Main Office | AGEG c/o EUREGIO | Enscheder Str. 362 | 48599 Gronau (Germany)
Project Office | AEBR c/o BISDN | Körnerstraße 7 | 10785 Berlin (Germany)
AEBR Antenna in the EU | Office of Extremadura in Brussels | Av. De Cortenbergh 87-89 | 1000 Brussels (Belgium)
AEBR Info Centre in the Balkans | Institute for International and CBC | Terazije 14/14 | 11000 Belgrade (Serbia)
AEBR Info Centre in Ukraine | Univ. Simon Kuznets (KhNUE) | pr. Lenina, 9a | 61001 Charkiw (Ukraine)

***b-solutions***

# FINAL REPORT BY THE EXPERT

**Advice case title:** Setting up a cross-border care network

**Full official name of the advised entity:** EGTC Alzette Belval

**Name of the expert contracted for the advice case:** Health Connect Partners (Petra Wilson, Isabelle Andoulsi and Anett Molnar)

**Date: 31 May 2023**

# Contents

## Executive summary

Alzette Belval is a geographical area in the French-Luxembourg border region with approximately 100,000 inhabitants, of whom many live in one country and work in the other. The inhabitants thus often have legal rights and obligations falling under the jurisdictions of both countries, as well as under the general rights of EU citizens as enshrined in the legislation of the EU. The healthcare facilities in the region are limited, with secondary care located predominantly on the Luxembourg side of the border, which has the only large hospital in the immediate area. However, not only healthcare infrastructure is limited, but the workforce is also becoming increasingly stretched as physicians retire and not enough new recruitments are being made to backfill the workforce. To address these issues, Alzette Belval Region aims to establish a cross-border care infrastructure, which would include a new Healthcare Centre focused on providing care to people in the region, regardless of their place of residence and insurance. The new Healthcare Centre would offer both general and specialist medical services, complementing the care services already available in the area. It is envisaged that the new Healthcare Centre would be able to attract staff because of its vision for integrated care services, as well as special benefit packages which reflect the needs of healthcare professionals providing cross-border care. It is hoped also that local agreements could enable patients to access care in the new Healthcare Centre on the same financial basis in the country of care provision as in their country of insurance affiliation.

The present report explores the legal challenges currently faced by patients accessing cross-border care,and explores how creating a Cross-Border Healthcare Centre might address them. The challenges considered are:

- Variation in care tariffs between countries can led to patients being out of pocket if care is provided under the Directive. This results in a two-speed system in which patients living in the same town might be reimbursed differently for the same care based on the country in which they are insured.
- Patients who benefit from the classification of 'frontier worker' or retired frontier worker will usually be able to avoid using the Directive, but new challenges will arise for teleworkers working across a border.
- Neither the Directive nor the Regulations address the concept of healthcare professional mobility to provide care, as such mobility is only in the context of the professional establishing themselves to provide care in another Member State. It cannot be used as a basis to meet the needs of a particulate patient.

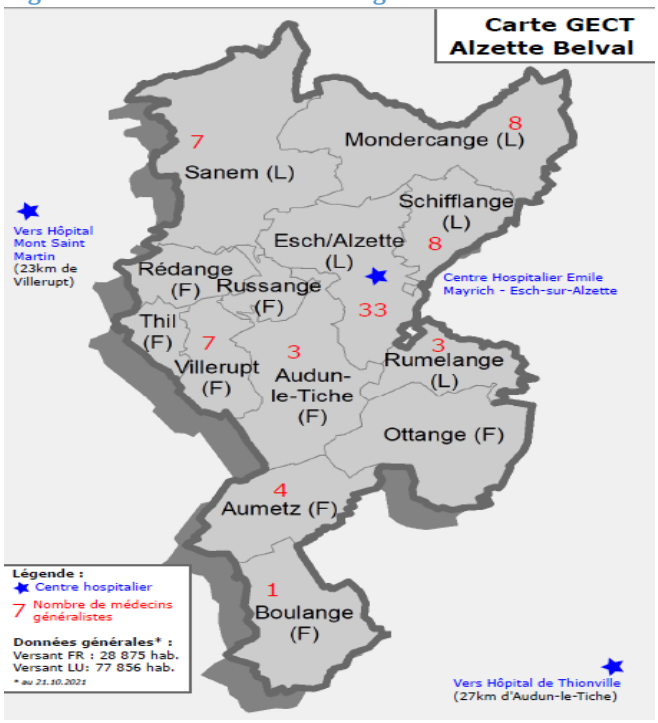
The report draws on interviews undertaken with care providers and political stakeholders in the Alzette Beval region in the spring of 2023.

