The Healthacross Initiative: How Lower Austria is Boosting Cross-border Collaboration in Health

World Health Organization

REGIONAL OFFICE FOR Europe

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Abstract

Cross-border collaboration in the field of health care can involve a transfer, movement or exchange of individuals, services or resources. It can comprise the sharing of health services, providers and expertise, as well as the provision of disease prevention, health promotion, curative and rehabilitative health services. This report tells the story of the cross-border collaboration in the field of health between Lower Austria and Czechia, and the beginning of collaboration with Slovakia. It focuses on the gradual provision of outpatient care and the exchange of medical expertise taking place in three border regions; documents the first large-scale effort to develop cross-border cooperation on health care between a long-standing and new European Union Member States; and provides information on how and why cross-border care started, mechanisms used to put it in place, key stakeholders and the lessons learned, including challenges and enabling factors.

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Foreword

Where people live and the accessibility of good-quality and affordable preventive and treatment services are important determinants of health and wellbeing. For people living and working near a national border, the nearest essential health services may be in a neighbouring country. The WHO Regional Office for Europe is committed to working with Member States, partners and academia to improve health for all and to ensure that, for example, national boundaries do not limit universal access to health care for all.

This report, showcasing the experience of Lower Austria, describes the first large-scale effort to develop cross-border cooperation on health care between two neighbouring states in the WHO European Region, where health care across borders is a reality, even if it takes work to achieve. Austria's experience demonstrates an important trend in new collaborative forms of health governance between countries. The benefits of cross-border cooperation include having accessible services in place that protect and promote population health and improve clinical knowledge and practice through the cross-fertilization of expertise.

The report includes examples of cross-border cooperation from other European countries, including that of the Meuse-Rhine Euregion, which has made great strides in supporting cross-border collaboration in many areas, such as health, and including health promotion and disease prevention.

The search for innovative solutions to improve health with existing resources continues to dominate the policy context. This report provides policy-makers with practice-based evidence and concrete know-how on what works, that they can use to ensure better lives and health for all. In this spirit, I am sure this publication will inspire and foster dialogue on public health in other cross-border regions, ultimately helping to improve the health of all in the WHO European Region.

Chris Brown
Head, WHO European Office for Investment for Health and Development,
WHO Regional Office for Europe

Foreword: patients' rights in cross-border health care

This publication gives the reader an excellent outline of cross-border health care on the border of Austria and Czechia.

Establishing cross-border health care in the European Union was a difficult challenge. Health care and social security were domains of each Member State. Since 1998, however, the European Court of Justice has held that the European treaty provisions on the freedom to provide services also include the freedom for patients to go to another Member State to receive health care services there. This innovative case law caught Member States unprepared, and they finally agreed on European Directive 2011/24/EU of 9 March 2011, which provided the legal framework for cross-border health care. The Directive regulates the reimbursement of costs of cross-border health care, the system of prior authorization and administrative procedures for cross-border health care.

Cooperation between Member States regarding mutual assistance, European reference networks, e-health and health technology assessment were further goals to achieve. Member States were to transpose the Directive into national law by 25 October 2013. In its report of 4 September 2015 on the operation of the Directive, the European Commission announced the launch of infringement proceedings against 26 Member States on the grounds of late or incomplete implementation of such measures. Since then, all Member States have transposed the Directive.

Even if the financial impact of cross-border health care represents only 0.5% of the costs of public health care costs in Member States, patient mobility seems to frighten politicians. Obstacles to patient mobility remain, related to reimbursement and prior authorization. In addition, many patients are still not aware of their rights in relation to the Directive.

As a result, efficient national contact points need to be installed, as required by the Directive, and fulfil the Commission's requirement that they be gateways to health care, not gatekeepers blocking access. Websites are not sufficient. Above all, patients' organizations need to provide their members, the patients, with much information on their rights, so that using cross-border health care

when needed soon becomes the instinctive reflex of every European patient.

Nicolas Decker
Member of the Board, European Patients Empowerment for Customised Solutions

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Abbreviations

DKMT	Danube–Criș–Mureș–Tisa Euroregion
ECDC	European Centre for Disease Prevention and Control
EMR	Meuse-Rhine Euregion
EU	European Union
EUREGHA	European Regional and Local Health Authorities
GPs	general practitioners
INTERREG IV	European Territorial Cooperation programme period IV (2007–2013)
INTERREG V	European Territorial Cooperation programme period V (2014–2020)
MRSA	methicillin-resistant *Staphylococcus aureus*
NGOs	nongovernmental organizations
NUTS-2	Nomenclature of Territorial Units for Statistics level 2 (regions)
SDG	Sustainable Development Goal
UHC	universal health coverage

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Executive summary

Cross-border collaboration in the field of health care can involve a transfer, movement or exchange of individuals, services or resources. It can comprise the sharing of health services, providers and expertise, as well as the provision of disease prevention, health promotion, curative and rehabilitative health services.

This report tells the story of cross-border collaboration in the field of health between Lower Austria and Czechia. It focuses on the gradual provision of outpatient care and the exchange of medical expertise taking place in three border regions; documents the first large-scale effort to develop cross-border cooperation on health care between long-standing and new European Union (EU) Member States; and provides information on how and why cross-border care started, what mechanisms were used to put it in place, who were the key stakeholders and what lessons were learned, including challenges and enabling factors. Other cross-border collaboration projects are briefly described and examples from other regions in the WHO European Region are shared to show the array of possibilities available for cross-border collaboration in the field of health care.

Eight key messages can be extracted from the experience of Lower Austria that could be helpful to other regions trying to carry out something similar.

1. **Identify champions or mentors that can help early on.** Securing political support early on from local authorities and, if necessary, national authorities, is important. In Lower Austria, local political support was key to overcoming many obstacles.

2. **Choose strategic ways of working**. People starting cross-border collaboration for health should find a strategic entry point. For Lower Austria, this was its involvement in a project on e-health; this gave Austrian politicians the opportunity to visit the Meuse-Rhine Euregion, which motivated to do something similar.

   Lower Austria also used the opportunity of a 2007 health conference for networking. It is also valuable to identify one or two brother or sister

regions that can support the implementation phase of cross-border health collaboration.

If feasible, a team of people should be organized to manage collaborative projects. The Healthacross projects described below benefit from funding from the EU, so the projects could cover staff time. This leaves key implementing stakeholders free to do their part.

3. **Time is key: allot sufficient start-up time to begin and carry out cross-border health collaboration**. Those starting cross-border cooperation should allot enough time to build the team and enable members to come to know each other. Time is also needed to complete every project component, as sometimes things move slowly, as can be seen in the process for enabling ambulances to cross borders in the Healthacross initiative. Projects are often perceived as moving too slowly, and many only last a few years. It should be clear that everything cannot be resolved at the beginning of the project.

4. **Involve stakeholders early on and continuously, and keep communication transparent**. Projects should maintain constant communication with stakeholders, which helps maintain the motivation of staff and keeps them from feeling threatened by the change in their way of working that result from cross-border collaboration on health. Communication is also needed to keep the local population informed about the project and it processes. Involving different people early on, to get stakeholder buy-in, is also important. It is critical that the population to be served gains trust in service providers. In the case of Lower Austria, 99% of the Czech people served reported being satisfied with care provided by the Austrian health system and hospital.

5. **Actively scope out the local population's needs**. Before starting the project, the people it would affect, in both Austria and Czechia, were asked what they thought about the idea; without their support, cross-border health in Lower Austria would never have worked. Project teams need to understand whether the local population really wants to have the proposed arrangement and/or structure. Thus, projects need to win the acceptance of the populations that they are intended to serve.

6. **Ensure that cross-border health collaboration considers equity and reduces inequities**. It is important to understand the barriers to accessing care, which might be language or cultural issues, or lack of transportation or services relevant to the local population. Incentives should be created to help reduce inequities in the quality of care in the area to be served. In the case of Lower Austria, an incentive was developed to help keep doctors working in the region.

7. **Pilot-test strategically**. Projects need a pilot phase to test their quality and get a preview of the plan's scalability; expansion can always happen later. The evaluation and collection of feedback from the pilot phase can help inform the implementation phase and save a lot of time and money.

8. **Make a plan to ensure the sustainability of the initiative**. This includes establishing a shared long-term vision with the staff and other stakeholders, so they see where the initiative will be in 10–20 years. It could be beneficial to have one macro objective or vision (such as a common health care centre) and to make sure that all the people working towards it know the importance of their contributions.

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1. Why this publication?

