Evaluating care across borders

ECAB

European Union Cross Border Care Collaboration

EUROPEAN UNION CROSS BORDER CARE COLLABORATION

GRANT AGREEMENT NO. 242058

European Care Across Borders Project

Project Summary

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1 Executive Summary

Key Findings

The project took as its starting point the EC Directive on Patients' Rights[1], along with the existing body of research on cross-border care. This project explored five aspects of cross-border health care: provisions with regard to the continuing quality of health professionals; treatment pathways; the content and scope of medical records; medical prescribing; and the reporting of quality in both health and long-term care. It also looked at three areas where there is existing cross-border activity, namely between hospitals in border areas, in the field of telemedicine, and with patients travelling across border to seek dental treatment.

Previous research suggests that relatively few patients or users of long-term care cross borders to seek health care. This project confirms that, even with relatively well-developed arrangements, such as for dentists in Hungary serving patients from Austria and Hungary, there are limited flows of patients.

This project included studies of some specific arrangements which are in place. This project explored the cases of French women choosing to give birth in Belgium; hospitals in Malta referring children to the UK for tertiary care; tourists receiving dialysis treatment in the Veneto region in Italy; and patients travelling to Hungary for orthopaedic or dental treatment. Patient satisfaction for these groups appears to be high, even where issues surrounding communication have been identified. However, the lack of data means that it is difficult to accurately quantify the scale of this phenomenon, and to identify appropriate policy recommendations.

The project's exploration of seven cross-border hospital collaborations showed that collaborations are complex and heavily context-specific. Collaboration adapts to circumstances and suffers when these are unfavourable. In general, policy-makers have few tools and few reasons for trying to encourage collaboration where it has not already taken root and provide its worth.

In contrast, there is significant movement of health and long-term care professionals across borders. The movement of doctors within Europe has increased in recent years, stimulated by EU enlargement and aided by the EU Directive on the Mutual Recognition of Professional Qualifications. The Modernisation of the Professional Qualifications Directive proposes minimum requirements of continuing professional education and training standards, although this does not include nor specify training content, skills or competencies. However, this research revealed extensive variability between systems and therefore achieving the new policies will take great investment of resources and time by national regulatory bodies. It also raises questions for assessing and comparing medical professionals.

While there have been moves at the EU level for standardisation, this research highlighted a number of areas where the variation between (and often, within) countries could undermine effective processes of care. For example, all of the Member States included in the research have established programmes in areas such as the development and use of clinical guidelines. However, the extent to which guidelines are implemented in Europe is unknown, as there is no systematic data collection and often no processes to support data collection. Other examples where variability is a barrier include the use of treatment pathways and processes such as infection control. In long-term care too, the systems for quality assurance and regulation differ widely between (and

[1] EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION 2011. Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare. *Official Journal of the European Union*.

sometimes within) countries, which has implications for the movement of service users, care professionals and care organisations.

One area where processes can be seen to be working effectively in terms of patient safety is in the dispensing of prescriptions. The Commission's decision to limit the mutual recognition of prescriptions as a general rule to products that have been prescribed by their International Non-proprietary Names (INNs), should enable pharmacists to recognise the right product. Legislation and regulation at the EU level are seen as necessary to enable the development of telemedicine across the EU. For hospital discharge summaries, there is a need to agree on minimum data requirements if patients seeking cross-border care are to move between providers and countries effectively.

For the public to make well-informed decisions on cross-border care, patients and service users need information on the quality of care and the quality of providers. It is therefore important to consider the circumstances under which quality information can be presented effectively. In fact, there is little evidence that the public uses the information on providers as it is presented currently, even within countries. Patients and users prefer information which is personalised to their needs, and also prefer this information to be provided directly by professionals. At the same time, the use of information by professionals also appears to be very limited. Almost 90 per cent of GPs in the Netherlands surveyed as part of this research said that they never or rarely suggested quality information as a support for decision-making for their patients. These results reinforce the finding that the actual location of both health and long-term care providers continues to be a dominant factor when selecting providers.

The fact that many patients still prefer to be treated 'close to home' has important implications for the prospects of cross-border care. Despite the lack of actual data on the extent of patients moving across borders to be treated in another EU member state, the preference of the majority of EU citizens is likely to continue to be arrangements for care in their home countries, unless financial or structural limitations force them to go abroad. The issues surrounding EU cross-border care collaborations are therefore closely linked to the questions of how universal access and adequate quality standards, including training of medical doctors, can be ensured in *all* EU countries. The added value of this project is to shed light on some of the challenges involved in harmonising quality and standards in the context of the EC Directive on Patients' Rights as well as to highlight successful examples of cross-border care collaborations in different countries.

2 Summary description of project context and objectives

The aim of the European Union Cross Border Care Collaboration (EUCBCC) Project[2] was to facilitate three different aspects of cross-border health care:

1. To facilitate a process whereby a patient in one Member State can make an informed choice about whether to seek health care in another Member State;
2. To ensure that the administrative and clinical processes of obtaining care are as straightforward as possible where patients choose to seek care in another Member State; and
3. To ensure that patients will experience continuity of care, even where they only undergo one phase of a larger episode of care abroad

The project took as its starting point the EC Directive on Patients' Rights, along with the existing body of research on cross-border care.

The project focused on those areas where information is incomplete. Over a period of three years, the project examined five aspects of health care delivery, identifying where it will be necessary for procedures to be compatible if patients are to be assured that the care they receive is safe, of adequate quality, and capable of providing continuity where some parts of the overall care process are provided in different Member States. These were considered across the following dimensions: provisions with regard to the continuing quality of health professionals; treatment pathways; the content and scope of medical records; medical prescribing; and the reporting of quality in both health and long-term care. It also looked at three areas where there is existing cross-border activity, namely hospitals in border areas, telemedicine, and dentistry, in order to to identify practical issues that have arisen and how they have or have not been addressed.

The project brought together a team of high level experts with extensive experience in the area of European health and long-term care policy, combining geographical and disciplinary diversity with academic rigour and policy relevance. These experts were drawn from thirteen partner institutions from eleven Member States:

- The London School of Economics and Political Science, UK
- European Observatory on Health Systems & Policies, Belgium/Denmark
- London School of Hygiene and Tropical Medicine, UK
- Observatoire Social Européen, Belgium
- Universiteit Maastricht, The Netherlands
- Technische Universität Berlin, Germany
- Universitat de Barcelona, Spain
- European Centre for Social Welfare Policy and Research, Austria
- Institute of Public Health of The Republic of Slovenia
- PRAXIS Center for Policy Studies, Estonia
- National Research and Development Centre for Welfare and Health, Finland
- Semmelweis Egyetem, Hungary
- Azienda Unita' Locale Socio Sanitaria N 10 Veneto Orientale, Italy

[2] Short name: European Care Across Borders (ECAB) Project

A variety of both quantitative and qualitative methods were used. Methods included surveys, a Delphi exercise, mystery shopping, interviews and focus groups. The project was broken down into fourteen separate work packages as described below.

Work Package 1: Health Care Professionals

Patient mobility requires that patients be reassured that the health professional who is treating them meets accepted standards. There is an implicit assumption, under the principle of mutual recognition, that a physician who is registered in one Member state meets the standards that are in place in all others. Yet it is already clear from research on revalidation (the process of requiring physicians to demonstrate formally that they have up to date skills and knowledge) that procedures vary widely across EU countries. Patient mobility also requires that patients who are unfortunate enough to suffer medical errors have a means of redress. This may be through a variety of mechanisms, from tort litigation to no-fault compensation schemes.

The objectives of the Work Package were:

- To undertake a mapping exercise to identify Europe-wide medical professional bodies engaged in the development of guidelines and standards;
- To describe the procedures for maintaining professional standards in each Member State and to assess the criteria used in disciplinary measures taken against physicians;
- To describe the scope of practice, skills and experience of designated specialists in EU Member States; and
- To describe the mechanisms for redress (legal and administrative) in the event of medical errors in each Member State and determine the extent to which they are compatible.

Work Package 2: Treatment pathways in different countries

There is a need to clarify how health providers and systems must cooperate to ensure continuity of care in the context of cross-border care. Once a patient has received treatment abroad and returns home, who is responsible for the follow-up care? What if there are complications from a treatment not provided in the patients' home country? Who has the authority to define procedures to resolve these questions? Treatment often involves a series of procedures delivered by a multidisciplinary team. Patients may not always be aware of the pathway of care and may instead see their treatment as discrete packages of care. Patients seeking care abroad may then lose the continuity of care that the pathway provides, or would have difficulties getting back onto the pathway of care on their return to the home Member State. Ensuring patient safety and continuity of care will require that cultural, language and other differences across the Member States be addressed; clear responsibilities within the pathway of care be assigned, including follow-up care, both planned and, when treatment goes wrong, unplanned (1).

The objectives of the Work Package were:

- To understand the commonalities and differences in the management of common conditions within EU Member States;
- To establish the extent to which practice in each Member State is underpinned by evidence-based guidelines;
- To extract the lessons from existing cross-border collaborations where clinicians have developed shared clinical guidelines and ways of working;
- To identify how national differences in packages of care might impact on cross-border care and how might problems be overcome.

Work Package 3: Medical records and systems of data collection

Electronic Health Record (EHR) systems are currently a priority in Europe as manifested by the range of European projects addressing the issue, the building of international networks and national efforts at implementing workable systems. EHR systems have the potential to facilitate communication between health professionals and thus enable continuity of care of patients. Of particular importance in this respect is the hospital discharge summary, a critical component in quality and continuity of care. Through the widespread use of EHR, also the discharge communication can benefit from information and communications technology and the information gathered in the records.

The objectives of the Work Package were:

- To undertake a mapping exercise of the extent to which electronic medical records are used within the EU, for what purposes (e.g. billing, clinical management, performance monitoring, research), what information is collected, what classification systems;
- To describe the nature of information supplied to patients and referring physicians on discharge from hospital in each Member State; and
- To examine the issues that have arisen in exchanging clinical records between health care providers across borders.

Work Package 4: Prescriptions and Medicines

The provision of health care across a border does not only imply the movement of the health service provided. In order to ensure the appropriate treatment, pharmaceutical products and medical devices may be essential. When these products are not purchased in the Member State of treatment, differences in legislation with regard to access to, and reimbursement of medical products can hinder cross-border collaboration and the cross-border provision of services.

This work package aimed at identifying potential obstacles to the cross-border dispensation of prescription-only medicinal products (POMs) from a public health perspective and assessing the public health risks associated with the removal of these obstacles.

We explored which differences in access to pharmaceutical products can potentially hinder the good functioning of cross-border provision of health care. These differences can relate to the applicable prescription forms; the qualification of the prescriber; different brand names of products, different dosages, ways to administer the product and indications; authentication of the prescriber; as well as language differences.

