

Cross-border health and emergency services (based on the results of *b-solutions* and beyond)

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Introduction

Aim and sources

The goal of this paper is to review, interpret, and critically synthesise the results of the *b-solutions* project (AEBR, 2024) concerning healthcare as well as emergency services (ESs), which are one of the five main thematic areas of the project (Medeiros et al. 2022, p. 507). The main sources for the analysis are the three *b-solutions* compendia on the obstacles identified in all the thematic fields, including healthcare (AEBR & EC, 2020a; AEBR & EC, 2020b; AEBR & EC, 2021a; AEBR & EC, 2024). Further, one of the three *b-solutions* thematic booklets, titled ‘More and better cross-border public services’ (AEBR & EC, 2021b), is relevant as it also covers healthcare and ESs. Another thematic booklet, titled ‘Vibrant cross-border labour markets’ (AEBR & EC 2021c), mentions healthcare in a few places but these are repetitions of the cases identified in the booklet on public services. In addition, recent secondary literature has also been consulted.

The rise of cross-border healthcare (CBH) particularly in the European Union (EU)

CBH is an emerging phenomenon globally (Chaudhary et al. 2024; Glass et al. 2022; Leung & Ku, 2024). For the sake of a definition, ‘[c]ross-border collaboration in the field of health care can involve a transfer, a movement or an exchange of individuals, services and resources’ (Schmidt et al. 2022, p. 1242). For several reasons that include ageing societies, various pandemics such as the recent Covid-19 (Frischhut & Levaggi, 2024, p. 5), and ongoing European integration, healthcare is of growing concern also to the EU. As noted by Schmidt et al. (2022, p. 1242), ‘[a]lthough healthcare is primarily a national responsibility’, CBH ‘is legally enshrined in Article 168 of the Treaty on the Functioning of the EU’, encouraging ‘cooperation between member states to improve the complementarity of their health services in cross-border areas’. Moreover, Directive 2011/24/EU on the application of patients’ rights in CBH mandates the European Commission (EC) ‘to ensure patient mobility in the EU, to facilitate cooperation in

healthcare across member states and to establish rules facilitating access to safe and high-quality' CBH.

According to the Preface to the *b-solutions* thematic booklet on cross-border public services (CPSs), a milestone has been the introduction of the above-mentioned EU Directive on patients' rights in CBH in 2011, which complements Regulation (EC) 883/2004 on social security coordination 'to ensure rights to safe and high quality healthcare across national borders in the EU and their right to be reimbursed for such' (AEBR & EC, 2021b, p. 4). Moreover, the 'Directive also aims to engage cooperation between border regions where citizens face a particularly unique situation'. At the same time, it is also acknowledged that 'the full potential from benefits of cross-border healthcare is not yet realised' as 'citizens continue to face burdensome reimbursement procedures, legal and administrative obstacles to access, sometimes life-saving, healthcare'.

The thematic booklet on public services also briefly assesses their state in border regions (AEBR & EC, 2021b, p. 5–6). It notes correctly that 'the debate about the value and sustainability of public services has intensified' at a time when 'both demographic and growth scenarios are putting pressure on the capacity of governments'. This is especially true for a number of border regions in which 'population decline and regional migration might be particularly visible'. Accordingly, representatives of the EU

and border regions aim to establish more cross-border services, with 579 already-functioning ones identified by 2019. But a number of different types of obstacles remain: it is acknowledged that '[f]or the 150 million European citizens living in border regions, regular access to public services is often difficult', leading to 'the use of facilities and services in the neighbouring country as an alternative solution' only.

Accordingly, the EC has outlined specific interventions (AEBR & EC, 2021b, p. 6–7), such as creating a dedicated database to showcase good practices; evaluating the application of the 2011 Directive on patients' rights with a specific focus on CBH; renewing support for the EU4Health program; and creating a European Health Data Space to support evidence-based regulatory activities. While all these measures sound constructive and future-oriented, they are only briefly listed here without providing any further details on when they were proposed or how they are progressing. The same cannot be said about the *b-solutions* project, which was initiated in 2017 and has been implemented by the EC's DG Regional and Urban Policy and AEBR since 2018. They have collected a unique set of cases that address obstacles to and solutions for CPSs. Using a bottom-up approach, a number of local and regional – transborder as well as subnational – stakeholders have participated, in turn having 'received advice from legal experts to find ways to overcome the obstacles'. It is to the presentation of these that we now turn.