The report concludes that while the existing EU level legal bases could allow Alzette Belval to operate a Cross-Border Healthcare Centre, significant cross-border political engagement coupled with a specific funding mechanism would be needed. It is noted that such agreements and funding mechanism could be developed drawing on the experiences of initiatives set up in other EU border regions, such as the cross-border health care collaboration in the French-Belgian border region, as well as of the MOSAR convention which provides for cross-border health care collaboration in the border region of France and Germany.

## 1. Introduction

The Alzette Belval region is made up of eight municipalities located in French-Luxembourg border region. The region benefits from a European Grouping of Territorial Cooperation (EGTC) which was set up on 8 March 2013 between Luxembourg and France. The EGTC is a cooperation instrument of the European Union created to respond to the particular difficulties encountered in the field of cross-border cooperation and to facilitate and promote cross-border, transnational and interregional cooperation between its members.

**Figure 1 – The Alzette Belval Region**




The EGTC in Alzette Belval comprises five municipalities in the Grand Duchy of Luxembourg (Esch-sur-Alzette, Mondercange, Sanem, Schifflange and Rumelange), the eight conurbation in France (Rédange,Russange, Thil, Villerupt, Audun-le-Tiche, , Ottange, Aumetz, and Boulange) which fall under the control of four French local authorities (the Communauté de Communes du Pays Haut Val d'Alzette, the Lorraine Region and the Moselle and Meurthe-et-Moselle Departmental Councils). The region has just over 100,000 inhabitants, of whom approximately half are employed or self-employed; of those workers nearly 10,000 cross the French – Luxembourg border regularly in order to work.

Cross-border workers are often in a situation of special social security arrangements, where they may be insured in the country in which they are legally employed, but may live in the other country. This means that the special social security provisions for cross-borders workers provided for in EU Regulation on the co-ordination of social security[1] apply to them. However, many people insured and living in the same country, be that France or Luxembourg, often also want to avail of health or other social services in the other country. They will then need to access such care either on the basis of the general rules in the or the **Regulations on Coordination of Social Security (883/2004/EU and 987/2009[1])** - hereinafter 'the Regulations' or the rights set out in **the Cross-Border Healthcare Directive (2011/24/EU[2])** – hereinafter 'the Directive'.

[1] Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems. Available at https://eur-lex.europa.eu/legal-content

[2] Directive 2011/24/EU of the European Council of 9 March 2011on the application of patients' rights in cross-border healthcare

## 2. Description of the challenges

At present, despite an official agreement between France and Luxembourg, it is often not easy for a patient to access their nearest hospital in the case of an emergency if that hospital is in the other country. This is especially true for people living on the French side of the border who may have only a journey of a few kilometres to the hospital at Esche zur Alzette in Luxembourg, but a journey of over 25 km to a hospital in France. As shown on the map above, they may also find it much easier to get a non-emergency appointment with a generalist in Luxembourg, where the per capita rate of doctors to inhabitants is far higher. However, patients will not only want to access emergency serivces in the other country, but also routine and planned care, which is also more easily available in Luxembourg than in France, based on healthcare professional to patient ratio which is also much more favourable to patients in Luxembourg.

The challenges faced by patients are however not only based on the low density of healthcare professionals on the French side of the border and the relative distance of a hospital, but also on the fact that many of those who live in Luxembourg work in France and are therefore insured in France. This means that their insurance coverage and reimbursement rates for care will be based on French tariffs, which are often not sufficient to cover the patient out-lay for care in Luxembourg. The result is that the patient is significantly out of pocket.

Furthermore, like all regions in Europe, Alzette Belval is facing a significant reduction of the healthcare workforce. As older healthcare professionals are retiring the recruitment of new healthcare professionals is becoming more difficult, in particular in areas like Alzette Belval where a practitioner will often be able to command a higher salary in Luxembourg than in France and may therefore be disincentivised to work on the French side of the border.

In order to address these challenges, EGTC Alzette Beval wishes to create a new cross-border care network supported by a dedicated physical infrastructure as well as dedicated staff.

The establishment of a cross-border care infrastructure and network faces legal and operational obstacles:

- The tariffs set for healthcare service may vary between the two Member States (FR and LU), creating a challenge
    - for patients who may not be reimbursed full costs, and
    - for healthcare professionals who may not be renumerated equally in the two countries.
- The lack of a specific regulatory framework for the exercise of a healthcare profession across borders, beyond the recognition of qualifications.

The legal issues related to these two obstacles are set out below.