1.1 Introduction

Cross-border cooperation is a key element of the EU policy towards its neighbours. This collaboration supports sustainable development along the EU's external borders, helps reduce differences in living standards and addresses common challenges across these borders. It also promotes cooperation between EU countries and neighbouring countries sharing a land border or sea crossing *(1)*. Cross-border cooperation is broad and takes place for a number of reasons, including:

- promoting economic and social development in border areas;
- addressing common challenges related to, for example, the environment, public health, safety and security; and
- putting in place better conditions for the mobility of people, goods and capital.

Cross-border collaboration in the field of health care can involve a transfer, movement or exchange of individuals, services or resources. It can comprise the sharing of health services, providers and expertise, as well as the provision preventive, promotive, curative and rehabilitative health services *(2)*.

This case story focuses on:

- Lower Austria's cross-border collaboration for health with Czechia and the beginning of collaboration with Slovakia;
- the gradual provision of outpatient care and the exchange of medical expertise in three border regions; and
- the first large-scale effort to develop cross-border health care cooperation between a longstanding and a new EU Member State.

It provides information on how and why cross-border care started, mechanisms used to put it in place, key stakeholders and the lessons learned, including challenges and enabling factors. Other projects for cross-border collaboration

are briefly described. Finally, this publication shares examples in other parts of the WHO European Region to show the array of possibilities for cross-border collaboration on health care.

1.2 Why cross borders for health?

Patients cross borders for many reasons, ranging from long waiting lists and lack of specialization in the home country to the cost and proximity of a neighbouring facility in another country. Health care providers may cross borders to share their skills, to engage in training or to carry out bilateral agreements with another country's border region. Services such as diagnostics and advice can also cross borders using either physical means (transport of laboratory specimens) or technology (e-health) *(2)*.

Various factors determine whether cross-border care could work. A country's geography, size, type of borders (geographical, legislative) and socioeconomic factors can influence whether and what kind of cross-border collaboration takes place. A country can have rigid borders – characterized by geographical and natural features, or complex administrative procedures and language or cultural issues – which make collaboration a challenge. In addition, political, administrative and legal structures can facilitate or hinder cross-border collaboration in the field of health. Fluid borders, on the other hand, make collaboration physically and geographically effortless, since administrative and cultural barriers are not present and the border area is not seen as a foreign territory. Political will at the national, regional and municipal levels can be instrumental in the smooth functioning of projects in border regions, as it is needed to overcome practical hurdles *(2)*.

1.3 Cross-border collaboration and health inequities

People residing in border regions can experience inequities due to their geographical location and an array of social determinants of health that might restrict their access to available care. For example, services in a wide array of medical specialties may be limited for people living in rural or isolated areas, due to the younger generation of health workers moving to city centres. When cross-border collaboration in the field of health is

available, inequities in accessing health care in another country might still arise from socioeconomic factors, education or health status, or sickness-fund coverage, which affect people's health-seeking choices. For example, people from higher socioeconomic groups may have better sickness-fund coverage or supplemental health insurance, which facilitates their movement across borders. They might be more likely to be able to afford travel and accommodation costs, and to miss work without putting their employment at risk. Second, socioeconomic and educational status can also determine whether individuals are able to self-manage their care abroad and communicate with health providers in the other country. Third, having complex health problems can also create inequities in access to health care abroad. Individuals with such problems might be excluded or discouraged from accessing health care in another country if they are deemed unfit to travel, or need long-term care or follow-up by a multidisciplinary team *(2)*.

If mechanisms can be put in place to address barriers to access to health care abroad, cross-border collaboration in the field of health can reduce inequities among the population living in border areas *(3)*. A first step can be gaining a realistic picture of the effectiveness of mechanisms for health facility planning in countries that are meant to counteract any inequitable distribution of health care providers. Inequities can also be reduced by addressing the so-called pro-rich inequity (the fact that richer people have a wider access to specialists through cross-border collaboration) by facilitating equal access for populations living in border regions. This is especially relevant in countries where private specialists are an option *(2)*.

1.4 Making the legal case for cross-border collaboration in health

Cross-border collaboration in the field of health has been under discussion since the 1970s, when the European Economic Community acknowledged that the free movement of people should also include those who moved in search of alternatives in health care. A 1971 Council Regulation put mechanisms in place to allow people to have planned treatment in another Member State with prior authorization from the originating health insurance institution *(4)*. A subsequent treaty on the free movement of goods and services explicitly stated that health care is an economic activity in and of itself, and should not be limited by prior authorization procedures *(2)* (Box 1).

Box 1. Kohll and Decker: making the case for cross-border collaboration in the field of health

Mr Kohll and Mr Decker, Luxembourg nationals, were the first people to contest refusals for reimbursement by their sickness fund for cross-border care sought abroad. Mr Decker requested reimbursement for glasses (considered goods) purchased in Belgium with a prescription from a Luxembourg ophthalmologist. Mr Kohll sought dental treatment (considered services) for a family member in Germany. Neither had obtained authorization from his home country before seeking both goods and services abroad, as required at the time. Reviewing these cases in 1998, the European Court of Justice affirmed that national social security schemes should respect the fundamental principles of free movement of goods and services and that requiring prior authorization was a hindrance to those freedoms. In fact, the Court found that hindering this access to care could only be justified if it was deemed necessary to maintain a balanced medical and hospital service accessible to all, treatment capacity or medical competence on national territory essential for public health or for preserving the financial balance of the social security system. The Court ruled that the two cases were in no way a threat to the financial balance or the quality of the health services in the home country.

These landmark cases set the stage for further understanding of the implications of seeking care in another country and many other cases followed these precedents.

Source: Wismar, Palm, Figueras, Ernst & van Ginneken *(2)*.

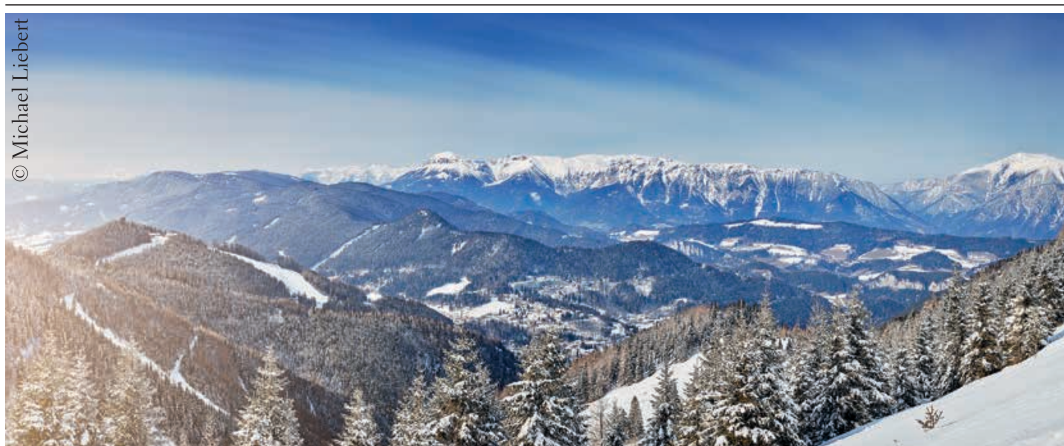
EU Regulation 883/04 on the coordination of social security systems was published in April 2004, and provided a further interpretation of the free movement of persons *(5)*. The Regulation formed the basis for receiving health care abroad and more specifically for its reimbursement, which became one of its main components. In 2011, the European Parliament and Council adopted the Directive on patients' rights in cross-border healthcare, which aimed to provide a clear legal framework and clarify ambiguities with regard to provision of cross-border health care *(6)*. The Directive aimed to promote citizens' rights and clarify entitlements. It reaffirmed that EU citizens can receive reimbursable care in another EU country, as long as the type of treatment and costs involved would be covered in the home country. It also clarified that care, excluding hospital care, did not require prior authorization and called for improving the availability of information by setting up national contact points. Finally, it made mutual recognition of prescriptions written abroad obligatory.

1.5 Relevant international policy frameworks

In addition to legal mechanisms, a number of international frameworks indirectly support cross-border collaboration in the field of health. This section uses a cross-border lens to show which parts of each framework advocate in support of such collaboration.

1.5.1 The Declaration of Alma-Ata

The 1978 Declaration of Alma-Ata provides an overarching framework for primary health care *(7)*. A number of its articles have indirect links to cross-border collaboration in the field of health care; for example, Article V states that: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures". Cross-border collaboration also fulfils the Declaration's calls for "bringing health care as close as possible to where people live and work (Article VI)" and "maximum community … participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources" (Article VII). A renewed commitment to the values and principles of the Declaration of Alma-Ata resulted in a new declaration, adopted at the Second International Conference on Primary Health Care: towards Universal Health Coverage and the Sustainable Development Goals, held in late October 2018 *(8)*. The commitment and approach are further supported by the Ottawa Charter for Health Promotion *(9)* and the WHO European health policy and strategy described below.