Obstacles to CBH identified and solutions proposed by *b-solutions*

Obstacles

The most common obstacles for establishing or running CBH as well as emergency services identified by *b-solutions* (AEBR & EC, 2021b, p. 10) are the following:

- 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 prevent cooperation between healthcare institutions;
- non-recognition of healthcare professionals' diplomas; and
- diverging technical standards of emergency transportation.

It is identified that the majority of the obstacles to CPSs is of a legal nature, which most often 'arise within the national provisions [...] but legislative inconsistencies were also observed within the European framework' (AEBR & EC, 2021b, p. 12). These include the following situations.

- Actors at the regional and local level do not have legislative competence to establish or operate services.
- Laws do not provide for the automatic recognition of foreign diplomas of service professionals.

- The presence of different national rules that regulate services.
- Technical standards or requirements allowing for service operations are regulated differently.
- EU law is transposed in a conflicting or contradictory manner, for instance 'when Member States choose to interpret laws and regulations differently, according to each national context' (AEBR & EC, 2021b, p. 14).
- Laws regulating the provision of services do not take into account the cross-border dimension. This has been observed not just on the national but also on the European level.

Beyond legal concerns, a set of further obstacles to CPSs has been identified (AEBR & EC, 2021b, p. 14–15), addressing which would require 'a good level of administrative coordination between stakeholders from both sides of a border'. The most common reasons for a lack of such coordination were found to be:

- lengthy diploma recognition procedures, despite harmonised basic requirements;
- the absence of joint administrative mechanisms that facilitate the operation of services;
- the presence of many actors with varying administrative competences in certain fields;
- different approaches to data collection as a preliminary step towards implementing public services; and

- the lack of knowledge of border stakeholders on the facilitative nature of the legal framework(s) that regulate certain services.

To name a typical example, the case of a Portuguese-Spanish border area can briefly be described where the much closer hospital in Spanish Badajoz is often frequented by Portuguese patients (AEBR & EC, 2024, p. 40). Although the latter are reportedly never refused treatment, both legal and administrative obstacles hinder more efficient CBH. Portuguese citizens must obtain prior authorisation and pay for the service in advance. Further, there are regulatory issues preventing mutual access to patients' data. Additionally, authorities on both sides require healthcare professionals from the other side to join their respective medical registries which is time consuming.

Hiring medical staff has proven to be challenging even at the Cerdanya Hospital along the Spanish-French border, which is often mentioned as 'Europe's first cross-border health centre' (AEBR & EC, 2024, p. 32) though it is in reality solely located in Spanish territory. Hence, recruiting French employees occurs but is complicated due to differences in social security contributions between the two countries. This would be desirable though due to the shortage of labour at the hospital as well as the binational composition of its patients.

There are even more challenges ahead of CBH involving repeated mobility, let alone remote care, for instance in a

Luxemburg-French border area. In France, follow-up care and hospitalisation at home are established practices, but not so in Luxemburg where physicians cannot prescribe any such even to the treated French patient (AEBR & EC, 2024, p. 51). But even if they could, current EU and national rules contemplate neither whether these would be considered long-term services (which is now decisive for reimbursement), nor the mobility of CBH professionals in home care. When it comes to telemedicine, teleworkers are disadvantaged compared to their border-crossing peers: whereas the latter 'are entitled to healthcare both in the country of employment and in the country of residence, teleworkers only have coverage in their country of residence if they work from home more than 50 % of the time' (AEBR & EC, 2024, p. 54).