### 2.1 Variation in tariffs and reimbursements

Each Member State of the EU is free to establish its own fee structure for care provision and organise the way in which such fees are paid. In some Member States the fees are paid directly to healthcare professionals by the public insurer for all services, with the patient experiencing a ‘free at the point of care’ model, with their only financial interaction with the healthcare system is to pay insurance contributions. Some Member States have a mixed system where a patient pays out of pocket for certain medical services, such as dental care and prescriptions, but does not pay for primary or secondary care provided by a physician or nurse. Finally, in some Member States all interaction with the healthcare system attracts an initial payment by the patient which is then reimbursed to the patient on the basis of their insurance.

The right of each Member State to choose how its healthcare system is financed and organised is enshrined in Article 168 of the Treaty on the Functioning of the EU which states that the organization and finance of healthcare is a Member State power, and the EU's work in public health and healthcare cannot harmonize Member State laws; paragraph 7 of Article 168 states: *Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.*

It is therefore entirely within the scope of EU law and policy that the tariff for care and the fee chargeable by a physician in Luxembourg may be higher than the fee charged by a similarly qualified professional in France for the exact same service. While these differences are legally and politically understandable, they create a significant problem for cross border-care for both the healthcare professional and the patient. Recognising this issue EGCT Alzette Belval asked two specific questions:

- **If a Luxembourg doctor practices in France, can they charge the Luxembourg fee?**
- **Would this care service provision be reimbursed as a French or a Luxembourg consultation?**

And also a more philospphical question:

- ***How can two-speed healthcare be avoided between those who are insured in France and Luxmbourg?***

Legally these first two questions have several answers, as detailed below and shown graphically in table 2. The second question, and indeed the wider questions posed by stakeholders in Alzette Belval on the occasion of our interviews, do not have a clear legal answer, as it is political in nature and fall beyond the remit of this report. However, the discussion in the report will provide some pointers towards addressing this broader issue.

### *2.1.1 Applicable fee tariff*

If a clinician is legally established in France and provides services in France, they will have to charge the fees set by the French healthcare system. Similarly, if the clinician is legally established in Luxembourg and provides care in Luxembourg, they will charge Luxembourgish fees.

If a clinician residing in Luxembourg or of Luxembourg nationality chooses to legally establish themselves in France and provide care there, they will be subject to French legislation and must therefore apply the French tariff. If they are also established in Luxembourg, then when providing care in Luxembourg, the local tariff is applied. The nationality of the clinician is irrelevant, legally the place of registration and practice defines the applicable tariff for care. This is because one of the freedoms enjoyed by EU citizens is the free movement of workers. It is laid down in Article 45 TFEU and is a fundamental right of workers, complementing the free movement of goods, capital and services within the European single market. It includes the rights of movement and residence for workers, the rights of entry and residence for family members, and the right to work in another Member State and be treated on an equal footing with nationals of that Member State.

.

### *2.1.2 Applicable reimbursement tariff*

When a patient is insured in France and receives care in France they will be reimbursed at the French rate, their legal nationality is irrelevant, what is important is that they are insured and have the right to receive publicly funded healthcare in France. However, if the patient is insured in France, and travels to Luxembourg to receive care, the rate of reimbursement will depend on the

type of care and the legal basis on which such care was provided, as provided for in Article 20 of Regulation 883/2004 on the co-ordination of social security. It should be noted here that the Regulation sets out the core rights, how these are applied and interpreted is guided by Decisions and Recommendations adopted by the European Union. A full list can be found on the Commission's website[3],, but in broad terms they define rights as set out below:

- If the patient is taken ill in Luxembourg and is treated in Luxembourg in an emergency on the basis of their European Health Insurance Card (EHIC) they will be reimbursed the full cost of the care, even if this is higher than the same care would have cost in France.
- If the patient travels to Luxembourg for care that has been planned and authorised by a physician in France and has been granted prior authorisation on the PDS2 form as provided for in the Regulations, such planned care will be paid for at the Luxembourg rate by the French insurer (CPAM).
- If the patient travels to Luxembourg, pays for care and seeks reimbursement upon returning to France, such care will be reimbursed at the French rate, and indeed only if the care provided in Luxembourg is a type of care include in the CPAM coverage.

Generally, a patient will want to access cross-border care on the basis the Regulations in order that the care will be fully paid for. In most cases this will be a direct payment between the two insurance bodies, with no claim having to be made by the patient. However, in some cases the Regulations may not be appropriate. This may be if the patient wants care quickly and cannot wait fo the prior authorisation process, or the care will be proivded by a private sector care provider, which can be reimbursed under the Directive. Where the care provided requires an overnight stay, this may be funded under the Directive or the Regulation, but both will require prior authorisation.

