



Easing legal and administrative obstacles in EU border regions

Case Study No. 1

Healthcare

Obstacles arising from different national systems

(Finland – Sweden)



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Abstract

Different national healthcare systems

European Union (EU) legislation gives EU citizens the right to receive healthcare services in all EU Member States, as well as the right to work in a different EU Member State. This is particularly important in order to ensure the health and well-being of EU citizens and to offer healthcare workers the opportunity to relocate where labour market needs exist.

According to the available data, the mobility of patients and healthcare professionals across EU borders is quite low. However, studies show a strong willingness of healthcare personnel to work in a different Member States and of patients to access services in other countries.

Multiple and interrelating factors contribute to the low mobility levels of patients, including: differences in the organisation and delivery of health services; differences in reimbursement procedures; tensions between healthcare authorities on the reimbursement of treatments; lack of information concerning the services available abroad; and lengthy procedures for the authorisation of services or their reimbursement. With regards to healthcare professionals, the main factors are differences in qualifications and job titles, and in some cases lengthy recognition of qualifications.

Access to cross-border healthcare is particularly important for citizens living in cross-border regions, where access to healthcare in the neighbour country might be the best option in terms of proximity of care, access to healthcare services lacking the home country or to better quality services. Similarly, healthcare professionals can have access to more job opportunities and in some cases better working conditions; most importantly they can respond to the labour market needs of the neighbouring country.

The case of the Torne Valley (or Tornio-Haparanda Region), situated in the Northern part of Finland and Sweden, is used to illustrate the obstacles of different healthcare systems in cross-border context. The Torne Valley region is characterised by a long history of cooperation, also in healthcare. However, some obstacles persist to cross-border mobility, both in terms of access to healthcare for patients and the mobility of health professionals.

Differences in coverage and reimbursement of services, imbalances in the mobility of patients and professionals, lack of skilled personnel in some areas, difficulties in the use of IT and telemedicine; difficulties in sharing information between health centres and inadequate IT infrastructures are some of the issues that the case of the Torne Valley highlights. Some of these problems have been the object of cooperation and have been partly solved while others persist and will need further interventions and initiatives to be effectively addressed.

The impact of these obstacles is not easily quantifiable, however, three main issues are worth noting: potential shortages and mismatches in the healthcare labour market; missed opportunities for increasing healthcare quality and healthcare delivery efficiency. These are highlighted in the report.

1 Outline of the obstacle (legal and administrative) and the policy context

Cross-border healthcare has become increasingly important in the European Union (EU) in the last years. Patients are more and more informed about healthcare services abroad and willing to travel to seek healthcare services.

The mobility of healthcare professionals is increasing as well; this aspect is receiving more and more attention at European level, given its relevance for the development of the EU common market¹.

In cross-border regions, cross-border healthcare is of even greater importance: territorial proximity with a region of another Member State can offer patients the opportunity to access better healthcare services. In some cases, healthcare facilities in the neighbouring country can be closer to the ones in the country of residence.

However, despite the implementation of EU regulations and rules in this field (see section 1.1), the mobility of patients and healthcare professionals across EU borders is quite low. Multiple and interrelating factors contribute to the low mobility levels of patients and healthcare professionals (see Box 1 and section 1.4).

Box 1. Legal and administrative obstacles to cross-border healthcare an EU

The main obstacles that can have negative effects on cross-border healthcare delivery and use consist in: lack of or insufficient information on the functioning of healthcare systems in the Member States where health services are sought (different from the country of affiliation), and on the availability, quality and cost of treatments in that country; language barriers; length and complexity of bureaucratic procedures to access healthcare services in a different Member State and receive a reimbursement; necessity in some cases to anticipate the cost of treatments, or a reduced level of reimbursement if compared to cost encountered. With regards to healthcare professional, obstacles in the recognition of qualifications can play role in hampering the mobility across the EU, as well as language barriers.

1.1 The legal framework

EU regulations and rules regarding access to healthcare in a different Member State have evolved in the last few decades as have the regulations regarding the mobility of healthcare professionals.

1.1.1 Regulations on patients' mobility

Up until 1998, access to foreign healthcare services was regulated under Regulation 1408/71, on the coordination of social security systems. This regulation offered the possibility for EU citizens to access healthcare services in a different EU Member State, provided that they had obtained the necessary authorisation from the competent authorities of the country of affiliation (the so-called Scheme E111). Later, access to planned healthcare was also granted through the European Health Insurance Card (E112).

In 2004 regulation 1408/71 was replaced by Regulation 883/2004², on the coordination of social security systems. In 2009 Regulation 987/2009³ was adopted,

¹ European Observatory on Health Systems and Policy (2011), Cross-border Health Care in the European Union: mapping and analysing practices and policies, 2011, http://www.euro.who.int/__data/assets/pdf_file/0004/135994/e94875.pdf?ua=1 (accessed in November 2016)

² Official Journal of the European Union (2004), Regulation 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, 30 April 2004, <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A02004R0883-20140101> (accessed in November 2016)

³ Official Journal of the European Union (2009), Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No

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laying down the procedure for implementing Regulation 883/2004. Both regulations came into force on 1 May 2010.

The two regulations state that a person insured in one Member State staying in a Member State other than the competent Member State is entitled to benefits in kind which become necessary on medical grounds during their stay, taking into account the nature of the benefits and the expected length of the stay. The Member State of stay provides these benefits taking into account their nature and the length of the stay. These benefits are provided by the institution of the place of stay in accordance with the statutory conditions, procedures and rates applied by this institution, as if the beneficiaries were insured under this legislation. To benefit from these provisions, the person concerned must submit the European Health Insurance Card (or EHIC) to the treatment provider in the State of stay. The insured person may claim reimbursement for any costs borne directly from the institution of the place of stay if the legislation applied by this institution allows reimbursement of these costs to an insured person. In this case, the institution of the place of stay will apply its reimbursement rates.

A series of European Court of Justice (ECJ) rulings were very important in recognising and extending the rights of patients to seek healthcare abroad. Focusing on cross-border healthcare cases, the ECJ stated that EU citizens were entitled to seek healthcare abroad and be reimbursed by their own healthcare system.

As a result of the number of judgements being made in the courts, the development of an EU-wide Directive to complement the existing social security regulation was seen as necessary to clarify the law and the rights of citizens across the EU.

After what was a lengthy process and debate between Member States, Directive 2011/24 on the application of patients' rights in cross-border healthcare was adopted in 2011. It came into force on 25 October 2013. Member states were supposed to implement it by 25 October 2015.

The Directive stated that EU citizens⁴ are entitled to receive healthcare abroad. They can be reimbursed of the costs incurred by their own Member State, if the treatment is among the benefits they would be entitled to in their country. Besides some exceptions, no prior authorisation is necessary.

The Directive has also resulted in the creation of National Contact Points, whose aim is to inform citizens about their rights, the availability of treatments in another country, their obligations and the necessary procedures to be followed in order to access healthcare services in a different Member State. The directive also aims at promoting cooperation on healthcare at regional and local level, and in cross-border regions of neighbouring countries⁵.

