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FINAL REPORT BY THE EXPERT

Advice Case: Cross-border healthcare

Advised Entity: Euroregion Neisse-Nisa-Nysa, regional association, CZ-DE-PL

Expert: Hynek Böhm

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Conetxt

The Šluknov tip (further also ´Šluknov area´) is the most northern edge of the Czech Republic which, is separated from the rest of the Czech Republic by mountains (Lusatian mountains and Labské pískovce). It is surrounded by Germany from 3 sides.

In this area, covering 50,000 inhabitants, there is only one general hospital which currently faces insolvency and a very real threat of a shut down. Another hospital in Varnsdorf focuses on the healthcare provision for the long-term patients and the outpatient care. Accessibility of other Czech hospitals (Děčín, Česká Lípa, Liberec) from most of the municipalities of the Šluknov area is at the border of the legislative limit of 50 minutes when the weather is good. In winter and under bad weather, the accessibility time extends significantly or may be limited fully due to blizzard and slippery roads when crossing the mountains.

However, two German hospital are very easily accessible (max 30 minutes) from all municipalities of the Šluknov area (Ebersbach, Sebnitz) without any geographical obstacles which would make the accessibility time uncertain under bad weather conditions.

Unfortunately, the utilization of care in these hospitals by Czech inhabitant is limited. Given the European legislation and price differences between the two countries, the Czech inhabitants have to pay fully or partly for their care, with the exception of prior consent of their insurance fund, if they opt for a German hospital. Nevertheless, even a partial co-payment is a large sum in absolute terms for a Czech patient which is a major factor when deciding whether to receive care in a short time or travel for care much longer. However, in case of emergency, time often decides whether a person survives or not.

Cross-border cooperation free from legislative and financial obstacles seems a natural step in securing save and accessible healthcare to the inhabitants of the Šluknov area.

I. Description of the Obstacle

There were following obstacles, which have affected/complicated the cross-border co-operation in healthcare provision in the Šluknov tip context:

1. The healthcare provision belongs among policies which have still remained area of national competences of the EU Member States.

2. Healthcare provision and reimbursement of care by health insurance funds within the Czech Republic is regulated mainly in Public Health Insurance Act No. 48/1997 and Health Services Act No. 372/2011 Coll. None of these regulate care provided to Czech patients abroad.

3. The costs of healthcare provision are higher in Saxony than in the Czech Republic, which creates a burden for Czech patients, as Czech health insurance companies reimburse costs of the medical treatment in Germany only up to the limit applicable in the Czech Republic, if prior consent was not obtained from the insurance fund.

4. Both in the Czech and European legislation, there is a missing concept which would define the situation requiring acute care that occurred in the border region of the country of citizenship of the patient with the easiest accessible hospital situated in another country. In both EU and Czech legislations, such a situation would be classified as planned cross-border care even though life-threatening circumstances occurred. Cross-border emergency cooperation agreement between the Czech Republic and Germany (https://www.mzcr.cz/Admin/_upload/files/8/Ujednani_Sasko_ZZS.pdf) deals with cooperation of emergency pre-hospital care. Further specific agreements regarding inpatient care are still missing. Although a Memorandum of cross-border cooperation in inpatient care was signed in August 2019, no specific conditions were defined.

5. There is an unclear situation regarding the legal claims and procedural steps in the case of cross-border complaints or the cases of deaths on the other side of the border.

II. Indication of the Legal / Administrative Dispositions causing the Obstacle

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Section 1 of this document identified five obstacles limiting utilization of care in Germany by the inhabitants of the Šluknov area, even though they can access German hospitals easier than the Czech ones in terms of travel distance and certainty of travel time. This section will elaborate on legal dispositions causing them.

1. The healthcare provision belongs among policies which have remained the area of national competences of the EU Member States.

The subsidiarity principle has left healthcare provision for the citizens and reimbursement of care within national competencies of the member states. Provision of care was dealt with already in the primary documents of the EU, for details see Appendix 1.

Since national healthcare systems within the EU differ, the EU legislation has to regulate cross-border healthcare provision, i.e. both planned and emergency care to foreign nationals who are at the same time EU citizens. The principle acts of secondary legislation in the field are Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems and Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare. There are thus following two concepts with the EU legislation defined, distinguishing between planned and unplanned care:

A. Health care needs when staying in another EU member state

When a need for acute care emerges when staying in a different EU country other than the country of citizenship for purposes other than healthcare provision, every EU citizen possesses the European Health Insurance Card (further "EHIC") upon which s/he receives care in another EU member state under the same conditions as the citizens of the respective EU member state (based upon Regulation (EC) No 883/2004). No direct payment from the patient is required,

the cost is reimbursed from the health insurance fund of the particular country. Reimbursement from the Czech insurance fund of the patient is then through the Health Insurance Bureau (HIB)