The key challenge here is for the patient insured in France who travels to Luxembourg to get ambulatory care from a physician of their choice. It is likely that this will be provided on the basis of the Directive, meaning that the patient will be reimbursed at the same level as they would have been reimbursed if they had received care in France, up to the level of actual out of pocket expense. This means that the patient could be out of pocket if the care in Luxembourg is more expensive than the care in France. This reimbursement scheme is required in the legislation a set out in Article 20 of Regulation 883/2004:

> Article 20
> Travel with the purpose of receiving benefits in kind — authorisation to receive appropriate treatment outside the Member State of residence
>
> 1. Unless otherwise provided for by this Regulation, an insured person travelling to another Member State with the purpose of receiving benefits in kind during the stay shall seek authorisation from the competent institution.
>
> 2. An insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his/her condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he/she were insured under the said legislation. The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness.

[3]. A full list Decisions and Recommendations in force of the Administrative Commission for the Coordination of Social Security Systems (Regulations (EC) No 883/2004 and No 987/2009) is available at: http://ec.europa.eu/social/BlobServlet?docId=4987&langId=en

### *2.1.3 Tariffs and reimbursements for frontier- and teleworkers*

Insured persons and their family members residing in a Member State other than the Member State in which they are insured are entitled to sickness benefits in kind provided for under the legislation of the Member State of residence. The healthcare provided in the Member State of residence is reimbursed by the competent Member State (where the patient is affiliated to an insurer) in accordance with the rates of the Member State of residence.

Where a person is employed or self-employed in Luxembourg but usually returns to France (country of residence) on a daily basis or at least once a week, they are entitled to healthcare both in the country of employment and in the country of residence. The frontier worker must file for a PDS1 form with the competent institution for health insurance of the country where he or she is subject to social security legislation (the country of employment). The PDS1 form must be presented to the institution for health insurance of the country of residence. This way the frontier worker and his or her family members will be entitled to healthcare in both countries, under the respective social security legislation and in each country with the same rights and entitlements as domestic patients with public health insurance.

If however the patient is 'teleworker' who exclusively works from home in France for an employer situated in Luxembourg, the location of a patient's laptop, or other work tool, is the place of employment within the meaning of the Regulations. This patient will not be able to avail of care in both countries like the frontier worker. This may vary if the patient works partially from home (France) and partially at the premises of the employer in Luxembourg, as new rules of the EU Administrative Commission for the Coordination of Social Security Systems will apply. These provide that if the patient works for a Luxemburgish employer but works less than 50% of the time from their home in France they will still be reimbursed as if they were living and working in Luxembourg.[4] The rights of the frontier worker also apply to the pensioner whose pension rights were acquired through working in another member state, as well as to the frontier worker's dependents.

### *2.1.4 Tariffs for planned care under the Directive on Cross Border Care*

As noted above, emergency care whilst in a Member State other than the one in which the patient is insured is covered by the EHIC. Planned care for which prior authorisation is required is usually provided for under the rules of Article 20 of Regulation 883/2004, as described above.

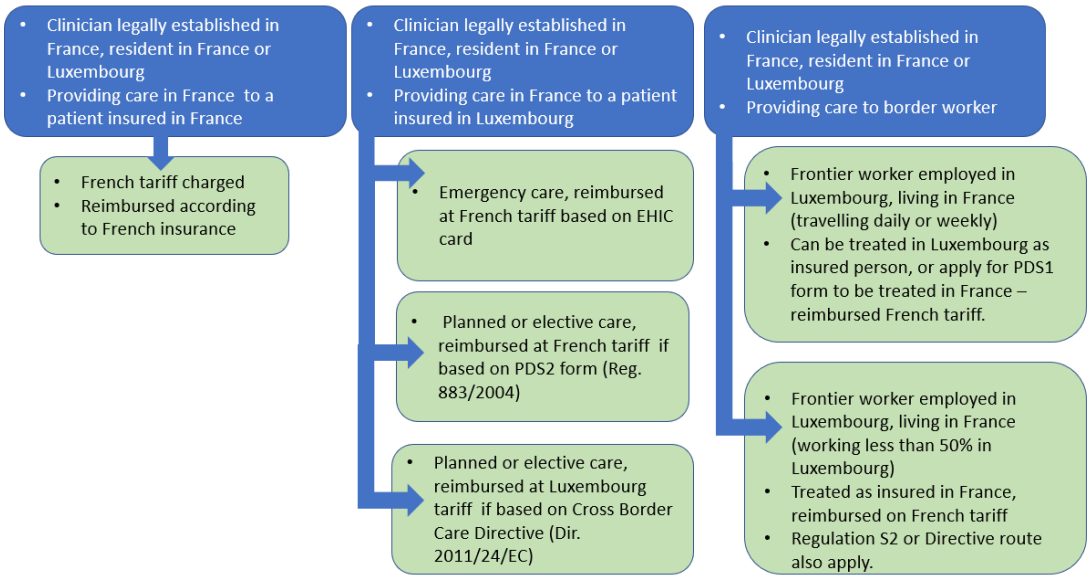
The Directive on Cross-Border care provides a second route for patients to travel to receive planned care, which will usually be without the need for prior authorisation. However, as Article 7(4) provides, the rate of reimbursement is the rate that would have been reimbursed if the care had been provided in the country of insurance - the 'home' country.