Regarding emergency services, some of the *b-solutions* cases appear to be faced with diverging obstacles. Along a long stretch of the Spanish-French border, an initiative has already been launched encompassing fire prevention, firefighting, and rescue services (AEBR & EC, 2024, p. 37). But this has not been fully implemented due to a lacking legal framework, in part delayed by the different administrative-territorial hierarchies in the two countries. The situation is particularly severe in the Serbian-Romanian-Hungarian borderland, where two countries remain outside the Schengen Area and one of which is just an EU candidate (AEBR & EC, 2024, p. 43). Hence, there are currently no cross-border emergency agreements but cooperation is nevertheless strived

towards. Finally, France and Luxembourg do have a CBH agreement since 2016 that also permits rescue services crossing the border (AEBR & EC, 2024, p. 58). But here – as probably elsewhere – the issue is that the emergency phone number (which, somewhat ironically, is EU-wide identical) only reaches services in the respective national territory without taking into account more proximate hospitals across the border.

Solutions

Likely triggered by the fact that the situation of each border region can be rather different, *b-solutions* has emphasised the necessity ‘to seek feasible and replicable solutions to the obstacles described’ (AEBR & EC, 2021b, p. 16). Laudably, in the cases investigated the experts involved have always indicated the different levels of governance and actors ‘expected to take part in the implementation’, also taking into account the nature and causes of the given obstacles. The interventions for more advanced CPSs suggested could be categorised into four types: legal solutions, introducing the European Cross-Border Mechanism (ECBM), proposals for a more efficient administration and coordination, and leaning on cross-cutting solutions.

Legal solutions

In their simplest terms, the legal solutions proposed revolve around changing the law by revising or updating

current provisions, or creating ad hoc legal frameworks. At the EU level, the legal framework was found to already offer provisions that sufficiently support coordination and cooperation (AEBR & EC, 2021b, p. 16). At the same time, *b-solutions* participants have highlighted a number of inconsistencies and obstacles remaining, solving which would require the revision of the current provisions by the European Parliament (EP) and the European Council. More specifically, a 2014 Directive of the latter two institutions had introduced the creation of a digital public procurement platform to be implemented in the Member States (MSs), but without indicating its technical aspects nor setting guidelines on digital public tenders. As a result, MSs ‘have developed platforms that are non-interoperable’ (AEBR & EC, 2021b, p. 17). Hence, *b-solutions* proposes amendments to the Directive ‘and introduce clearer common technical criteria for the digital platforms’.

Two inspiring practices are also mentioned here. On the one hand, some ongoing research projects are already working on improving the digitalisation of CBH services: for instance, mGov4EU aims to facilitate such mobile ‘government services by combining the secure data exchange of the Single Digital Gateway Regulation with mobile identities’ (AEBR & EC, 2021b, p. 17). On the other hand, a late 2020 EC ‘proposal for a regulation on serious cross-border threats to health’ is described that aims at ‘testing strategies to respond quickly and jointly to medical emergencies’.

Last but certainly not least, legal changes would also be required on the national as well as subnational levels as ‘obstacles tend to arise from missing or inconsistent provisions’ (AEBR & EC, 2021b, p.17) in the legislative frameworks of the MSs. Implicitly in a subsidiarity spirit, *b-solutions* acknowledges that national parliaments, ministries, and local and regional stakeholders need to coordinate here with neighbouring areas, but proposes change in scenarios of which two can be mentioned here. One is where changes to national law would be desirable in either one or both of two neighbouring MSs. As an example, the German and Dutch transpositions of the 2011 Directive do not contain clear information on the reimbursement of costs for CBH and should therefore be amended and aligned (AEBR & EC, 2021a, p. 35). Another set of scenarios is where signing or updating ad hoc bi- or multilateral agreements would be constructive. For example, the Benelux Union already has established legal criteria on cross-border emergency ambulance traffic, but it does not specify which Dutch hospitals are included which could be fixed with an amendment to the Decision already in place (AEBR & EC, 2021a, p. 96).

The European Cross-Border Mechanism

The ECBM is a tool proposed by the EC ‘in 2018 with the objective of facilitating the resolution of legal and administrative obstacles to cross-border

cooperation’ (AEBR & EC, 2021b, p. 18) which MSs could apply voluntarily for specific projects in their borderlands. If opted for, ‘an evaluation process would be set in motion to identify the legal obstacle. The ECBM would then provide for different measures to overcome the obstacles, which may involve allowing for derogations from the normally applicable national rules for the specific cross-border project.’

