions* support from 2018 until 2023. All cases referenced are specifically drawn from the cohorts of cases published in successive compendia and thematic publications by AEHR between 2020 and 2023. The cases variously relate to particular technical themes and system problematics within a variegated spectrum of activity which can be loosely referred to as cross-border healthcare cooperation. Cases are referred to below in terms of the primary indicative theme to which they were relevant-however, depending on the case and as will be clear to the reader, a case very seldom relates only to the specific primary obstacle which was the point of entry for the work on the case.

Broadly, as a practical conceptual framework for this topic, it is fair to suggest that cross-border healthcare systems need a number of enablers in order to operate, serve patients and citizens to optimal effect, and to grow and develop into the future. At a systems level, these include being based on evidence of population health needs and the use of population health data to inform decision making, effective reciprocal or integrated cross-border financing mechanisms for care, willingness and leadership to explore innovative business models of healthcare which can operate across borders, arrangements for the mobility and mutual recognition of professional healthcare qualifications, regulatory alignment measures to enable seamless operation of emergency and unplanned healthcare services, and effective information and reimbursement systems to underpin effective cross-border systems for planned care (non-emergency), and elective care. At a professional and clinical level the necessary factors include a willingness of healthcare professionals and leaders to work together across borders to offer the best standard of care possible for the cross-border population. At a civic and governance level these include the availability of data and statistical data sharing on a cross-border basis in order to achieve evidence-informed service planning, investment and development (including infrastructure, facilities, and regional strategic spatial planning frameworks that are transboundary and cross-border).

All of these enablers require the ongoing input of stakeholders at local, regional, national and occasionally EU levels. All of them benefit from a shared understanding of their relevance. Many of them are enabled by existing EU frameworks such as the Directive and the Social Security regulation but these are not the only factors needed to facilitate success. The key catalytic factors lie within the sphere of influence and interrelationship between border regions, their healthcare institutions, and national decision makers and institutions in the healthcare and related sectors.

*b-solutions* health-related cases represent a geographical and thematic/sectoral mosaic which can be laid over the conceptual framework set out above, to illustrate some of the issues and contribute to a reflective understanding of how healthcare systems in border regions can be supported to work in the future.

## **Cross-border cooperation to enable seamless access and operation of healthcare in border regions**

In the first wave of *b-solutions*, a number of specific pilot initiatives were supported which included one between France and Spain focused on enabling cross-border emergency healthcare to operate in the border region surrounding Cerdanya Hospital (Catalonia, North Eastern Spain) and including Perpignan Hospital (South Eastern France). This

pilot (C1 Annex)<sup>1</sup>, advised by producing an agreement governing the regulation of healthcare professionals qualified and certified in one jurisdiction, and operating from time to time in the other. It also led to a number of other specific *b-solutions* cases generated by the EGTC Cerdanya hospital: specifically a case advised by M.O.T. relating to mutual recognition of qualifications (C1 Annex); and a case advised by Maria Garayo on resolving cross-border employment and worker mobility issues associated with regional ecosystems services SMEs supporting the hospital at Cerdanya (C3).

A range of specific cases deal with the issue of cross-border workforce development for healthcare, which includes the issue of recognition and certification of professional healthcare qualifications. In border regions where there is a language border, an added factor in this is the certification of language competency for the purposes of providing care to patients. Language in itself is a key care quality issue which is central not only to patient experience but also to patient safety and the effective operation of clinical governance. A case led by EGTC Eurocity Chaves-Verin (C2), advised by Maria Teresa González Ventín, focused on enabling Spanish nursing students who had trained in Portugal to return and be certified for practising in Spain, through ensuring that a solution was recommended that could allow Spanish

nursing students to obtain the requisite language certification for working in Spain. The anomaly was that this was not deemed necessary by the Portuguese training framework given that they were assumed to be competent in Spanish, and therefore was not routinely provided to Spanish nursing trainees qualifying in Portugal.