1.1.2 Regulations on professional mobility in healthcare

Cross-border healthcare also concerns the mobility of healthcare professionals. The Directive 2013/55 reformed and simplified the system of recognition of professional qualifications. The main EU regulation in this area is Directive 2005/36, which defines rules that allow professionals qualified in one Member State to pursue their profession in another Member State. It foresees an automatic system of recognition for the main

883/2004 on the coordination of social security systems, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:284:0001:0042:en:PDF>

⁴ Third country nationals satisfying the conditions of the legislation of the Member State of affiliation for entitlement to benefits are also entitled to receiving healthcare abroad; Art.3, 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, 4 April 2011, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF> (accessed in November 2016)

⁵ Official Journal of the European Union (2011), 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, 4 April 2011, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF> (accessed in November 2016)

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healthcare professions. The directive also foresees a simplified mechanism for temporary mobility that allows professionals to work in another EU country on the basis of a declaration, without a pre-check of qualifications.⁶

Three systems of recognition of qualifications were created: recognition on the basis of professional experience, the 'general system' for certain regulated professions and automatic recognition for professions with minimum training conditions. Nurses, midwives, doctors (general practitioners and specialists), dental practitioners, pharmacists all fall into the third category⁷.

While within the general system the Member States operate on the basis of a case-by-case evaluation and have some discretion in granting recognition of the qualifications, the automatic system simply consists of a verification of whether the qualifications are in line with what is described in the Directive.

In the process of authorisation, the principles of public health, public safety and consumer protection have to be respected. Professionals are also required to have the necessary linguistic skills to practice their profession. An 'alert mechanism' was also created whereby Member States would inform each other about professionals that have been restricted or prohibited to practice by national authorities or courts^{8 9}.

The Directive was amended in 2013 and some new measures were introduced:

- the 'Internal Market Information System' (IMI), which allows authorities in different Member States to exchange information concerning applications to qualification for recognition. The use of this platform has increased in recent years¹⁰;
- the European Professional Card (EPC), an electronic certificate issued via the IMI. The card is available since January 2016 for five professions including general care nurses, physiotherapists and pharmacists;

The Directive 2011/24 on the application of patients' rights in cross-border healthcare mentions the need for Member States to 'facilitate cooperation between healthcare providers, purchasers and regulators at national, regional and local level, in order to ensure safe, high-quality and efficient cross-border healthcare'¹¹.

1.2 Cross-border healthcare in practice

The legal framework described above allows patients to seek healthcare in a different EU Member State and healthcare professionals to practice in a different country.

1.2.1 Patient mobility and access to services

The limited data available on patients' mobility show that patient flows are quite low in the EU: in a 2007 survey, 4% of citizens declared to have received healthcare

⁶ This excludes professions with health or safety implications.

⁷ European Commission (2016), Free Movement of professionals: Recognition of professional qualifications in practice, 2nd November 2016, http://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition/index_en.htm (accessed in November 2016)

⁸ Official Journal of the European Union (2005), Directive 2005/36/EC of 7 September 2005 on the recognition of professional qualifications (consolidated version), January 2014, <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:02005L0036-20140117&from=EN> (accessed in November 2016)

⁹ Specifically, the Directive poses a duty on the competent authorities in the Member States to inform their counterparts in all other states within three calendar days (not working days) of any decision to restrict or prohibit that individual from certain practising rights.

¹⁰ European Commission (2016), Internal Market Information System Statistics, July 2016, http://ec.europa.eu/internal_market/scoreboard/performance_by_governance_tool/internal_market_information_system/index_en.htm (accessed in November 2016)

¹¹ Official Journal of the European Union (2011), Directive 2011/24/EU of 9 March 2011 on the Application of patients' rights in cross-border healthcare, 4 April 2011, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF> (accessed in November 2016)

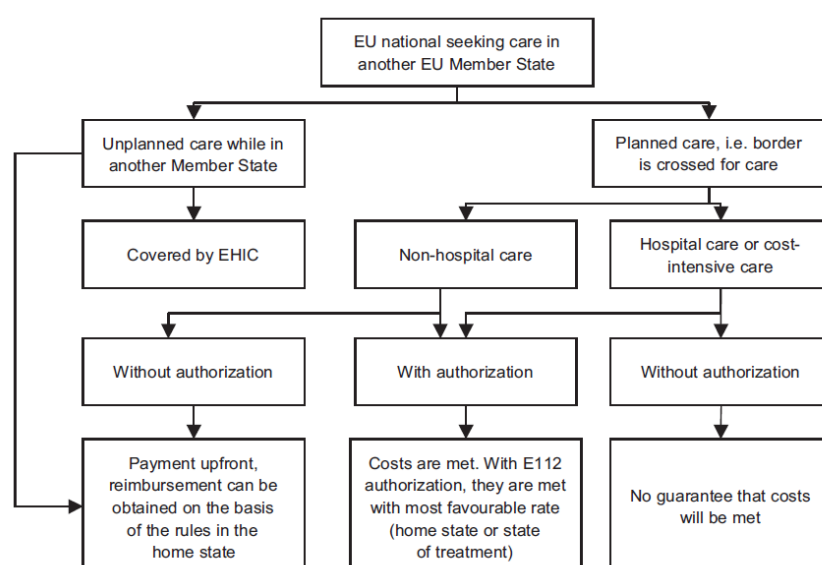
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abroad¹². The data were reported by Member States on the basis of requests for authorisation for treatments abroad and the requests for reimbursements^{13 14}. However, it seems that the number of EU citizens wanting to travel and, therefore, potentially needing unplanned healthcare abroad, has increased over the years. An increased number of citizens is also now better informed about health treatments and seeks healthcare in a different country¹⁵.

With regards to mobility of patients, two different categories can be identified: those receiving health treatment while already abroad (seeking 'unplanned healthcare') and those moving in order to receive health treatment in a different country (and seeking 'planned healthcare').

While unplanned healthcare is generally not subject to prior authorisation, hospital care and cost-intensive care is, in order to be reimbursed, subject to prior authorisation by the country of affiliation.

Figure 1. Financing of cross-border healthcare



Source: EU Observatory on Health Systems and Policy, Policy Summary 14, 'Cross-border healthcare in Europe', Denmark 2014, p.6.

Figure 1 illustrates the process of authorisation and reimbursements when seeking cross-border healthcare.

The services will be reimbursed according to the rules and rates of the country where the treatment was received.

¹² Flash Eurobarometer (2007), Cross-border health services in the EU: Analytical report, June 2007, http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (accessed in November 2016)

¹³ European Commission (2015), Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM(2015) 421 final, 4 September 2015, http://ec.europa.eu/health/cross_border_care/docs/2015_operation_report_dir201124eu_en.pdf (accessed in November 2016)

¹⁴ A survey commissioned by the EU in 2014 shows that in 2013 only 5% of people living in the European Union declared having received medical treatment in another EU country (Special Eurobarometer 425 (2015), Patients' rights in cross-border healthcare in the European Union: Summary, May 2015, http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_sum_en.pdf (accessed in November 2016))

¹⁵ European Observatory on Health Systems and Policy (2011), Cross-border Health Care in the European Union: mapping and analysing practices and policies, 2011, http://www.euro.who.int/__data/assets/pdf_file/0004/135994/e94875.pdf?ua=1 (accessed in November 2016)

1.2.2 Mobility of healthcare professionals

The data on the mobility of health professionals is also very scarce. Available data show that the number of health professionals seeking employment in another EU Member State has increased since 2009, in particular for professionals leaving Southern and Eastern countries and moving towards other EU Member States¹⁶. Nevertheless, this mobility seems to remain low in absolute terms, not exceeding 3% of the domestic workforce¹⁷.

The European Commission database for regulated professions provides data on the requests for recognition of professional qualifications which can shed some further light on the mobility of healthcare professionals. Between 2009 and 2015, for temporary mobility 921 decisions were taken on requests from general doctors; for the purpose of permanent establishment within another EU Member State (including EEA countries and Switzerland) 75,296 decisions were taken on requests from general doctors and 63,183 on requests from nurses.

1.3 Drivers of cross-border healthcare

1.3.1 Mobility of healthcare professionals

Statistics show that the mobility of healthcare professionals has increased over the years, especially after the two EU enlargements in 2004 and 2007, and since 2009. The flows indicate movements from the east and the south of Europe towards the western and northern countries.