To this author at least, the mechanism essentially appears much like what *b-solutions* has already been doing (likewise since 2018), something also implicitly hinted at in the thematic booklet: ‘the cases collected under the *b-solutions* initiative help assess the role that the ECBM could play in effectively solving obstacles of a legal nature’ (AEBR & EC, 2021b, p. 18). Some of the cases *b-solutions* investigated include addressing diverging national regulations on the technical requirements of emergency vehicles between Belgium and France (AEBR & EC 2020b, p. 108), or recognising the qualifications of professionals involved in building a bridge at the German-Polish-Czech tri-border (AEBR & EC, 2020b, p. 89). Indeed, although recently prolonged (Medeiros et al. 2024, p. 4), *b-solutions* is a project whereas introducing ECBM would give these activities a more formalised structure in a longer term.

However, up to mid-2024 at least, ECBM has remained a proposal. It has been abandoned by the European Council in 2021, ‘mainly due to

concerns about territorial sovereignty, subsidiarity, and the legal basis of the instrument’ (Setti, 2024). Yet thanks to the lobby of a number of stakeholders advocating for cross-border cooperation, in December 2023 ‘the Commission presented an amended proposal responding to the request of the Parliament but also to the Member States’ concerns’ (Medeiros et al. 2024, p. 19). In March 2024, the EP’s support seemed firm and the legislative procedure was therefore expected to restart (Setti, 2024). In the same month, an EP Rapporteur ‘was positive with respect to the [upcoming] Hungarian Presidency’, estimating that ‘[t]here could be an agreement between the new Parliament and the Council at the end of the year 2024’ (ITEM, 2024).

The redesigned tool has also been renamed from ECBM to Cross-Border Facilitation Tool (CBFT) to reflect the changes, which go beyond relabelling. An academic has recently praised CBFT as ‘[a] framework regulation making a clear distinction between direct obligations and guidelines’, having ‘a sharpened scope’, and implying less administrative procedure but more guidance (Van der Auwermeulen, 2024). In her assessment, ‘the Commission attempts to switch from a procedural approach to a facilitative approach. Moreover, the Commission is introducing a ‘learning network’ of national coordination points. Accordingly, behind the shift from solving to facilitating lies the valuable opportunity to build up expertise at the interstate level.’

More efficient administration and coordination

Although categorised as solutions of an administrative nature, b-solutions recognises that – similarly to the first two categories – many cases here are also related to legal hurdles (AEBR & EC, 2021b, p. 19). Two types of measures are suggested here, the first of which consists of creating new coordination structures. As an example, a cross-border reimbursement centre *is proposed* at the Austrian-Czech border to help patients who received medical care on the other side. The second type of intervention suggested is to develop ad hoc conventions in certain situations. For instance, such a convention could be drafted to guarantee a smoother mobility of healthcare professionals at the Franco-Belgian border, based on a health agreement already in place between the two countries (AEBR & EC, 2021a, p. 126).

Cross-cutting solutions

Last but not least, there is a number of obstacles that ‘are manifold and arise due to a combination of several factors’ and thus need to be ‘complemented with additional actions’, which ‘can include raising awareness and capacity building actions aimed at enhancing better coordination and making better use of legal and financial tools’ already provided (AEBR & EC, 2021b, p. 19–20). b-solutions proposes four more specific types of measures here, which are:

formalising cooperation actions through targeted memoranda; implementing training activities for local stakeholders; involving Interreg funds to complement solutions; as well as establishing cross-border bodies such as EGTCs (European Grouping of Territorial Cooperation). In addition, developing protocols and task forces or technical working groups on specific themes is also recommended.

Concluding analysis: some critical reflections and future outlook

As seen above, the regulation of CBH is a relatively new process even in the EU where healthcare has traditionally been, and largely still remains, a member-state competence. However, over the past two decades the EU has gradually been taking more responsibility in this field, which is both understandable and welcome given the reality of ever-more millions of Europeans living transborder lives. Given the complexities of CBH which involves many different regulations, actors, and spatial levels, a review of the developments across Europe can be challenging in itself.