B. Planned treatment in another EU member state

Planned treatment of an EU citizen in another EU country different from the country of her/his citizenship is regulated by the Regulation 883/2004, which is complemented by Regulation (EC) No 988/2009 of the European Parliament and of the Council of 16 September 2009 amending Regulation (EC) No 883/2004 on the coordination of social security systems, and determining the content of its Annexes, and Directive 2011/24/EU, all of which allow citizens to travel to another EU member state to receive healthcare. the Regime of Regulation 883/2004 complemented by the Regulation no. 988/2009 allows, upon the basis of prior approval of the patient´s insurance fund in the home country, to obtain healthcare costs abroad with full reimbursement of healthcare cost provided that the care is not available in the home country. With prior approval, healthcare cost is paid by health insurance companies in the state of treatment, whichthen charges the costs to a health insurance company of the patients´ "home state or state of healthcare insurance affiliation". Under Directive 2011/24, the patient does not need a consent of his/her insurance fund, but has to pay the full cost of healthcare abroad and subsequently asks his/her home insurance fund for reimbursement him/herself. The patient is reimbursed only up to the level of costs usually paid for such care in the home country.

Table 1 sums up three main ways of the cross-border healthcare provision in the EU: (i) unplanned healthcare based on European health insurance card (Regulation 2004/883), (ii) planned healthcare based on Regulation 2004/883 complemented by the Directive no. 988/2009 and (iii) planned healthcare based on the Directive 2011/24. Appendix 2 of this report illustrates its financing in simplified way.

Table 1. Ways of cross-border healthcare reimbursement in the EU

	Regulation		Directive
	Unplanned	**Planned**	
Purpose of the journey	Temporary stay non-related to healthcare	Healthcare	Irrelevant
Healthcare coverage provided	Medically-necessary case during the stay	Complete healthcare	Complete healthcare
Basket of services	MS of treatment	Competent MS	MS of affiliation
Prior authorisation	No	Yes	Depends on implementation
Issued by	-	Competent authorising MS	MS of affiliation
Payment procedure	Standard procedure in MS of treatment	Standard procedure in MS of treatment	Upfront payment by the patient
Reimbursement procedure	Reimbursement between institutions Reimbursement to patient in case of upfront payment	Reimbursement between institutions Reimbursement to patient in case of upfront payment	Upfront payment by the patient Reimbursement to patient
Extent of the reimbursement	Tariff of the MS of treatment	Tariff of the MS of treatment	Tariff of the MS of affiliation

Source: Carrascosa Bermejo 2014

Planned healthcare based on Regulation (EC) No 883/2004 on the coordination of social security systems and Regulation (EC) No 988/2009 amending Regulation (EC) No 883/2004 on the coordination of social security systems, and determining the content of its Annexes

The procedure of obtaining prior authorisation is initiated at the request of a patient. The health insurance company where the patient is registered is considered the competent institution. If the insurance company decides to grant the prior authorisation it issues a S2 form, which is necessary to submit to an institution in the state of treatment. This authorisation can be granted for health in all EU and EFTA countries. Insured persons are entitled to the same treatment as citizens of the state of treatment. In most cases, healthcare is paid by health insurance companies in the state of treatment. These insurance companies will additionally charge the costs to a health insurance company of the patients´ state of healthcare insurance affiliation – in Czech case it is through the Health Insurance Bureau "HIB" to a Czech health insurance company.

Planned healthcare based on 2011/24 Directive on the application of patients' rights in cross-border healthcare

A reimbursement of cross-border healthcare costs based on the Directive will be provided to an insured person upon his/her request. The costs will be reimbursed only up to the level of costs of healthcare if it was provided in the country of patients´ health insurance affiliation – in our case of the Czech Republic. It is a system of additional reimbursement. Patients have to pay for the costs of cross-border healthcare upfront and afterwards they will be reimbursed at their request. The calculation of reimbursement costs is based on the relevant legislation in force at the date of issuing the accounting document for the healthcare provided in another member state. The disadvantage of this system is that it is not possible to precisely determine in advance what will be the extent of the healthcare provided and what the cost of the reimbursement will be, but patients have the option to ask their health insurance company about approximate costs of healthcare. It is roughly estimated – in the Czech-German context – that the price of „average Czech healthcare unit cost" is around 70% of the price of its German equivalent, but this should be precisely calculated. (Appendix 3 provides an overview of possible obstacles of this "Directive-based type" obstacles).

Directive 2011/24/EU on patients' rights in cross-border healthcare sets out the conditions under which a patient may travel to another EU country to receive medical care and reimbursement. It covers healthcare costs, as well as the prescription and delivery of medications and medical devices. Cross-border healthcare in this Directive means 'healthcare provided or pre-scribed in a Member State other than the Member State of affiliation' (Article 3e). The Directive concerns thus patient mobility: the patient receives medical care (or buys medicines or medical devices) in another Member State than the one in which she/he is insured (Peeters 2012). The Directive applies to the provision of healthcare to patients, regardless of how it is organized, delivered and financed. **Member State of affiliation shall ensure that the cost of cross-border healthcare is reimbursed (Art. 5a) and it is the responsibility of the Member States to establish mechanisms in place to provide patients on request with information on their rights and entitlements in that Member State relating to receiving cross-border healthcare** (Riedel 2016).