Work Package 5: Patient Choice and Public Reporting on Quality of Care

One of the overarching aims of the EUCBCC project is to facilitate a process whereby Europe's citizens can make informed choices about whether to seek health care in another Member State and, if they so choose, to ensure that the care they receive is safe, of adequate quality, and capable of providing continuity where some parts of the overall care process provided differ. Numerous quality measurement and management initiatives have been implemented in EU countries with the purpose of ensuring high quality clinical outcomes and responsiveness. Despite the fact that patients say they wish for transparency and public reporting on quality issues, they tend to 'underuse' publicly available quality information for making decisions concerning health care. The lack of reliable and standardised quality information is also a key problem in comparing, evaluating and improving health care.

This work package is specifically concerned with how quality is measured and reported in the different Member States in order for the public to make decisions, only once these mechanisms are understood within the Member States is it possible to consider their usefulness for facilitating choice of cross-border provision. It also looked more broadly at the systems in place for quality assurance and regulation, public perceptions of healthcare quality and patient safety in a cross-country setting, information needs of adult patients, patient choice and preferences for healthcare services, the influence of public reporting on patient flow, the use of improved measures to evaluate hospital quality across countries, and at the movement between countries of older people seeking care, care professionals and migrant workers.

Work Package 6: Measuring and Reporting Quality of Long-term Care

There are increasing demands from both government and from the public that providers should be more accountable for the quality of long-term care that they provide. A fundamental tool for accountability takes the form of publicly available 'report cards' that document the comparative performance of long-term care providers. Information about the performance of long-term care providers has been published in the United States for over fifteen years, but many European health systems are now also experimenting with public disclosure, and public reporting of performance information is likely to play an increasingly significant part in the governance, accountability and regulation of long-term care systems.

The objective of the work package was to describe the mechanisms in place in selected Member States to provide the public with information on the quality of long-term care services and the performance of providers. In addition, it highlights the challenges involved in the delivery of long-term care across borders for both providers and users in four different case studies.

Work Package 7: Hospital collaborations in border-regions

Collaboration in European border-regions in the field of health care has received increasing attention in recent years. Earlier studies have mapped past and current projects across Europe (2-4), and so-called promoting and hindering factors have been assessed with the intention of encouraging cross-border collaboration (5-7). The present research builds on these contributions but takes a different view. The purpose is not to describe or advocate collaboration, but to explore the underlying reasons. The work package focused on actual cases of cross-border collaboration involving hospitals in border-regions. A collection of seven border-regions in different parts of Europe were selected for the case-studies in this project.

Work Package 8: Telemedicine

Cross-border telemedicine has often been promoted as a promising approach to encourage innovation in healthcare and safe service movement across EU Member States' borders. At the same time the evidence on benefits remains scarce and opinions are heterogeneous regarding the true value of the phenomenon. This work package was set to assess policy options for feasible expansion of cross-border telemedicine in the EU. Successful cross-border initiatives often arise from successful national ones, characterised by strong team leadership, appropriate training, flexibility, local responsiveness, avoidance of expensive and complex systems, and undertaken within a clear legal and regulatory framework. However, detailed evidence of the effectiveness of cross-border initiatives is largely lacking. There is a danger that enthusiasm based on their perceived potential runs ahead of what they can deliver.

The objectives of this work package were to:

- To understand the existing scale and nature of telemedicine services within the EU; and
- To identify barriers to expansion and scope to overcome such barriers.

Work Package 9: Cross-border Care in Dentistry

Under the principle of mutual recognition, it is expected that a professional who is registered in one Member State meets the standards that are in place in all others. In particular for dental services, there is the potential for patient mobility as there is no gate keeper combined with out-of-pocket payment. Existing research on cross-border care in dentistry deals with the scale of movement, locations for cross-border care, geographical distribution of patients and dentists, the motivations for seeking cross-border care and quality of care obtained abroad. However, this evidence is limited. Different hubs of movement have been investigated to varying extents and depths. This research aimed at complementing the existing body of literature by expanding on the assessment of the mechanisms in place to maintain and enhance quality in different countries, the process of seeking dental care abroad and the effects on local health systems. The considerable potential of cross-border care specifically for dental services makes this work package particularly relevant.

The objectives of this work package were to:

- To identify Europe-wide dental professional bodies engaged in the development of guidelines and standards;
- To describe the procedures for maintaining dental professional standards in each Member State;
- To identify the locations in Europe where cross-border dental care is prevalent;
- To identify the drivers of cross-border dental care; and
- To detail the potential knock-on effects to stakeholders and health systems from dental care provided outside the home Member State.

Work Package 10: Media Reporting on Quality of Care

The media (for example, newspapers, television, internet and radio) serves important goals in informing the public about health and health risks. This project was particularly concerned with the communication process around health risks, and infectious diseases and MRSA in particular, and how the different players in the communication process interact, share information and build publicity of health risks.

Antimicrobial resistance and healthcare associated infections (HCAIs) are major topics on the health policy agenda across Europe. While a large body of evidence reflects the medical situation of multidrug-resistant microbes and HCAIs, the project explored MRSA and HCAIs from the perspective of health policy and risk communication in a cross border healthcare setting.

The objective of this work package was to describe and analyse the role of media in reporting quality of health and long-term care in selected EU member states.

Additional Work Packages

The following work packages spanned the activity in Work Packages 1-10:

Work Package 11: Assessment of the Scale of Cross Border Care

The objective of this work package was to assess the scale of cross border care collaboration building on work resulting from the other work packages. This was done by presenting a collection of case studies to summarise key findings of interest to the programme across all previous work packages, whilst addressing both new and established areas of cross-border care collaboration.

Work Package 12: Potential implications: Lessons learnt, Policy recommendations

The objective of this work package was to identify the potential implications for cross-border care of the existing operations of health care systems and, in consultation with key stakeholders, make recommendations for how they might be addressed.

This work package drew from the work developed in Work Packages 1-10 to describe EU cross-border care policy developments, how the project addresses current gaps in the literature and to provide a critical assessment of the EU Directive articles based on the EUCBCC activities. The analysis also identified the potential implications for cross-border care of the existing operations of health care systems, and made recommendations on future direction for EU cross-border care.

Finally, the goals of Work Packages 13 and 14 spanned the full extent of the project.

Work Package 13: Dissemination

The goal of the dissemination work package was to effectively link researchers, policy makers, and stakeholders to the research and policy evidence. A number of activities were specified at the outset of the project, including the organisation of workshops and a conference and the publication of policy briefs, as well as the requirement to disseminate the findings of the project through articles, conferences and other channels.

Work Package 14: Project Management

The aim of the final work package was to provide the overall project administration and scientific direction to support the planning of the activities, relevance and timing of the task's progress, the alignment and coherence of their accomplishment, the effective communication between the project partners and linking with (WP11) dissemination and communication with other possible stakeholders.

3 Findings

Health Care Professionals

Professional mobility of doctors within Europe has increased in recent years, stimulated by EU enlargement and aided by the EU Directive on the mutual recognition of Professional Qualifications (2005/36/EC) which simplified the process for doctors to practice in other member states. However, this Directive assumes that all doctors sharing the same qualifications also share the same competencies and meet the same professional standards, yet the diversity in training and registration procedures suggest that this is unlikely to be so. This work package addresses the regulation and scope of practice of health professionals working in the EU, pertaining to the issue of professional mobility and the EU Directive on Professional Qualifications.

The outputs of the project fall into three main themes, linked to the objectives of the work package: clinical guidelines; regulatory procedures and processes; and scope of practice of medical specialists.

Clinical guidelines

Our research undertook a mapping exercise of clinical guidelines use and development across Member States, as well as a systematic review on the effectiveness of clinical guideline development in Europe for the management of chronic diseases.

We found that most EU countries have an established national, regional or local clinical guideline programme, and a substantial proportion have developed guidelines on the prevention and management of chronic diseases. Several countries have mechanisms in place to ensure that the quality of scientific evidence used for the development of guidelines is high and that the process is consistent and transparent. Others are only now taking an interest in guideline development and are taking the first steps towards establishing ways of implementing them. The majority of countries have no legal basis for the development of guidelines and those that have well established systems mostly implement them on a voluntary basis. The process of guideline development varies in its degrees of decentralisation across countries with many different types of organisations taking on this responsibility. There is general acceptance of the value of the instrument developed by the AGREE collaboration for evaluating the methodological robustness of guidelines. However, the extent to which guidelines are implemented in Europe is unknown, as there is no systematic data collection and, in most countries, no structure to enable it. There are few examples of formal evaluations of the development, quality, implementation and use of guidelines.

Our findings call for renewed efforts to respond to the severe lack of standardised guideline terminology and accessibility as well as rigorous studies to evaluate the relationship between different ways to develop guidelines and their methodological quality, between their quality and the actual implementation and usage, and finally between implementation and health outcomes.

Regulatory procedures and processes[3]

Our research, which analysed regulatory processes relating to EU-trained doctors in different member states indicate that, whilst regulatory systems are in place everywhere, they vary in content, stringency and terminology to a degree that casts doubt on their comparability. A questionnaire survey was rolled out with representatives and experts from regulatory bodies across

[3] These results are reported in Kovacs, E, Schmidt, AE, Szocska G, Busse R, McKee M, Legido-Quigley H. Licensing procedures and registration of medical doctors in the European Union. Clinical Medicine (forthcoming).

various EU countries, looking at the processes of registration and licensing, revalidation, fitness-to-practice procedures and professional standards.

It was found that following graduation, the processes of becoming registered and licensed to practice medicine – although regulated by law – vary in content and applicability. Although all countries have established professional standards to which physicians are expected to adhere if they are to continue to practice, there is a great variation in the skills and competencies they are expected to demonstrate. Whilst almost all standards include basic principles of patient safety and quality of care, others extend further to include non-clinical competencies such communication and management skills, and in some countries extend to behaviours outside of the working environment. Consequently health professionals can be penalised for not upholding such competencies or values, meaning that a doctor could be professionally disciplined by a medical regulator for a case of poor management or even a drink-driving charge in one country, but not in another. For example, an analysis of medical regulators' responses to hypothetical scenarios of misconduct found that the Netherlands and Estonia regulated little beyond basic medical errors, suggesting a narrower scope of authority, whilst regulators in the UK and Germany consider that the behaviour of the doctor in any setting may have consequences for their professional status.

A few countries are requiring doctors to re-certify or revalidate at regular intervals, but this is not widespread, so some receive "life-long" qualifications whilst others must demonstrate their continuing competence every 3 to 5 years. Thus, the professional standards by which a doctor is judged to assess their "fitness-to-practice", as well as the disciplinary processes to regulate them, vary considerably, which may result in discrepancies between what training and capacities a doctor holds and what is expected of them when they move between countries.