The motivations behind this type of migration, especially of doctors, can be traced back to the search of higher salaries, better working conditions, but also to new training and career opportunities¹⁸. Due to territorial proximity, people living in border regions are more motivated than the other populations in the country to work in a different Member State. In this case, individuals might become 'cross-border workers'¹⁹.

1.3.2 Patients seeking healthcare abroad

With regards to patients, different reasons can be the reason for seeking healthcare abroad:

- individuals travelling abroad, who fall ill during their stay; they can use the European Health Insurance Card and are then entitled to reimbursement by their own country (if the necessary conditions are met);
- people going abroad of their own initiative in order to seek health treatments that are less expensive or provided more quickly, that are not covered by the country of affiliation, or that are considered of better quality;
- people retiring to other countries, usually to Southern Member States or in their country of origin.

¹⁶ Major destinations countries are Germany, France, Italy, UK and Spain. These countries receive doctors from Poland, Greece, Romania and Czech Republic. A dynamic exchange of doctors between western countries appears to take place as well (Costigliola, V. (2011), Mobility of medical doctors in cross-border healthcare, *The EPMA Journal*, December 2011, 2(4): 333–339, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405407/> (accessed in November 2016))

¹⁷ Footman, K. et al (2014), Policy Summary 14: Cross-border healthcare in Europe, 2014, http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1 (accessed in November 2016)

¹⁸ Costigliola, V. (2011), Mobility of medical doctors in cross-border healthcare, *The EPMA Journal*, December 2011, 2(4): 333–339, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405407/> (accessed in November 2016)

¹⁹ Cross-border workers' (or 'frontier workers') are defined under EU law as individuals who work in one Member State and reside in another Member State, to which they return daily or at least weekly (Art. 1 of Regulation 883/2004 on the coordination of social security systems) (Official Journal of the European Union (2004), Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, 30 April 2004, <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A02004R0883-20140101> (accessed in November 2016))

The main reasons motivating patients to seek healthcare abroad can be summarised as having access to: healthcare services that are not available in their home country, better quality healthcare treatments; treatments more quickly; and cheaper treatments than at home.

People living in border regions seek healthcare in the neighbour country for similar reasons, but the territorial proximity, relative scarcity of facilities in peripheral areas and bonds between populations can help facilitate and further encourage this phenomenon.

Cooperation between authorities and healthcare providers can facilitate this type of mobility. Public authorities and health services providers can also avoid the duplication of services and therefore improve efficiency²⁰.

1.4 Legal and administrative obstacles and challenges to cross-border healthcare at EU level

While EU rules state that patients have the right to access healthcare services in a different Member State, statistics show that the flows of patients are still low in terms of numbers²¹. Different issues and challenges might explain the limited use of this instrument.

1.4.1 Difference among Member States' healthcare systems

The definition of health policies and the responsibility for organising and delivering healthcare is in the hands of the Member States, while EU institutions have the responsibility to support the Member States and foster collaboration between them (Article 168 of the Treaty on the Functioning of the EU). EU Member States' healthcare systems differ in the organisation and delivery of services, and in the way that they are financed. These differences are not likely to disappear in the short or medium term, nor are convergences between the systems expected²².

In cross-border regions the provision of exhaustive information to the patients, willing to access healthcare in the confining region, and an efficient cooperation between competent authorities are particularly important in view of favouring the mobility of patients across the two countries.

1.4.2 Pressure on healthcare budgets and on reimbursements

National healthcare budgets are under pressure, given the increasing share of ageing populations, increases in chronic diseases, higher costs of inputs and increasing demand for better healthcare; restrictive budgetary policies also exercise pressure on healthcare budgets. This creates tensions between national healthcare authorities or insurance bodies responsible for the reimbursement of treatments²³, given the need to keep control over their expenses and save as much resources as possible.

1.4.3 Lack of information and awareness of services available across the border

Even though Directive 2005/36 foresaw the creation of National Contact Points with the purpose of informing patients about healthcare abroad, which were established in

²⁰ European Observatory on Health Systems and Policy (2011), Cross-border Health Care in the European Union: mapping and analysing practices and policies, 2011, http://www.euro.who.int/__data/assets/pdf_file/0004/135994/e94875.pdf?ua=1 (accessed in November 2016)

²¹ 4% of citizens declared to have received healthcare abroad in a 2007 survey (Flash Eurobarometer (2007), Cross-border health services in the EU: Analytical report, June 2007, http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (accessed in November 2016))

²² European Commission Expert Panel on effective ways of investing in health (2015), Request for an expert opinion: Cross-border cooperation, July 2015, https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/cross_border_cooperation_en.pdf (accessed in November 2016)

²³ These considerations were drafted on the basis of the information collected during the interviews

each Member State, citizens are often poorly informed about the availability, quality and cost of healthcare services abroad. This can be explained by the fact that citizens don't know where to search for the relevant information and the language barriers that exist. Information websites are often difficult to understand by patients and sometimes incomplete. Healthcare workers and people involved in health policy would also need to be better informed about citizens' rights and procedures that need to be followed to seek healthcare abroad²⁴.

1.4.4 Lengthy and complex bureaucratic procedures

Even when patients are informed and willing to access healthcare abroad, the bureaucratic procedures for obtaining the authorisation for the treatment (when requested) and the reimbursement once the treatment is provided, can be discouraging, given their length and complexity.

1.4.5 Cost of services abroad

The necessity of anticipating the cost of the treatments and the reduced level of reimbursement obtained can also play a role in discouraging patients to seek treatments abroad; this is true in particular for economically disadvantaged groups of citizens²⁵.

1.4.6 Low mobility of healthcare professionals

With regards to healthcare professionals, obstacles to the recognition of qualifications are acknowledged as hampering mobility across the EU. A 2009 study²⁶ commissioned by the European Commission involved a survey for the European Jobs Network (EURES) and other cross-border labour market experts from government departments, universities and trade unions. The study identified obstacles regarding the recognition of foreign diplomas in a variety of countries.²⁷ Healthcare professionals also encounter difficulties in dealing with two different jurisdictions²⁸. The low mobility of healthcare professionals has an impact on the healthcare offered to patients and reduces the potential for increasing healthcare delivery efficiencies²⁹.

The obstacles identified, which apply to patients and healthcare professionals around the entire of the EU, also apply to cross-border regions. In general, healthcare is organised at the national level, not taking into account the demand and supply needs across the border. This represents a missed opportunity for increasing the efficiency in the delivery and organisation of healthcare services.

²⁴ European Commission Expert Panel on effective ways of investing in health (2015), Request for an expert opinion: Cross-border cooperation, July 2015, https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/cross_border_cooperation_en.pdf (accessed in November 2016)

²⁵ These considerations were drafted on the basis of the information collected during the interviews (e.g. interview with Elisabeth Eero, Director, Övertorneå Health Centre, County of Norrbotten Sweden)

²⁶ MKW Wirtschaftsforschung GmbH, Munich Empirica Kft. (2009), Scientific Report on the Mobility of Cross-Border Workers within the EU-27/EEA/EFTA Countries - Final Report, January 2009, ec.europa.eu/social/BlobServlet?docId=3459&langId=en (accessed in November 2016)

²⁷ It was considered a major obstacle in AT-SK, FR-ES, DE-FR, DE-CZ, AT-HU, DE-PL, FR-IT, AT-SI, PT-ES, IT-SI, DE-NL, DE-CH and IT-AT

²⁸ Transfrontier Operational Mission (2015), Preparation of the Luxembourgish Presidency of the EU Council: Cross-border cooperation: obstacles to overcome, 19 May 2015, http://www.espaces-transfrontaliers.org/fileadmin/user_upload/documents/Documents_MOT/Etudes_Publications_MOT/Obstacles_to_CBC_LU_EU_presidency.pdf (accessed in November 2016)

²⁹ This will be explained in the following sections of the case study.