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1.5.2 The Ottawa Charter for Health Promotion

The Ottawa Charter *(9)* offers indirect opportunities for cross-border collaboration on both curative and preventive measures such as health promotion. It states that *(9)*:

> *The prerequisites and prospects for health cannot be ensured by the health sector alone. … Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.*
>
> …………………..
>
> *Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health.*
>
> …………………..
>
> *The participants in this Conference pledge: … to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies.*

The Charter's statement, that "The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services", is also relevant to cross-border collaboration in health *(9)*.

1.5.3 Health 2020

Priority area 3 of the WHO European policy framework and strategy, Health 2020, calls for "strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response" *(10)*; this speaks directly to cross-border collaboration in the field of health. It specifies the need to collaborate not only on curative care but also on preparing for public health emergencies and controlling infectious disease. It acknowledges that *(10)*:

> *Health care has become more complex, with rapidly advancing technological progress, ageing populations, more informed service users and increasing cross-border movement. Health system responses to these changing trends require innovative solutions focused on the end-users (both healthy and less healthy people) that are systematically informed by sound evidence and are as resilient to economic cycles as possible.*

With regard to the provision of public health services, it calls for "cooperation on global health and health challenges of a cross-border nature …" *(10)*.

1.5.4 Sustainable Development Goals

Sustainable Development Goal (SDG) 3 focuses on ensuring healthy lives and promoting well-being for all at all ages. SDG target 3.8 aims to *(11)*: "Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". Further, target 3.8.1 calls for coverage of essential health services among the general population, as well as the most disadvantaged people. SDG target 9.1 calls for cross-border collaboration in a number of fields, including human well-being and equity, aiming for the development of *(11)*:

> *… quality, reliable, sustainable and resilient infrastructure, including regional and cross border infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all. Develop quality, reliable, sustainable and resilient infrastructure, including regional and cross border infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all.*

1.5.5 WHO's Thirteenth General Programme of Work

WHO's Thirteenth General Programme of Work (2019–2023), linked to the SDGs, calls for the removal of inequities to accessing health care and pledges the Organization to take action to achieve this. Two points are particularly relevant to cross-border collaboration in health *(12)*. The section on overarching goals, linked to SDG 3, calls for a focus on promoting health rather than merely fighting disease, and especially on improving health among vulnerable populations and reducing inequities. By doing so, WHO aims to give everyone in all social groups the opportunity to live not just long but also healthy lives. It also acknowledges that responding to social, environmental and economic determinants of health calls for multisectoral approaches and is anchored in a human rights perspective. Multisectoral action is central to the SDG agenda because of the range of determinants acting upon people's health, such as socioeconomic status, gender and other social determinants *(12)*.

The section on service access and quality *(12)* states that:

> *The main challenge to making progress towards [universal health coverage (UHC)] comes from persistent barriers to accessing health services. These barriers can be economic (as a consequence of out-of-pocket expenditures and insufficient public financing), geographic (where services are simply not available for the population, or not within reach), epidemiological (the service package does not meet the health needs of the population) or cultural (the services or the workforce providing them do not have the necessary cultural sensitivity for effective delivery or utilization). Equity of access is central to UHC, and by making the initial political choice countries are in fact committing to progressively break down these barriers and expand access to comprehensive services in order to meet the needs of the population. The WHO Secretariat will work with countries to identify these barriers to access health services and provide evidence-based solutions to support progressive expansion in access, while ensuring the highest possible quality, including patient safety.*

Border regions need cross-border collaboration to support citizens with not only clinical and curative services but also services for health promotion and disease prevention. Combining cross-border collaboration with health promotion and disease prevention, however, is even more challenging. In this case, while citizens are not crossing borders for health care services, they are immediately affected by the rules and regulations related to health promotion and disease prevention in neighbouring countries. For this reason, the above-mentioned frameworks also support cross-border collaboration in this field by promoting the following: providing services close to home, making the fullest use of available local resources and sharing health information.

2. About Lower Austria

2.1 General information

Lower Austria is often described as the province around Vienna because, from a geographical point of view, Vienna, which is both Austria's capital and a separate federal province, is located in the centre of Lower Austria, a situation similar to that of Berlin and Brandenburg in Germany. St Pölten has been Lower Austria's provincial capital since 1986 and the regional parliament, government and administration, followed by other important institutions, were transferred there in 1997.

Fig. 1. Map of Lower Austria

Source: NÖGUS *(13)*.

Lower Austria has the largest area and the second largest population (after Vienna) of the nine federal provinces in Austria. Lower Austria is bordered by Czechia to the north, Slovakia to the east (where the river system of Thaya

and March marks the frontier) and the Austrian provinces of Styria to the south (where the foothills of the eastern Alps form a natural boundary) and Burgenland to the south-east, where the province also has a share in the Pannonian basin, which stretched 4 km away into Hungary *(13)*.

The Danube River plays a very prominent role in both topographical and historical terms. Once the northern boundary of the Roman Empire, it is the lifeline of the region and divides Lower Austria into northern and southern parts: the *Wald*- and *Weinviertel* and the *Most*- and *Industrieviertel*, respectively. The Danube remains of great importance as a transport artery, remains critical today as it forms part of the Rhine–Main–Danube canal, linking the Atlantic Ocean to the Black Sea.

Lower Austria is not only the historical heart of Austria, with countless points of cultural interest, but also important from the economic point of view, because it generates the bulk of Austria's agricultural products and has a highly developed industrial sector. In addition, the region has major sources of raw materials, as well as extensive leisure facilities that draw tourists year after year.

The name Lower Austria refers to the position of the province in relation to the Enns river, whose lower course forms the boundary between the provinces of Upper and Lower Austria. The name Lower Austria refers to the land below the Enns, as opposed to the region above it *(13)*. Table 1 give a snapshot of Lower Austria.

Table 1. Lower Austria – a snapshot

Characteristic	Content
Position	North-eastern Austria (the province around Vienna)
Area (km^2)	19 174
Population (million)	1.62
Citizenship (%)	
Austrians	92.83
Other EU citizens	3.17
Non-EU citizens	4.00
Capital	St Pölten (52 000 inhabitants)
Administrative districts	25

Table 1. (contd)

Characteristic	Content
Municipalities	573
Major rivers	Danube, Enns, March, Thaya, Traisen, Ybbs
Highest elevation	Schneeberg (2 076 m)
Lowest point	Municipality of Berg in the Bruck/Leitha district (129 m)
Length of boundaries (km)	414 (333 with Czechia and 81 with Slovakia)

Source: NÖGUS *(13)*.

2.2 The Austrian health system

Austria is a democratic republic and a federal state composed of nine provinces. The main actors in health at the federal level are the Austrian Parliament (which consists of the National Council and the Federal Council), the Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, social security institutions and advocacy groups (social partners: representatives of employers, employees and professional associations). While the Federal Government plays a central role in making and enforcing legislation, many competencies are delegated to the provinces or social security institutions. Federal, provincial and local authorities jointly provide public health services and administration, and the provinces are in charge of ensuring hospital care for their inhabitants and offering health promotion and prevention services. The local governments are in charge of social welfare benefits and services *(13,14)*.

Health care in Austria traditionally emphasizes hospital care, with inpatient health care predominantly provided by public hospitals and those owned by private non-profit-making organizations, social insurance institutions and private profit-making entities. Since January 2008, all 27 hospitals in Lower Austria have been part of the NÖ *Landeskliniken-Holding* (Lower Austrian Hospital Holding). Lower Austria is the only Austrian province in which all hospitals are legal entities of the federal state itself.

Self-employed physicians working in individual practices predominantly provide outpatient health care in Austria; about half of them have signed contracts with the social health insurance scheme. In addition, patients

have direct access to outpatient clinics, which are run by both the social health insurance scheme and private individuals. Hospital outpatient departments also provide outpatient health care, even if this is financially and organizationally considered part of the inpatient sector *(14,15)*.

The Austrian health system is financed by contributions to social insurance and taxation (75%) and private sources (25% – from user charges and direct payments, private health insurance, non-profit-making organizations) *(15)*. Lower Austria is responsible for the provision of health care and social services. While the provinces are responsible for the public health service in Austria, they delegate most tasks to district or local administrative authorities *(14)*.

