

Statistics on Patient Mobility in the Nordic Countries



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Statistics on patient mobility in the Nordic countries

- Pre-study

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Preface

This pre-study was prepared with the help of NOMESCO, the Nordic Medico-Statistical Committee. The principal purpose of the Committee is to produce comparable health statistics on the Nordic countries, but it also conducts investigations to support the development of compiling statistics as necessary and commissions thematic studies contributing to its sphere of operations (see www.nowbase.org).

In accordance with the mandate received from the Nordic Council of Ministers for Health and Social Affairs, NOMESCO set up a joint Nordic project group for this project in March 2016.

All countries nominated their national experts and the project was lead by Finland. This editorial team prepared the text of the present report on the basis of the material produced by the national experts, and the contents were reviewed by the project group. We hereby submit the collective output of the group for discussion by the relevant Nordic cooperation bodies.

3 July 2017

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Chapter 1

Introduction

Patient mobility has not been high on the agenda of Nordic cooperation until recent years. A report entitled *Det framtida nordiska hälsosamarbetet* [Nordic health cooperation in the future] by investigator Bo Könberg, published in 2014, contained 14 recommendations¹. The recommendation no. 7 addressed the potential for promoting patient mobility between the Nordic countries.

A written question on this matter was tabled at the Nordic Council in September 2015, *Gränsöverskridanden hälso- och sjukvård i Norden* [Cross-border health and medical care in the Nordic countries]. In the same autumn, the Nordic Council of Ministers returned a response to the effect that the impacts of the EU Cross-border Healthcare Directive were impossible to assess, because it had only been in force for a few years and not enough relevant statistics were available (see e.g. *Commission Report on the Operation of Directive 2011/24/EU on the application of patients' right in cross-border health care*). The Nordic Council of Ministers further noted that it had not initiated any measures to promote the use of health care services across borders.

Therefore mentioned matters were taken into account when preparing the programme for Finland's Presidency of Nordic cooperation in 2016. A requirement to launch a pre-study with a situational and statistical review for reinforcing the knowledge base for the needs of the current debate was entered into the sector programme for health and social welfare. This assignment was seen to fall within the purview of the Nordic Medico-Statistical Committee, NOMESCO, which was charged with preparing the project plan and returning a report within about one year.

The preliminary project plan was discussed and appointed by the NOMESCOs and NOSOSCOs budget and planning meeting on 8 December 2015 in Copenhagen. After receiving additional comments to the project description and the content of the project plan, the Finnish team finalised the project description in the annual sector program for the Minister Council for Social Policy and Health.

¹ The report is available in Swedish, English, Finnish and Icelandic: <http://norden.diva-portal.org/smash/record.jsf?pid=diva2%3A723233&dswid=1497>

In the sector programme, the patient mobility project was required to exchange information and to collaborate with three other Nordic groups: *the Nordic Network on Rare Diseases*, *the Nordic eHealth Group* and *the Nordic Group on Highly Specialised Care*. The purpose of this was to avoid overlaps, to verify the interfaces between executive bodies and to ensure that the outcomes of this pre-study would be made available to the aforementioned more permanent cooperation groups.

The adopted project plan allowed for the expert group to augment its mandate with regard to relevant subordinate issues in patient mobility as necessary. The mandate, according to the requests presented in the aforementioned steering documents and expressed in political debate in the Nordic Council, was to explore how the EU Patient Mobility Directive had been implemented in the Nordic countries through national system descriptions. It was also considered necessary to describe the extent of the phenomenon by information on patient mobility volumes between countries. NOMESCO itself is particularly interested in whether the project group will make recommendations for improving the joint Nordic compiling of statistics.

The expectation of completing the pre-study rapidly, together with the known shortage of available statistics, presented major challenges for the project group. It quickly became clear at the first meetings of the national experts that the realistic approach was to draft a situational review on a comparative basis (*a state of the art* report). The report has been structured on the basis of the information requirements given in the mandate. We use situational reviews from the various countries as case studies in the various chapters and present material produced in other countries as empirical sources in the appendices to support the summaries and conclusions of the main chapters.

In the final chapter, we present a number of recommendations for further discussion by the Nordic cooperation bodies. In preparing these, the national experts in the project group consulted their respective national authorities concerning needs in developing Nordic cooperation, with specific reference to their wishes regarding the monitoring of and statistics on patient mobility.

Chapter 2

Mandate given for this group by NOMESCO and the aims of the study

NOMESCO was notified of the recommendations in Könberg's report for developing health care cooperation between the Nordic countries in 2014. In the joint preparation of work programmes for the statistical committees NOMESCO and NOSOSCO, the Finnish government indicated willingness to assume leadership in conducting a pre-study on patient mobility. Project preparation was dovetailed into the preparations of Finland's Presidency of Nordic cooperation in 2016.