2 Case Study Context

2.1 Cross-border healthcare mobility in the Nordic Countries

The Nordic countries are similar in terms of the organisation of healthcare: health systems are funded through taxes and healthcare services are mainly provided by public organisations. The private sector has a limited but increasing role as a healthcare provider.

In Sweden, the responsibility to provide healthcare is decentralised among the 21 counties; municipalities are responsible for primary care. Counties have a high degree of autonomy in determining how healthcare is organised.

In Finland, the organisation of healthcare is more decentralised and funding is more complex. Municipalities are responsible for the provision of primary healthcare, while secondary care is provided at district level. Hospitals are therefore present at district level.³⁰

Each municipality must be a member of one hospital district. Hospital districts are financed and managed by the member municipalities

National-level cooperation between these two countries is well developed. It is mainly structured in the context of the Nordic Council cooperation as healthcare constitutes one of the areas of collaboration.

2.1.1 Nordic cooperation in healthcare

There is a long-standing tradition of cooperation between the Nordic Countries. A cooperation Treaty was signed in 1962 between Denmark, Finland, Iceland, Norway and Sweden (the 'Helsinki Treaty'³¹). Amended many times between 1971 and 1996, it included two provisions on health and allowed for further cooperation in the field.

The 'Nordic public health preparedness agreement' was concluded between the same countries in 2002 and foresaw cooperation between health and medical authorities, with the aim of increasing the capacity to deal with emergencies and disasters.

The 'Nordic Convention on Social Assistance and Social Services' was also concluded on 14 June 1994, covering the Nordic Countries, the Faroe Islands and Greenland. It foresees the possibility for nationals of those countries to use Danish, Finnish, Icelandic, Norwegian or Swedish³² when having written contact with the authority of another Nordic country, in matters concerning social assistance or social services (including healthcare services and medical treatment). The Convention also states that Nordic Countries' competent authorities should favour the relocation of nationals requiring long-term treatment or care and wishing to move to a different Nordic country to which they have a special connection. The competent authorities of the two countries involved (the country of emigration and of immigration) can make an agreement on the division of the costs of health treatment or care³³.

³⁰ Vuorenkoski Lauri (2008), Health Systems in Transition Finland Health system review, Vol. 10 No. 4 2008, p. XVII, European Observatory on Health Systems and Policies, http://www.euro.who.int/__data/assets/pdf_file/0007/80692/E91937.pdf

³¹ Nordic Cooperation, About the co-operation: The Helsinki Treat, <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/basic-agreement/the-helsinki-treaty> (accessed in November 2016)

³² The language used should be the one the person understands, in cases where the language is of great importance for attaining the objective of social assistance and social services; Art. 5, Par. 2, Nordic Convention on Social Assistance and Social Services, 14 June 1994, Arendal, Norge, <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/social-and-health-care/nordic-convention-on-social-assistance-and-social-services> (accessed in December 2016)

³³ Art. 5 and Art. 9, Nordic Convention on Social Assistance and Social Services, 14 June 1994, Arendal, Norge, <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/social-and-health-care/nordic-convention-on-social-assistance-and-social-services>

2.1.2 Mobility of patients in Sweden and Finland

The principle of free choice of hospital or provider was established both in Sweden and Finland, as well as maximum waiting time guarantees for a treatment. However, the data available regarding cross-border mobility of patients in the Nordic countries are very limited. The data provided by social insurance bodies in Sweden and Finland show that the number of people accessing healthcare abroad has been very low.

In Sweden, between 2004 and 2009, the National Social Insurance Board received 1,382 requests of prior authorisations for planned care. The main types of treatments were treatments for cancer, pregnancy-related disorders and circulatory system diseases (data collected between 2005 and 2007). During the same period (2004-2009), nearly 8,000 requests for reimbursement after the treatment abroad were received. However, many of these patients travelled to countries other than the Nordic ones³⁴.

The data provided by the Finnish authorities indicate an even lower level of patient mobility: between 2000 and 2009 the National Social Insurance Institution recorded only 71 patients accessing healthcare services abroad; of these 42 accessed services in Sweden. Over the same period, 443 foreign patients were treated, of which 85 came from Sweden³⁵.

Data collected by the Norrbotten County shows that in 2009, 488 consultations were registered for Finnish citizens and 819 for Norwegian ones. These calculations include primary care, planned care and dental care. With regards to planned care, the Finnish Social Insurance Institution (Kela) reported that between 2000 and 2009 reimbursement was paid to 42 Finnish citizens, who had accessed healthcare in Sweden; 85 Swedish patients were reimbursed for having received treatments in Finland³⁶. The data show that patient mobility is primarily related to primary care.

Even though official levels of patients' mobility are low, a survey carried out in Torne Valley found that a high proportion of patients would like to seek treatment across the border. Indeed, 66% of Finnish respondents and 69% of Swedish ones declared their willingness to access healthcare on the other side of the border³⁷.

2.1.3 Mobility of healthcare professionals

The Nordic countries concluded an agreement in 1982 regarding the mobility of healthcare professionals. This agreement was amended a few times, most recently in 1998. It provides for an automatic provision of the authorisation to practice in a different Nordic country after completion of education. The scope of application of this agreement is larger than the scope of the EU Directive 2005/36, i.e. it applies also to other categories of healthcare professionals, like physiotherapists, psychologists, opticians, etc.

The data available regarding the mobility of healthcare professionals between the Nordic countries is limited, as is the case for data on patients. 460 authorisations were given to Swedish healthcare professionals in 2006 and 55 to Finnish ones. However, existing data show that very few authorisations were given to healthcare professionals by the other Nordic countries³⁸.

³⁴ Hem, K. et al (2011), Patient mobility in the Nordic Countries: Volume and obstacles, June 2011, http://www.nordicinnovation.org/Global/_Publications/Reports/2011/2011_patientMobility_report.pdf (accessed in November 2016)

³⁵ Ibid.

³⁶ Hem, K. et al (2011), Patient mobility in the Nordic Countries: Volume and obstacles, June 2011, http://www.nordicinnovation.org/Global/_Publications/Reports/2011/2011_patientMobility_report.pdf (accessed in November 2016)

³⁷ Ibid.

³⁸ Mahncke, H. et al (2009), Nordic collaboration in health services: a feasibility study on the potentials and barriers towards an open market for health services in the Nordic Countries, February 2009, http://www.oxfordresearch.eu/media/55292/08022_nordic_collaboration_in_health_services_full_report.pdf (accessed in November 2016)

2.1.4 Border regions

Cross-border healthcare is of particular importance for border regions. Patients living in these areas are generally familiar with the neighbour country and willing to access health services there.

The reasons for seeking healthcare in the neighbour country are diverse. Geographical proximity might play a role, since the services provided in the neighbour country may be closer to the patient than the same facilities in their home country. Linguistic and cultural similarity or shared history might also have an impact on the willingness to access health abroad³⁹. Other reasons for seeking healthcare abroad are the lack of competence or medical technology to give patients the best treatment in their home country, or differences in waiting times between the two countries.

Frontiers workers, traveling daily or weekly to the neighbour country also exist in these areas. As patients, frontier workers, are likely to have regular access to the healthcare systems of both countries. Unfortunately, data is lacking in this regard; it would be important to have evidence on this specific point in order to understand the scale of this phenomenon.