Often the cross-border obstacle is caused by simple oversights or variations in interpretation of legal provisions, but the results can be complex and have implications for regions, their economies and their people. Increasing the mobility of healthcare professionals was also looked at not only on the Spain-France border but also on the French-Belgian border in a case led by EEIG Franco-Belgian Health Observatory and advised by Pauline Pupier (C2). Such cases not only relate to realizing the right to labour mobility for healthcare professionals, but also enabling mobility of healthcare professionals in ways which can meet the needs of healthcare labour markets and therefore of the healthcare systems themselves in border regions. This issue is emphasised in a further case on mutual recognition of qualifications in the health and social sector, led by EGTC Euroregion Nouvelle-Aquitaine Euskadi Navarra and advised by Petai Tzvetanova of M.O.T., in which it is remarked that ‘professional mobility is an essential aspect of the area’s economic development’. (C2)

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<sup>1</sup> References on individual cases are ascribed to the AEHR Publication which features them: for Compendia, of which there are three, reference is C1, C2, C3 etc. Individual smaller publications are referenced by title in brackets in the text.

## Cross-border emergency health services

Early cases in this thematic area such as one commissioned through the Municipality of Woensdrecht in the Netherlands and advised by Martin Unfried (C1 Annex), also revealed the presence of obstacles to cross-border emergency services operations caused by divergence in regulatory frameworks for emergency vehicles and mutual recognition of emergency medical staff qualifications. Another case on cross-border emergency medical services between Belgium and France, led by the Agence Regionale de Sante Grand Est Region (C1 Annex) and advised by Petia Tzvetanova and team at M.O.T, identified a simple divergence in the interpretation in the respective country regulatory frameworks of a single technical phrase used in both jurisdictions: Services Mobile d'Urgence et de Reanimation (SMURS). In France, SMURS denotes fully equipped ambulances but in Belgium SMURs are not full ambulances but light vehicles transporting doctors. Because of this differentiation Belgian emergency ambulances were not allowed to cross the border and reimbursement to patients of care costs became limited to the interventions of SMURS. This simple and possibly unintended difference of detail, meaning and language, is informative by its discovery and can act as a reflection point on quality checking for administrations seeking to develop bilateral agreements which can release the full potential of that which they seek to enable. Language matters, as does attention to detail.

## Relevance of cross-border emergency health services cooperation for wider emergency cooperation and civil assistance in border regions

The regulation of emergency healthcare co-operation on a cross-border basis is also closely related to and relevant for the wider issue of overall cross border emergency planning and emergency/disaster response and management. In this sense, paying attention to overcoming often minor regulatory divergences or discrepancies, may also be relevant for and assist with wider work relating to cross-border emergency co-operation including disaster response and readiness. A number of cases, including one relating to the Karlovy Vary Region on the Czech border, advised by Michael Frey and Ondrej Dostal (C2), also identify where one Member State's regulatory framework can be used to amend domestic legislation in a way which takes account of the opportunity to eliminate regulatory obstacles which prevent cross-border emergency care access.

A wider reading of emergency services co-operation and disaster response cases across the *b-solutions* publications – such as the case led by Vilkaviškis District Municipality in Lithuania and advised by Šarūnas Radvilavičius (C1 Annex) reflects that often the differences in individual regulatory member state legislative arrangements can benefit from a co-ordinated, place based cross-border approach to creating area-based

governance for emergency response and disaster management which meets the needs and challenges of cross-border regions and allows neighbouring Member States to demonstrate solidarity with their neighbours in times of emergencies and natural disasters, such as forest fires, flooding and earthquakes. The role of *b-solutions* in solving legal and administrative obstacles as a necessary enabler to wider co-operation and Interreg-funded activities is also noted in a case from the Departmental Fire and Rescue Service of Pyrénées-Atlantiques advised by expert Maria Garayo Maiztegui where *b-solutions* is the route to resolving legal regulation of a developing emergency services and civil protection cooperation model. The relevance of learning from emergency medical care services is valuable for the wider EU civil protection and civil preparedness agenda where borders are concerned, which is 40% of the EU territory. Again, getting these arrangements right in border regions is not a minority issue or concern if we acknowledge the combined geographical scale at EU level.

## **Cross-border healthcare access and cross-border patient catchments: sustainability of healthcare facilities**

An early case supported by *b-solutions* related to the provision of services at Valga Hospital, Estonia, in the cross-border twin city of Valga-Valka, where Latvian patients wished to access ongoing hospital care locally (C1 Annex). The hospital itself is

uniquely viable on a cross-border patient catchment model and this case is currently also being supported into implementation and further elaboration of additional solutions under *b-solutions* objective 2. The case looked at solutions to the sustainability of hospital care based on serving a cross-border patient catchment, focusing on the continuing operation of cross-border hospital services that could be supported by funding care for Latvian citizens in their twin city of Valga-Valka, a city shared by Latvia and Estonia. The case revealed a range of issues which are commonly found where there are obstacles to cross-border care access and/or patient mobility- these relate to the presence of an enabling framework through EU mechanisms such as the Directive, and more local divergences or differentials that require joint working to reach creative solutions, such as care pricing differentials. The case did, importantly, highlight that, as a result of both Estonia and Latvia having correctly transposed the Directive into their respective national legal frameworks, a facilitative framework now exists for both healthcare systems to work together to find a financial model tailored to the unique situation of Valga-Valka hospital and to the specific needs of the cross-border patient population. Work on implementing and further developing this model in the Estonia-Latvia border region continues in 2024 and onwards.