3. The Healthacross initiative

All Lower Austria's projects on cross-border collaboration in the field of health are carried out under the umbrella of the Healthacross initiative, which aims to make health without borders a given for all in the near future. The initiative's cross-border projects bring regional and supraregional health care interests together in a single international network for cooperation and the exchange of information. This has been achieved particularly by initiating and implementing innovative, cross-border and international projects in the health care sector that are in line with the Lower Austrian state strategy, which is a common agreement between the governors of Lower Austria and neighbouring regions in Czechia and Slovakia. The following section provides a narrative description of cross-border collaboration between the regions. Fig. 2 provides an overview of the milestones in the initiative since its start.

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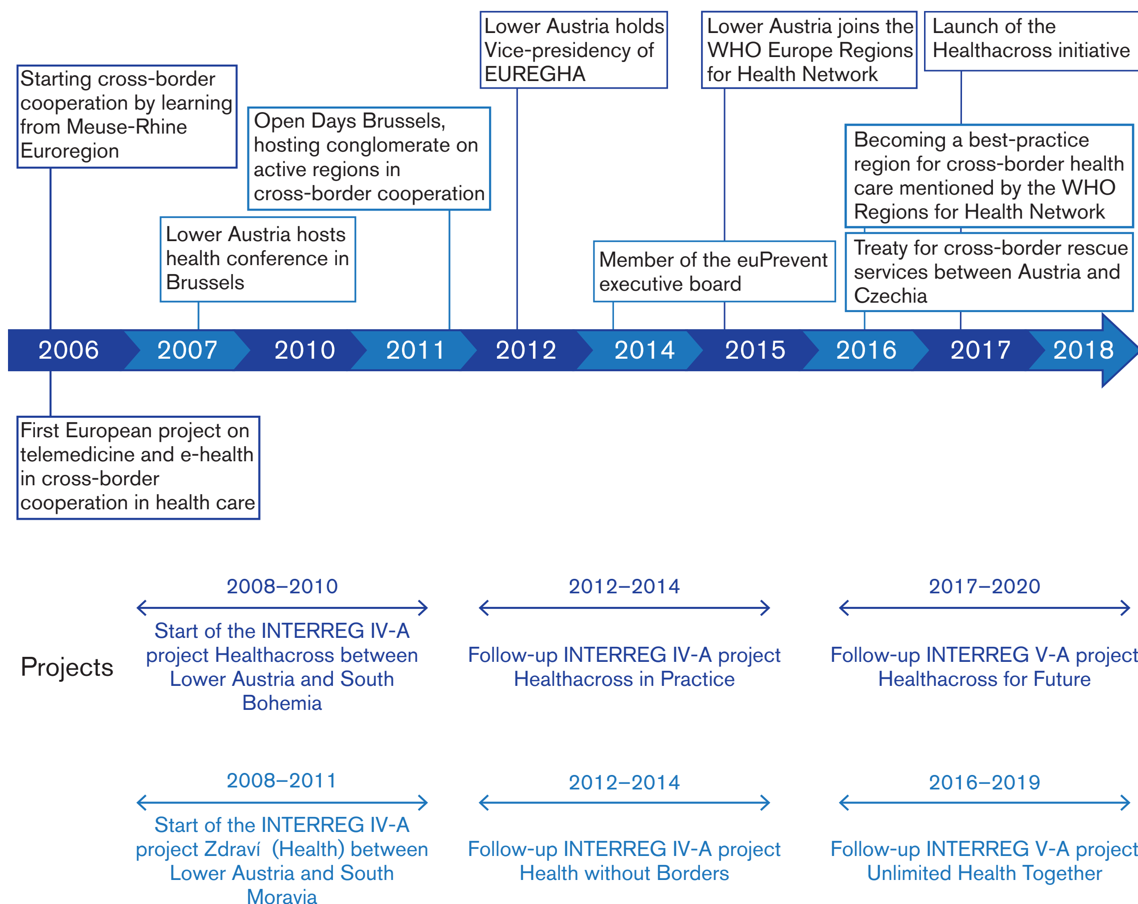
Fig. 2. Networks and milestones in the Healthacross initiative's work for cross-border collaboration in health



Note. EUREGHA means European Regional and Local Health Authorities, INTERREG IV means European Territorial Cooperation programme period IV (2007–2013), and INTERREG V means European Territorial Cooperation programme period V (2014–2020).

3.1 The rationale for cross-border collaboration by Lower Austria

Cross-border collaboration is taking place between Lower Austria and the regions South Moravia and Vysočina in Czechia. This section describes the reasons for Lower Austria's cross-border collaboration in the field of health and the three kinds collaboration taking place with Czechia in two sets of projects. Some of the project descriptions below are more complete than others because

their work is farther advanced or completed, and so more results can be reported. Section 5, on key steps, gives further details on projects' key components, and serves as guidance on mechanisms that made the collaboration work and elements that could be transferred to other settings.

One of the main reasons that Lower Austria embarked on cross-border collaboration in the field of health was to guarantee that border communities had better and equitable access to health services with reduced travelling distances. This was found to be especially important for emergency health care, including neonatal emergencies, where time can be critical. Building partnerships between hospitals and opportunities to exchange expertise and medical capacity in specialty areas were other important factors. Such arrangements helped to optimize the provision and costs of health care services through joint use of equipment and human resources.

3.2 Lower Austria and South Bohemia – the first collaboration across borders

The Healthacross project was the first cross-border collaboration in the field of health on which Lower Austria embarked. It took place in the Austrian town of Gmünd (population: 5500), which lies on the border with České Velenice (population: 3500), Czechia. Historically, the two comprised a single town, but they were divided after the First World War.

Today, Gmünd has a hospital with the capacity to care for 154 people in five specialty areas. The Healthacross project assessed the feasibility of allowing Czech citizens living in České Velenice to access the hospital in Gmünd. For people residing in České Velenice, Gmünd is five minutes away by car, but the nearest Czech hospital is 60 km away (35 minutes by car) and the closest Czech physician's service vehicle is 18 km away. Access to the Gmünd hospital would save time, which could save lives in emergencies.

Healthacross was the first large-scale project to develop cross-border health care collaboration in the field of health between a longstanding and a new EU Member State. Part of its early work involved an **analysis** of the Austrian and Czech health care systems, looking at service provision by the project partners, Lower Austria and South Bohemia. Box 2 gives a short description of Czechia's health system.

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Box 2. Czechia's health system

In Czechia, the Ministry of Health is responsible for setting the policy agenda for health care, supervising the health system and administering several health care facilities. The National Institute of Public Health, the State Institute for Drug Control and regional public health authorities report to the Ministry of Health.

The Czech health insurance system is based on universal coverage and a basic universal benefit package that provides benefits in kind for all insured people (paid for by a third party). Legislation stipulates universal accessibility of health by means of a specific law on public health insurance. The health system is financed primarily through mandatory, wage-based health insurance contributions administered by the health insurance funds, general taxation and out-of-pocket payments.

All Czech citizens and residents are obliged to become members of one of the seven health insurance funds. The country's health insurance funds are semipublic, selfgoverning bodies that both pay for and purchase health care while competing for insured individuals. Health insurance does not cover sick pay and other cash benefits, which are part of the social security system administered by the Ministry of Labour and Social Affairs and financed through separate contributions.

In Czechia, the public sector owns and directs a number of health care facilities and licenses and supervises service providers. Pharmacies and diagnostic laboratories, as well as almost 90% of outpatient facilities, are privately owned. Hospitals employ some outpatient specialists, who provide ambulatory care in polyclinics. Providers of emergency health care services are mostly publicly owned.

Source: Czech Republic. Health system review *(16)*.

Existing cross-border cooperation projects were reviewed to define areas in which the opportunities and challenges presented by such cooperation might be encountered in the project region. Lower Austria subsequently carried out a **feasibility study** to understand the practical and legal aspects that would need to be in place for successful collaboration, including needs and challenges, and to explore avenues for long-term cooperation across borders. Options for legal cooperation were also examined: first individual contracts and then the creation of a legal instrument to cover cross-border care. The first option was not feasible since, on the Czech side, agreements are only possible between Czech health insurance companies, and not foreign health service providers and health insurance companies *(17)*. For this reason, the formation was proposed of a European Grouping for Territorial Cooperation, to facilitate strategic long-term cooperation and provide a single entry point for the clarification of practical issues *(18)*.