After the preliminary project plan was presented at the NOMESCOs and NOSOSCOs budget and planning meeting on 8 December 2015 in Copenhagen and receiving additional comments to the project description and the content of the project plan, the Finnish team finalised the project description in the annual sector program for the Minister Council for Social Policy and Health.

The aims of the preliminary study are:

- to prepare system descriptions, how the Nordic countries and autonomous areas have solved patient mobility questions and the practical arrangements
- to map and present the existing statistics on patient mobility
- to prepare a proposal how health statistics should be developed in the future
- to consider, if a full-size project on patient mobility in the Nordic countries should be launched

The preliminary plan left room for manoeuvring in the mandate to allow for exploring subordinate issues in patient mobility, should the forthcoming expert group consider it necessary. At the launch meeting in Helsinki (18-19 April 2016) and at the following working meeting in Copenhagen (30 August 2016), where all countries and the interested autonomous regions¹, Åland and Greenland were represented, the mandate was finalised. It was already clear by then that it would not be possible to compile very much new national data within the brief time period allocated to the pre-study. We also excluded those private health services, which Nordic people

¹ The Faroe Islands government has not participated actively in the work of the project group but has been kept informed and has followed the progress of the pre-study.

purchases without reimbursement from the public sector. These include for example cosmetic surgery and assisted reproductive technologies not provided in their country of origin.

On the basis of a question tabled at the Nordic Council, it was agreed that the pre-study should involve an investigation of patient mobility in border regions, possibly in the form of a case study. Because of the low availability of national data, there was a desire to explore whether regional authorities along borders had any monitoring systems of their own in place for patient mobility and further whether it would be possible to combine the data in such systems with data from national hospital discharge registers and health insurance compensation systems to create a more comprehensive big picture.

Another current phenomenon - increased immigration - contributed to the specifications of the mandate. Refugee mobility to Europe from neighbouring areas began to increase substantially in 2015. A record number of humanitarian migrants arrived in the Nordic countries in 2015-2016. It could be anticipated that a large percentage of these migrants would not be granted permanent asylum, and there is a risk of the number of illegal immigrants in the Nordic countries increasing considerably in the near future.

Undocumented immigrants may come to pose a serious challenge for health care if legislation, resourcing for health care services and funding are not brought up to speed commensurate with the new situation. Because of this new and challenging situation, the project group decided to request national system descriptions concerning the rights of and regulations on undocumented immigrants to care from all Nordic countries, with a rapid response time. It is also intended in the course of the project to compile evaluation data on the number of undocumented immigrants in the various countries and autonomous regions.

Chapter 3

Background: EU directive and regulation

3.1 EU Cross-border health care directive and regulation 883/2004

Directive 2011/24/EU on patients' rights in cross-border healthcare clarifies the rules on access to healthcare in another EU country, including access to care and reimbursements. All EU countries had until 25 October 2013 to pass their own laws implementing the Directive. Norway implemented the legislation in 2015 and Iceland in 2017. The directive is also valid in Faroe Islands and Åland Islands. Greenland is not a member of EU and has not formally joined the directive, but joins a general treatment obligation.

Citizens needing care when temporarily in another EU/EEA country or Switzerland will benefit from the existing Regulation 883/2004 and the European Health Insurance Card (EHIC), and be provided with the medically necessary care that cannot be postponed until patient returns home care they need and benefits in kind that becomes necessary on medical grounds, taking into account the nature of the benefits and the expected length of the stay. Emergency care is to be provided for all, but EHIC ensures medically necessary care with the same customer fee as for residents of the country.

For planned care, under the Regulation, a patient can apply for prior authorisation. This authorisation cannot be refused if he/she cannot be treated in the home country within a time limit which is medically justifiable. The treatment, however, must be included in the selection of healthcare services in the country of residence.

The legal instruments do not cover all healthcare providers. Some private providers are excluded, for example. In addition, under the Regulation, patients are usually obliged to apply for authorisation for all planned/elective treatments, whereas under the Directive, authorisation should be the exception rather than the rule.

The Directive is based on the fact that the patient without pre-judice is entitled to receive treatment in an EU/EEA country but will pay all the costs of the treatment him- or herself. He/she will apply for a reimbursement for his/her competent (with a health insurance) country under the legislation of the country of residence only after returning home.

The Regulation is based on the fact that the patient has a European Health Insurance Card or any other document - a certificate provisionally replacing the European Health Insurance Card) - showing the right to care if it is a person residing in another country than the country of insurance. The medically necessary care of the citizens of all Nordic countries can also be obtained by displaying an official identity

card and providing their address information to the service provider. Forms (S1/respective E-forms) are generally not used in the Nordic countries, but when moving to another Nordic country, the Nordic residents have full access to health care based on Regulation 883/2004 and the legislation of the country where they live.