Another early case led by Public Institution Marijampole Hospital in Lithuania (C2), and advised by Gintaras

Skamaročius, identified the opportunity to improve overall quality and efficiency of healthcare services in the border region between Poland and Lithuania. The proposed solution was to adapt a bilateral model made in 2019 between Lithuania and Latvia, to achieve improved coordination between national health systems for the benefit of citizens in the Lithuanian-Polish border region. The case solution proposed to adapt this precedent to an agreement between Polish and Lithuanian hospitals and emergency services for better-optimised use and access by cross-border citizens of available facilities in the cross-border region. This case points to the benefits of a Member State with more than one land border recognizing the value of *b-solutions* for developing solutions which can be replicated or adapted for use on other parts of their borders.

Cases involving the place-based availability and sustainability of healthcare facilities and services to cross-border patient catchments represent opportunities for developing healthcare ecosystems across borders which can mobilise available mechanisms and combine these with local and sectoral assets on a place-based multilevel governance and cooperation model. Such circumstances provide opportunities for EU level enablers to be interwoven with innovative approaches by neighbouring Member States to deepening their own cooperation for mutual benefit. Such a scenario is clearly demonstrated in the EUROPEC

Eurocity case advised by Amparo Montán involving the municipalities of Badajoz in Spain and Elvas and Campo Maior in Portugal (C3). In this case, the opportunity to solve remaining obstacles lies with the neighbouring Member States' already-strong, treaty-based commitment to cross-border healthcare co-operation, which has included innovative cooperation to ensure access to women's health and maternity services for the women of the cross-border region.

As with Valga-Valka, and where statutory stakeholders are involved as partners to *b-solutions* cases, the opportunity presents further for Member States working with cross-border regional stakeholders, supported by local government of the place (therefore with enhanced mandate and democratic governance linked to the people) to take a whole-systems approach to securing a 21st Century health ecosystem for a 21st Century cross-border patient catchment. Such systems can be developed in ways which feature needs-based patient mobility, data sharing for improved patient safety and increased clinical co-operation between facilities, clinical workforce mobility and mutual recognition of qualifications.

## **Cross-border patient mobility**

The reasons why people travel across borders for healthcare range from those related to regional connectivity

and access to points of care (where the nearest point of access may be across the border rather than in one's own country), to highly personal choices based on care quality, care specialty and other issues such as language.

### ***Obstacles and solutions relating to the reimbursement of the costs of healthcare***

A number of *b-solutions* cases have made specific examination of obstacles to patient mobility which relate to difficulties around patient reimbursements. In some cases, such as an early case led by Euroregion NISA and advised by expert Hynek Böhm (C1 Annex), these difficulties are caused by pricing differentials between neighbouring countries combined with Member States exercising their legal entitlement under the Directive to regulate reimbursement costs in accordance with national price lists. Such cases often involve invisible deterrents to patient mobility because patients travelling under Directive 2011/24/EU to a country whose care costs are higher may only be reimbursed to the level of the pricing structure in their country of residence. This means that patients may be financially disadvantaged in accessing cross-border care. Equally, Member State health insurers may refuse to authorise certain types of treatment for reimbursement under either the Directive or the Social Security Regulation, in which case the patient can end up having to access care further away, within their own jurisdiction. For care such as emergency care, certain

types of cardiac intervention, and maternity/obstetric care, travel time to the point of care is a safety issue and can literally mean the difference between life and death. In such cases it is clear where a solution lies in the principle of active subsidiarity - Member States using the power that they have deriving from the principle of subsidiarity, in ways which are for the benefit of border citizens. This sometimes implies a tailored solution-focused approach in order for border citizens to access the same benefits as those living away from the borders (and often closer to specialist healthcare centres).