From an economic point of view, the study considered using existing infrastructure or setting up a cross-border health centre. A modified option was chosen, involving the construction of a health centre at the border of the two countries, with the Austrian side offering inpatient services and the Czech side, a connection to an outpatient service that would provide premises for specialists and general practitioners' (GPs') practices. Finally, the study deemed it imperative to determine the centre's economic impact on the area. The historical link between Gmünd and České Velenice, as well as growing economic and cultural exchange and increasing tourism, were seen to be advantageous to cross-border collaboration *(17)*.

The Healthacross project also had a strong **networking** component that was necessary to engage partners in understanding what needed to be done. The project sought to have a health infrastructure that Austria could share with Czechia, so Austrian partners needed to get to know their Czech counterparts, as they would make the link with new clients of the Gmünd hospital.

While both sides thought that collaborating was a good idea, the partners had to resolve a number of **legal, customs-related and administrative issues**. One was the need for an emergency contract with Czechia to permit ambulances to cross the border to the Gmünd hospital. This contract took almost nine years to negotiate, but was successfully achieved in 2016 (see section 5), thanks to years of dialogue and the buy-in of national policy-makers, which helped them to understand the importance of crossing borders in emergencies.

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Questions also arose on how to charge for the provision of services in accounting terms (the costs gap) and how to conduct long-term, joint regional structural planning (for increased efficiency and cost savings). One particularly urgent topic in the EU context was how to make it financially viable to put in place health care services provided between Member States with very different levels of wages and costs. Box 3 describes the need for incentives to attract and keep doctors in border regions.

Box 3. Incentives to attract and maintain doctors in border regions

In assessing the need for specialties in the region, the Healthacross project addresses an important equity component: access to medical treatment and the availability of doctors.

Some parts of the border area between Austria and Czechia are rural and economically disadvantaged. Most medical treatment is offered in city centres, with fewer doctors in rural areas. On Czechia side, most doctors are elderly and their numbers are insufficient. Young Czech doctors tend to move to city centres in search of more opportunities.

This demographic challenge calls for incentives to keep young doctors and other health personnel, such as nurses, in border regions. Providing doctors with housing is one possibility; doctors who choose to work at the health centre are provided with housing free of charge and pay only for utilities.

3.3 Testing the waters – the Healthacross in Practice project

The follow-up project, Healthacross in Practice, was considered the pilot phase of the collaboration between Gmünd and České Velenice and ran for about two years (January 2012 through March 2014), with the actual pilot test running from 25 February to 31 May 2013. The project aimed to allow a limited number of Czech patients from the border region to have simple and uncomplicated access to medical treatment at the Gmünd hospital. During the pilot test, around 100 Czech patients received outpatient treatment in Austria. The pilot project was institutionalized and about 5000 Czech patients have now received outpatient treatment at the Gmünd hospital.

The pilot period focused on the practical implementation of cross-border health care provision and issues arising from the daily exchange of patients between Lower Austria and Czechia. Preparatory work ranged from coordination meetings between the project partners, the Gmünd hospital and GPs from the Czech public health insurance organization to establish the scope of services; services needed to be well balanced and meet project needs within financial limits. In addition, a comprehensive publicity campaign was planned to reach prospective Czech patients.

A key precondition for the pilot test was that the Czech patients would not be required to make a direct financial contribution; either their health insurance or the pilot project's budget would need to handle all costs. Czech patients needed first to be seen by their GPs, who would make diagnoses and referrals in accordance with the spectrum of services offered by the Gmünd hospital. The GP would then get in touch with a Czech-speaking person at the Gmünd hospital, who would arrange for further care. Czech-speaking personnel were available at the Gmünd hospital every Wednesday, and translators were on call during the hospital's core hours throughout the week. Box 4 describes a survey of patient satisfaction with the pilot test of Healthacross in Practice.

Box 4. The survey of patient satisfaction with Healthacross in Practice

An evaluation of the pilot test of Healthacross in Practice was carried out through questionnaires given to Czech patients who received cross-border care at the Gmünd hospital, almost 80% of whom came from České Velenice. Over half of the patients reported having found out about the pilot test through their GPs, information events and the mass media.

The main reasons to seek care at the Gmünd hospital were: GP recommendation and the proximity of the Gmünd hospital and lack of corresponding care at the person's place of residence. While almost 80% of the patients involved did not speak or understand German, the provision of Czech-speaking personnel and translators addressed this possible barrier to accessing care. The project also directly reduced inequity in access to health care by allowing patients to access a health facility that offered them the specific services they needed, closer to their place of residence.

As a result, most patients receiving care in Gmünd reported not encountering language difficulties (93%), and only 10% noted differences in culture and language. Satisfaction with hospital personnel (doctors, nurses and admission staff) was in general high (over 70%) and almost half of the patients surveyed found services provided by the Gmünd hospital to be "decisively better" (45%) and "rather better" (34%) than those in a similar Czech facility. Referring Czech physicians reported satisfaction with the project procedure and high satisfaction among their patients. The future developments they proposed included increasing the service spectrum to include inpatient treatment and the cross-border transfer of patients to Austria.

Healthacross in Practice was not meant to replace the equivalent type of care in a Czech hospital; its aim was to enable facilitate access for people that would otherwise have had to travel much greater distances to receive care.

3.4 Widening the spectrum of care – the Healthacross for Future project

The third project in this series, Healthacross for Future, runs from May 2017 to September 2020. It aims to broaden the spectrum of care by increasing cross-border care provision and expanding to inpatient care, and setting up a common cross-border health centre (Box 5). The infrastructure component of this project makes it unique, since it integrates personnel and services in a structure that lies on the border of Austria and Czechia. This project also

benefits from the free movement of ambulances across borders, achieved in 2016.

Box 5. Building a health care centre on the border

Building the first cross-border outpatient health centre exemplifies the long-term cooperation between Austria and Czechia. It will be located on the border of the two countries, employing both Austrian and Czech health teams. Its main focus will be primary health care and it will offer treatment not available at the Gmünd hospital so as to make the most of existing resources and prevent duplication. The preparatory work included meetings with all local GPs and nurses to assess patient needs and to decide on the range of treatment to be offered, and a stakeholder analysis to define patient needs in this special cross-border region.

The health care centre will be open 60 hours a week, using funding from Austria, and will have rooms for events and patient education and health professionals' continuing education. It will also contribute to expanding the role of primary care nurses by giving them more responsibilities while offering patients new health treatment.

The municipality of Gmünd offered the land to build the health centre. As infrastructure could not be covered by the project, this was an opportunity to use alternative funds such as the European Regional Development Fund. The construction of the health centre is intended to start the in the middle of 2019.

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The project made an assessment to understand whether treatments were available in Czechia that Austria could offer to Gmünd residents. While the pilot test of the Healthacross in Practice project offered outpatient treatment to 100 Czech patients, inpatient care at the Gmünd hospital under Healthacross for Future will be initially limited to 50 Czech patients. Putting inpatient care in place depends on understanding whether the Czech social insurance could cover it, since treatment costs more in Austria than Czechia. At the time of writing, a solution was being sought with the Czech social insurance, to see if it could cover the costs of Czech inpatients.

Capacity exchange has been built into Healthacross for Future, with opportunities for Czech and Austrian experts to exchange visits and make study visits that will be organized by the participating hospitals for different groups of health professionals. As mentioned, the possibility of exchange of treatment between Austria and Czechia is also under consideration.

3.5 Lower Austria and South Moravia: the Zdravi (Health) project

Collaboration between Lower Austria and South Moravia includes three projects. The third of these grew from cross-border collaboration between the towns of Melk, Lower Austria and Znjomo, South Moravia, which focused on the exchange of **health expertise** and the **opening of specialty services** from each country.

The initial project, *Zdravi* (Health), sought to lay the groundwork for cross-border collaboration by: resolving all questions related to working and providing future services through two different health care systems, settling legal issues and setting up ways of working. The project first mapped the health care situation in the area and set up cooperation in specialty areas between hospitals. It assessed the feasibility of opening specialist treatment in Czechia to a limited number of Austrian patients, and documented the health situation in this particular border region. The project also carried out initial groundwork for a cross-border agreement among emergency services, an important future operational component to transport patients across the border.

The project produced a cross-border health report and patient information

folders on: medical treatment in Europe, and the rights of Austrian patients in Czechia and Czech patients in Austria. The project also tried to overcome language barriers by providing language courses to personnel in health care facilities and by publishing a phrasebook entitled *Czech language for health care services*.