The content of the Directive 2011/24 is divided into two categories: rules of obligatory implementation and rules of facultative implementation. One of the obligatory rules is the new principle of reimbursement of costs. According to this principle, **the amount reimbursed for healthcare provided in another member state will be the same as the amount that would be paid by a health insurance company for healthcare provided in the Czech Republic**. Other parts of the Directive which are obligatory to implement is a provision regarding national contact points providing information to patients and provision setting up an administrative procedure.

2. Healthcare provision and reimbursement of care by health insurance funds within the Czech Republic is regulated mainly in Public Health Insurance Act No. 48/1997 and Health Services Act No. 372/2011 Coll. None of these regulate care provided to Czech patients abroad

The Czech public health insurance system is based on obligatory participation of insured persons. There is no possibility of voluntary participation. Every person is insured individually. The Czech health insurance system is administered by seven health insurance companies. Each citizen can choose in which health insurance company he/she wants to be registered, because each provide different benefits for patients. However, the scope of benefits provided by all those companies doesn´t differ substantially.

Health insurance companies conclude contracts with healthcare providers. The conditions set in these individual contracts can be partly different for each healthcare provider. A healthcare provider can make a contract with more than one or with all insurance companies in the market.

Czech healthcare legislation doesn´t regulate care provided to Czech patients abroad. It defines that the Health Insurance Bureau (HIB) is designated as a national contact point on the basis of Art. 14 of Public Health Insurance Act No. 48/1997 and EU Directive 24/2011 on Patients' Rights in Cross-Border Healthcare.

The HIB has to publish general information about possibilities of using healthcare services in other member states on its official website. It also must provide specific information regarding the possibility of obtaining healthcare abroad upon a request of patients.

Unplanned healthcare (based upon European health-insurance card) during stays non-related to healthcare has been the most used way of cross-border healthcare. All Czech citizens are entitled to access to medically necessary healthcare during a temporary stay (tourism, business) in any of the EU/EFTA member states, as every other EU citizen. This right is based on the European health insurance card, as indicated in the subchapter above. Patients have the access to healthcare under the same conditions and at the same cost as people insured in that country. If a patient receives care from a public provider abroad, s/he pays only user-charges the same as the citizen of the particular country. If the patient receives care from a private provider abroad, s/he pays the full cost of care and asks for reimbursement from the national institution while still in the country and gets reimbursement directly there or asks for reimbursement from their Czech health insurance company when they return home. Expenses will be reimbursed according to the rules and rates of the country where the treatment was received. This means that patients will be reimbursed for the full cost of the treatment, but will always have to pay the user fee according to the rules of the country where they were treated.

3. The costs of healthcare provision are generally higher in Saxony than in the Czech Republic, which creates a burden for Czech patients, as Czech health insurance companies reimburse costs of the medical treatment in Germany only up to the limit applicable in the Czech Republic, if prior consent was not obtained from the insurance fund.

The difference of healthcare costs between both countries constitutes a barrier for Czech patients. As this is not administrative or legal barrier, its solution is not relevant for this study.

4. Both in the Czech and European legislation, there is a missing concept which would define the situation requiring acute care that occurred in the border region of the country of citizenship of the patient with the easiest accessible hospital situated in another country. In both EU and Czech legislations, such a situation would be classified as planned cross-border care even though life-threatening circumstances occurred.

Cross-border emergency cooperation agreement between the Czech Republic and Germany (https://www.mzcr.cz/Admin/_upload/files/8/Ujednani_Sasko_ZZS.pdf) deals with cooperation of emergency pre-hospital care only. Further specific agreements regarding inpatient care are still missing. Although a Memorandum of cross-border cooperation in inpatient care was signed in August 2019, no specific conditions were defined.

In the EU core, defined by the six founding countries, a strong functional cross-border integration with numerous and frequent cross-border flows can be observed (Durand and Decoville 2019), including those in healthcare. There are several zones of organised cross-border health-care in this European core, aiming to reduce administrative challenges from EU health care legislation. One of the well working examples are Franco-Belgian ZOAST (Les Zones Organisées d'Accès aux Soins Transfrontaliers). Establishing them required two types of additional agreements. Firstly, a Belgian-Franco framework agreement on health care co-operation that provided, secondly, the grounds for the conventions developed for the different ZOAST (ESPON 2018a). Based on this agreement and the conventions, patients in these zones who wish to access health care across the border do not need prior medical authorisation from their domestic health insurance. They obtain reimbursement for their health care costs from their health insurance by applying the tariff for care services of the country where the care is provided.

Similar bilateral agreements focusing mainly on cross-border emergency health care can also be seen outside of the EU core: Czech government concluded them with Germany (see Appendix 4) and Austria. These bilateral agreements open the way towards more technical agreement on the levels of regions, which enabled the existing co-operation levels. This indicates that despite the care itself is run by the locals, it asks for an involvement on actors from other vertical levels of public administration to make the cross-border healthcare happen.

5. There is an unclear situation regarding the legal claims and procedural steps in the case of cross-border complaints or the cases of deaths on the other side of the border

There is no actual pressure on clearing up this situation, as the cross-border flows in healthcare provision are rather low in the region. Once their intensity is higher, the obstacle will have to be addressed. However, this is beyond the scope of this report.