The European objective to simplify practices while assuring quality of care in the light of increased professional mobility puts new demands on professional regulation processes. The Modernisation of the Professional Qualifications Directive proposes minimum requirements of continuing professional education and training standards, an alert mechanism for mobile professionals and the introduction of a European Professional Card, all initiatives to support professional mobility whilst supporting quality assurance. However, given the variability of systems as revealed by this research, achieving the new policies will take great investment of resources and time for negotiating their integration by the respective Member States' regulatory bodies. The findings from this collection of papers could help facilitate the discussions on integration as the new components of the Directive are rolled out.

Scope of practice of medical specialties

A series of qualitative interview-based studies looking at the scope of practice and training of medical specialists in member states showed that, despite holding the same nominal qualifications, the processes of achieving or maintaining basic and specialist medical qualifications are not standardised. The length and content of medical and specialist training programmes vary greatly between and within countries, with differing emphases on practical versus theoretical training. Although the EU specifies a minimum length of medical training – strengthened by the new standards within the Modernisation of the Directive – it does not specify content, skills, or competencies, leading to variation in the knowledge and experience of medical graduates among member states. The introduction of the European Working Time Directive, which limits a medical trainee's working week to 48 hours, may have increased this variation as implementation seems to have been quite variable and few authorities have adapted the length and content of training to take account of the provisions of the Directive. We found widespread concern that doctors in many parts of Europe are graduating with a lower level of training and skills experience than their predecessors.

This series of papers highlights the breadth in scope of practice and training of medical specialties across different Member States, and raises concerns over maintaining quality of care regarding professional mobility. It is reported that whilst efforts are being made to harmonise and standardise training and practice across Member States, this is far from becoming a reality due to the rich cultural and political underpinning of different medical specialties. However it is hoped that these papers will open the dialogue on how this issue can be approached and what research could be further undertaken to bring clarity to this issue.

Treatment Pathways[4]

Introduction

One of the biggest challenges facing disease management is overcoming the fragmentation of care so as to achieve a seamless transition of service users across service interfaces, both within and between countries. The European Directive on the application of patients' rights in cross-border health care encourages enhanced cooperation between health care providers, purchasers and regulators in different Member States, and explicitly identifies the need to ensure that cross-border provision of services appropriately meets the health needs of mobile populations. Underpinning this, however, is the assumption that service models and disease management approaches are similar and compatible across the EU.

Against this background, we conducted research on commonalities and differences in the management of common conditions in the EU, as this will have important consequences for continuity of care for patients travelling across borders or living in another EU Member State. We developed a conceptual model of the journey from the home country to the host country and back (Figure 1), highlighting the importance of establishing disease management processes in both, so as to enhance transparency, integration, continuity of care, responsiveness to patient needs, and communication between key actors.

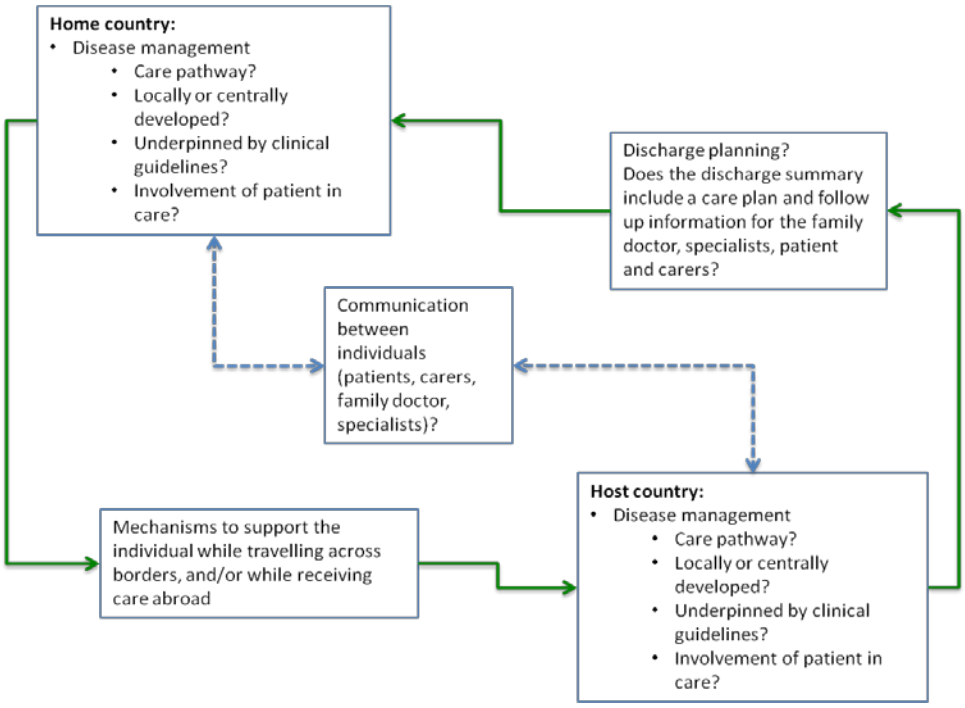
Commonalities and variations

This model informed the development of our study, which followed a multi-pronged approach. First, we conducted two systematic literature reviews on the commonalities and differences in the management of common conditions within EU Member States. We found that there is considerable scope for improvement in the methods used to develop clinical guidelines for the prevention, management and treatment of chronic diseases in Europe (8). We also found that there is very little primary data on the extent of cross-border care within Europe and its impact on continuity of care.

Then, we looked in depth at an innovation in care coordination, the care pathway, as this is a means to improve the quality, organisation and consistency of care (9). However, little is known about the current scope and implementation of care pathways across Europe, and their potential to support cross-border care. We collected 163 responses (25% response rate) in our survey on care pathways from countries across the world. Of the 39 countries represented, 19 were European, with the highest proportion of respondents (30%) were from the United Kingdom. The survey uncovered variability in the use of evidence-based guidelines, a continued reliance on giving patients information rather than investing in self-management training, and reported challenges of evaluating the effectiveness of care pathways against a range of indicators (10).

[4] These results are reported in Knai C, Footman K, Glonti K, Risso-Gill I, Warren E, Panteli D. Disease management across borders. EuroHealth. 2013;19(4).

Figure 1. A model of a patient journey across borders, highlighting key processes of care



We sought to understand commonalities and variations in the management of three specific conditions or procedures: type 2 diabetes (to represent long-term conditions in patients living abroad), acute myocardial infarction (to represent a tourist requiring emergency care) and hip arthroplasty (to represent elective cross-border care). Of 338 responses from clinicians in 14 European countries, 91% of study participants reported using care pathways but only half reported employing national clinical guidelines and one-third referred to local clinical guidelines. The majority of respondents had treated foreign nationals but lacked guidance on cross-border care.

Cross-border care collaborations

We also looked at four case studies of well-established cross-border care collaborations in order to elucidate the success factors of the existing cross-border agreements. A study of French mothers going to Belgium to deliver their baby highlighted high levels of satisfaction and perceived quality of care despite evidence of poor communication and collaboration between providers (11).

However, a survey of orthopaedic patients choosing treatment in Hungary pointed to the importance of clear communication along the care continuum and useful discharge summaries in supporting patient satisfaction and perceived quality of care. A study of the long-standing healthcare collaboration between Malta and the United Kingdom attributes success in delivering highly specialised care to the collaboration's longevity and personal relationships between health professionals, communication and data sharing, a shared care approach and well-established patient support systems (12). A study of patients seeking dialysis services in the Veneto Region in Italy attributed the strengths of the service to coordination of care prior to going abroad and the use of patients' pre-existing care plans (13). However, some challenges remain, mainly revolving around accessibility, language and communication barriers.

Continuity of care

Finally we explored potential issues that could impact on continuity of care by analysing the experience of over 17,000 patients in Germany who had obtained services abroad. These data were drawn from the Europa Survey 2012 in collaboration with Techniker Krankenkasse (TK), one of the major sickness funds in Germany, and the Technical University of Berlin. Preliminary analyses find that 37% of respondents reported requiring follow-up treatment, which was in most cases planned and carried out by a German physician. Communication between the treating physician abroad and the patient's physician in Germany took place relatively seldom and this was usually achieved through the patients themselves. However, only few respondents reported that they would have wished for more exchange. Interestingly, the majority of respondents indicated that the language of communication was German, although this was clearly related to the country the services were obtained in. Very few of the respondents who were prescribed medications encountered difficulties, and these were mostly attributable to different products and only rarely to the prescriptions themselves.

Conclusion

Analysed together, the various components of this study identify potential strategies for improving a patient's journey to receive cross-border care, including measures to improve follow-up and address cultural, language and related factors, making care pathways mutually compatible, and harmonising hospital discharge summaries.

Medical Records and Systems of Data Collection[5]

Summary

Discharge from hospital is an important time for ensuring continuity of care for patients receiving health care abroad. As there is no official guidance standardising discharge summaries in the EU, wide variations exist in their national management. A systematic literature review on discharge summary content and an exploratory analysis of existing discharge summary guidance reveal wide variations in the categories of information used, and some important categories for continuity of patient care are not well represented. A set of discharge summary categories is suggested that could comprise the minimal data requirements for a harmonised European discharge summary.

Importance for patients

Discharge from hospital can be a challenging time for patients (14). Much has been written on improving discharge planning and practices as a result of the deficits identified in transferring information between hospital and primary care providers (14-18). The discharge summary is particularly important for patients who have received care abroad and are thus potentially more vulnerable. Whilst the estimated number of patients crossing borders for care is relatively small, the importance of clear directives for both the patient and the family practitioner or specialist will be essential if patients are already outside of their home country (on holiday or in retirement), living in a border region, sent for specialist treatment abroad, or seeking more rapid access to treatment in another EU country.

[5] These results are reported in Knai C, Footman K, Glonti K, Risso-Gill I, Warren E. Improving continuity of care across borders: the role of discharge summaries. EuroHealth. 2013; 19(4).

Earlier studies, most notably the EU funded 'MARQUIS' project (2004-2007), which focused on health care quality in Europe, called for a standardized European discharge summary (18). Another, more recent EU funded project, HANDOVER (2008-2011), found many problems with the discharge process within countries, attributed to an inward focus of hospital care providers, an unwillingness to collaborate, and a low priority placed on the provision of comprehensive discharge summaries. The project found that the amount and quality of information provided to patients, family members and primary care providers was often insufficient (16, 17).

Wide variation across Europe

Building on the existing evidence, we sought insights into discharge summary content within EU countries and explored the scope for a harmonised European discharge summary. We developed a conceptual model of the journey from the home country to the host country and back (see Figure 1 in our article on disease management across borders in this issue), highlighting the importance of discharge planning and harmonised discharge content to support communication and continuity of care.

To the best of our knowledge, no official guidance on standardised discharge summaries exists within the EU. We identified wide variations in the management of hospital discharge summaries across countries, with countries proposing national standards (e.g. Poland and Lithuania), or others suggesting minimum data requirements (e.g. Spain and Scotland), a standard form for all electronic discharge summaries (e.g. Denmark), a set of national standard headings for the structure and content of clinical records including discharge summaries (e.g. England) and hospital accreditation bodies defining standards (e.g. Finland).