> Reimbursement of costs of cross-border healthcare
> Article 7
> The costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare receive

[4] Belgium is one of the first countries to set out guidance on the new rules for teleworkers which can be found at https://campaigns.eranova.fgov.be/m-4fe0d8137eb155b13d14d17db3f7df650d78dfbc68ca8b51

The points above are summarised in figure 2 below.

**Figure 2 – Applicable tariffs and reimbursements**




### *2.1.4 Tariff variability*

The obstacle created by variable tariffs, as explained above, is a very real challenge for the patient who lives in a country where the legally established fees are lower than those in the country in which care is provided. The legal framework is not well adapted for people living in border regions, who need to use a cumbersome process under the Regulations or the Directive. Where the patient is employed it is somewhat easier, but still burdensome. The interviews with nurses in the Alzette Belval region demonstrated the severe impact of the different tariffs, as well as different care pathways provided for in France and Luxembourg graphically.

| Example 1 - Patient is out of pocket |
| --- |
| Nurses established in Luxembourg provide care in Luxembourg for patients resident in Luxembourg, but insured in France. Taking the example of phlebotomy for routine testing, the nurses visits the patient at home to take the sample. They must recover the fee payable directly from the patient. The fee is higher than the patient is reimbursed and is often difficult for the patient to provide. The relationship between nurse and patient is stressed and undermined. |

The challenges described above are well documented in the literature, and demonstrate the problems that arise when tariffs for services are different and result in the patient not being able to get full reimbursement when the care is provided under the rules of the Directive on Cross-Border Care. A further challenge arises when the care that a patient requires is not provided in the same way in the patient's country of affiliation and the country where care is provided. Both the Directive and Regulation are designed to cover care that is provided for in the patient's care package, but that for some reason cannot be provided at all or not in a timely manner. However, to be reimbursable a code must exist for payment to be made. A significant challenge can arise when no code for the care provided exists. Although insurers can issue temporary codes, in practice this is not common.

| Example 3 - Full package of care provided cannot be billed |
| --- |
| Nurses from established in Luxembourg provide care in Luxembourg for a patient resident in Luxembourg, who was treated in France with a lower leg amputation. The nurses can provide basic care in Luxembourg on the basis Cross Border Care Directive (reimbursed at French rates) but cannot provide support with the patient's prosthetic as the prosthetic supplied in France is not covered for support in Luxembourg. ` |

| Example 2 - Care provided cannot be billed |
| --- |
| Nurses from established in Luxembourg provide care in Luxembourg for patients resident in Luxembourg, but insured in France, seek to provide oncology care to patients receiving chemotherapy. The nurses are willing and able to provide chemotherapy in the home, which the patient desires. However, there is no code for billing and reimbursement for nursing care for chemotherapy at home in the French system. As a result, the nurse cannot offer the care the patient wants and needs. |

### 2. 2 Professional Mobility

The free movement of citizens is a fundamental principle of the European Union, enshrined in the Treaty on the Functioning of the European Union (TFEU).[5] This principle allows citizens of EU Member States to move freely and reside in any EU country, as well as work, study, and do business there without being discriminated against on the basis of their nationality.

This means that the national legislation of the individual EU Member States may not restrict the freedom to provide services within the European Union. The "prohibition of restriction" stipulates that it is not permitted to restrict the movement of services within the European Union for citizens of EU Member States, without exception. Accordingly, a doctor qualified in France may move to establish themselves in Luxembourg, or may provide service in Luxembourg on an occasional basis, such as providing services in a hospital or care centre in another country at weekends, or as a locum.

With respect to the right to practice medicine, the Directive on Mutual Recognition of Professional Qualifications (Directive 2005/36/EC) applies in principle to all the professions where specific professional qualifications are required to access them under national regulations. The Directive applies to healthcare professionals who want to move physically to provide services in a Member State. A key element of Directive 2005/36/EC is that the professional must decide if they wish to establish themselves permanently in a new Member State, or simply to offer services in a Member State by travelling there occasionally. The choice will dictate the sort of checks a Member State will complete. However, a doctor with basic medical training, general practitioner and doctor with medical specialisation, nurse responsible for general care, dental practitioner, or pharmacist who holds one of the qualifications listed in Annex V to Directive 2005/36/EC (i.e. the formal qualification and any certificate accompanying the latter) will usually benefit from automatic recognition of the qualification, if the qualification attests to training that meets the minimum training requirements established by the Directive.