III. Description of a Possible Solution

Making healthcare the area of common policy co-ordinated by the EU institutions would probably remove most of the obstacles. As this is hardly feasible, modifications of the legal acts on the Member States level are necessary – in Czech context it could be desirable to **change Acts** on health insurance and services, i.e. the **Public Health Insurance Act No. 48/1997 and Health Services Act No. 372/2011 Coll.** jointly with **measures based on multi-level governance structures and bilateral agreements**.

It is very likely that it will not be possible to propose a solution which would suit to all inhabitants of the whole border region. However, I believe that mechanism outlining sufficient solutions for most of the cases can be found and proposed.

A possible solution may be similar to the situation of Gmünd/České Velenice in Autrian-Czech borderlands. As their co-operation is often mentioned as a good practice and reference example, we will in this section present the outline and several principles upon which their cross-border co-operations based.

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Inspiration České Velenice – Gmünd

The geography of both Šluknov tip and České Velenice-Gmünd is rather similar.Czech citizens face geographical disadvantage in both contexts, as the nearest Czech emergency ambulance is 18 km away and the nearest Czech hospital is 60 km away from České Velenice, whereas the Gmünd clinical centre is just a few hundred metres away from the border. The co-operation activities started by the series of the INTERREG funded projects (Healthacross - 2008-2010, Healthacross in Practice (HIP) – 2012-2014 and Healthacross for Future (HFF) – 2017-2020).

The first Health across project was the feasibility study. It developedguidelines and designed a pilot project for cross-border healthcare provision, it was accompanied by the language courses and dictionary for emergency services.

The follow-up ***"Healthacross in Practice" project was run in co-operation between Lower Austrian and South Bohemian Region.*** *It was a pilot project the main focus of which was the practical implementation of cross-border healthcare provision, as well as working on any issues that could arise as a result of patients moving between Lower Austria and the Czech Republic. To begin with, a defined number of Czech patients received outpatient care at the Gmünd clinical centre. During the preparatory stage, it was necessary to agree a specific range of services and set outpatient times. The pilot project was extremely successful, the services on offer were very sought-after and patients made the most of them. Moreover, outpatient treatment of Czech patients continued even after the pilot project ended (https://www.healthacross.at/projects/healthacross-for-future/?L=1). The costs of cross-border treatment of Czech patients were borne by project partners.*

Currently ongoing "Healthacross for Future" (HFF) project (2017 – 2020) focuses also on pilot verification of inpatient treatment of Czech patients at the Gmünd clinical centre and a last phase of testing the feasibility of sharing medical services between Austria and the Czech Republic.

The current situation, resulting from three INTERREG funded projects, is perceived as a success story as it is documented by many obtained awards appreciating innovative cross-border projects and healthcare initiatives. This is a sharp contrary to some sceptical initial expectations, which were very pessimistic on perspectives of a cross-border healthcare. There were several crucial points, which must have been fixed for the proper functioning of the system. The joint commitment to solve the problems helped to overcome problems mostly of technical nature.

The overview of technical barriers and their solution:

- *Austrian emergency cars could not have intervened in Czechia due to the missing liability insurance of physicians; this was solved.*
- *Language issues were fixed by the use of video-based interpretor, medical reports are elaborated in both languages and their Czech version sent to the GPs, there is also a strong presence of Czech speaking personal in the Gmünd hospital.*
- *The legislative framework was provided by a bilateral agreement on emergency care between border regions of Austria and the Czech Republic, concluded in 2016 (https://www.ris.bka.gv.at/Dokumente/BgblAuth/BGBLA_2016_III_213/COO_2026_100_2_1310821.pdfsig)*

However, the key problem of cross-border healthcare is linked with the reimbursement of the treatment costs. The current state-of-play is based upon re-imbursement of the costs for the

medical treatment of Czech patients by the Czech health insurance company, but only up to the level of the costs applicable in Czechia. The additional costs, as Austrian - mainly inpatient - healthcare costs more than the Czech one, is actually paid by the EU sources as a part of INTERREG co-financed measure ("institutional co-operation priority axis" of the AT-CZ INTERREG). This means that outpatient treatment seems to be rather feasible, as most of the problems at operative base have been solved, but the inpatient care still presents an unresolved issue. Therefore the project partners plan to verify provision of inpatient healthcare of 45 Czech patients in Gmünd.