When comparing guidance for discharge summaries provided by seven EU Member States, we found agreement on a core set of categories, including provider and admission details, clinical information, diagnosis, treatments and procedures, medications information, discharge details and follow-up. However, when comparing actual discharge summary templates from 15 countries, we found wide variations in categories of information used, and particular categories relevant to the continuity of patient care do not seem well represented (19).

Our findings from this exercise were reflected in a systematic review of twenty-five studies from eight European countries (19). A total of 31 discharge summary content categories were identified in 21 papers, the most frequent being diagnosis, procedures, tests, treatment received, medications prescribed at discharge, and follow-up. Other than the content analysis, the most frequently discussed issues in these papers were the reduction of medication errors at discharge and the tendency towards (and challenges inherent to) electronic communication of discharge information.

Towards harmonised discharge summaries

Our research on discharge summaries in Europe suggests that a number of discharge summary categories could comprise the minimal data requirements for harmonised discharge summaries across Europe (Box 1). In addition, several categories that might be particularly relevant to supporting continuity of care in a cross-border care scenario include social and psychosocial support for the patient, support for the carer, contact details for close relatives, and patient and carer concerns/information given to the patient. Information in discharge summaries is potentially critical when questions or clarifications arise with respect to treatment and follow-up.

Additionally, the use of internationally recognized diagnostic and procedure classifications would bring many benefits, not only in relation to cross-border care, but also in research and evaluation. Yet it was striking how infrequently the diagnosis was coded. There is an on-going need for an internationally accepted system of procedure coding to replace the myriad of national systems.

Box 1: Recommended data for harmonised discharge summaries

- Patient details (name, date of birth);
- Hospital details (including ward and department);
- Specialist details (name, contact details, preferably phone/e-mail);
- Primary health care professional details (name, practice);
- Admission details (date, mode, presenting complaint);
- Clinical information;
- Diagnoses (using ICD codes);
- Operations, treatments, procedures;
- Medication information (using international non-proprietary names);
- Discharge information (date, reason, discharge diagnosis, person signing the discharge summary); and
- Follow-up / future management.

Conclusion

There is relatively little relevant research on discharge summaries, despite the importance of communication across the primary-secondary care interface and the speed with which electronic communication is advancing. More research on a broader scale is needed to assess practices on hospital discharge summary management within Europe and to explore the similarities and differences in content and practice.

Cross-border recognition of prescriptions for medicinal products[6]

Mutual recognition of prescriptions

The EU Directive of patients' rights in cross-border healthcare (20), provides that medicinal products legally prescribed in a Member State should be dispensed by pharmacists in other Member States in which the medicinal product is authorised (Article 11). Restrictions on the recognition of individual prescriptions are prohibited unless limited to what is necessary to safeguard human health or based on legitimate and justified doubts about the authenticity, content or comprehensibility of an individual prescription. Medicinal products containing narcotic and psychotropic substances and products likely, if incorrectly used, to present a substantial risk of medicinal abuse, to lead to addiction or be misused for illegal purposes are excluded from this mutual recognition (21). In an implementing act, the Commission ruled that Member States have to ensure that prescriptions which are issued upon the request of a patient who intends to use them in another Member State, should contain a minimum set of elements, including professional qualifications and contact details of the prescriber. Additionally, aside from some exceptions, these types of prescriptions should be written using international non-proprietary names (INN) (22). The Directive had to be transposed into national law by 25 October 2013.

[6] These results are reported in Baeten R, San Miguel L. Cross-border recognition of medicines prescriptions: results from a mystery shopping experiment. EuroHealth 2013; 19(4).

Our research aimed to identify potential challenges from a public health perspective that could arise when this provision is implemented; in particular, a prescribed product may not be dispensed to a patient who needs it; an inappropriate product could be dispensed or inappropriate instructions may be given at the time of dispensing and finally, a product may be dispensed and further consumed or sold based on a false prescription.

The methodology used included a review of national legislation regarding prescribing and dispensing, stakeholder interviews and a mystery shopping experiment to capture pharmacists' reactions when confronted with cross-border prescriptions.

Ensuring cross border access to medicinal products

Between October 2011 and February 2012, 192 Belgian or Finnish prescriptions were presented in pharmacies in five other Member States (Belgium, Finland, Germany, Spain and the United Kingdom) in order to assess whether pharmacists would dispense the prescribed product and to identify factors that influence such decisions (23). Over half of pharmacists were willing to dispense, yet willingness varied greatly depending on the country where prescriptions were presented, with pharmacists in Finland (33% of the prescriptions) and the United Kingdom (29%) being less willing to dispense than in Belgium (67%), Germany (79%), and Spain (67%). The main reasons given by pharmacists in Finland and the United Kingdom not to dispense was a belief that their national laws barred them from dispensing foreign prescriptions. However, there is no such legal restriction in the United Kingdom, while Finnish prescribers are constrained in relation to non-Nordic prescriptions. This finding suggests that having an enforceable law in place is not sufficient to change dispensers' behaviour; clear guidelines on how pharmacists should respond to EU prescriptions are necessary.

Reasons for not dispensing in the remaining countries were primarily linked to the impossibility of identifying the correct product when pharmacists were presented with prescriptions using country-specific brand names. This obstacle appears to be key to dispensing. In most countries, prescribing by brand is still common practice. Furthermore, generic substitution is forbidden for private prescriptions in three of the five countries analysed (Belgium, Germany and the United Kingdom), which makes the dispensation of an equivalent product illegal.

Our legal analysis revealed that there are differences in the information requested for a prescription to be valid in the different countries. As a result, pharmacists may consider prescriptions coming from another Member State to be 'incomplete'. Our interviews revealed that pharmacists are more likely to dispense against an incomplete prescription in case of an emergency, or if the product was for the treatment of a chronic condition and presented no potential risks for the health of the patient (24). This reflects the findings of the experiment, where no prescription was refused due to lacking information that was legally required in the country of dispensing. Nevertheless, having a minimum list of elements included in cross-border prescriptions (as defined by the Commission) would avoid refusals to dispense on the grounds of insufficient information.

Avoiding confusion:

Although in our experiment the right molecule was dispensed in all cases (brands and pack sizes sometimes differed from the prescribed ones), the potential for dispensing the wrong product, primarily due to pharmacists' inability to recognise its commercial name, or to read and understand the instructions on the prescription form, should be taken seriously. The Commission's decision to limit the mutual recognition of prescriptions as a general rule to products that have been prescribed by their INN, should enable pharmacists to recognise the right product.

Avoiding fraud or abuse

Products that could reasonably lead to inappropriate, illegal or commercial use are excluded from the mutual recognition of prescriptions. This limits the risk of dispensing against a false prescription. To reduce the risk of fraud further it is necessary to facilitate the authentication of both the prescriber and the prescription. Although during the experiment, the verification of the authenticity of the prescription or the prescriber did not appear to play an important role in the decision of whether to dispense a product; we should recognise that our scenarios were for common conditions with few risks. Thus, our results should not be generalised to more complex cases in which the safety of the patient could be put at risk. Tools used nationally/locally to this end, such as prescriber codes, stamps and signatures would not help in the validation of foreign prescriptions, since codes are only valid within the specific national territories. The obligation in the Commission's implementing act to insert contact details, in particular a phone number of the prescriber in EU-wide prescriptions, could enable pharmacists to both verify the authenticity of the prescriber, and ask for further information in case of doubt.

Conclusion

Overall, the provisions on medical prescriptions in the Directive do safeguard patient safety. Yet, clear information and guidelines for pharmacists and prescribers on the legal framework are indispensable to ensure effective implementation.

Patient Choice and Public Reporting on Quality of Care

Dealing with innovations in health care quality measurement and management

A series of six case studies examined the existing quality measurement and management tools used in healthcare in the following countries: Austria, England, Germany, the Netherlands, Spain, and Finland. EUCBCC research teams in each country were asked to describe and highlight gaps and limitations on particular areas of quality measurement and management. The findings of this activity regarding provision of information to patients were limited but pointed to the variety of modes of public reporting/disclosure of information across country. For instance, in Austria, data are usually published in anonymous form or at aggregate level, hence the impact of patients' choice of providers based on public information remains limited. In Germany, on the other hand, public reporting on hospital performance is primarily based on hospital report or sickness funds. Finally, in England – there are online reports on which providers meet essential standards and patient experience of care.

Population's perception of healthcare quality and patient safety in a cross-country setting

Here, the authors found robust evidence for the impact of socio-demographic variables on the perception of quality of healthcare. More specifically, they found a non-linear impact of age on the perception of quality of healthcare and patient safety, as well as a negative impact of poverty on both perception of quality and patient safety. The authors also found robust evidence that countries with higher corruption levels are associated with worse perceptions of quality of healthcare. Finally, according to the paper, there is evidence that income inequality has an impact on patients' perception vis-à-vis safety, thus feeding into the poverty/healthcare quality nexus.

Information needs of adult patients in Europe: a systematic review

This study addressed the issue of information needs of adult patients in Europe. Evidence from the literature was reviewed to consider how patients access and use quality information to make decisions about provision of health care. Patients wanted the information given to them by health professionals to be personalized to their own circumstance. Additionally, patients wanted verbal information to be reinforced with written documents which could be revisited and shared with family and friends. People used a wide range of sources to look for information including the Internet, books, newspapers, radio, other patients, families, hotlines, and patient narratives. Generally, older people, men and people with less education required more detailed information.

Analysis of disease-specific websites on whether they meet patient information needs

An analysis of disease-specific websites was conducted to capture whether they meet patient information needs. The findings showed that even though the issue has received more attention across Europe in recent years, patient still lack the means to gain helpful information about their diagnosis, treatment, recovery and quality of life. Websites are not able to give patient-specific information and should only be used as a supplement to the health-care provider. If website quality improves, it is important that it is still viewed as an additional resource and not a replacement for doctor provided information and support.

Information-seeking behaviour of German patients receiving healthcare services abroad

How patients use quality information to make decisions about provision of health care was investigated from the The Europa-Survey 2012. Approximately 24% of respondents reported having received planned care abroad and 11% indicated that they used cross-border services on a regular basis. About 59% of patients who received planned services in 2010 informed themselves before their journey, primarily on issues regarding coverage of costs, mode of reimbursement and access to services. The preferred medium for information was the sickness fund customer service followed by their German physicians, family and friends, travel agencies or hotels in the country of treatment and only lastly internet pages.