3.6 Defining where collaboration makes most sense: the Health without Borders project

The second project of the Lower Austria–South Moravian collaboration, called Health without Borders, aimed to deepen the cooperation between the partners, building on the results of the preceding project. Collaboration was thereby expanded to involve the Vysočina administrative district in Czechia. Networks have been built to provide a direct link on the spot and across the national border. The aim was to equalize the value of the provision of medical care on both sides of the border. Having agreed on long-term cooperation, the partners' the overall vision was to implement joint regional structural planning in health care. Moreover, the project also sought to transfer know-how to other regions confronting similar problems.

Health without Borders focused on:

- the development of human resources in the health sector – analyses in Lower Austria, South Moravia and Vysočina;
- strategic possibilities for cross-border hospital cooperation; and
- innovative approaches to solutions for the health sector in the areas of demographic change, including the ageing of the population.

3.7 A focus on knowledge transfer: the Unlimited Health Together project

The third project of this set focused on knowledge transfer from Czechia to Austria. The new project, called Unlimited Health Together, aims to achieve several goals.

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First, an endometriosis centre is being established in the Melk hospital. At the beginning of the project Lower Austria had no certified centre for endometriosis and this illness is barely known among the public, although studies say that it affects one in 10 women. The hospital in Znojmo already has an endometriosis centre that is EU certified (with level-2 medical certification). Through knowledge transfer from Znojmo to Melk, joint training courses for medical specialists and joint surgeries in the hospital, Melk has developed the first approved endometriosis centre in Lower Austria (with level-1 certification).

Austrian patients are to be enabled to receive radiotherapy in the hospital in Znojmo. Radiotherapy in Lower Austria is provided by two hospitals in the central region of the country. Patients from the border region can find the long journey from their homes to the hospital to be exhausting. The hospital in Znojmo is not far from the border, however, and has capacity for additional patients; with the help of the pilot project, 15 patients from Lower Austria should therefore receive radiotherapy treatment in the Znojmo hospital. At the time of writing, one patient (of the mentioned 15) had already received

treatment in Znojmo thus demonstrating that the project is working as planned.

Lower Austria, South Bohemia and South Moravia intend to establish cross-border cooperation on emergencies. As mentioned, the Federal Government of Austria signed a treaty with Czechia in January 2016, which enables cross-border emergency care. The Unlimited Health Together project aims to link the emergency control centres of Lower Austria, South Bohemia and South Moravia through a web application that enables the cross-border dispatch of ambulances.

Box 6 describes a new project for cross-border collaboration between Austria and Slovakia.

Box 6. Bridges for Birth

Bridges for Birth, the Healthacross initiative's newest project, started in the middle of 2018 and involves a hospital called *Landesklinikum Hainburg*, Austria and the University Hospital in Bratislava, Slovakia. This is the first cross-border collaboration on health between Austria and Slovakia.

Bridges for Birth focuses on the provision of emergency assistance to the newborn babies of Austrian and Slovakian mothers who live near the border. These women usually seek care in Austria. The Austrian hospital is rather small and offers basic health services, including in a gynaecology and obstetrics ward, but no specialized care for neonatal complications. The closest Austrian hospital with a neonatology ward is in Mistelbach, which is 72 km from the border, and transport time can be critical in a neonatal emergency.

Bridges for Birth aims to open the neonatology ward at the University Hospital in Bratislava to Austrian babies. The Austrian and Slovakian hospitals are carrying out a pilot study on the feasibility of transferring newborn babies to the latter in neonatal emergencies. In addition, the partners are working out collaboration between rescue services and developing a strategy for further cross-border cooperation between their two countries.

4. Cross-border collaboration for health in other European regions

4.1 The Meuse-Rhine Euregion

The Meuse-Rhine Euregion (EMR) is one of the oldest cross-border regions in the EU. It was created in 1976 and achieved legal status in 1991. For the past 35 years, EMR has brought together five partner regions in three countries with different languages and cultures: the southern part of the Dutch province of Limburg, the German Zweckverband (specific administration union) of the Aachen region, the German-speaking community of Belgium, and the Belgian provinces of Liège and Limburg. EMR covers a geographical area of about 11 000 km2 around the city corridor of Aachen–Maastricht–Hasselt–Liège. This cross-border partnership has created new opportunities for and has made an important contribution to the quality of life of the region's approximately four million inhabitants *(19)*. Since 1 January 2007, EMR's office has been in Eupen, Belgium. EMR hosts around 150 municipalities, 49 of which have one or more borders with another country. It has more than 50 hospitals, 22 universities and higher educational institutions, and around 43 000 daily commuters.

Life expectancy varies within EMR. That of people born in southern Limburg is lower than the average for the Netherlands: 82.5 and 83.4 years for women and 79.4 and 80 years for men, respectively. Similarly, life expectancy is lower in the province of Liege than Belgium as a whole: 77.3 and 78.8 years for men and 82.3 and 83.7 years for women, respectively *(20)*.

EMR has practised cross-border cooperation on health care since 1990. Stakeholders shape this cooperation, which focused mainly on hospitals and ambulance services until 2001. Since then, it has expanded to include public health care, specifically disease prevention and health promotion.

Stakeholders in EMR cooperate across borders in the field of health care and public health for various reasons. EMR regions face the same challenges and changes in the perception of health and lifestyle, and demographic and social changes; they also share concerns about existing health inequalities, the ageing of the population and the growing need for public health.

In addition, citizens in EMR have become more informed, mobile and empowered; people regularly cross borders for shopping, leisure, education, work and health. As a result, the health sector in EMR must adapt to these developments, taking account of three different countries' health care systems and policy frameworks.

Differences in legislation and health systems also result in citizens taking advantage of cross-border arrangements. For example, the law on the consumption of alcohol in the Netherlands was amended a number of years ago to raise the age limit for drinking from 16 to 18 years. Because people can buy wine and beer at age 16 (hard liquor cannot be purchased until age 18) in neighbouring Belgium and Germany, young Dutch people now organize parties in Belgium or Germany because they are allowed to drink alcohol there from the age of 16. This is just one example of the issues that health professionals working on disease prevention in EMR increasingly face.

Another example is related to infectious disease control. Data from the European Centre for Disease Prevention and Control (ECDC) show huge differences in antimicrobial resistance in the Netherlands, Germany and Belgium *(21)*. The Netherlands has very strict rules and regulations to prevent methicillin-resistant *Staphylococcus aureus* (MRSA). If people from other countries who are infected with MRSA end up in a Dutch hospital, they have a high chance of being quarantined. Similarly, Dutch people who have been treated in a hospital in Belgium or Germany and afterwards go to a Dutch hospital will be seen as a risk for infecting other patients in the ward. The higher probability of a person getting MRSA in Belgium or Germany affects free movement and choice for the citizen, and the protocols of hospitals and their employees in EMR.

These examples show how different policies and legislation can affect cross-border cooperation in EMR. The exchange of knowledge and experience between professionals in EMR is therefore invaluable, because it helps them to deal with the consequences of changes in policy or legislation, including their effects on day-to-day practice.

EMR has delegated action to achieve its objectives in the health area to the euPrevent | EMR Foundation. EuPrevent initiates, supports, stimulates and facilitates cross-border cooperation between professionals and organizations

working to promote and preserve population health. It brings together partners from the countries involved in EMR to work on challenges and create opportunities for the population. EuPrevent also initiates, encourages and facilitates collaborative relationships between health organizations. Activities and collaboration focus primarily on institutions involved in care and prevention. Where necessary, other parties are also involved, including citizens, patients' associations, welfare and educational organizations, governments, the private sector and public and private funders. The ultimate target group is residents of EMR. EuPrevent works via a collaboration programme, entitled Crossing Borders in Health, which uses the approaches of two frameworks: positive health and health in all policies. One of the aims of Crossing Borders in Health is to collect and compare data at the EMR level for use by both health care professionals and policy-makers.

4.1.1 Collaboration between EMR and Lower Austria

Many health-related cross-border projects and strategies had been implemented in EMR since 2005, when Lower Austria contacted the University Hospital of Maastricht, an organization with experience in cross-border collaboration. Cooperation between EMR and Lower Austria started with a project on e-health and telemedicine in multiple border regions. EMR and euPrevent have continued to collaborate with Lower Austria to exchange experience and insights on strategy development and management of cross-border projects, including through study visits and other exchanges.

4.2 The Centro Region, Portugal

The Centro Region of Portugal shares its geographical border with two Nomenclature of Territorial Units for Statistics level 2 (NUTS-2) regions in Spain: the autonomous communities of Castille and León and Extremadura. About 1 million people in these three regions, representing almost 18% of the population, live close to the border shared by Portugal and Spain. This territory is characterized by four demographic risks: decreasing size of the population and of the employment-age population, ageing of the population and low population density. These present new challenges to the search for ways to guarantee the quality of life and access to health care in both countries.