A number of subsequent cases have dealt with this theme in its regional and place-specific variations. Across all such cases, solutions invariably point to a crucial and central success factor of healthcare insurers working together across borders on the shared premise that they wish to use available frameworks and means to effectively coordinate their efforts, and to support the cross-border population in accessing care based on need and in attaining adequate levels of health. Solutions also point to the discretion which Member State health insurance funds have to make this happen and be part of the solution. The cross-border health insurance card pilot led by DKMT in the Hungary/Romania/Serbia border region (C3), and advised by Petra Wilson and Anett Molnar, identified an approach which involved starting with a small basket of agreed care procedures for which the health insurers could provide

mutual automatic authorisation, to allow patients to access care in the cross-border region. This case is currently proceeding towards full implementation from late 2024.

The prevailing humanitarian impact of co-operation between national health insurers and relevant authorities is also highlighted by cases such as Zeeland, which took forward a *b-solutions* case advised by Martin Unfried, Sander Kramer and Susanne Sivonen of ITEM (C2). This case focused on creating access for Dutch patients, particularly of an older generation, to care in Belgium, within their own cross-border region. Such patients were seeking access to medical care across the border in Belgium as a result of shrinkage of services in their own side of the border and the solution was found in recommending a bilateral agreement between insurers, simplifying administration of reimbursements, and allowing for automatic granting of prior authorisation for a patient to access care across the border. In such cases (and all discussions relating to co-operation on healthcare reimbursements and insurance provision), the model of the ZOASTs – created between Belgium and its neighbouring countries of France and Germany- remain an inspirational and durable model of possibility and practice. A similar issue arose in the Eems Dollard Region’s case – advised by Anton Bouwmeister and Marlene Plaß, relating to treatment and reimbursement of expenses for Dutch and German patients (C2). All these cases point to solutions being reachable

when healthcare insurers work together for their clients in border areas. This is particularly important when services in border areas shrink due to depopulation. Member States may not be able to avoid reduction of service levels, but they can still lever their own and EU legal frameworks to enable their citizens to access those services across the border. In such cases, a cross-border approach may not lead to (or necessitate) direct provision of the service, rather it will use innovation and smart collaborative approaches to enable the citizen to access the service- which is another way of serving the public and achieving the same citizen outcomes, sometimes even better ones. This is the magic of cross-border co-operation for effective and efficient public administration working with limited resources.

### ***b-solutions’ support for health cases as a lens for understanding public services in border regions (and how they can be improved)***

In November 2021 the European Commission and AEHR produced a thematic publication on the overall issue of cross-border public services and the role played by the *b-solutions* initiative in assisting with the development of this important field (European Commission & AEHR, 2021a). The introduction to the publication, by Caroline Hager of the European Commission, emphasised the challenges remaining in making cross-border health services a reality and

the importance of cross-border public services in a post-pandemic context, particularly in the healthcare sector and in terms of fully releasing the benefits of EU frameworks such as Directive 2011/24/EU. The evidence which informed this publication drew heavily on healthcare *b-solutions* cases, which in themselves are fertile ground for understanding the detail of what enables cross-border public services at operational, legal and administrative levels; and for arguing for innovative resourcing models to underpin effective cross-border services (including shared services models).

The publication outlines the specific types of obstacles to cross-border public services development, revealed by *b-solutions* cases, across a range of sectors. For healthcare, the generic types of obstacles are identified as: different criteria on reimbursement of healthcare costs; limitations in the provision and accessibility of cross-border medical services; incompatible national provisions on data collection, accessibility and confidentiality preventing cooperation between healthcare institutions; non-recognition of healthcare professionals' diplomas; diverging technical standards of emergency transportation; lack of horizontal cooperation between responsible administrative bodies; diverging standards on taxation, financing, staff qualifications and safety.

While this is a useful summary of sectoral issues, the wider framework that the thematic publication on

cross-border public services offers is additionally useful and could become part of a methodology to be used for systematic approaches to developing cross-border healthcare ecosystems. Using the learning revealed by *b-solutions* on the typical and frequent obstacles in cross-border health, and combining this with other forms of evidence and best practice (including population health data and clinical best practice guidelines) in the design and organisation of healthcare systems has the potential to drive innovative cross-border services models which are designed on the needs of cross-border patient catchments and are viable precisely because they serve such catchments.