The role of cross-border cooperation

Cross-border cooperation in healthcare across border regions can be particularly beneficial as it can be a way to provide better access to healthcare to patients located a long way from their own country's facilities, and it can also increase the cost-efficiency of the services, by sharing resources.

Different types of arrangements can be concluded: emergency coordination, arrangements among providers, arrangements between insurers and providers (based in different countries); or arrangements designed to facilitate access to care abroad, but not involving the provision of care⁴⁰.

An example of cross-border cooperation is the 'Nordic public health preparedness agreement', which was agreed at national level, but which was the basis for the conclusion of other agreements on emergency care, also beyond cross-border regions. Cross-border regions should therefore seek local cooperation and aim to conclude cross-border arrangements to deal with specific issues.

The willingness of the actors involved in organising and delivering healthcare is crucial to conclude these kinds of agreements. Sometimes, however, the willingness of actors doesn't correspond to the actual legal competence required to conclude the agreements. This stems from the fact that in most cases the legal competence resides in the regional or even national health authorities⁴¹.

2.2 The Tornio-Haparanda Region (Torne Valley)

The Tornio-Haparanda region is located in the Gulf of Botnia, on the frontier between Sweden and Finland. Haparanda, located in Sweden, covers an area of 918 km² and has around 10,200 inhabitants; Tornio, located in Finland, covers an area of 1227 km² and has around 22,300 inhabitants. The two cities are separated by the Torne River and are part of the Torne Valley, hosting 20,000 inhabitants on the Swedish side and 40,000 on the Finnish side. The rest of the region is a rural area with a low density

³⁹ Hem, K. et al (2011), Patient mobility in the Nordic Countries: Volume and obstacles, June 2011, http://www.nordicinnovation.org/Global/_Publications/Reports/2011/2011_patientMobility_report.pdf (accessed in November 2016)

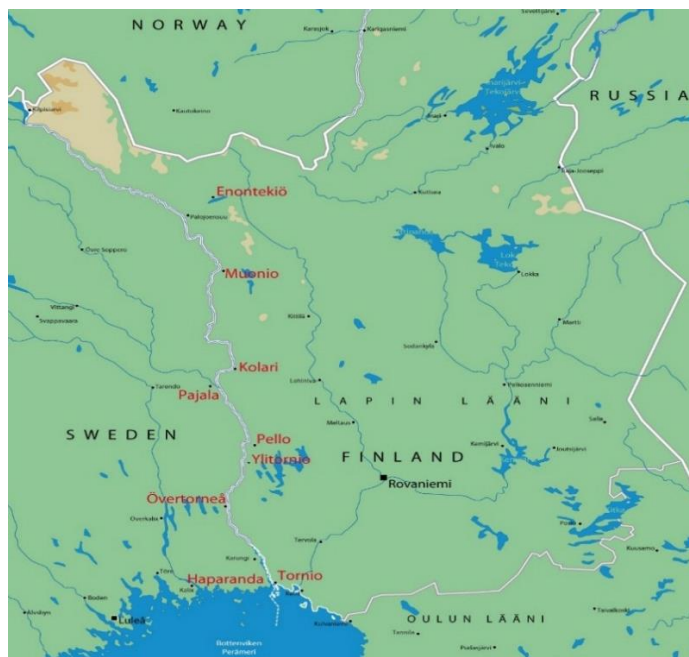
⁴⁰ Ibid.

⁴¹ These considerations were drafted on the basis of the interviews conducted with the experts.

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population. The area is also part of the North Calotte region, which includes parts of Finland, Sweden and Norway⁴².

Figure 2. Torne Valley



Source: Cross-border Healthcare in Torne Valley, presentation from Anna-Greta Brodin, Council of Norrbotten, 19 January 2016

2.2.1 Existing forms of cooperation in the area

The cooperation in the North Calotte region started in 1967 with the creation of the North Calotte Committee, renamed North Calotte Council in 1997. It includes regional representatives from the three countries (Finland, Sweden, Norway) and produced different types of agreements between the regional authorities. Areas of cooperation in this context were for instance cooperation agreements between hospitals in Finland and Norway.

The Torne Valley Council, based on the cooperation of 10 municipalities in the area, including Haparanda and Tornio, has a long tradition of cooperation, since being set up in 1987. Among others, the area of cooperation includes healthcare.

The cooperation between the cities of Tornio and Haparanda started in 1987 as well, with the creation of the Bothniensis Provincia. This aimed to promote cooperation between the two towns. The two City Councils appoint five members each, to lead the meetings and negotiations. Working groups are formed, in order to deal with specific issues, such as business and tourism, education and training, city planning and environmental issues, social services and healthcare, culture.

While the limited⁴³ statistics available at national level indicate limited flows of patients and professionals across the border, the experts contacted from the region and sources consulted⁴⁴ highlight that mobility across the border is quite common, in particular from Sweden to Finland⁴⁵.

⁴² Northern Research Forum Open Meeting (2006), Tornio-Haparanda – a Unique Result of City Twinning, October 2006, <http://www.rha.is/static/files/NRF/OpenAssemblies/Oulu2006/haparandatornio-presentation.pdf> (accessed in November 2016)

⁴³ See data provided in paragraph 2.1.2 above.

⁴⁴ Johnsen, I. et al (2014), Local and regional approaches to demographic change in the Nordic countries, 2014, <https://www.diva-portal.org/smash/get/diva2:843811/FULLTEXT01.pdf> (accessed in November 2016)

⁴⁵ One of the healthcare professionals from the Region mentioned in the interview that every year there is a 15-20% increase of patients going to Finland from Sweden, to seek specialised care

Many people living in the area cross the border every day in order to work (cross-border workers) and are therefore entitled to access healthcare in that country. Others seek healthcare (mainly primary care) across the border, mainly because they are culturally attached to the other country (e.g. because they have Finnish origins or have family there), or because they are entitled to access healthcare services mainly in that country.

2.3 Cross-border obstacles to healthcare in the North Calotte region

The North Calotte region is facing demographic challenges, primarily an ageing population (a high proportion of the population is already of advanced age), and most towns in the area have a negative labour force replacement ratio⁴⁶. Between 2000 and 2009 the population decreased by 6,000 in Norrbotten and by 10,000 in Lapland.

Resources for healthcare services are quite scarce and the ability to provide high-quality healthcare is at risk. The main obstacles and challenges to cross-border healthcare and cooperation in this area are set out in Table 1⁴⁷.

Table 1. Obstacles to cross-border healthcare in Torne Valley as identified by the interviewees

Differences in the amount of reimbursements
Reimbursement levels in the two countries differ: the reimbursements from the Swedish authorities are in general more generous than the Finnish ones. This means that Swedish patients are more advantaged in seeking healthcare in Finland.
Differences in legislation and organisation of healthcare delivery
Differences in national regulations and legislation seem to exist between the two countries. Also, differences in the organisation of healthcare appear to constitute an obstacle to further cooperation in the region. While on the Swedish side regional authorities are the main competent contracting parties, in Finland the contracting parties are the municipalities.
Imbalances in the flows of patients
Even though agreements exist between local and regional healthcare providers on primary care, no exchanges of money were foreseen in these agreements. This can be explained by the fact that local authorities on both sides consider cooperation in healthcare as a win-win cooperation; this should in principle facilitate cross-border healthcare flows. However, this also causes imbalances in some municipalities where a high in-flow of patients from across the border exists.
Limited proximity of health services and high levels of resources needed
Large distances exist between patients and healthcare providers in the rural area, which entail the use of high levels of resources when these patients need to seek healthcare or when care needs to be provided in their homes.
Organisation and delivery of emergency care
Given the distances to be covered, the lack of personnel and the high proportion of older population, difficulties are encountered in the organisation and delivery of emergency care (acute care). Very often emergency care facilities across the border are the nearest ones and can reach the patient more rapidly and more efficiently. Uncertainties also exist with regards to the insurance coverage when ambulances and staff cross the border to provide acute care.
Difficulties in the use of technology (e-health)
The use of e-technologies (telemedicine, electronic health records, mobile health, etc.) needs to be supported by adequate technological infrastructure, in order to provide the necessary support to the work of healthcare professionals.
Management and sharing of patients' records
Issues exist with the management and sharing of patients' information (patients' records) and inadequacy of ICT infrastructure. Differences in the regulations between Finland and Sweden impede further development of cooperation in this area.