The three regions are developing and implementing initiatives to coordinate interventions and share human resources, such as a cross-border innovation network for the early diagnosis of leukaemia between the Centro and Castille and León regions, funded by European Territorial Cooperation programme period V (2014–2020) (INTERREG V). This multidisciplinary network aims to promote healthy ageing and health gains by the early detection and treatment of leukaemia through implementing adult-population-based screening studies for specific cells, increasing knowledge about cancer and its development and creating innovative, highly sensitive and minimally invasive diagnostic tools.

The Portuguese Local Health Cluster of Guarda (which encompasses two hospitals and 14 primary health care services: 13 primary care centres and 1 primary care unit), and the Spanish University Hospital of Salamanca, located 120 km from the border, are developing another cross-border initiative, to cover health care provision, human resource training and research on cardiology, orthopaedics, gastroenterology, radiology, ophthalmology and anaesthesiology. The Local Health Cluster of Guarda suffers from a shortage of specialized professionals, so the University Hospital of Salamanca, when requested, will support surgical interventions and medical examinations or offer clinical support by providing the necessary human resources in those specialties. Similarly, the Local Health Unit of Guarda will give health professionals and medical and nursing students from Salamanca access to all its services, and, scope permitting, enable them to carry out internships or conduct research.

These two initiatives will benefit the health services on both sides of the border and therefore the health outcomes of the people living in these regions.

4.3 Eurotown Gubin-Guben

A project entitled Health without Borders is being implemented in the double town of Gubin-Guben, on the border of Germany and Poland. The two have been worked together for many years to create a model Eurotown. The project has opened up new avenues for cooperation in response to residents' urgent needs for quick access to health care, which is of particular importance in emergencies. The nearest Polish hospitals are 30 km and 60 km from the

border, while a German hospital is only 500 m away; this shows the need for cross-border cooperation on health care.

The project aims to strengthen Polish–German cooperation on health services to create be fully operational cross-border health care, particularly for emergency medical assistance. The project is expected:

1. to improve residents' quality of life through better access to health services;
2. to create a long-term cooperation network in the field of health care; and
3. to promote bilingualism in cross-border health care.

Work to achieve this includes language courses for medical professionals, information materials on the possibilities of cross-border health care in Germans and Polish; a multilingual hospital labelling system; translation services for patients and the possibility of translating hospital forms. A series of meetings on cross-border health care for German and Polish specialists will take place, including workshops for health professionals, professional conferences and study visits to other border regions for the exchange of experience. Finally, a feasibility study will be carried out to explore specific solutions for the practical implementation of health care in Gubin-Guben. This project provides an example of knowledge transfer of a best practice from one region to another, in this case from the Gmünd–České Velenice cooperation to the Eurotown Gubin-Guben reality.

4.4 The Danube–Criș–Mureș–Tisa Euroregion

The Danube–Criș–Mureș–Tisa Euroregion (DKMT) covers the border region of three countries – Hungary, Romania and Serbia – and it includes the Hungarian counties of Bács-Kiskun and Csongrád, the Romanian counties of Arad, Caraș -Severin and Timiș, and the Serbian Autonomous Province of Vojvodina. DKMT has a twenty-year history of institutionalized, cross-border cooperation to develop and strengthen the connections between the local communities, institutions and individuals. The towns and villages, chamber of commerce, universities and nongovernmental organizations (NGOs) of the region have a functional network of connections, but cooperation is often hindered by problems such as having to spend several hours waiting

to cross a national border or the lack of international public transportation. Providing solutions to these problems is among the primary objectives of DKMT and, with continuous communication with the decision-makers of the three countries, it is implementing a number of cross-border projects on transportation, tourism, disaster management, culture and employment.

The development of cross-border transportation is especially important, since the lack of it has negative social and economic effects. DKMT has participated as a lead partner in the implementation of a Hungarian–Serbian Instrument for Pre-accession Assistance Project, as a result of which permanent crossings have been opened on the Tisa River, which forms the border between Hungary and Serbia. Also in this region, DKMT aims to revitalize the Szeged–Subotica–Baja railway line, since rail connections between these towns are lacking or very complicated. This constitutes a major disadvantage for the local inhabitants, tourists, commuting students and business people, since crossing the border by public roads often takes several hours and has rather negative environmental effects. To solve this problem, DKMT, in partnership with the Government of the Autonomous Province of Voivodina and based on support from the Hungarian–Serbian Project, designed a railway line between Szeged and Subotica; at present, a train journey covering the 45 km takes two hours. Both construction and environmental permits have been obtained, and a railway line is being planned for the section between Subotica and Baja, where none exists at present.

Regional actors rarely tackle such large infrastructure developments. DKMT's success is due to the commitment of regional and county representatives, and support from the Hungarian and the Serbian railway companies and the two countries' governments.

DKMT has also created cross-border projects in hospitals and clinics in areas such as neonatal metabolic screening and oncological radiotherapy during 2007–2013. Cross-border medical developments will continue to increase in 2014–2020, and there are projects of large volume and strategic importance to create the strongest possible cooperation among the medical institutions and the professionals and the medical universities and research institutes in DKMT.

5. Key steps

This section extracts the six key steps followed by the Healthacross initiative's projects described above. Where possible, the description of each includes examples from the various projects. The steps reflect some projects more than others, owing to the projects' timing and status of implementation. The project examples used are intended to help readers visualize those steps.

5.1 Networking for buy-in from cross-border partners

Projects reported that networking was key for successful cross-border collaboration in health. In Lower Austria, this took place by participation in a project (Change on Borders) that promoted interregional cooperation among 25 different border regions in and beyond the EU. This project provided a forum for exchanging experience and served as a starting point for cross-border cooperation in Lower Austria and learning how to work on EU projects. Involvement in this initial project was a mechanism for networking and getting in touch with other regions and exchanging experience in cross-border health care. Today, Lower Austria forms part of a number of networks such as European Regional and Local Health Authorities (EUREGHA), the WHO Regions for Health Network and euPrevent, all of which have been very important for future projects.

In addition, all the projects described carried out interviews and met with stakeholders, such as the local population to be affected, health personnel and local politicians. Networking with partners in the hospitals or service provision centres was also essential, since their staff would be implementing the project on a day-to-day basis. Further, the projects set up working groups with project management teams and operational personnel, which met regularly to assess progress.

Finally, the Healthacross initiative has won several awards for its work:

- the Euregio innovation award, funded by the European Regional Development Fund and the Lower Austria (2007);

- the European Health Award, second place, from the European Health Forum Gastein (2010);
- recognition of Best Practice for Social Cohesion by the managing authority of the INTERREG project involving Czechia and Austria (2011); and
- pioneer project, from the European Forum Alpbach (2015).

5.2 Carrying out feasibility studies

Each project reported starting with some kind of assessment phase that provided an understanding of the current situation and informed strategy development. The Healthacross initiative's early work included an analysis of the Austrian and the Czech health care systems, looking at service provision by the two project partners: Lower Austria and South Bohemia. Cross-border cooperation projects were analysed to identify the opportunities and challenges that they might encounter. Background reports, including data on health and other factors, were also compiled. Further, a feasibility study on cross-border cooperation by Gmünd and České Velenice on inpatient and outpatient care was carried out to show what types of cooperation could be set up in these sectors.

The projects between Lower Austria and South Moravia also mapped out the health situation on the border, to identify synergies and possible collaboration between hospital specialty areas and emergency services.

5.3 Understanding the cross-border legal and administrative context

Legal, administrative and even customs-related issues can hinder cross-border collaboration if they are not resolved at the outset. Prior to the start of cross-border collaboration, people residing in České Velenice could not receive care in the Gmünd hospital owing to national health insurance validation issues, and because Czech ambulances were not allowed to cross the border owing to legal issues related to the medications and materials transported in ambulances. An Austrian regional minister could not solve the latter issue, so it had to be taken to the central government.

This step should also include a financial assessment to determine all funding sources for the project, and the clarification of administrative issues related to human resources and logistics, including contracts and supply needs, and specifying which side pays for what.

5.4 Communicating and addressing language barriers

Most projects reported having integrated multifaceted communication materials into their work in a number of ways. These included:

- materials development and stakeholder consultations for health professionals and the general public;
- opportunities for in-person exchanges of experience and their application to cross-border collaboration in the field of health;
- the development of language manuals to facilitate communication among medical staff and emergency workers; and
- opportunities for language education and study visits offering first-hand opportunities to put collaboration in place.