Between the Nordic countries, however, there are several Nordic agreements on health care and social services¹:

- Agreement between Denmark, Finland, Norway and Sweden on cooperation over territorial boundaries, the purpose being to prevent or limit damage to people, property or the environment in cases of accidents and emergencies
- Nordic public health preparedness agreement between Denmark, Finland, Iceland, Norway and Sweden, signed on 12 June 2002
- Nordic Convention on Social Assistance and Social Services of 14 June 1994
- Nordic Convention on Social Security of 12 June 2012
- Agreement on common Nordic labour market for certain health professionals and veterinarians of 14 June 1993, as amended by the Convention of 11 November 1998

Furthermore, the Nordic countries have several regional agreements for cross-border collaboration. Therefore, most of utilisation of cross-border services are not done on the basis of EU agreements.

More information:

http://ec.europa.eu/health/cross_border_care/policy_en
<http://ec.europa.eu/social/main.jsp?langId=en&catId=849>

3.2 European Health Insurance Cards

In 2015, approximately 3.5 million European Health Insurance Cards (EHIC)² were issued and there were almost 10.9 million EHICs valid in the five Nordic countries. Almost 45 per cent of population had an EHIC in 2015. The share was substantially higher in Denmark (62 per cent) and Sweden (53 per cent) than in Norway and Finland (both just under 29 per cent).

Table 3.2.1 The number of European Health Insurance Cards in the Nordic countries in 2015

	Denmark	Finland	Iceland	Norway	Sweden	Total
EHIC						
- issued in 2015	688 707	913 880	54 115	665 311	1 198 614	3 520 627
- valid in 2015	3 494 847	1 578 400	141 354	1 500 000	4 162 822	10 877 423
- insured people	5 600 000	5 490 376	332 529	5 189 893	7 841 769	24 454 567
- valid EHICs in 2015, %	62.4	28.7	42.5	28.9	53.1	44.5

Source: EU statistics

¹ www.nordicinnovation.org/Global/Publications/Reports/2011/2011_patientMobility_report.pdf

² The European Health Insurance Card is issued free of charge and allows anyone who is insured by or covered by a statutory social security scheme of the EU/EEA countries and Switzerland to receive medical treatment in another member state free or at the same costs as residents, if that treatment becomes necessary during their visit (for example, due to illness or an accident), or if they have a chronic pre-existing condition which requires care such as kidney dialysis. The term of validity of the card varies according to the issuing country.

Chapter 4

National system descriptions

All the Nordic countries are also obliged by the legislation given in 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 and Regulation 883/2004 on the coordination of social security systems as well as the Nordic Agreements. The basic rule in the Regulation is that all citizens of EU/EEA countries have access to healthcare services in other EU/EEA countries or in Switzerland. Appendix 1 presents the main rules for visits to doctor and dentists, hospital outpatient care, hospital inpatient care, prescriptions, and the use of ambulance services in the Nordic countries based on the Regulation. Pre authorisation is not required. Regarding claims based on the Directive, Finland and Norway applies for a dead line of six months for all claims and in Iceland the deadline for the claims is four years. In Denmark, claims must be submitted within a three years deadline. The national system descriptions are given in Appendix 2.

Nordic Convention on Social Security and the rules of coordination under EC-Regulation 883/2004 in relation to healthcare apply to all people health insured in Nordic countries. The EHIC does not cover expenses for transport back home. However, travelling expenses is included in the Nordic Convention for visitors between the Nordic Countries, who for medical reasons have extra expenses for travel home.

4.1 The Danish cross-border healthcare system as an example

The Danish healthcare system is a residence-based system, which means that a person will only be covered under the public Danish healthcare system as long as he/she is registered with the Danish Civil Registration System as resident in Denmark. If a person moves abroad on a permanent basis, he/she will no longer automatically be covered by the public Danish health insurance unless he/she is covered pursuant to EU-legislation (EC-Regulation 883/2004 on coordination of social security systems) or other international agreements e.g.:

- Frontier workers, who work in Denmark and live in another member state, may obtain a special health insurance card from Denmark. That card gives the right to healthcare in Denmark on the same terms as other citizens in the country

- Danish officials and workers posted by a Danish company in another EU/EEA-country or Switzerland on a short assignment (2 years) can remain under the Danish health insurance scheme and obtain a special health insurance card from Denmark
- Students, who travel to another EU/EEA-country or Switzerland as a part of their study for a temporary period of time (up to 1 year) can stay insured in Denmark during this period of time and will be covered by the European Health Insurance Card in the country, where they study