⁴⁶ Johnsen, I. et al (2014), Local and regional approaches to demographic change in the Nordic countries, 2014, <https://www.diva-portal.org/smash/get/diva2:843811/FULLTEXT01.pdf> (accessed in November 2016)

⁴⁷ These obstacles were identified on the basis of the views of the interviewees

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Other obstacles mentioned by the interviewees included:

- Further centralisation of services - the increase in the costs incurred to maintain healthcare facilities in the area (hospitals, health centres and dental centres) is likely to lead to changes in the organisational structure of healthcare systems in both Sweden and Finland. This could lead to a further centralisation of services. This would extend travel times for patients and healthcare providers.
- Lack of highly skilled personnel - given the scarce population density, the remoteness of this region from big cities, and the negative demographic trend, there is a lack of highly skilled personnel, in particular, doctors and nurses. It is difficult to attract highly-skilled professionals to these areas and for this reason, doctors are temporarily hired and employed in the area (e.g. for two-week periods). This has a negative impact on the quality of the care.
- Linguistic barriers - limited language barriers exist in the region, as well. Even though a common dialect is generally spoken in the area, linguistic barriers exist between Finnish and Swedish speaking people who do not speak the other language (nor the local dialect).

3 Impact analysis

Given the lack of systematic data, it is very difficult to quantify the adverse effects of cross-border obstacles to healthcare for the population in the region. However, a few adverse direct effects can be identified.

First of all, patients crossing the border and accessing health services there incur high costs. The cost of the treatments might have to be anticipated and the reimbursements provided might not cover the entire amount paid. This has a particular impact on economically disadvantaged citizens, who might not be able to afford to anticipate the cost of the treatments or cover the entire cost. Cross-border workers, who are insured and, therefore, covered by the country in which they work, will also be particularly affected by reimbursement issues, when accessing health services in their country of residence.

Secondly, the big distances that must be covered by patients to reach healthcare facilities might mean that low numbers of patients seek care. For the same reason, the levels and quality of home healthcare might also be affected. For instance, some of the experts consulted made reference to the challenges incurred by healthcare professionals when providing emergency care, given long distances in the region. Emergency care requires timely interventions, which when not provided, can seriously threaten patients' health.

Thirdly, the difficulties in sharing patient information and records between the two countries will mean that more complex and lengthy administrative procedures will need to be followed by patients willing to share their records with health professionals in the other country. For instance, access to patients' records and the digital transmission of X-ray images in different health centres was identified by one of the experts as one of the challenges in ensuring continuity of care across the border⁴⁸.

Indirect and secondary effects can also be identified. These will mainly consist of reduced healthcare quality, which in the medium and long term can lead to higher levels of chronic diseases, higher levels of mortality and, more in general, reduced quality of health among citizens⁴⁹.

⁴⁸ This is also explained in the project report: Cross-border Healthcare II – Tornedalen, Project report, Norden, Interreg Nord IV A Nord, Lansstyrelsen Norrbotten, Lapin Laani, The North Calotte Council, Norbottens Lans Landsting (contacts: Elisabeth.eero@nll.se; tapani.risku@pello.fi);

⁴⁹ These considerations were drafted on the basis of the information collected during the interviews.

4 Solutions and good practices

Some of the identified obstacles have been fully or partially tackled thanks to the bottom-up cooperation set up in the region. This will be illustrated in the following paragraphs.

The first type of cooperation implemented in the Torne Valley, which started in the 1970s, was the cooperation on emergency care. It involved two health centres and was driven by the shortage of resources and the challenges to the delivery on services on the Swedish side. The two health centres negotiated with their respective ministries of health and were authorised, after a trial period of one year, to share emergency duties.

In 2008, an EU project called 'Borderless care in Torne Valley' started in the region. Funded by the Interreg programme, it was led by the Council of Norrbotten and had six Finnish Municipalities as partners⁵⁰. The project lasted until 2011 and its main objectives were to: further deepen cooperation between local health services in the Torne Valley and, therefore, create the conditions for increased mobility; increase efficiency in the use of healthcare resources; strengthen relations to improve cooperation; and improve the transfer of information between different care providers.

The outcomes of the projects seem to have addressed some of the obstacles to cross-border healthcare identified in previous sections. Coordination was reinforced in emergency care, a coordinated system in responding to emergency calls was established. Efficiency and effectiveness were increased. Improved sharing of information between healthcare centres and the use of telemedicine and video communication, which was tested, helped reduce distances and the necessity to travel for both patients and healthcare professionals. Reduction of costs will, therefore, certainly result from this type of initiatives, as well as faster responses to the needs of patients. Unfortunately, no evaluation of this project is available for the moment; this would have helped understand the impact of these initiatives in quantitative terms.

Other solutions have also been found at local level. For instance, given the lack of local highly-skilled staff, doctors coming from more urbanised areas are hired to work in the region on a temporary basis (e.g. for two-week periods). This, however, causes issues with the quality of healthcare provided, given the lack of continuity of care, and it is financially burdensome. At the same time, nurses are trained to respond to acute care consultations, so doctors can work only during the day, and therefore cover patients' needs over the entire territory.

Also, the role of local stakeholders, mainly health centres and healthcare professionals, was crucial in fostering new forms of cooperation and delivering new agreements. This approach was possible also given the high degree of autonomy in the organisation of healthcare existing in the region, and the support provided by the local authorities. This bottom-up approach has proven very successful.

An example of cooperation among local stakeholders are Norrbotten County Council from Sweden, Lapland and Länsi-Pohja Hospital Districts, Oulu University Hospital from Finland and Helse Nord from Norway. These organisations meet regularly since 2008 and cooperate in areas like emergency care and psychiatric care.

Another example of very successful local cooperation is primary care; cooperation in this area has been in place for years and patients have the right to choose in which country they want to access primary care services. No reimbursement procedures are in place, as no exchange of money is foreseen between healthcare authorities for this type of care.

A few structural obstacles, however, persist and would probably need be addressed beyond at local or regional level.

⁵⁰ The project partners were the Municipalities of: Tornio, Ylitornio, Pello, Kolari, Muonio and Enootekiö.

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Differences in the coverage of services (benefits) and in reimbursement levels present obstacles to cross-border healthcare that have to be addressed at national level. The political willingness to cooperate is crucial to improving and bringing cooperation in healthcare to a new level.

For instance, some of the experts interviewed highlighted that coverage and reimbursement levels from the Swedish healthcare authorities is higher than the Finnish ones, leading to higher mobility from the Swedish to the Finnish side. This could be solved only through an agreement between the health national authorities and coordination in healthcare planning and coverage.

In order to adequately respond to the needs of people living in cross-border regions, healthcare national authorities of the two Member States could also take a step further: cooperating with each other and planning together the organisation and delivery of healthcare, while taking into consideration the supply and demand of healthcare services in border regions. This should of course be done in consultation with the local authorities in those areas. Doing this could improve the efficiency, quality of services and, as a result, the well-being of citizens.