The *b-solutions* project has laudably contributed to not just a unique and extensive inventory of obstacles to CBH but also provided proposals for tailor-suited solutions to each case consulted. As evidences of immediate impact, the final, 'What's next' sections of the majority of the case descriptions point to local stakeholders adopting the

b-solutions advices, forwarding them to the authorities in charge and asking them to implement the proposals (see e.g. AEBR & EC, 2024, p. 44, 48, 52, 56, 59, 73). In addition, the project has been prolonged under the label *b-solutions* 2.0 (Medeiros et al. 2024, p. 4).

The author has also been requested to provide some critical remarks. Here, only two among the few that can be made are directly related to *b-solutions* as the rest are rooted in wider structures, institutions, and regulations. I begin with the former and then move on to the latter.

Remarks more directly related to *b-solutions*

To begin with, there are some issues with the geographical distribution of the cases consulted. There is a particular concentration in the west-central and southwestern parts of the continent, as at least a map in the thematic booklet reveals (AEBR & EC, 2021b, p. 7). The least-covered regions include, in the following order: pre-accession countries – which are also eligible to participate in *b-solutions* (Medeiros et al. 2024, p. 18) –, northern Europe, as well as parts of eastern Europe. No reasons for this bias have been provided, but participation in *b-solutions* is voluntary. Accordingly, one can only assume that it also reflects the varying levels of integration into EU structures by the different subregions of Europe. Still, Medeiros et al. (2024, p. 18) also note that '[a] stronger effort should be made to involve those territories not taking part yet'.

A type of services *b-solutions* deals little with are private and especially public-private solutions. This is somewhat surprising given that unlike the 2004 Regulation, the 2011 ‘Directive can also cover private health care’ (Van Delm, 2024, p. 198). Indeed, the privatisation of healthcare is a very controversial process but nevertheless remains a growing reality. And indeed, *b-solutions* is largely focused on public services (AEBR & EC, 2021b) which is understandable given that public bodies play a larger role in regulating them. Accordingly, private solutions are not even mentioned at least in the first two compendia. Yet in the third one, they are mentioned in a few places. For instance, it has been recommended to the Cerdanya Hospital (see above) to appoint an expert in the social and tax law of the neighbouring country, a measure which is “common among private entities operating in several Member States” (AEBR & EC, 2024, p. 34). Elsewhere, Dutch healthcare interns working part-time in Belgium face the situation of being ineligible for insurance in any country (AEBR & EC, 2024, p. 135). One of the solutions proposed has thus been to opt for private health insurance (AEBR & EC, 2024, p. 137).

It would be wrong to suggest that *b-solutions* generally prefers (or should prefer) private solutions. In fact, in several other cases the proposed solutions have rather been embracing the public. To avoid that German patients, need to use ambulant therapeutic services in Austria on a

market basis, it has been proposed that the two countries conclude a bilateral agreement (AEBR & EC, 2024, p. 71–72). As another example, as the Öresund Agreement only covers private-sector workers it has been suggested that the public sector also be included (AEBR & EC, 2024, p. 132–133).

Nevertheless, the private sector is growing and can often quicker adjust to local needs. For patients in southernmost Slovakia, the hospital on the Hungary side is just across the border while the closest one on their side is about fifty km away. This has triggered a Slovakian private health insurance company to also cover in-patient services in the Hungarian hospital (Balogh & Pete, 2018, p. 612) already since 2009 (i.e., two years after both countries joined the Schengen Area). This is somewhat akin to the Badajoz case (see above) but in the form of a public-private partnership. In any case, private CBH is booming also in Europe – whether it be dental tourism to Hungary, abortion trips from Poland, or opting for in-vitro fertilisation in Czechia. Whatever we make of it, it is a reality that needs to somehow be related to.