“Making choices in health care” survey

This study explored patients making choices in healthcare through a unique survey administered in UK, Slovenia and Germany. It also examined patients’ perspectives on what information is needed to choose a health care provider in both GP and hospital settings, and report on their access to information when choosing health care providers. The majority of respondents could select their doctors. When making choices for GP care patients mainly accessed information from personal sources (rather than form internet or other media sources). Within media sources, the importance of using internet was high; this was the leading media source in all three countries for making decisions on a GP. Different types of information were available to them, but location was the most preferred, regardless of their country. When choosing GP care, patient preferred their current care to other options available, and the most valued aspects of the service were accessing the information they wanted and receiving the best care available for their condition. A large amount of respondents claimed that it was possible for them to make the choice on a hospital. Respondents mainly relied on professional’s recommendation when selecting a hospital. Internet was still one of the most widely used media sources when making a decision on a hospital across countries. When looking at the type of information accessed to make their choice of hospital care patients did rely heavily on health information.

The influence of public reporting on patient flow in the Netherlands

The role of the GP in patients' decision making was explored to get insight into GPs' awareness and perception of publicly available quality information and their actual use of it in daily practice for the dialogue with the patient concerning hospital and/or health care provider choice. GPs' perception towards quality information was mostly negative. Respondents perceived that the indicators used were often not relevant for quality of care. Furthermore, for their daily practice the indicators needed were not available or were presently too crude. Almost 90% of respondents never or rarely suggested quality information as support for decision making to their patients.

Measuring the quality of hospitals in England, Austria, and Spain

Given the lack of reliable and standardized quality information when comparing, evaluating and improving health care, this study wanted to demonstrate the use of improved measures to evaluate hospital quality across countries using a quality measurement technique introduced and used by McCllellan and Staiger in 1999 (25). A series of conditions were chosen in order to be able to evaluate how well the quality measures performed for different clinical areas, different sample sizes and different type of admissions. This type of technique proved to be a powerful and coherent tool to describe and forecast data, as well as quantify different assumptions about the relationships between variables.

Measuring and Reporting Quality of Long-term Care

Quality assurance and reporting of LTC systems

The design of the quality assurance and regulatory regimes in each country is influenced by the underlying characteristics of the LTC system. These include how the system is financed and organised; the balance between different services, for example, the balance between residential care and community care; the emphasis on cash benefits and support for informal carers; and the processes for testing of need and eligibility. The outsourcing of LTC provision to the private sector (either for-profit or not-for-profit) exists at some level in all seven countries. With this, the role of governments is increasingly focused on using market and regulatory mechanisms to manage quality, rather than the direct management of service delivery itself. However, there tends to be more extensive regulation of residential care than of community-based care in most countries. There is no common framework for measuring quality across countries, and in Austria, Finland, Spain and Switzerland, few or no quality standards exist at the national level.

Mapping exercise on public reporting[7]

Public reporting has not yet been firmly established as a mainstream tool to bring about increases in quality in long-term care in Europe. Of the six countries surveyed, only three (Germany, England and The Netherlands) had public reporting mechanisms in place. Owing to particular difficulties in measuring quality in home care settings, public reporting of quality was much more likely to be implemented in the residential care sector. The impact of reporting is difficult to assess, partly due to its relatively recent introduction in most countries.

[7] These results are reported in Rodrigues R, Trigg L, Schmidt AE, Leichsenring K. 2014. The public gets what the public wants: Experiences of public reporting in long-term care in Europe. Health Policy (online)

Preferences for public reporting of LTC quality and to explore the issues with decision-making for LTC

In England and The Netherlands, there is a policy emphasis on using market-based mechanisms for driving quality and efficiency in the care home market. However, our research shows that the concept of the user behaving as a rational consumer in choosing residential care is flawed. The circumstances of the decision are often sub-optimal, with the choice being made in a crisis situation, and older people selecting a care home, are increasingly too frail and/or cognitively impaired to make decisions without considerable support, if at all. The quality of decision-making is influenced by a lack of information, and where it is available, the fact that it is often not easily accessible by older people. The research highlighted the need for education, so that older people are more aware of the importance of quality issues such as financial stability of providers, the quality of clinical care, and building design.

Delivery of LTC across borders, both for providers and for users

German care home providers: German providers found it very difficult to establish themselves in Austria, despite the existence of some 'pull' factors. The barriers to relocation were related to the idiosyncrasies of the political culture and practice in Austria, but particularly to regulatory differences in long-term care legislation. Access to the Austrian care market faced a number of institutional barriers to entry, namely the lack of objective and well publicised tendering procedures. Another barrier to the establishment of German care home providers were different collective agreement rules for staff and different quality assurance mechanisms. These continue to vary greatly within the EU and sometimes even within states, as is the case in Austria.

German care professionals: The main finding from this case study is that despite the favourable context in terms of language, curricula and regulatory prerequisites for the recognition of professional qualifications in the EU (2005/36/EC), equivalent mutual recognitions of care diplomas are still not a reality in many professional domains. The long-term care sector is particularly affected by this, given its diversity in terms of professional regulations and requirements not only between countries but also within regions of one country. Difficulties in recognising qualifications could thus hamper the movement of workers in a sector characterised by chronic labour shortages.

Privately paid migrant carers: The case-study highlighted the impact of recent legislative changes in Austria that have contributed to improving the status of migrant carers working in private households (24-hour carers), and offered new ways of formalising their employment status in a sector thus far characterised by informal arrangements. The evidence gathered in this report seems to indicate that, despite the scope for improvement and still existing gaps, raising quality awareness and introducing qualification standards are some of the advantages from regulating 'round the clock care' provided by migrant care workers in private households.

Users of long-term care[8]*:* The experience of older EU migrants seeking access to LTC benefits is extremely complicated, involving a range of institutions and assessments. The prevalence of older EU migrants in a geographic area appears to most influence the ease of gaining information and support, as public resources are designated to ensure that protocols are in place and that frontline health and social care staff receive appropriate training. Older EU migrants who may experience restrictions to LTC benefits and entitlements are those who lack formal residency status; the means

[8] These results are reported in KUMPUNEN, S. & TRIGG, L. 2013. Intra-European retirement migrants' access to state-funded long-term care and health entitlements. EuroHealth. 2013; 19 (4).

to support themselves financially (or specifically a pension in France); or an immediate family member to attach themselves to as beneficiaries.

Hospitals and borders: seven case-studies on cross-border collaboration[9]

Introduction

Cross-border collaboration in the field of health care is not new but as of 25 October 2013, a legally binding text promotes it. Article 10 of Directive 2011/24/EU calls upon Member States to "facilitate cooperation in cross-border healthcare provision at regional and local level" (Article 10.2) and upon the European Commission to "encourage Member States, particularly neighbouring countries, to conclude agreements" and "to cooperate in cross-border healthcare provision in border regions" (Article 10.3). Given that patient mobility in border-regions concerns mostly secondary care (26) the Directive places hospitals and their interactions across borders at the centre of attention, and raises new questions.

As they implement the Directive, Member States need to consider under which circumstances cross-border collaboration is likely to work, and what implications it might have for health systems. For the EC questions of whether and how cross-border collaboration can be promoted are equally relevant. It is against this background that a study on hospital collaboration in border-regions has been conducted.

Objectives of the study

Article 10 of the Directive and earlier studies (5, 6, 27) assume that cross-border collaboration in health care is desirable. This study takes a different approach: by critically exploring why collaboration takes place and whom it benefits, the aim is to expand the scope of analysis to focus on three aspects in particular: the underlying incentives, stakeholder motivations, and needs driving hospital collaboration; the means (i.e. governance formulas, resources and EU-sponsorship) which collaborating actors use; and the interaction between collaboration and its surroundings (i.e. the border-region context, health system context, and political context).

Methods and country coverage

The study is based on in-depth qualitative case-studies. Primary data were collected through stakeholder interviews. Each case-study zooms in on one case of collaboration to bring out how collaboration works, its context, stakeholder behaviour and motivations, the beneficiaries, and the role of the EU. Box 2 lists the seven cases of collaboration included in the study.

Box 2: In-depth case studies on collaboration in border-regions

- *Austria–Germany, between hospitals in Braunau and Simbach*
- *Belgium–France, involving the hospital at Dinant and French health care actors*
- *Germany–Denmark, between the hospital at Flensburg and Danish health authorities*

[9] These results are reported in:

Glinos IA. Hospitals and borders: seven case-studies on cross-border collaboration. EuroHealth. 2013;19(4).

Glinos I, Wismar M. Hospitals and borders. Seven case studies on cross-border collaboration and health system interactions. Copenhagen: World Health Organization; 2013. Available from: http://www.euro.who.int/en/publications/abstracts/hospitals-and-borders.-seven-case-studies-on-cross-border-collaboration-and-health-system-interactions.

- *Finland–Norway, covering hospitals in Finnmark and Lapland*
- *The Netherlands–Germany, between Maastricht and Aachen University Hospitals*
- *Romania–Bulgaria, between hospitals in Călăraşi and Silistra*
- *Spain–France, between Catalan and French health care actors to build Cerdanya Hospital*

Observations

A selection of key findings is presented below.

Cross-border collaboration is not easy. Of the seven cases of collaboration, one has been terminated, three are in doubt, two are at an early or transitory phase, and one is working smoothly. While collaboration can bring benefits, it is vulnerable to the changing needs and priorities of health systems as authorities tend to prioritise domestic solutions to service provision. This makes the duration of cross-border arrangements unpredictable.

Patients sometimes benefit, but partners always benefit. While most cross-border initiatives serve to improve patient access to care, what drives collaboration are the advantages it brings to stakeholders: providers extend their catchment areas or recruit health professionals to expand service capacity, while purchasers use foreign facilities to overcome domestic capacity constraints.

Border-regions are anchored in domestic health systems. Cross-border collaboration is complicated because collaborating partners are bound by the rules of their health systems. As these rarely coincide, partners need derogations and permissions from competent authorities, or to invent solutions. Moreover, stakeholders react to domestic incentives and constraints, even when these are played out locally.

Cross-border collaboration is neither constant nor standard. Collaboration adapts to circumstances and suffers when these are unfavourable (Box 3). Second, while collaboration has its use and purpose, the bulk of health care will continue to be provided and consumed nationally. Cross-border collaboration may not be a rarity in Europe, but it is the exception rather than the rule.

Box 3: Prerequisites to initiating and maintaining cross-border collaboration in health care

- *An objective, local need for cross-border collaboration:* this activates and motivates partners and justifies collaboration to external actors. The need usually stems from patients who require access to care locally, or in some case, that of border-region hospitals seeking health professionals to fill vacancies. If the need changes or disappears, the rationale for collaboration may do so too.
- *Committed individuals:* collaboration is unlikely to take off without the involvement of "militants" who believe in the cause, push collaboration forward, invest time/ effort, and take risks. If frontrunners leave, collaboration is less likely to continue.
- *Shared interests among partners:* while partners inevitably have different and varied interests, these must not be conflicting. If interests clash, collaboration can quickly transform into competition. Where interests change, partners re-assess their involvement in collaboration.
- *Support from external actors:* this can be passive, meaning that actors do not obstruct collaboration, or active. Active support usually stems from three sources: the community and stakeholders affected by cross-border collaboration (such as local doctors), public authorities that are not partners in the collaboration, and funding institutions.
- *A suitable governance structure:* this should be as simple as possible within the particularities of the border region and the purpose of the collaboration. Whether partners

choose a relational, contractual or ownership-based approach to governance, it has to suit the institutions, rules and interests of the health systems involved.