The Directive applies only where the healthcare practitioner travels to provide the service (either permanently or occasionally); if the service is provided virtually e.g. by remote analysis of an x-ray, then the professional does not need to certify the qualifications for the purposes of the Directive,

[5] Article 45 of the TFEU.

although a service provision contract may still require it. Furthermore, neither the Directive on Cross-Border Care nor the Regulation on Social Security address the possibility of virtual care in which the patient and clinician interact via telehealth technology such as video calling and remote monitoring. Furthermore, neither piece of legislation addresses the situation of a healthcare professional crossing a border to provide care - the focus is patient mobility, not healthcare professional mobility.

The legislation on freedom of movement for professional establishment or service provision is not specific to healthcare professionals, even if the mutual recognition of qualifications is quasi automatic. As a result, a healthcare professional will need to make a significant personal investment in time and organisation to provide care across borders, unless they move entirely into the employment of a health care provider who undertakes all the registrations. Wismar et al note in a recent study that health workforce mobility has been growing with EU enlargements and has changed directions and magnitude with the economic and financial crisis. The system, the authors note, "while not broken could benefit from some changes to improve the trade-offs between efficiency and equity, between EU labour markets and health systems, between sending and receiving countries and between employers and the health workers. Mobility and cross-border collaboration in the health workforce is essential, especially for smaller countries or in highly specialised care".

### Summary of challenges

- Variation in care tariffs between countries can led to patients being out of pocket if care is provided under the Directive (Ref Article 7(4) Directive 2011/23/EC). This results in a two speeed system in which patients living in the same town might be reimbursed differently for the same care based on the country in which they are insured.
- Patients who benefit from the classification of 'frontier worker' or retired fronteir worker will usually be able to avoid using the Directive, but new challenges will arise for teleworkers working across a border.
- Neither the Directive nor the Regulations address the concept of healthcare professional mobility to provide care, as such mobility is only in the context of the professional establsing themselves to provide care in another Member State. It cannot be used as a basis to meet the needs of a particulat patient.

## 3. Description of possible solutions

The goal of the legislation and policy in cross-border healthcare in the European Union is to ensure that patients have access to quality care in another Member State, whether this is because they are visiting a Member State where they are not usually resident, or because they choose to travel expressly to access care in another Member State which is not available, or not available in a timely manner, in their home Member State. As outlined in section 2, the legislation is poorly suited to address care in the Alzette Belval region where the tariffs for consultations and procedures are much higher in Luxemburg than in France, but where Luxembourg has more resources in terms of healthcare professionals and institutions in the border region. The objective is therefore to outline possible solutions to allow for simpler and fairer access to cross-border care in Alzette Belval region, where the crossing the border is a part of everyday life, not an exception.

### *3.1 Transparency of healthcare costs for patients*

An interim measure to address patient concerns about unknown costs of accessing care in the neighbouring country could be the adoption of a transparency mechanism, as outlined in Article 7(6) of Directive 2011/24/EC, to ensure that healthcare costs in each country are transparent to patients before costs are incurred. This approach would ensure that patients are fully informed of potential out-of-pocket expenses.

This could be coupled with an interface for patients and healthcare professionals to seek information on cross-border care. A good example of this can be found in the in thre Upper Rhine between the French-Germany-Switzerland border the TRISAN project coordinates networking activities in the healthcare sector, and has recently developed a project to develop a comprehensive on-line information tool, the ' Guide de Mobilite', which may provide a useful model for adaptation and replication in the Alzette Belval region, perhaps in the context of the new Healthcare Centre which could include also a information and contact point.

### *3.2. Bilateral agreements on the application of the Regulations and prior authorisation*

Given that patients are not reimbursed fully when using the Directive in cases where care is more expensive than in their state of affiliation, a potential solution would be to establish a bilateral agreement between the public insurers and state departments in France and Luxembourg to adopt special procedures to facilitate the exercise of the right to access care despite differences in tariffs.