## **The intersectionality of health with other domains of border life (and EU policymaking):**

*b-solutions* health cases are variously connected with other domains of cross-border co-operation and territorial development such as transport, emergency cooperation and civil protection, cross-border labour markets and labour mobility, regional innovation capacities, digitalisation, education and training/skills development, shared services, and best practice in the use of public resources. One such area which is heavily illustrated by *b-solutions* cases published to date is that of how healthcare access interacts with labour mobility and workforce planning in cross-border functional economic areas:

## **Cross-border patient mobility as a component of EU cross-border labour mobility and a skills base to support EU competitiveness and the Single Market**

Frontier workers, as citizens entitled to the same patient mobility as everyone else, can experience difficulties accessing their entitlements to healthcare insurance in ways which either deliver or hinder their entitlements. In some cases this acts as an indicator of wider obstacles to patient mobility in the region, such as one of the first *b-solutions* cases relating to cross-border health insurance in the Eurodistrict PAMINA region on the border between Germany and France (C1 Annex). This case was advised by TRISAN, and identified solutions to difficulties experienced by frontier workers in accessing reimbursements for care as well as initially registering for healthcare services. Another early case led by Borderland Association Nasza Suwalszczyzna (NGO) and advised by Marcin Kyzymuski, identified similar issues for cross-border workers in Lithuania and Poland and solutions which included a bilateral agreement governing and simplifying rules and procedures to be applied in a cross-border context, removing cumbersome barriers for employees and employers alike (C1 Annex). Cross-border patient mobility, as enabled by cross-border co-operation on healthcare insurance, is therefore an important enabler for the wider EU agenda of labour

mobility and cross-border workforce development. These themes have taken on new significance in the post-pandemic context of a need for balanced regional development across the EU. Border regions, effectively developed, can take the pressure off large urban agglomerations and indeed in many cases have the potential – with the right shared vision across borders – develop as sustainable agglomerational ecosystems benefitting multiple economies. Competitiveness is enabled by the presence of workforces in places and workforces need to be enabled to support competitiveness of places. Ease of healthcare access for workers is a key consideration in decisions as to whether to work cross-border, and is therefore a key factor in a wider economic context.

Other issues related to cross-border labour mobility, which involve coordination between healthcare systems or professionals and social insurance systems, can also relate to the certification of sickness in connection with receipt of benefit entitlements for frontier workers- as in the case led by Euregio Rhein-Maas-Nord between the Netherlands and Germany, advised by Sonja Adamsky, which focused on an obstacle which was preventing Dutch parents working in Germany from accessing paid sickness leave related to illness of a child (C2). Identifying again a simple procedural difference between how children’s sickness was certified in Germany and in the Netherlands, the case recommended a combination of bilateral agreement on social security

arrangements combined with giving Dutch paediatricians the authority to issue children's medical notes for recognition by German social security and employers. A case led by the Government of Extremadura, Spain, in partnership with the Alentejo region of Portugal and advised by Amparo Montán, relating to creating more streamlined access to healthcare for cross-border workers in the region (C3). The case emphasised the importance of continuing to facilitate labour mobility and helping cross-border workers through an improved simplified annual procedure for seamless access to healthcare insurance. While the case related specifically to workers residing in Spain and working in Portugal, the case nevertheless states that the measure will benefit the whole Spain-Portugal border region. Awareness of the territorial applicability of local solutions, and the sharing of these solutions, is an ongoing part of the *b-solutions* methodology.

The wider importance of healthcare access for cross-border workers, and co-operation for mobility of healthcare workforce in border regions where commuting is common, are emphasised further in the European Commission & AEHR (2021b) publication of 'Vibrant Cross-Border Labour Markets'. This thematic publication cites healthcare access and healthcare workforce as issues connected to developing vibrant cross-border labour markets. The role of *b-solutions* in identifying the ways in which national systems can work facilitatively when they meet in cross-

border functional economic areas, and, crucially, in signalling the possibility of overcoming such obstacles, are emphasised in the preface by Slawomir Tokarski, Director, European Commission.