The role of the EU is ambiguous. Collaborating partners can make use of the EU in three ways: as a branding to boost the legitimacy of their project; to obtain financial support; or by using EU legislation which facilitates collaboration. On the other hand, the EU did not play any direct role in three of the case-studies while in some cases, partners expressed disappointment that it had not done more to support collaboration.

Conclusion

It is questionable whether cross-border collaboration can be encouraged given its complexity and context-dependence. If the prerequisites for collaboration (Box 2) are not in place, no amount of funding or official support can, for example, foster the need for cross-border collaboration, shared interests between partners or dedication among individuals. Where the prerequisites are in place and collaboration initiated, external encouragement can probably help cement existing practices or contribute to the funding of infrastructure. In general, policy-makers have few tools and few reasons for trying to encourage cross-border collaboration where it has not already taken root and proved its worth. This suggests that the impact of Article 10 of Directive 2011/24/EU may be limited.

Telemedicine[10]

The DREAMING (elDeRly-friEndly Alarm handling and MonitorING) project piloted services using information and communication technology to support the independent living of elderly people with three chronic diseases: diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.[11] Semi-structured interviews with project participants were carried out to evaluate their experience with the pilot and qualitative analysis was used to address mainly evaluative and strategic questions. A conceptual framework developed by Saliba and colleagues (28) was used for the data analysis.

The project involved thirteen private and public organisations from seven different EU countries (Italy, Belgium, Denmark, Germany, Estonia, Spain, Sweden)[12] to conduct a multi-centre randomised controlled trial. Cooperation between hospitals and municipalities was the main vehicle for project implementation, but in Estonia one hospital took the leading role. The technological solution consisted of three components:

- a monitoring and alarm handling system that included a health monitoring subsystem, an environmental monitoring subsystem, and a mobile alarm and localisation subsystem;
- a data management tool to collect, organise, analyse and store data collected by the subsystems;
- video conferencing technology.

Potential for cross-border service

In addition to a locally provided, useful home-monitoring telemedicine service we were also interested in the potential to move from loose project-based collaboration to the formal cross-border provision of a monitoring service facilitated by intelligent software. Although home monitoring is a local service by nature and the need for culturally and logistically close contact with some health

[10] These results are reported in Aaviksoo A, Kruus P. Cross-border potential of telemedicine solutions. EuroHealth 2013;19(4).

[11] http://ec.europa.eu/information_society/apps/projects/factsheet/index.cfm?project_ref=225023

[12] Pilots occurred only in six countries.

professionals remains, the technology is transferrable. Thus, monitoring and data-management could be organised centrally, which allows for the improvement of decision-support algorithms using a richer data-pool. A recent systematic review (28) identified factors that hinder or support cross-border telemedicine implementation: legal, sustainability, cultural and contextual factors.

Legal factors

Legal considerations in the context of provision of cross-border telemedicine are crucial to ensure trustworthiness and quality of service. The interview statements reveal that a medical doctor should decide the final diagnosis and treatment on the basis of the information provided by the monitoring data and algorithm (i.e. this function should not be delegated to a technological solution). Thus, liability should also lie with the doctor, whether the service is provided in a single country or across borders. Since specific provisions for doctors providing services via telemedicine solutions to patients in other countries are not stipulated in EU legislation (29), prior agreements addressing the liability issue have to be made for cross-border service provision. In this respect, EU regulation on cross-border health care provision should consider liability issues in telemonitoring. Patient data is moved across borders and thus requires patients' informed consent to data sharing and storage. Data security concerns were felt to be relevant especially where legal clarity was lacking at national level.

Sustainability factors

The financial sustainability of telemedicine remains a critical issue, regardless of the rapid decline in the cost of technology over the last few years. While start-up costs for setting up the technical infrastructure for data transfer are considerably low, costs for technical maintenance exist; however, these are outweighed by personnel and management costs. For example, estimates from Estonia reveal that costs for technology and its maintenance accounted for around 30% of the project budget while personnel and management costs absorbed 70%.

In general, telemonitoring was integrated into the everyday practice of the service provider involved in the pilot. However, challenges remained due to the limited involvement of staff members in the project as well as non-integration of the IT platform into national health information systems. In addition, integration into national health systems in terms of reimbursement continues to be a challenge, particularly when the telemonitoring service includes elements of health and social care that rely on different financing mechanisms. Currently, such mechanisms do not provide incentives to enable patients to live at home, but reward health care providers for curative service provision, such as hospital stays. Thus, a rethinking of reimbursement and the financing of telemedicine is necessary in order to deploy telemedicine on a larger scale.

Cultural, language and contextual factors

In addition to the challenges of liability and sustainability, it was acknowledged that working across countries with different languages needed to be addressed through common standards, definitions and guidelines. Equally, cultural differences arising from different working methods, patterns of communication and perception of privacy across countries need to be addressed.

Trust and acceptance between health professionals and in relation to patients was pursued through training of health professionals and running support schemes for patients in order to overcome resistance to change and fear of technology. Moreover, infrastructure has to be suitable for the given service and user preferences, which means adequate and forward-looking planning of investments, as the cost of technology is dropping fast.

Conclusion

The review by Saliba and colleagues (28) identified that most cross-border telemedicine services link professionals, but only a few link professionals directly to patients. It also revealed that the main motivation for developing cross-border telemedicine is to compensate for the lack of specialist health care workers, improve access to care in low-middle income countries and enable cost containment in high income countries.

The internationally piloted telemonitoring service described here responded to a need for such services in local health care systems. In Estonia, the participating hospital had a large ambulatory patient base, but significant space constraints in acute care, creating an incentive to find alternative means to service the high number of patients. This could be achieved by timely medical intervention and keeping patients in home settings. Whether it be space constraints, lack of health professionals or more efficient use of resources, these are quite universal factors and indicate that there might be potential for moving from loose project-based collaboration to formal cross-border service provision with this type of service.

Issues of liability, clinical governance, patient consent and data security were seen by the service providers participating in the pilot programme as important barriers where no national or EU-wide guidance on telemedicine services existed, and therefore special agreements between providers are requested to facilitate implementation. Financial sustainability was highlighted as a critical issue for long-term service provision in cases of small-scale collaborations while low levels of integration into national health information and reimbursement systems also caused problems, particularly for larger scale and longer-term service provision.

Overall, the respondents claimed that since current health systems are organised mainly to cure and not to prevent ill-health, a paradigm shift would contribute to the enhanced provision of cross-border telemonitoring services. Nevertheless, preconditions for cross-border telemedicine are the development of sustainable payment models and a legal framework for data security and liability issues.

Cross-border Care in Dentistry[13]

Previous research on cross-border movements for dental services had investigated the magnitude and type of the phenomenon across different hubs in Europe and beyond, usually exploring issues related to patient motivation and quality particular to the movement at hand. The work undertaken here aimed to systematize and supplement this knowledge, focusing on quality, reasons for and process of obtaining services and the potential impact of cross-border dental care on local health systems. In light of the commencement of the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, it further strived to provide recommendations for emerging issues that should be taken into consideration at European level.

To achieve these goals, the cornerstone of this research comprised four case studies which explored cross-border movements to and from five European countries (Austria, Estonia, Finland, Germany and Hungary). Thus, the sample included both traditionally sending and receiving countries. A number of methods were utilized across the case studies and for the contextualizing research carried out within the work package. Participatory approaches included interviews with dentists in Austria and Germany, survey of dental care providers and foreign patients in Estonia, analysis of dental care services received abroad and reimbursed by state authority in Finland,

[13] These results are reported in Winkelmann J, Hofmarcher MM, Kovacs E, Szocska G. Cross-border dental care between Austria and Hungary. EuroHealth. 2013; 19(4).

interviews with authorities and surveys of providers in Hungary as well as patient interviews (Austria) or surveys (Germany and Hungary).

A number of interesting insights were gained from the different components of this research. Regarding quality assurance mechanisms, it becomes clear that professional associations within oral health care play a very important role in standard definition and control. Despite differing structures in different countries, the Dental Chambers are always involved in the process, a fact which suggests that networks of these associations on a European or international level can have a major contribution to collaboration and coordination. Initiatives in this direction are already in place and this research further supports that this is a pathway for exchange that can be of increased usefulness. External quality control also seems to be standard procedure for dental care, despite provisions and implementation varying across countries. Harmonization or a common guiding principle in this respect could be useful, particularly in view of patient safety and the fact that there are hubs where cross-border movement is substantial. Research conducted in this work package is in line with previous findings and supports that patients having obtained dental services in other countries were to a great extent satisfied with the quality of the work done. Still, supranational agreements on quality standards and/or other assurance mechanisms could enhance service provision and simplify processes, particularly with respect to follow-up and liability issues.

From the locations in Europe where patients travel to obtain dental services most frequently, ECAB research focused primarily on the movement between Austria and Hungary. Additionally, quantitative data from Germany confirmed that planned treatment was most frequently obtained in neighbouring countries such as Poland and Hungary, but the volume of the stream did not seem to be particularly substantial, a fact which was confirmed by German dentists approached qualitatively in triangulation. Lastly, the movement between Finland and Estonia is of limited, albeit increasing, size despite being established and supported by the health systems in both countries.

Two main motivations for seeking dental care abroad were identified across case studies: high prices that are not covered in the benefit basket in sending countries coupled with lower prices and good service in receiving countries and the combination of a trip for affordable treatment with planned holidays in the destination country. Both insights confirm the initial hypotheses of the work package while the former is also in line with previous research findings reported in the literature. This knowledge is useful both for sending and receiving countries, be it in the planning of benefit baskets or service provision. Cultural affinity coupled with lower prices in receiving countries can also be a push factor for travel, as was demonstrated by German patients with a Turkish migration background.

The recognized impact of cross-border movements for dental care varies with the movements' volume. For example, while Austrian dentists interviewed perceived care provided in Hungary as competition, their German colleagues did not have a strong view on the matter as the phenomenon was almost negligible. The difference in impact is not only attributable to the scale of the movements themselves but also to contextual aspects. For example, Austrian dentists are not allowed to advertise their work or organize themselves in joint practices in contrast to their Hungarian colleagues. From the perspective of a high-influx receiving country, the Hungarian case study (Activity 2.2) recognizes that increased income due to an inflow of foreign patients can contribute to better equipment, a reduction of outflow of dental professionals as well as a boost to tourism that is often combined with treatments.