A local agreement could allow the insurers on each side of the border to agree special border region tariffs which will be reimbursed to eligible citizens, regardless of the country in which they access care. It could also allow people living in a designated geographic area to access care on the basis of the Regulation without prior authorisation. Agreements of this nature have been put in place in several European border regions, which could serve as a template for EGTC Alzette Belval to begin discussions. An example is the Dutch/German initiative which is a collaboration between the German Health Insurers AOK Rhineland Hamburg and the Dutch Health Insurer CZ Health Insurance[6] to operate a system of a special insurance card which allows patients to access defined healthcare services from defined healthcare providers in the neighbouring country without seeking a prior authorisation. The system operates on the basis of a patient held card, like the EHIC card, and an on-line eligibility verification system. From the insurer perspective, the card also allows for simplification and for maintenance of local eligibility requirements.

### *3.3 Local agreement for a special care centre*

The adoption of new rules set out above could be taken to the next level by integrating the rules in the operation of a border care centre, as envisaged in the EGCT Strategic Plan. Based on the principles of care with out prior authorisation and common tariffs, a new care centre could be developed where these new rules apply. However, this would require significantly more than a bi-lateral agreement, as joint budgets for the building and operation of the centre would need to be adopted, which would have to be funded from both French and Luxembourg public funds.

In order to attract staff, special local employment and taxation rules would have to be adopted to ensure that staff would not feel a financial disincentive to provide care services in the new centre. This would therefore imply negation not only between the region (and potentially national) Departments of Health and Departments of Social Security, but also Departments of Employment and Department of Taxation, as relevant for each country. In order to advance on such a complex project, EGTC Alzette Belval should carefully examine existing projects which provide some useful examples of special regional rules, including:

- **CommonCare[7]**

CommonCare brings together a consortium of partners from different sectors, including healthcare providers, patient organizations, public authorities, and academic institutions in the border region

[6] For further detail see https://health.ec.europa.eu/system/files/2022-02/crossborder_patient-mobility_frep_en.pdf

[7] Interreg Deutschland-Nederlands, Common Care Project, https://www.deutschland-nederland.eu/en/project/common-care.

between Germany and the Netherlands. The partners collaborate to develop innovative solutions and best practices that can be shared across the Region to improve access to cross-border healthcare. Some of the specific activities that CommonCare is undertaking include the development of a digital platform that allows healthcare providers to share patient information across borders, the creation of a cross-border patient mobility centre to provide assistance to patients seeking healthcare services in neighbouring countries, and the establishment of a network of healthcare providers that will work together to provide cross-border healthcare services.

- **Ems Dollard Region**[8]

The region in the Netherlands and Germany border is seeking to develop innovative financing arrangements that are coordinated in consultation with patients, healthcare providers, and insurance companies. The project has begun by focusing on orthopaedics and radiotherapy, with patient transfers taking place between countries. By promoting these pathways, the project partners hope to encourage the development of additional cross-border healthcare options in the region, involving healthcare providers, insurance companies, patient organizations, and administrators.

- **MOSAR convention**[9]

The target audience of this project is the inhabitants of the cross-border region of Moselle and the Saarland. The MOSAR convention covers cardiological emergencies, polytrauma emergencies, and neurosurgical care. In 2019, the project was expanded to include other specialties such as follow-up care, rehabilitation, and nuclear medicine. Under the convention, patients will not have any additional administrative steps and will still benefit from the usual care reimbursement system. This health agreement facilitates cross-border healthcare and improves access to care for residents of the cross-border region. Patients receive the most appropriate care within an optimal timeframe, while taking into account their health condition. The convention allows for care in several fields, and patients benefit from the usual healthcare reimbursement system without additional administrative procedures.

### 3.4 Regional Agreements on cross-border care

Political agreements to address the care needs in a region can be very focussed on a small area, as in the initiatives described above, or cover an extensive area. Several Mmeber States have adopted agreements on cross-border care in border regions which address the special needs that arise in their region. An example of this is the Zone Organisée d'Accès aux Soins Transfrontaliers (“ZOAST”). A ZOAST is often seen as a solution to the obstacles that residents living in border regions face when seeking healthcare services near to their home and across national borders. Some border areas are indeed so close to each other - as it is the case for the Esch-Sur-Alzette border region - that the population, healthcare institutions and health professionals express a desire to develop the provision of cross-border health care services. Seven ZOASTs have already been established all along the French-Belgian and the French-Luxembourg borders with the objective to improve the access to healthcare services for patients leaving on the border. To this end, administrative and financial ar rangements for the treatment of patients in hospitals on both sides of the border have been simplified.

Creating a ZOAST between France and Luxembourg, more specifically in the Alzette-Belval territory, would provide residents of this border region with access to healthcare services on either side of the border. This would be particularly beneficial for residents living in smaller towns and villages near the border, where nearby healthcare services may be limited. A ZOAST would also help to address the shortage of healthcare professionals in some areas, as healthcare

[8] The Ems Dollard Region (EDR) is the northernmost European border region along the Dutch-German border.
[9] MOZAR https://www.saarmoselle.org/fr/sante.html

professionals from neighbouring countries could provide services in the region.