One of the experts interviewed also highlighted that the need to build a new system, with an integrated network of services, supported by the use of e-health and IT, is becoming more and more important. The use and diffusion of new technology in healthcare, however, depends on various factors. First, national and in particular local leaders need to understand the importance of this paradigm shift. Second, technical and structural support is needed, like broad band internet connections, secure connections and mobile networks. Third, healthcare staff have to be adequately trained to use these systems. Lastly, support and trust from patients and their families is essential. However, resources are needed to put these changes in place, while at the same time continuing to deliver healthcare on a daily basis⁵¹.

The role of the EU is essential in proving examples of solutions enabling the use and spread of new technologies and in supplying funding for these purposes. Difficulties and lack of resources were highlighted in particular for the broad-scale implementation of existing technologies.

Also, in this context, the role of cooperation as a means of avoiding duplication of services and increasing efficiency will acquire increasing importance in the future.

With regards to the lessons that could be derived from this case study, a crucial aspect appears to be the bottom-up approach. The organisations and the staff involved in the process of pushing for increased cooperation were perfectly aware of the obstacles and necessary improvements in their day-to-day work. This factor, together with a certain degree autonomy to conclude agreements and the support from local authorities, seem to be key to the success of the cooperation in the region.

The issues highlighted, and the solutions suggested can certainly be applied to other regions, characterised by similar challenges and by a comparable division of competencies in the organisation and delivery of healthcare.

⁵¹ These considerations were made on the basis of the topics discussed with the experts interviewed from the region.

List of references

- Brodin, A. (2016), Cross-border Healthcare in Torne Valley, Council of Norrbotten, 19 January 2016, <http://www.docfoc.com/cross-border-healthcare-in-torne-valley-swedenfinland-anna-greta-brodin-county-manager-primary-healthcare-north-county-council-of-norrbotten-anna-gretabrodinllse> (accessed in November 2016)
- Costigliola, V. (2011), Mobility of medical doctors in cross-border healthcare, *The EPMA Journal*, December 2011, 2(4): 333–339, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405407/> (accessed in November 2016)
- Cross-border Healthcare II – Tornedalen, Project report, Norden, Interreg Nord IV A Nord, Lansstyrelsen Norrbotten, Lapin Laani, The North Calotte Council, Norbottens Lans Landsting (contacts: Elisabeth.eero@nll.se; tapani.risku@pello.fi);
- European Commission (2016), Internal Market Information System Statistics, July 2016, http://ec.europa.eu/internal_market/scoreboard/performance_by_governance_tool/internal_market_information_system/index_en.htm (accessed in November 2016)
- European Commission (2016), Free Movement of professionals: Recognition of professional qualifications in practice, 2nd November 2016, http://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition/index_en.htm (accessed in November 2016)
- European Commission (2015), Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM (2015) 421 final, 4 September 2015, http://ec.europa.eu/health/cross_border_care/docs/2015_operation_report_dir201124_eu_en.pdf (accessed in November 2016)
- European Commission Expert Panel on effective ways of investing in health (2015), Request for an expert opinion: Cross-border cooperation, July 2015, https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/cross_border_cooperation_en.pdf (accessed in November 2016)
- European Observatory on Health Systems and Policy (2011), Cross-border Health Care in the European Union: mapping and analysing practices and policies, 2011, http://www.euro.who.int/__data/assets/pdf_file/0004/135994/e94875.pdf?ua=1 (accessed in November 2016)
- Flash Eurobarometer (2007), Cross-border health services in the EU: Analytical report, June 2007, http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (accessed in November 2016)
- Footman, K. et al (2014), Policy Summary 14: Cross-border healthcare in Europe, 2014, http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1 (accessed in November 2016)
- Hem, K. et al (2011), Patient mobility in the Nordic Countries: Volume and obstacles, June 2011, http://www.nordicinnovation.org/Global/_Publications/Reports/2011/2011_patientMobility_report.pdf (accessed in November 2016)
- JOB Reklambyrå in cooperation with the Haparanda and Tornio towns (2008), Haparanda and Tornio welcome brochure, 2008, <http://www.haparanda.se/download/18.4c3d66cd13b6ad043ec1c/1354709136433/Welcome.pdf> (accessed in November 2016)
- Johnsen, I. et al (2014), Local and regional approaches to demographic change in the Nordic countries, 2014, <https://www.diva-portal.org/smash/get/diva2:843811/FULLTEXT01.pdf> (accessed in November 2016)

Case Study 1

Kostera, T. (2013) Toward European Integration II: EU cross-border health care in practice, 15 August 2013 http://www.alpbach.org/wp-content/uploads/2013/08/Forum2013_Kostera1.pdf (accessed in November 2016)

Mahncke, H. et al (2009), Nordic collaboration in health services: a feasibility study on the potentials and barriers towards an open market for health services in the Nordic Countries, February 2009, http://www.oxfordresearch.eu/media/55292/08022_nordic_collaboration_in_health_services_full_report.pdf (accessed in November 2016)

MKW Wirtschaftsforschung GmbH, Munich Empirica Kft. (2009), Scientific Report on the Mobility of Cross-Border Workers within the EU-27/EEA/EFTA Countries - Final Report, January 2009, ec.europa.eu/social/BlobServlet?docId=3459&langId=en (accessed in November 2016)

Nordic Convention on Social Assistance and Social Services, 14 June 1994, Arendal, Norge, <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/social-and-health-care/nordic-convention-on-social-assistance-and-social-services> (accessed in December 2016)

Nordic Cooperation, About the co-operation: The Helsinki Treat, <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/basic-agreement/the-helsinki-treaty> (accessed in November 2016)

Northern Research Forum Open Meeting (2006), Tornio-Haparanda – a Unique Result of City Twinning, October 2006, <http://www.rha.is/static/files/NRF/OpenAssemblies/Oulu2006/haparandatornio-presentation.pdf> (accessed in November 2016)

Official Journal of the European Union (2011), 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, 4 April 2011, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF> (accessed in November 2016)

Official Journal of the European Union (2009), Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:284:0001:0042:en:PDF>

Official Journal of the European Union (2005), Directive 2005/36/EC of 7 September 2005 on the recognition of professional qualifications (consolidated version), January 2014, <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:02005L0036-20140117&from=EN> (accessed in November 2016)

Official Journal of the European Union (2004), Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, April 2004, <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A02004R0883-20140101> (accessed in November 2016)

Special Eurobarometer 425 (2015), Patients' rights in cross-border healthcare in the European Union: Summary, May 2015, http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_sum_en.pdf (accessed in November 2016)

Transfrontier Operational Mission (2015), Preparation of the Luxembourgish Presidency of the EU Council: Cross border cooperation: obstacles to overcome, 19 May 2015, http://www.espacestransfrontaliers.org/fileadmin/user_upload/documents/Documents_MOT/Etudes_Publications_MOT/Obstacles_to_CBC_LU_EU_presidency.pdf (accessed in November 2016)

Case Study 1

Vuorenkoski Lauri (2008), Health Systems in Transition Finland Health system review, Vol. 10 No. 4 2008, p. XVII, European Observatory on Health Systems and Policies, http://www.euro.who.int/__data/assets/pdf_file/0007/80692/E91937.pdf