It is clear that with increasing patient flows a number of stakeholders are or can be influenced: apart from the patients and dentists, also insurers, who are called to reimburse services provided abroad at potentially lower rates, are affected. Not all patients can make use of the option to travel abroad to obtain services, a fact which also needs to be taken into account by policy-makers, particularly in sending countries. In general, dental care – a concrete and clearly definite area of health care usually involving the ambulatory setting – is a good example on which to further investigate the exact short- and long-term impact of increasing cross-border flows.

Based on these insights on cross-border care in dentistry, a number of issues arise that could and should be addressed on supranational and/or European level. First of all, monitoring cross-border care movements can supply useful information regarding patient and system needs and possible fields for action. Patient safety as one of the pinnacles of health care provision should be protected: existing gaps in communication possibilities between health professionals in sending and receiving countries should be addressed and collaboration between professional associations fostered and encouraged. Several measures could further aid in the improvement of continuity of care, such as agreements between the insurance funds reflected in EU legislation and clearly formulated, overarching standards for liability and redress issues. Clear and transparent guidelines on accreditation (licencing and certification), information provision and advertising would facilitate safer and more effective care and support fruitful competition and quality of care.

Risk communication for cross border health threats[14]

Introduction

Anti-microbial resistance (AMR) and health care associated infections (HCAIs) are high on the health policy agendas across Europe. The European Centre for Disease Prevention and Control (ECDC) has placed the “Antimicrobial Resistance and Healthcare-associated Infections Programme” among its top priorities for the future (30), with while the Chief Medical Officer in the United Kingdom recently describing the threat posed by AMR as “catastrophic” and on a par with international terrorism (31). The recently adopted European Directive on the application of patients’ rights in cross-border health care facilitates European citizens’ access to health care in Member States other than their own. However, with these opportunities come increased risks of cross-border health threats such as AMR.

Risk communication encompasses all measures that contribute to perceptions of the risk associated with certain practices. It is an important component of infection control measures as accurate assessment of risk can have a large impact on appropriate risk-compensating behaviours (e.g. frequent hand washing) (32). Recent research has highlighted a number of areas which are key to understanding effective risk communication, such as the nature and quality of information provided (33), patients’ and the general public's perceived information needs (34) and the role of the media (35).

[14] These results are reported in Dickmann P, Keeping S, Wittgens K, Jivraj N, Schmidt A, Doering N, et al. Risk communication for cross border health threats: infectious diseases and anti-microbial resistance. EuroHealth. 2013; 19(4).

Study framework and findings

A framework of key elements of MRSA infection control policy was developed and applied to five EU countries (Austria, Germany, Netherlands, Spain, United Kingdom) in order to find out how chosen approaches differed between and within countries. Our assumption was that infection control practices are implicit messages that can either reinforce or refute explicit risk communication measures and consequently can impact on the public perception of the risk posed by MRSA.

Strategies aimed at limiting the impact of MRSA were found to vary significantly between the countries. Only the Netherlands has a proactive "search and destroy" strategy involving screening of all patients and staff for carriage as well as symptomatic infection with MRSA. In hospitals, all patients are subject to a risk assessment, with those deemed at high-risk placed in pre-cautionary isolation until testing can confirm the absence of carriage or infection. The United Kingdom screens a select number of high-risk cohorts (e.g. A&E admissions) and since 2009 all elective admissions. The other three countries have a reactive risk-based approach recommending that only patients that are likely to be colonised are tested. Despite themselves being an important vector for transmission, health care workers are only regularly screened in the Netherlands. The reporting of MRSA is voluntary in Austria and Spain, whereas Germany and the United Kingdom have mandatory reporting for MRSA bacteraemia, the most advanced stage of MRSA. Only the Netherlands has mandatory reporting of screening results down to the level of carriage. The quality of the data across countries is therefore variable, and thus it is difficult to offer solid scientific evidence for the risk communication of MRSA.

While all countries in our study have a legal obligation to implement measures to assure basic levels of hygiene, implementation is not rigorously enforced. Only the Netherlands has controlled implementation. It appears that current approaches to MRSA control do not adequately reflect the risks associated with infection. Misconceptions about the role that patients, staff and the general public can play in spreading the disease highlight the importance of consistent application of infection control measures. It is also apparent that there is a need for greater attention to be paid to effective service organisation and hospital/care facility architecture, as well as policies which encourage the rational use of antibiotics.

Risk communication

In order to further examine the minutiae of risk communication of MRSA, we analysed data on helpdesk interactions pertinent to MRSA from a public health authority that hosts one of the biggest MRSA networks in Germany. After applying pre-determined eligibility criteria, data on 501 helpdesk interactions between 2010 and 2012 were coded, with descriptive statistics generated for different classes of questions (including the trigger for the contact), grouped by caller type. The main finding from the study was that both health care professionals and private individuals regularly contacted the helpdesk to request information which was already available from various other public sources, ultimately suggesting this information is either insufficient or not being routinely accessed. Individuals commonly required further explanations on the management of MRSA. They reported receiving either incorrect or confusing information or no information at all from health care professionals. This highlights the need for improved risk communication measures during patient discharge and transfer between services and levels of health care.

In another case study, we conducted interviews with a number of key stakeholders (journalists, public health officials and hospital representatives) regarding the strengths and weaknesses of risk communication surrounding MRSA that has been delivered in the United Kingdom over the past decade. Having clean hands, being "bare below elbows" and the presence of alcohol gel dispensers were the main goals for commentators, with MRSA appearing to become a catalyst for a broader discussion around quality of care. The complex reasons for the increase of MRSA

prevalence were thus narrowed down to hygiene issues and developed into a control mechanism for staff: patients were asked to check whether their nurse or doctor was bare below the elbow and whether they had washed their hands before dealing with them. Interviewees felt that the public was one of the key drivers of the MRSA discourse; without the fervent public interest, media coverage around MRSA could not have been sustained. Major barriers to effective risk communication were seen in a reactive communication policy. Journalists felt the need to communicate critical findings; however, a lack of access to first-hand information restricted them in this endeavour. A more proactive and transparent communication policy was seen by all as key to more balanced reporting of future health events.

Conclusion

Risk communication is focused on individual infection control measures. This narrow focus is congruous with the limited approach used in risk-based screening and surveillance. This results in obscuring the broader role that all patients, health care workers and members of the public play in spreading disease. The variability of recommendations within, and across, countries may be further contributing to these misperceptions. Having consistent European guidelines could improve infection control through encouraging effective risk compensating behaviour. Risk communication is not only about providing explicit scientific information on a health-related topic; implicit messages such as the way health care providers implement and apply infection control measures is another consideration.

4 Potential impact

Potential implications: Lessons learnt, and Policy recommendations

Health care professionals: training and standards

There is a severe lack of standardized guideline terminology and accessibility as well as rigorous studies to evaluate the relationship between different ways to develop guidelines and their methodological quality, between their quality and the actual implementation and usage, and finally between implementation and health outcomes. The professional standards by which a doctor is judged to assess their "fitness-to-practice", as well as the disciplinary processes to regulate them, vary considerably across country settings, which may result in discrepancies between what training and capacities a doctor holds and what is expected of them when they move between countries. Findings highlighted the breadth of variation of regulatory processes across Europe. The current European legal framework has been slow to address these disparities, although amendments – such as an alert mechanism to allow countries to exchange information on discredited practitioners – are under consideration. If the safety of patients and quality of care are to be protected, there is a strong case for revisiting the existing Directive, to ensure the protection of patients as well as the medical profession.

Treatment Pathways

Improvements in the methods used to develop clinical guidelines for the prevention, management and treatment of chronic diseases in Europe should include: the explicit and transparent involvement of key stakeholders (especially scientific experts, guideline users and methodological specialists); and consideration of their applicability and how they will be implemented early in the process. There is very little primary data on the extent of cross-border care within Europe and its impact on continuity of care. There continues to be little knowledge about the extent of use of care pathways. Most health professionals, policy makers and patients valued the cross-border collaborations as it meets a clear patient need and is also a vehicle for professional and service development. Most case studies indicated increasing annual volumes of mobile patients. The studies also illustrated the challenges of providing a service to deliver care across borders or for tourists.

Medical Records

There is a need for standardised hospital discharge summaries to allow the effective hand-over of patient care to different professionals and care providers in different countries. The following discharge summary categories could comprise the minimal data requirements for a harmonized record across Europe: Patient details (name, date of birth); Hospital details (including ward and department); Specialist details (name, contact details, preferably phone/e-mail); Primary health care professional details (name, practice); Admission details (date, mode, presenting complaint); Clinical information; Diagnoses (using ICD codes); Operations, treatments, procedures; Medication information (using international non-proprietary names); Discharge information (date, reason, discharge diagnosis, person signing the discharge summary); and Follow-up / Future management.

Prescribing

Potential challenges from a public health perspective could arise when this medical prescription provision is implemented, as for example: prescribed product may not be dispensed to a patient who needs it; an inappropriate product could be dispensed or inappropriate instructions may be given at the time of dispensation; and a product may be dispensed and further consumed or sold

based on a false prescription. The provisions on medical prescriptions in the Directive do generally safeguard patient safety. Yet, clear information and guidelines for pharmacists and prescribers on the legal framework are indispensable to ensure effective implementation.

Patient Choice and Public Reporting

EU countries presented a long tradition of quality legislation and infrastructure, and offered a series of innovations that might influence Member States developing quality data collection and/or reporting schemes in light of the implementation of the Directive. Patient perception of healthcare quality and safety is tied to endemic problems, such as corruption, low transparency and income inequality. Health care professionals have to be aware of their influential role and possibly have to take more responsibility in guiding the patients through the jungle of quality information (see web, media, family and friends) in order to achieve more patient involvement. Policy makers have to be aware that in order to increase the use of public available quality information by GPs, this information has to be targeted and tailored to GPs' information needs. Findings also showed the breadth of the information gap between what patients want to know and what they are able to find. Patients value the support received by healthcare providers and healthcare insurers when making choices on healthcare, and want to access clear information about their rights to cross-border care when planning to obtain care abroad. More effort should be made to help patients to get in contact with the healthcare providers from the Member State of treatment, and inform the referring healthcare providers in their home country about the potential needs of patients when they go abroad. Results could inform possible challenges and opportunities when setting up National Contact Points in Member States. Indicators on quality of hospital care tested here are able to predict and forecast hospital quality very well, and prove a suitable tool with which to comparatively assess hospital quality and being used to guide policy. However, more data should be collected in a standardized way across Member States for this method to be useful for comparative purposes in policy decision making.