### *3.5 Integration of Digital Health and remote care solutions*

Digital health solutions are beginning to play a significant part in healthcare provision in all Member States of the EU, and indeed feature strongly in the plans developed by the Member States under the EU Recovery and Resilience Facility (RRF), a financial instrument designed to support member states in recovering from the socio-economic impact of the COVID-19 pandemic. Digital health is also seen as a potential channel for cross-border care, but in reality -its use is limited. The Directive includes telemedicine in its defintions (Artilce 3) using the term for digital health that was more commonly used in 2011. It states that *'Member State of treatment' means the Member State on whose territory healthcare is actually provided to the patient. In the case of telemedicine, healthcare is considered to be provided in the Member State where the healthcare provider is established.* The Directive also created the eHealth Network, an informal committee to advice the European Commission on digital health. Its focus has been mainly on the adoption of technical and legal standards to promote the use of ePresciptions and Patient Summaries to support cross-border care. The eHealth Network still exists, but is planned to be replaced by a new formal committee created under the draft European Health Data Space Regulation[10], the advent of which bodes well for more digitally empowered approach to cross-border care.

The potential for including digital soultions for the proposed Cross-Border Healthcare Centre should be carefully explored, in particular because it could prove a useful tool for allowing healthcare professionals to provide care in both France and Luxembourg without having to travel and potentially without having to complete professioanl registration formatlities. This could be achieved in particular by integrating digital solutions into care plans developed under a ZOAST or similar tool.

The benefits for patients of integrating digital solutions are also significant, reducing the need for travel, but perhaps more importantly providing the opportunity for new reimbursed codes based on remote care which could address the disparity between Luxembourg and France.

## 4. Conclusion

The EGCT Alzette Belvan has already shown the political will to take positive steps to address the challenges for cross-border care. The creation of a dedicated cross-border healthcare centre could be a signifcant step forward and could go a long way towards addressing the sort of challenges stakeholders reported in our interviews.

On a purely legal basis the Regulations and Directive provide a good basis for care provision, but local steps need to be taken to address the differences in tariffs. As noted, local agreements and the use of digital solutions are likely to be the best solutions to be considered in a complimentary manner. It will, of course, be necessary not only to secure continued political support, but funds need to be made available, from EU level regional funds as well as from national and local resources in each country.

[10] The proposal for a Regulation on EHDS can be found at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A52022PC0197

## Annex 1 - List of legal provisions relevant to the case

- Consolidated version of the Treaty on the Functioning of the European, OJ C 326, 26 October 2012, p. 47-390, link: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012E%2FTXT
- Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, *O.J.*, L 166/1, 30 April 2004, link: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32004R0883. ;
- Implementing 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, *O.J.*, L284/1, 30 October 2009, link https://eur-lex.europa.eu/legal content/EN/TXT/?uri=CELEX:32009R0987. ;
- Directive (EU) No 2011/24 of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *O.J.*, L88/45, 4 April 2011, link : https://eur-lex.europa.eu/legal content/EN/TXT/PDF/?uri=CELEX:32011L0024. ;
- Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualification, OJ L 255, 30 September 2005, p. 22–142, link : https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32005L0036

## Annex 2 - Interviews Conducted

- 28 March 2023 – Dr René Metz, Director of the Centre hospitalier Emile-Mayrich Esch-Sur-Alzette, as well as members from the legal department (Luxembourg)
- 28 March 2023 – Mr Laurent Jomé, Luxembourg Ministry of Health (Luxembourg)
- 28 March - Mrs Friedrich, Head of the liberal nursing practice of Audun-le-Tiche (France) and Mrs Gaelle Fisch, Liberal Nurse (France)
- 19 April 2023 - Mrs Carine Pigeon, Luxembourg Ministry of Social Security (Luxembourg)
- 19 April 2023 – Dr Véronique Guillotin, Senator, Member of the Regional Council and of the GECT Board (France)
- 24 May 2023 – Mr Jouin – Agence Régionale de Santé (ARS) du Grand-Est and Mr Orcier, Agence Régionale du Grand-Est, Direction Meurthe et Moselle (France)

## Other References


- USER GUIDE Directive 2005/36/EC Document date: 04/03/2020 - Created by GROW.R.2.DIR Last update: 05/03/2020
- Wismar M et al. (eds) (2011). Health professional mobility and health systems. Evidence from 17 European countries. Observatory Study Series No. 23. Copenhagen: WHO Regional Office for Europe, on behalf of the European Observatory on Health Systems and Policies.