The *Zdravi* (Health) project, for example, tackled possible language barriers among health workers by developing a phrasebook for emergency workers and a Czech–German dictionary to facilitate communication.

5.5 Pilot-testing and conducting an initial evaluation

Having a pilot phase enables a project for cross-border collaboration to test certain key project components with limited numbers of people and adjust them, if needed, before full implementation. The Healthacross initiative carried out a **simulation study** to see how cooperation between Austrian and Czech emergency staff might work and to identify opportunities for improvement. A test exercise was conducted, simulating a bus accident involving 15 injured people on the border between Gmünd and České Velenice. Austrian and Czech emergency personnel, police and firefighters provided first aid and nine people were transported to the Gmünd hospital for medical attention by German- and Czech-speaking staff prepared for the exercise.

A **pilot study carried out with patients** was an opportunity to identify issues that can emerge as part of a daily exchange of patients. Part of the study involved preparatory work between the project partners, agreement on the scope of services to be provided and a publicity campaign to reach patients in Czechia. Logistics had to be organized, such as the exact location of the pilot setting and the source of payments for various services, and language courses for Austrian health professionals were offered to allow them to learn some basic terms in Czech to help patients feel at ease.

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Both tests provided an opportunity to show stakeholders at the European level, as well as the population and the health care representatives on both sides of the border, the importance of implementing cross-border care in a way that matches the previously identified demand. The evaluation of the pilot phase allowed the receipt of feedback and fine-tuning.

5.6 Putting full implementation in place

Once projects reach the implementation phase, a number of factors need to be in place to ensure success. Lower Austria and South Bohemia, which sought to expand cross-border care to more patients and include inpatient care, had to consider a number of legal, sustainability, cultural and contextual factors. Legally, it was critical to have transnational agreements that allowed the transport of patients across the borders, and permitted physicians and other health workers to work freely in the other country's hospital. A mechanism such as the European Grouping for Territorial Cooperation *(18)* can facilitate strategic long-term cooperation and serve as the entry point for the clarification of practical issues.

In addition, appropriate infrastructure and incentives need to be in place for implementation, including the planning and development of facilities that will be needed to support scaling-up. Stakeholder buy-in and professional skills needs to be maintained, as the new arrangement needs strong understanding and conviction to succeed. The main target, the population of the border regions, should be regularly informed of the progress of the collaboration through, for example, a newsletter. A comprehensive monitoring and evaluation system should be in place, with indicators that allow evaluation of the impact on the health care system. The indicators should reflect the insights of all relevant stakeholders such as patients, physicians and other health care workers, and health care managers and administrators *(21)*. The existing service spectrum should include a mechanism to understand patients' changing needs and collaboration between health care providers and users to identify potential improvements.

6. Lessons learned

6.1 Challenges

Lower Austria faced a number of challenges throughout the various stages of the development of cross-border collaboration. **Demographic change** was a challenge for the implementation of cross-border care, since most doctors in the border regions are elderly and young doctors are moving to cities. Incentives were sought to keep young doctors in border regions. The issue of **financing** needs to take centre stage. In Lower Austria, it was necessary to identify ways to finance the various projects so they could continue over the longer term and guarantee sustainability to the local population. Multiple financial mechanisms were used from EU funding and European regional structural funds.

Maintaining political support was another challenge, as high-level support always needs to be maintained, to set up new projects and continue work in this growing area. **Keeping hospital staff** motivated to support the initiative was a challenge that was addressed by involving them at an early stage and keeping them informed throughout. **Legal barriers**, including transporting patients across the border, took years to settle but were resolved by a treaty made at the national level.

Finally, **language issues** were a challenge for a number of reasons. First, cross-border collaboration for health entails carefully translating sensitive health information on patients. In Lower Austria, all documents on Czech patients were in the Czech language and Austrian medical staff needed to be careful and to react quickly. To address this issue, language courses were offered in the Gmünd hospital and translators were used to welcome patients and help them understand medical terms and feel more comfortable.

6.2 Facilitating factors

Despite the challenges faced, an equal number of factors facilitated Lower Austria's experience with cross-border collaboration. Excitement about the **novelty of the project** was motivating, since no other hospital had such a

project. Cross-border collaboration in health offered a **win–win combination**, as hospital employees were proud to be part of an EU-funded project with an international component in the border region and better access to care improved health in the area.

Networking and support – from other regions such as EMR and networks such as the WHO Regions for Health Network – were also very valuable, as was the possibility to join EU-funded projects, which offered an entry point for work in this area. Opportunities for **educational growth** became available to hospital employees, who had opportunities to visit other regions. This factor also helped them to apply the knowledge gained from such study visits in their work.

Most stakeholders showed an overall **willingness to make cross-border health work**. For example, an Austrian insurance company was instrumental in facilitating the access of 15 Austrian patients to the new radiotherapy centre at the Znojmo hospital. The company provides each patient with a form for planned treatment abroad, including use of the emergency vehicle, which now can cross the border.

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7. Key messages

1. **Identify champions or mentors that can help early in the project**. Securing political support early from local authorities, and, if necessary, from the national level, is important. In Lower Austria, local political support was key to overcoming many obstacles, such as getting permission for ambulances to cross the border with Czechia.

2. **Choose strategic ways of working**. People starting cross-border health collaboration need to find a strategic entry point. For Lower Austria, this was involvement in a project on e-health. This enabled politicians from Lower Austria to visit EMR, which motivated them to start similar efforts.

   Lower Austria also used the opportunity of a 2007 health conference for networking. It was valuable to identify one or two brother or sister regions that could provide support during the implementation phase of cross-border health collaboration.

   If feasible, a team of people should be organized to manage the project. Healthacross projects benefit from being EU funded, so the projects pay for staff time. This leaves key implementing stakeholders free to do their part.

3. **Time is key: allot sufficient time to begin and implement cross-border health collaboration**. People starting cross-border cooperation need enough time to build up the team and get to know each other. Time is also needed to implement every project component, as things sometimes move slowly, as seen in the time needed to make the treaty on ambulances crossing the border between Austria and Czechia. Projects are often perceived as working too slowly and many only last a few years. All parties should understand that everything cannot be resolved at the beginning of the project.

4. **Involve stakeholders continuously and keep communication transparent**. Constant communication with stakeholders keeps up the motivation of staff, who will not feel threatened by the changes in their ways of working resulting from cross-border health collaboration. The

project team should keep the local population informed about its work and processes, and secure stakeholders' buy-in by involving local people early on. It is critical that the population to be served gain trust in the service provider. In the case of Lower Austria, 99% of the Czech people served reported being satisfied with the care provided by the Austrian health system and the Gmünd hospital.

5. **Actively scope out the local population's needs**. Before starting the project, both Czech and Austrian people were asked what they thought about it; without their support, cross-border health in Lower Austria would never have worked. For this reason, securing the acceptance of the project from the people that it serves is important, as is understanding whether the local population really wants the new arrangement and/or structure.

6. **Ensure that cross-border health collaboration considers equity and reduces inequities**. It is important both to understand the nature of barriers to accessing care – such as language or cultural issues, transportation or a lack of services relevant to the local population to be served – and to create incentives that will help reduce inequities in the quality of care in the area to be served. In the case of Lower Austria, the provision of housing to doctors working at the health centre is intended to encourage them to remain there.

7. **Pilot-test strategically**. Pilot tests are needed to get a preview the plan's scalability and to try out project activities. These can be expanded later. Evaluating and collecting feedback on the pilot test can help inform the implementation phase and save a lot of time and money.

8. **Make a plan to ensure the sustainability of the initiative**. This requires establishing a shared long-term vision with the staff and other stakeholders, so they see where an initiative will go in 10–20 years. It could be beneficial to have one macro objective or vision (such as the common health care centre) and make sure everyone working on it knows they have an important contribution to make.

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Cross-border collaboration in the field of health care can involve a transfer, movement or exchange of individuals, services or resources. It can comprise the sharing of health services, providers and expertise, as well as the provision of disease prevention, health promotion, curative and rehabilitative health services. This report tells the story of the cross-border collaboration in the field of health between Lower Austria and Czechia, and the beginning of collaboration with Slovakia. It focuses on the gradual provision of outpatient care and the exchange of medical expertise taking place in three border regions; documents the first large-scale effort to develop cross-border cooperation on health care between a long-standing and new European Union Member States; and provides information on how and why cross-border care started, mechanisms used to put it in place, key stakeholders and the lessons learned, including challenges and enabling factors.

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