Measuring and reporting the quality of long-term care

Despite the explicit exclusion of long-term care in the EC Directive on Patients' Rights, the work conducted also included some analysis of the challenges facing both users and providers of long-term care in moving across borders. These focused on the experiences of retirement migrants in seeking entitlements to long-term care, care home provider organisations; nurses working in the formal long-term care sector; and of 24-hours carers. The experience of older EU migrants seeking access to LTC benefits is extremely complicated, involving a range of institutions and assessments. The prevalence of older EU migrants in a geographic area appears to most influence the ease of gaining information and support, as public resources are designated to ensure that protocols are in place and that frontline health and social care staff receive appropriate training. The research on provider organisations showed that the conditions for fair and transparent cross-border tendering in long-term care require improvement. It has been shown that existing legal dispositions for contract tendering across borders in long-term care are not sufficiently enforced. The movement of skilled staff between countries is impeded by the lack of definition and recognition of qualifications in long-term care across EU borders – as opposed to health care where the Professional Qualifications Directive applies. This may inhibit the free movement of workers and harm the quality of care provided. An overview of existing mutually recognized qualifications in the area of long-term care among countries could, for instance, contribute to increased transparency in this field and the introduction of qualification standards.

Cross-border Hospital Collaborations

If cross-border collaboration is to work it has to fit into the wider frameworks set by domestic health systems, which consist of institutions and incentives. Border regions are special in many ways: their demographic and geographical challenges can be acute; their proximity encourages exchanges; and they embody the places where the logic and the limits of domestic capacity planning become obvious – as a result of either a lack of services due to relative isolation or an abundance of services, with (university) hospitals located on each other's doorsteps. The combination of factors forms a context in which sharing across the border presents an advantage or an outright necessity. First, institutions are domestic. Health care actors are bound by the rules, regulations and standards of the domestic health system, which cover everything from how medicine is practised and the safety and hygiene criteria to which hospitals must adhere, to how health professionals are trained and remunerated, the scope of benefit packages and how health services are paid for. This creates innumerable points of divergence between health systems and means that collaboration needs exceptions, derogations and permissions from the competent authorities when it does not play by the rules of the game. Second, incentives are often domestic. Despite the particularities of border regions, most of the reasons stakeholders put forward in all seven case-studies enumerated in this work package to explain why collaboration takes place, or not, are rooted in domestic contexts. Moreover, other factors influencing collaboration (such as the role of individuals and international competition) are also unrelated to border regions. These findings are important as they avoid any geographical determinism and go beyond "regionalistic" arguments that give disproportional attention to location aspects of collaboration. They also confirm what other research shows: that cross-border activities leave health systems, and their borders, largely intact.

Telemedicine

Data security risk remains one of the main obstacles that hinders the development of cross-border telemedicine. Moreover, due to increasing volume of data and expansion of data users the risks related to the security and proper use of patient data become more pressing. Solving the issues of secure transfer and storage of health information are essential to further development of cross-border telemedicine. Political actions, such as legal framework of cross-border care or reimbursement schemes supporting the use of telemedicine, seemed to be more influential in promoting cross-border telemedicine as compared to technical actions, such as promotion of R&D or developing strategies and standards. To speed up the process mostly national governments are seen to play the key role, while European level institutions could contribute via facilitating role.

Dentistry

Professional associations within oral health care play a very important role in standard definition and control. Despite differing structures in different countries, the Dental Chambers are always involved in the process, a fact which suggests that networks of these associations on a European or international level can have a major contribution to collaboration and coordination. External quality control is a standard procedure for dental care, despite provisions and implementation varying in each country. Harmonization in this respect could be useful, particularly in view of the fact that there are certain hubs where cross-border movement is substantial. Patients having obtained treatment in other countries were to a great majority satisfied with the quality of the work done. Still, supranational agreements on quality standards and/or other assurance mechanisms could help in enhancing service provision and simplifying process if the need for follow-up or redress arises.

Media reporting

Risk communication in the sphere of infectious disease appeared to be excessively focused on individual infection control measures. These results obscured the broader role that all patients, healthcare workers and members of the public play in spreading disease. The variability of recommendations within, and across, countries may be further contributing to these misperceptions. The practice of infection control at the provider level was found to be inconsistent within and between countries. Having consistent European guidelines could therefore potentially improve infection control through encouraging effective risk compensating behaviour.

Influencing policy

The project has the potential to make a substantial impact on policy making in relation to cross-border collaborations that involves the mobility of patients, professionals, and services in an enlarged Europe.

The main impact of the project stems from identifying the various factors which both obstruct and facilitate patient, professional and services mobility, generation of policy options that address them, and a better understanding of the scope for implementing these various policy options in different health care systems and at the European level. Ultimately, therefore, this project can be expected to contribute to the development of effective models of coordination among Europe's health care systems (i.e. cross-border collaborations) that balance more effectively supply and demand, so enhancing the opportunities for Europe's patients to obtain timely and appropriate care.

The development of improved arrangements for mobility of patients, professionals and services in Europe could enable sharing of capacity between each Member State as well as fostering the exchange of best practices. In turn this would represent a step towards more effective and efficient health care systems in both present and future Member States, ultimately reducing improving costs in the health and long-term care sectors. More generally, this could identify better ways of working and collaborating, for example, on medical records, telemedicine, public reporting of quality or treatment pathways, and assist with improving the effectiveness and efficiency of relationships between health care providers, medical technology industries and health systems.

The topic of the project is, intrinsically, relevant to European policy. It is designed to provide policy options for developments at European level, and explores a variety of options ranging from enhanced use of the Open Method of Co-ordination through the Directive. The insights gained from this analysis also provide options for change at national level, whether this be greater alignment of national policies with European developments; enhanced bilateral agreements between some Member States; or greater use by Member States of existing European policies and legislation; or changes based on the Open Method of Co-ordination.

This project represents the first comprehensive overview of current patient and professional mobility across Europe, and contributes empirical knowledge which can be used to underpin policy decisions. Such information comes at a critical time given the European Commission's current interest in patient mobility across European borders.

Aside from the Europe-wide lessons learned, the work packages and case-studies provide important new insights in relationship to the particular settings involved. These identify options for change in areas such as policy and regulatory considerations, mechanisms for exchange of information and financial flows, and policy options in relation to capacity planning, quality assurance and other developments.

While this project has made important contribution to the debates about cross-border care in the EU, some of the results underline that the actual location of both health and long-term care providers continues to be a crucial factor for treatment. The fact that many patients still prefer to be treated 'close to home' has important implications for the prospects of cross-border care. It is likely that the majority of EU citizens will continue to seek health and long-term care in their home countries, unless financial or structural limitations force them to find alternatives abroad. The issues surrounding EU cross-border care collaborations are closely linked to the question of how universal access and adequate quality standards, including training of medical doctors, can be ensured in *all* EU countries. The added value of this project is to shed light on some of the challenges involved in harmonising quality standards in the context of the EC Directive on Patients' Rights, as well as to highlight successful examples of cross-border care collaborations in different countries.

Dissemination Activities

The following are some of the main ways in which the results of the project have already been disseminated. (Further details of the publications and dissemination activities listed below can be accessed via the project website, *www.ecabeurope.eu*.)

- A short film, *Cross-border Care in Europe,* has been produced to publicise the findings of the project and can be found at http://www.youtube.com/watch?v=XgHgcBPqYys&feature=youtu.be
- Seventeen peer-reviewed articles have been published, with a further 33 articles at various stages of development. The articles already published span a range of subjects.
- A special edition of EuroHealth[15] has been published and includes ten case studies from across the project. *Eurohealth* is a quarterly publication that provides a forum for researchers, policy-makers and experts to express their views on health policy issues and so contribute to a constructive debate on health policy in Europe.
- Two books have been published and are available to the public via the website of the European Observatory on Health Systems and Policies.
    - LEGIDO-QUIGLEY, H., PANTELI, D., CAR, J., MCKEE, M. & BUSSE, R. (eds.) 2013. *Clinical Guidelines for Chronic Conditions in the European Union*, Copenhagen: World Health Organization. Available at http://www.euro.who.int/en/publications/abstracts/clinical-guidelines-for-chronic-conditions-in-the-european-union
    - GLINOS, I. & WISMAR, M. (eds.) 2013. *Hospitals and borders. Seven case studies on cross-border collaboration and health system interactions*, Copenhagen: World Health Organization. Available at: http://www.euro.who.int/en/publications/abstracts/hospitals-and-borders.-seven-case-studies-on-cross-border-collaboration-and-health-system-interactions
- The following book will be published in February 2014:
    - MOR, V., LEONE, T. & MARESSO, A. forthcoming. The challenges in regulating long-term care quality: An international comparison, Cambridge, Cambridge University Press.

15 Eurohealth, Vol. 19(4), 2013, available at http://www.euro.who.int/__data/assets/pdf_file/0003/236811/Eurohealth_v19-n4.pdf

- The following policy summaries have been developed as part of the series of policy summaries published by the European Observatory on Health Systems and Policies. These policy summaries will be available on the website of the European Observatory from February 2014[16].
    - Policy Summary 10 Cross-border health care in Europe cuts across many of the themes explored by the project and updates a previous publication from 2005.
    - Policy Summary 11 How can choice of provider be facilitated with public reporting in health and long-term care? draws mainly on the work packages entitled Patient Choice and Public Reporting on Quality of Care and Measuring and Reporting Quality of Long-term Care, as well as a broad range of academic and other literature.
- The ECAB partners have all been active in disseminating the results of the project at conferences. Some of the main events included:
    - A workshop entitled EU Collaboration on Cross-border Care: exploring quality information and its impact on user choice and provider behaviour in residential care across six European countries, held at the International Long-term Care Policy Network Conference, 5-8 September 2012, London, UK.
    - A workshop entitled Is the grass always greener on the other side? Mobility of patients, and health and long-term care professionals to and from Eastern European countries, held at International Conference on Challenges for Health and Healthcare in Europe 2012, 1-2 November 2012, Aalborg, Denmark.
    - Multiple presentations at:
        - European Conference on Health Economics (ECHE) 2012, Zürich, Switzerland, 18-21 July 2012
        - European Public Health Association (EUPHA) 2012, Malta 7-10 November 2012
        - International Society for Quality in Healthcare (ISQua), Edinburgh, UK, 13-16 October 2013
        - European Public Health Association (EUPHA) 2013, Brussels, Belgium, 13-16 November 2013
    - The 6th Partners Meeting and Final Conference, held in London, UK on 25 October 2013 to coincide with the implementation of the Directive. Sessions on Research findings and implications for policy and Implementing the Directive.
    - In addition to these conferences, partners have been active in meeting and discussing results with stakeholder groups, for example, with presentations on prescriptions and on hospital collaborations to DG Sanco at the European Commission, discussions about licensing and registration of health professionals at the General Medical Council in England, and a presentation on hospital collaborations at a regional conference for policymakers on the German-Polish border.

[16] http://www.euro.who.int/en/about-us/partners/observatory/policy-briefs-and-summaries

Further details

More information on this project can be found at www.ecabeurope.eu.

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