Lessons learnt and recommendations:

1. **Active project leader – finding the best possible key actor**

The success of the project stems from the active role of the Lower Austrian government who initiated and financed initial stages of the project. The need for cross-border cooperation was however not only altruistic since at the start of the project Lower Austrian healthcare providers faced decreasing number of patients and existence of some provider would be threatened. Efficient cross-border cooperation was a win-win situation for both parties - for Czech who were allowed to receive an affordable, good quality and accessible care, but also for the Austrians who received more patients. Lower Austria is the only federal state with a recognisable long-term strategy for health in the European border area. It was also the first federal state in Austria to be recognised as a model region by the World Health Organisation (WHO) in 2017. For a success of a cross-border project, **it is necessary to specify the main project leader. In the Šluknov Tip case, both euroregions – Elbe/Labe and Nisa-Nysa-Neisse, among which the area is divided should be very active actors.** As opposed to the hospital in Gmünd, , neither Sebnitz nor Ebersbach hospitals are owned by strong public subjects and Ústí Region on the Czech side is rather hesitant in finding the solution. **.**

2. **Involvement of relevant stakeholders and institutionalisation of co-operation**

The application of multi-level governance (Hooghe, Marks 1993) is highly desirable here, as the possible smooth cross-border healthcare provision will ask for the involvement of following key stakeholders:

	Czechia	Saxony
European level	Support from the Commisssion, CoR and INTERREG managing authority and other intermediary bodies	
National level	Health ministry, health insurance companies	Health ministry, health insurance companies
Regional level	Region Ústí/L and its Krajská zdravotní as the healthcare provider	Free State (Bundesland)
Local level	Euroregions Nisa and Elbe/Labe, municipalities of Šluknov tip	Euroregions Neisse and Elbe/Labe
	Healthcare providers – LHR (Lužická nemocnice/hospital Rumburk), possibly also in Varnsdorf	Hospitals in Sebnitz, Ebersbach and other

Source: own elaboration

Following the Gmünd/České Velenice example, it is necessary to keep the key stakeholders involved. This can be done by the means of **joint projects and/or institutionalisation of this broad partnership**, ideally in the form of European Grouping Territorial Co-operation (EGTC). These steps should contribute towards building the environment of **mutual trust and support.**

Possible first step in this direction was made on 28 August 2019, when the multilateral memorandum of understanding between Saxon and Czech ministries, Ústí nad Labem Region and all Czech health insurance companies was signed. The memorandum declared the commitment of its signatories to establish a system of cross-border health provision enabling Czech citizens to seek medical treatment on the Saxon part of the border. However, concrete implementation steps must be taken and maintained until at least partial solution is achieved. The EU funds can be employed to keep the partners engaged.

3. European solution based on mutual complementarities

The situation in the Šluknov tip calls for a more complex "European" solution exploiting mutual complementarities. The existing healthcare providers on the Czech side (hospitals in Varnsdorf and Rumburk) would in such a scenario serve as Czech providers offering healthcare to German patients in the specialities missing in the German border region. Varnsdorf is a long-term care hospital providing also ambulatory services in selected specialities. It is quite likely that the range of services in Rumburk will be restructured and limited to surgery and internal medicine Rumburk will thus have free capacities which may be restructured for the needs of German patients. Specifically, long-term and rehabilitation care, both of which are scare in Germany and comparatively cheaper in the Czech Republic, would be provided to both Czech and German patients in the hospitals of Varnsdorf and Rumburk.

It seems that the German healthcare providers are motivated to seek the way to conclude agreements with the Czech healthcare providers. To make this happen, **a proper comparison of the prices of individual units of medical treatment both in Saxony and Czechia must be made.** At the moment, based on the qualified estimates, the price of „average Czech healthcare unit cost" is around 70% of the price of its German equivalent, however no exact calculation has been made. There are several solutions to compensate for the price difference

The sources could come from local sources (foundation, EGTC, specialized legal body). Another chance is – for the pilot phase of project functioning, which can then be until 2027 (+2) - in **application of the INTERREG funds**.

4. Role of European Funds

Assistance of the European Structural and Investment Funds (ESIF Solutions) is necessary The cross-border initiatives in the Šluknov tip are in line with EU policy objectives for the Cohesion Policy 2021-2027 which urge for a smarter, greener, more connected and social Europe which would be closer to citizens.

The strategic objective 4.4 calls for "Ensuring equal access to healthcare through developing infrastructure, including primary care" and offers rather broad potential investment areas, which create a sufficient space to prepare a future project, as it aims to support :

- Health prevention facilities and equipment.
- Home care and community-based services.

- Primary healthcare (e.g. facilities for general practitioners, nurses), secondary healthcare (e.g. facilities for specialists, outpatient clinic), tertiary healthcare (e.g. acute and long-term care hospitals, emergencies services).
- Integration of care between the above three and between healthcare, social care and long term care.
- In the scope of digitalisation of health services: e-health, public information systems and telemedicine enabling condition.
- Strategic policy framework for health, including mapping infrastructure needs.

There are also numerous opportunities for synergies: Investments in health may be envisaged both under PO1 and PO4, as PO1 investments may target health as a potential sector contributing to the regional economic development in the scope of the national or regional Smart Specialisation Strategies. Under PO4, actions should focus on better access to healthcare facilities, taking into account in particular the needs of marginalised people.

All these future ERDF policy objectives and specific objectives are available also for the INTERREG programmes. Except for a better INTERREG governance (capacity building, macro-regional strategies, border obstacles) the healthcare can easily be addressed in these programmes, as the PO should also assist in enhancing the equal and timely access to quality, sustainable and affordable healthcare services across borders and improving accessibility, effectiveness and resilience of healthcare systems and long-term care services across borders.