List of consultees

- Interviewees from the European Commission Directorate General for Health and Food Safety, European Commission, face to face interview, 10 May 2016;
- Elisabeth Eero, Director, Övertorneå Health Centre, County of Norrbotten Sweden, telephone interview, 4 May 2016;
- Ulla Isaksson, Operation strategist, Norrbotten County, Sweden, answered to questionnaire, 31 May 2016;
- Anna Greta Brodin, Project Leader, The Swedish Agency for Participation, Sweden (previously working at the County of Norrbotten), telephone interview, 17 May 2016;
- Agneta Granström, County Council Commissioner, County Council of Norrbotten, Sweden, telephone interview, 26 May 2016;
- Paula Mikkola, Secretary-general, Council of Pohjois-Kalotti, Finland, telephone interview, 5 September 2016;
- Eva Salomaa, Chief Physician, Lapland Healthcare district (until 2015), Finland, telephone interview, 6 September 2016;
- Juha Kursu, Chief Physician, Lansi-Pohja Healthcare district, Finland, answered questionnaire, 9 September 2016;

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Methodology

During the case study on April 29, 2016 an email with a request to recommend employees whose work is related to the reception / provision of healthcare services in the Finnish-Swedish border region, or who are expert on the topic was sent to:

- the National Institute for Health and Welfare , on April 29, 2016 (adam.adam@thl.fi; Lotta.Englund@stm.fi);
- Lotta Englund, Communications Officer, Ministry of Social Affairs and Health Finland, on May 11, 2016 (lotta.englund@stm.fi);
- Swedish Association of Local Authorities and Regions; on April 26, 2016 (Marcus.Holmberg@skl.se);
- Lisa Hagberg, from the Swedish eHealth Agency, on May 17, 2016 (lisa.hagberg@ehalsomyndigheten.se);
- Martha Bahta, North Sweden EU-office; on April 28, 2016 (martha.bahta@northsweden.eu);
- Merja Halonen, Social Service / Health Care, City of Tornio; on May 12, 2016; (merja.halonen@tornio.fi);
- Dorota Witoldson, European Commission Directorate-General for Regional and Urban Policy, on May 13, 2016 (Dorota.Witoldson@ec.europa.eu);
- Jari Jokela, Director, Lapland Hospital District, on May 11, 2016 (jari.jokela@lshp.fi; tel. +358405323998);
- Jukka Mattila, Medical Director, Lapland Hospital District, on May 11, 2016 (jukka.mattila@lshp.fi, tel. +358505726277);

Among the contacts provided, the following people were available for an interview or provided information in writing:

- Elisabeth Eero, Director, Övertorneå Health Centre, County of Norrbotten Sweden, and Project Director of the 'Cross-border Healthcare II - Tornedalen' project; telephone interview, held on 4 May 2016 (Elisabeth.eero@nll.se; mobile tel.: +46 (0)70 560 8112);
- Representatives from the European Commission Directorate General for Health and Food Safety, European Commission; a face to face interview was carried out (with two representatives, during the same interview – who wished to remain anonymous) on 10 May 2016;
- Anna Greta Brodin, Project Leader, The Swedish Agency for Participation, Sweden (previously working at the County of Norrbotten; a telephone interview was carried out on 16 May 2016 (Anna-Greta.Brodin@mfd.se; tel. +46 86008414);
- Agneta Granström, County Council Commissioner, County Council of Norrbotten, Sweden; a telephone interview was carried out on May 26, 2016 (Agneta.Granstrom@nll.se; tel. +46(0)703055258);
- Ulla Isaksson, Operation strategist, Norrbotten County, Sweden; she answered to our questionnaire via email, on May 31, 2016 (Ulla.M.Isaksson@nll.se);
- Paula Mikkola, Secretary-general, Council of Pohjois-Kalotti, Finland, telephone interview, on 5 September 2016;
- Eva Salomaa, Chief Physician, Lapland Healthcare district (until 2015), Finland, telephone interview, on 6 September 2016;

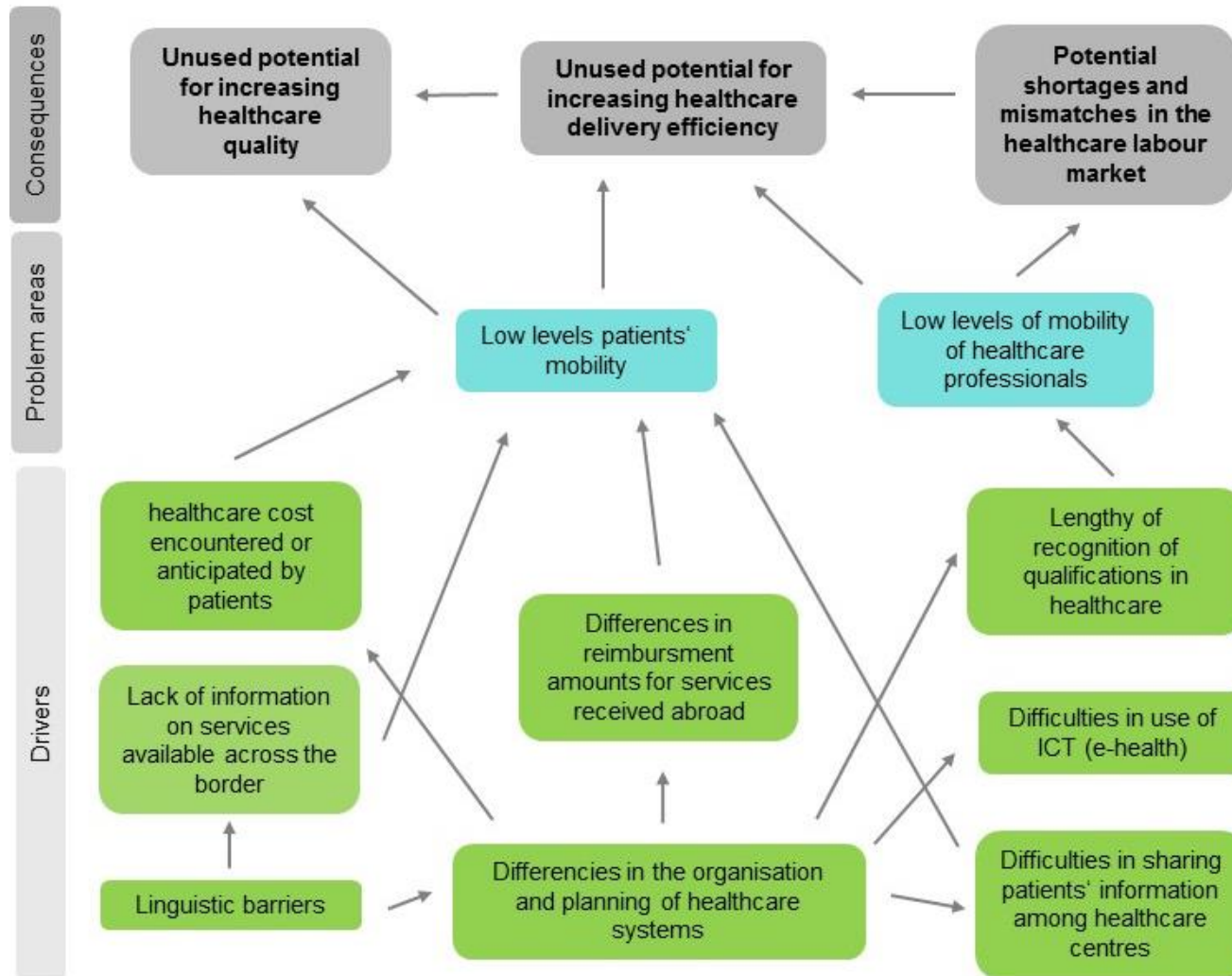
Case Study 1

- Juha Kursu, Chief Physician, Lansi-Pohja Healthcare district, Finland, answered questionnaire, on 9 September 2016;

Telephone conversations took place in a structured way, by asking questions to identify the legal and administrative obstacles to cross-border health care in the in the Finnish-Swedish border region.

Annex 2

Figure 3. Problem tree



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