Remarks on wider structures affecting CBH in the EU

There is a set of circumstances limiting CBH that *b-solutions* can do little more about than advising the respective bodies in charge. Among these, deficiencies with the existing

regulations stand out. Obstacles caused by the diverging national legislations are a frequently recurring point across the cases studied, but also common is pointing out inconsistencies between national and EU laws on the one hand, and within the latter on the other. It is worth elaborating on these in some detail since however multi-institutionally governed the EU may be, it still represents one single constituency.

Based on recent literature and *b-solutions* results, there seem to be two main issues with current EU rules concerning CBH, one of which is their deficiencies and the other their partial outdatedness. Regarding the latter, it should be noted that the 2011 Directive shall have been amended at the start of 2024. But unlike the original version, the new document available (EUR-Lex 2024) was not published in the Official Journal of the European Union and begins with a disclaimer that it ‘is meant purely as a documentation tool and the institutions do not assume any liability for its contents’. In an absence of clarity on the status of the changed Directive, one can only analyse those regulations that are certainly in force.

The main source of uncertainties stems from several regulations being in place, the two most important of which are the already-mentioned 2004 Regulation and the 2011 Directive. In theory, the parallel enforcement of the two different regulations also serves the purpose of offering two different models of reimbursing CBH services which

patients can choose from (Van Delm, 2024, p. 198). The two regulations differ in whether they cover private services, whether they require pre-authorisation by the insurance-providing MS, whether they cover full reimbursement and, relatedly, the tariff of which of the given two countries applies (Van Delm, 2024; AEBR & EC, 2024, p. 54). Yet according to Van Delm (2024, p. 204–205), ‘eventually, everything depends on the approach of the member state’ since ‘the criteria adopted by the member states determine whether the prior authorisation scheme of the Regulation or Directive is more lenient for patients requesting cross-border care’. The question of which state’s tariffs apply is particularly important for less-affluent patients, for instance from poorer MSs, who would need CBH in more expensive ones. All these circumstances are mirrored in the very low share of CBH expenses under the Directive and the Regulation which, despite increasing, in 2019 remained below half a percentage of the EU-wide annual healthcare budget (Van Delm, 2024, p. 198–199).

Current EU CBH regulations are particularly deficient and outdated on mobility and digitalisation, both of which have now been increasing for some time. For instance, it is unclear whether the Directive covers certain services, such as hospitalisation at home (AEBR & EC, 2024, p. 51). Similarly, ‘the legal framework does not clearly address reimbursement for both patients and medical providers when ambulant therapeutic services are provided at a patients’ home on the

other side of the border’ (AEBR & EC, 2024, p. 71). Remote work (AEBR & EC, 2024, p. 140, 100) and telemedicine (Van Delm, 2024) remain particularly under-regulated fields, despite being cost-efficient and growing.

Due to these and other deficiencies, Sivonen and Büttgen (2021, p. 27) concluded that ‘although the EU legal framework does promote patient mobility in general, the Directive does not necessarily address the special characteristics and needs of cross-border regions’. This is because ‘[t]he EU’s legal framework on cross-border healthcare generally seems more suitable for individuals who seek healthcare services in another Member State on an occasional basis than for inhabitants of cross-border regions who may have a structural need for cross-border healthcare services’.

To be fair, more recently there are quite a few EU projects promoting the digitalisation of CBH (AEBR, 2021b, p. 17; Bruthans & Jiráková, 2023; Schmidt et al. 2022, p. 1246). This is of course positive, but then again running a risk of fragmentation. Hence, at least some of these tools and databases could be harmonised or even unified. Separate tools for different spatial entities (EU/MS/cross-border area) make sense, but having parallel e-systems on the EU level less so.

Quo vadis, European CBH?

Beyond its overall very positive assessment of the *b-solutions* project, this paper has tried to show that while

CBH is emerging across Europe, its development is hindered by inconsistent regulations on and between various administrative levels and such that sometimes have difficulties catching up with fast-changing trends in the health sector. Surely there is a long way ahead for the EU to ‘becoming also a European Health Union’ as envisioned by the EC president in 2020 (Schmidt et al. 2022, p. 1245–1246), but it is indeed gradually moving toward that direction.

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