## ***b-solutions* as a policy tool with impact**

In concluding this snapshot of reflection on what *b-solutions* means for the field of cross-border healthcare cooperation and access to health, it is possible to suggest from a practice-based perspective that the value of *b-solutions* as a policy and practice tool goes far beyond the net value of individual case solutions which are necessarily developed for application in a local and specific context. Individual case solutions can be viewed in the range of AEHR's publications to date on *b-solutions*. However, to assume that *b-solutions* solutions are too specific and tailored to individual border regions to be useful in a broader sense is to miss the point. Beyond this, and from observing the similarities and common themes across the full range of cases published, it is clear that a *b-solutions* case has two types of relevance. First, it acts as an indicator - across a number of sectors including health - for what are often obstacles which exist in similar format or construct in other border regions throughout Europe. These may be caused by the same kinds of unintentional "border blindness" or oversights in understanding the other

which it is necessary to recognise and tackle in developing effective bilateral and multilateral agreements which can deliver what they intend to e.g. different meanings being ascribed to identical terms, depending on which side of the border one stands. To learn from such examples might be for Member States and their border regional authorities and sectoral authorities to review existing bilateral agreements for efficacy, perhaps operating what in the construction and engineering sector is known as a “snag list”- in which possible pitfalls are diagnosed and then addressed to ensure the agreements and arrangements work in the way they are intended to for all parties. *b-solutions* cases can, in this way, act as stimulus for the replication and multiplying of place-based co-operation in healthcare, across any border where parties are interested in working together.

Second, a *b-solutions* case can suggest the presence of issues which cannot be solely addressed by border regional stakeholders at the level of a region. Such issues include those that need to be addressed by whole systems approaches by Member States acting together and with their border regions on a bilateral basis, and in some cases by Member States working with the European Institutions to eliminate avoidable obstacles borne out of a siloed approach to implementing common legislation, or the absence of enabling legislation. At a whole-systems European level, removing and preventing avoidable border

obstacles - where our national systems colliding can lessen the benefits of the European project for border citizens, societies and economics- needs to be a symphonic effort involving attention to detail, extrapolation of learning, and horizontal and vertical mobilisation at all levels of public governance – local, regional cross-border, national and at EU level. *b-solutions* at a global project level continues to offer a model for this kind of solution-focused collaborative methodology which works best in combination with social change models and best practice in placemaking, where ideas and ambitions are shared and transmitted across networks of actors.

For cross-border health, this chapter provides an overview of selected cases and suggests a perspective on their relevance as indicators and situational elaborators for what are known and established ‘glitches’ in the practical matter of creating optimal conditions for cross-border health- either co-operation or access, or health of the population itself. The chapter further points to *b-solutions*’ contribution to the broader task of creating the necessary understanding and enabling Member States to work together in active subsidiarity to deliver access to healthcare for their citizens in ways which include the deployment of cross-border models and approaches. In practical terms, using the learning from the cases can also help with developing early warning systems approaches for avoidable obstacles to health cooperation and access across borders,

for which Member States and other stakeholders are in a position to develop alternative solutions and avoid.

The *b-solutions* initiative continues to commission expert case studies identifying evidence-based solutions on health-related obstacles in border regions and is beginning to provide the necessary technical, mentoring and brokerage support for the multilevel ecosystems processes and stakeholder engagement in order for the identified solutions to be implemented. This translational action also allows for the absorption into pathfinder processes of a range of thinking on healthcare systems transformation, modernisation and resilience, and to explore and test supportive whole-systems conditions in cross-border areas which can support improvements to health access and to population health outcomes. It is likely that over time, not only in cross-border health co-operation but in all the fields in which *b-solutions* cases are supported through to implementation, that *b-solutions* will have created an applicable evidence base for specific solutions to identified legal and administrative obstacles across many subthemes related to healthcare and healthcare access. It is also likely that *b-solutions* will have contributed to the development of capacity in cross-border areas for the implementation of cross-border healthcare solutions and systems in a wider context which supports the full extent of innovation which cross-border regions uniquely offer.

In healthcare, *b-solutions* indicates the relevance of local solutions in combination with more global or higher level enabling frameworks, for spreading the learning across the EU. It also indicates that sometimes only the local or regional application of the EU-level enabling frameworks is what will bring the benefits directly to the citizen. Member States' roles are crucial, working with their regional stakeholders. Overall, *b-solutions* health cases continue to illustrate how cross-border health systems can continue to develop and grow to support border regions as they grow, innovate and become sustainable places for our future generations. And they ultimately demonstrate the kind of diagnostic approaches to border region interfaces between Member State frameworks – both legal and administrative – which can help to deliver fully on the promise of the EU for all its citizens and on a range of fundamental rights which are at the heart of a social vision of Europe. Cross-border healthcare co-operation, healthy populations and accessible healthcare are key to a healthy population base and therefore to innovation systems which can support the EU for future growth and competitiveness in a changing world.

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