It seems therefore highly desirable that this option is sufficiently reflected in the text of the Saxony – Czechia INTERREG 2021-2027 programme, which should be communicated by involved stakeholder already in the drafting of the programme.

Project proposals:

Ideally there should be 2 projects, sequenced one after the other, inspired by the GmündČeské Velenice example.

<u>Preparatory project:</u>

The first project can be linked with the current Saxon-Czech microproject scheme and can partially contribute to the **development of guidelines and a pilot study for cross-border healthcare facilities**, it could be accompanied by the **pilot language courses**. The first project should also help to define the long-term vision of cross-border health provision in the territory.

Other proposed activities:

- To calculate the real costs of medical treatment in both countries (ideally by a separate research project).
- To select fields of medicine to outsource to Germany, but some of the planned intervention can be easily done in Č. Lípa.
- To identify possible complementarities –long-term care in Varnsdorf on the Czech side.

During the meetings held to conduct this study the representatives of Elbe/Labe Euroregion offered to co-finance part of the project funds from its own sources for Saxon-Czech cross-border co-operation as they run their own group focused on cross-border healthcare provision. The scientific experts outsourced to provide a critical feedback to this report agreed on their participation in this group.

Implementation 2020+ project:

The second project, implemented in 2021-2027 period, should make the condition for cross-border healthcare provision feasible. The project should verify feasibility of the cross-border health provision in practice in the Šluknov tip border region. Its scope should be defined during the first project after a proper discussion of all stakeholders. If the SN-CZ programme opens the possibility of flagship initiatives, it should be the case. When preparing the 2021 SN-CZ programme, the representatives of the Ústí Region and Euroregions Nisa/Neisse and Elbe/Labe should make this option possible and lobby for that.

IV. Pre-assessment of whether the Case could be solved with the European Cross-Border Mechanism

Despite the Czech Republic´s position towards ECBM has remained rather reserved, Czech authorities explicitely mention cross-border healthcare provision as one of the areas where the application of ECBM would be highly possible and useful, as the current status quo based upon the interplay of EU acquis and international agreements is less systemic.

V. Other relevant aspects to this case

The eventual mental barrier to get medical treatment in Germany is still very substantial. Czech inhabitants of Šluknov tip insist on keeping the hospital with the scope of services it had 30 years ago – any other option is hard to accept for them, despite the danger of its immediate closure. However experts consider, also thanks to the Gmünd/České Velenice example, that this could be overcome by a proper publicity and very simple and clear explanation of the employed procedures. Probably the most important factor of the success is in a shared cross-border will to cope with the problems and preparedness to work towards finding an appropriate solution. However, this will require patience, as all efficient cross-border solutions need their time.

Another key towards a future success is inclusiveness in terms of the partnership scope. As the hesitant approach of Czech health insurance companies towards reimbursing the costs of Czech patients incurred in Germany can prevent an implementation of the whole concept, they should be involved in partnership implementing the whole concept. Involvement of all relevant public and private actors from all levels of public administration is an ultimate pre-condition of successful long-term solution. Involvement of local and regional actors is more crucial than it seems. Hence the representatives of both Euroregions agreed to get involved in this solution and decided to send official request to both ministries (Czech and Saxon) asking for their involvement in the working group including expert support.

The vital pre-condition for a later success is a time.. Cross-border co-operation as such is a process with its own dynamic, which is much slower than vertical processes in individual systems of national administrations. The Gmünd-České Velenice case showed that the preparation of even only partially functional system took more than 10 years. An effective functioning of the cross-border program must be preceded by a detailed feasibility study.

The use of the INTERREG programme to co-finance the whole process should not be primarily motivated by the possibility to obtain funds which will enable to verify the feasibility of the concept. The more important contribution of the INTERREG programme is in keeping the partners engaged and co-responsible.

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Appendix 1)

How primary EU legislation approaches healthcare provision

Before the Single European Act (1986) health was not addressed at the EC/EU level except indirectly or under exceptional circumstances. It was the Maastricht Treaty (1992) which created the legal basis of the EU's jurisdiction in the field of health.

The Maastricht Treaty on the Functioning of the EU obviously reflected the four freedoms principle, which implies the right to offer, and to receive, services across national borders within the territory of the EU. 'Services' are defined in Article 50 of the Treaty as activities of an industrial character, activities of a commercial character, activities of craftsmen and activities of the professions, which are normally provided for remuneration. Additionally, according to Article 49 of the EC Treaty, restrictions on the cross-border provision of services are prohibited (Riedel 2016). This also gives expression to the general principle of EU law of non-discrimination on the grounds of nationality (Hunt & Wallace, 2006).

The legal basis of future secondary legislation is laid out in Articles 114 and 168 of the Treaty on the Functioning of the European Union (TFEU), stating that "a high level of human health protection is to be ensured in the definition and implementation of all Union policies and activities" (Art. 168(1)). Union legislation has to rely on this legal basis even when public health protection is a decisive factor in the choices made (Art. 114) and achieving harmonisation, a high level of protection of human health is to be guaranteed (Art. 114(3)). According to Article 152 of the Treaty of the European Union (TEU), the Union should ensure a high level of human health protection in the definition and implementation of all Community policies and activities, and that it must furthermore complement national policies regarding public health measures. However, **it is also stipulated that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care**" (Hartlev, 2010). Founding treaties thus opened the way for secondary legislation acts, which specified how the EU citizens can benefit from the right to access healthcare in any EU country and how be reimbursed for care abroad by their home country (Delecosse, Leloup, Lewalle, 2018).

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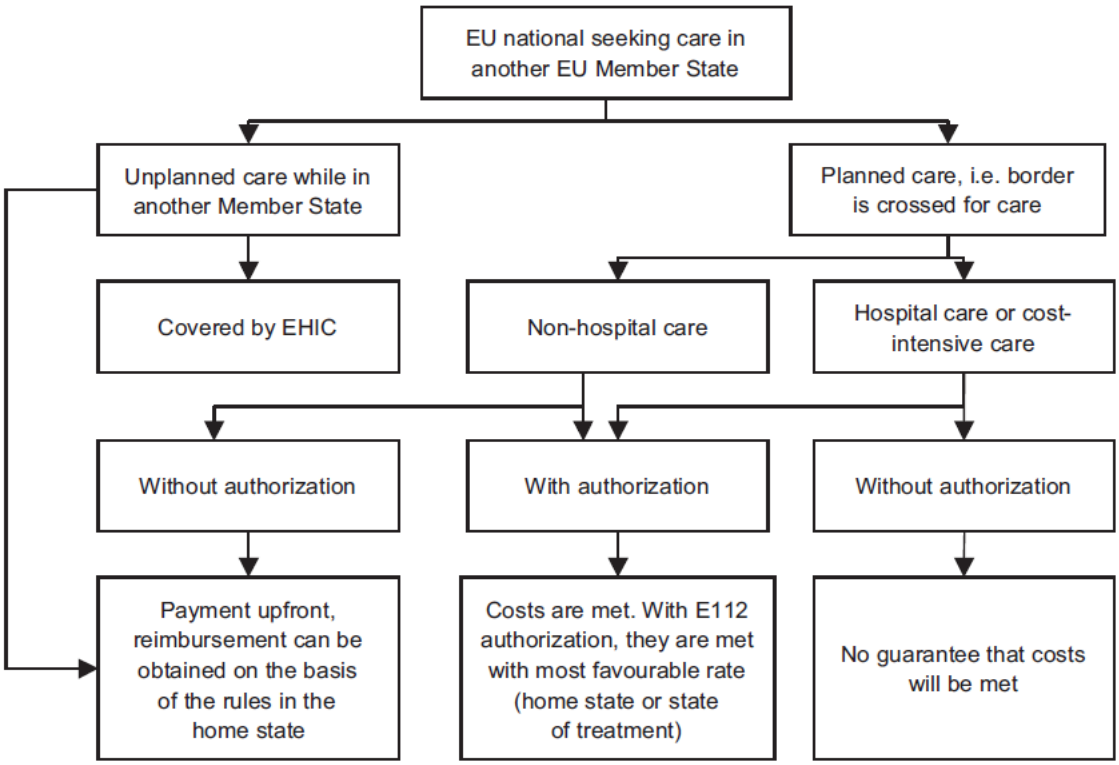
Appendix 2) Financing the cross-border healthcare in the EU:



Source: EC2017

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Appendix 3) Obstacles to a planned healthcare provision

The Commission identified **four priority areas which had the greatest potential to act as barriers** to patients if left unaddressed: **systems of reimbursement, use of prior authorisation, administrative requirements and charging of incoming patients** (Commission 2018)

Group of obstacles:

a) systems of reimbursement of costs for cross-border healthcare

According to Article 7(4) of the Directive, the costs of cross-border healthcare shall be reimbursed or paid up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory, without exceeding the actual cost of the healthcare received. Article 7(9) permits Member States to limit application of the rules on reimbursement of cross-border healthcare for overriding reasons of general interest.

Although the Commission has received no specific notifications under Article 7(9), certain transposition measures could be questioned as limiting the level of reimbursement for cross-border healthcare. This refers to Member States granting reimbursement of cross-border healthcare on the basis of lower levels of reimbursement, applicable to healthcare received from private or non-contracted healthcare providers within their own territory, compared to the level of reimbursement within the system of public healthcare or contracted healthcare providers.

b) Prior authorisation

The Directive (Article 8(2)) introduces the possibility for Member States to make reimbursement of costs for healthcare received in another Member State subject to prior authorisation. ***Presently only six Member States – including Czechia - plus Norway have no prior authorisation system in place at all****, giving patients freedom to choose and reducing administrative burden.*

c) Administrative procedures regarding cross-border healthcare

Article 9(1) of the Directive requires Member States to ensure that administrative procedures for cross-border reimbursement are based on objective, non-discriminatory criteria which are necessary and proportionate to the objective to be achieved.

d) Fees for patients from other Member States

Article 4(3) requires Member States to observe the principle of non-discrimination with regard to patients from other Member States. It also notes that Member States may, under certain circumstances, adopt measures regarding access to treatment; however, such measures must be justified, proportionate and necessary; they must also be announced publicly in advance.

Member States may define the fees for the delivery of healthcare in their territory. However, Article 4(4) requires Member States to ensure that healthcare providers apply the same scale of fees to patients from other Member States as they do for domestic patients in a comparable medical situation. If there is no comparable price for domestic patients, Article 4(4) places an obligation on providers to charge a price calculated according to objective, non-discriminatory criteria. Once defined, fees and tariffs must be applied equally to both nationals and non-

nationals. Outside the public schemes, the Commission has not identified any issues of implementation and Member States did not choose to introduce measures regarding access for incoming patients.

However, under the Directive itself, reimbursement entitlement always accrues only to the amount that would have been incurred for the treatment used in the insured person's home country.

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Appendix 4) Functioning of ambulance services based upon bilateral agreement

The Saxon-Czech cross-border ambulance service operates on basis of a cooperation agreement concluded between Czech and German governments that has been in force since January 2016 (ESPON 2018b). It allows rescue teams to support each other and operate across the border in the case of need and mutual benefit. The service addresses everybody having as an accident while sojourning in the immediate border area and needs medical assistance (ESPON 2018b).

The need to have such bilateral international agreement was defined once a German citizen suffered severe consequences from an accident on the Czech side of the border. Although the next hospital in Germany was only 5 km from the accident site, the patient was taken consecutively to two different Czech hospitals, one 24 km, the other one 70 km away. As a consequence, negotiations were launched by national and state governments to improve the situation (ESPON 2018b).

Cross-border cooperation thus became an important component in the border area to address increasing cross-border mobility of wide parts of the population and to ensure sufficient quality and availability of emergency services as a fundamental part of healthcare provision. As no legal basis was in force, the national and regional governments decided to close this gap and establish a consistent legal framework as basis for service provision on both sides of the border.

As a consequence, a bilateral framework agreement (Bilateral national agreement, 2013) between the German and the Czech government was negotiated and eventually adopted in 2013. Based on international law, this agreement established the framework for further regional cooperation agreements. According to article 4 (1) of the bilateral agreement of the two Member States, such regional cooperation agreements can be concluded to define more specific rules. The regional cooperation agreements shall include details, inter alia, regarding the following points (article 4 (4)):

- code of conduct for rescue teams and rules for emergency vehicles;
- to which country and hospital patients shall be taken (if possible);
- how to treat patients to ensure uninterrupted care on the vehicle and in the hospital;
- criteria to monitor the quality and security of services;
- documentation, statistics and evaluation;
- liability insurance;
- communication between the involved rescue directing centres and the rescue teams;
- procedures in case of death.

In order to respect the domestic allocation of competences, rights and duties, only regions bordering with the neighbours - two German ‘Länder’ (the Free States of Bavaria and Saxony) and five Czech regions (Liberecký, Ústecký, Karlovarský, Plzeňský and Jihočeský kraj) - may conclude regional cooperation agreements (cf. article 4 (2) of the bilateral national agreement). This agreement establishes a regulatory framework to be further specified and implemented in the regional cooperation agreements.

Based on the provisions of the bilateral agreement, the regional cooperation agreement (Regional cooperation agreement, 2015) for the Saxon-Czech border was negotiated between, and adopted by the Free State of Saxony and three Czech regions (Liberecký, Ústecký, Karlovarský kraj). The agreement entered into force in January 2016 and allows rescue teams to operate in a 10 km strip along the Saxon-Czech border (5 km on each side). On a rather general level, the cooperation agreement defines forms of cooperation, operations on the spot, directing centres, documentation, reimbursement of costs and liability (articles 3-8). More important, however, are eight annexes to the agreement with specific details on 50 pages, e.g.

a map of the area of operations, members of the working group with their contact details, bilingual forms and operation protocols, and tables with the names, addresses and contact details of relevant medical-care facilities (incl. specialist departments), directing centres and service providers.

The service benefits all emergency patients within a 10 km strip along the Saxon-Czech border. As can be seen on the map, however, the zone is not defined precisely. According to information from people working in the area the zone is hence extended pragmatically in case of emergency for the benefit of the patient's health. According to the framework agreement, and if appropriate in view of the patient's state of health, a German patient shall be brought to a German facility and a Czech patient to a Czech facility. The CPS therefore supports treatment of patients in their home country even if the case occurs in the neighbouring country.

CPS is provided based on existing infrastructures, facilities (hospital, directing centres etc.), emergency vehicles and rescue teams. In case of an emergency that cannot be covered immediately on the same side of the border, the directing centre in charge contacts another centre on the other side of the border and asks for their support. Afterwards, the directing centre, which was approached, checks the availability of staff, informs the other centre about the decision and, in case a team is available, instructs the team to take over. Hence, the cross-border emergency service relies entirely on mutual support and is not based on new or extended infrastructures. All staff members, facilities, vehicles or infrastructures belong to the respective institution that also uses and/or owns them in the national context.

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