Persons residing in another EU/EEA-country or Switzerland can according to EU-legislation be entitled to public healthcare in their country of residence paid for by Denmark e.g.:

- Danish pensioners, who only receive social pension from Denmark.
- Frontier workers living in another member state.
- Danish officials and workers posted by a Danish company in another EU/EEA-country or Switzerland may be entitled to healthcare funded by Denmark in the country, where they are posted

A valid European Health Insurance Card (EHIC) issued by Denmark gives the right to access public healthcare for unplanned treatment during a temporary stay in another EU/EEA-country or Switzerland at the cost of Denmark. The EHIC covers treatment, which becomes medically necessary during the stay, taking into account the nature of the benefits and the expected length of the stay. Treatment should be provided on the same basis and at the same costs as it would to an insured person of the country in question. The EHIC also covers treatment of pre-existing medical conditions and routine maternity care, provided the reason for the visit is not specifically to seek treatment or give birth. The EHIC does not cover private healthcare or transport back home after falling ill or having an accident, while visiting another member state.

The National legislation in Denmark complements the Danish patients' rights under Regulation 883/2004. According to the Danish national legislation the regions can refer patients in need of highly specialized treatment to treatment abroad if the treatment in question is not available in Denmark. The regions may also refer patients to receive research-related treatment abroad if relevant treatment is not available in Denmark. Patients suffering from life-threatening diseases can be referred to experimental treatment abroad if public hospitals in Denmark are unable to offer further treatment. The referral in these cases is subject to approval of the Danish Health Authority. The hospital authorities can also offer patients hospital treatment abroad for instance if the treatment cannot be provided in Denmark within a time limit, which is medically justifiable. If a patient is referred for planned treatment at a public hospital in another EU/EEA-country or Switzerland the authorities may issue a S2 form.

Pursuant to the EU Directive on cross-border healthcare, Danish insured persons have the right to reimbursement of the costs of healthcare provided in other EU/EEA member states. The Directive 2011/2004 covers both public and private healthcare, however, the patients have to pay the costs for their medical treatment upfront and then apply for reimbursement, when they return to Denmark. Expenses will be reimbursed up to an amount corresponding to the costs of the treatment in Denmark.

The conditions for reimbursement are the same as those in force for healthcare received in Denmark.

In some cases, patients may need prior authorization before receiving hospital treatment abroad. Prior authorization is granted by the regional authorities in Denmark and is required for hospital treatment if the treatment requires overnight hospital accommodation or the treatment involves highly specialized and cost-intensive equipment. The conditions and formalities for Danish patients seeking healthcare abroad are the same as if the treatment was received in Denmark, and the same or a similar treatment must be available in the public healthcare system in Denmark.

EU/EEA citizens or Swiss nationals, who are covered by a public health insurance scheme in their countries, have the right to obtain public healthcare that becomes medically necessary during their stay in Denmark under the EHIC. The EHIC covers treatment on the same basis and at the same costs as for Danish insured persons. The charge for the treatment will be forwarded to the statutory health insurance service that issued the EHIC. However, nationals from non-EU countries, who are legally residing in another EU-country and thereby are covered by a social security scheme, cannot use their European Health Insurance Card for medical treatment in Denmark.

According to the Danish legislation implementing the Directive 2011/2004/EU the public hospitals in Denmark offer treatment against payment to patients covered by a public health insurance scheme in another EU/EEA-country. However, the patients need to be referred by a specialist or a GP. The Danish regions and municipalities also provide a number of public healthcare services against payment, for instance general dental care for children and young adults up to the age of 18, nursing care at home and municipal physiotherapy (subject to a referral by a doctor or a GP), rehabilitation following discharge from a hospital, provided a doctor has determined that rehabilitation is required. There may be limited access to regional or municipal healthcare services in Denmark due to lack of capacity e.g. if the waiting list for a particular type of treatment is long and other patients would be postponed as a result of the acceptance of patients from other EU/EEA-countries. The authorities must be able to explain their decision to refuse treatment.

Treatment in private hospitals or by licensed Danish health professionals within the private sector is offered in various places in Denmark. The private hospitals or health professionals are required to offer treatment to patients from other EU/EEA-countries at the same price and terms, which apply for Danish patients in a similar health situation.

In accordance with the Danish Health Act, all non-residents (regardless of nationality), who are staying in Denmark temporarily, are entitled to emergency hospital care free of charge in the event of an accident, childbirth, acute illness or sudden aggravation of a chronic disease.

4.2 Comments on any differences for other countries

The basic principle in all the Nordic Countries is a tax-financed universal public health service for all citizens and permanent residents. There are, however, differences in how health care services are produced and financed. Whilst Denmark and Iceland provide tax financed universal public healthcare service for all residents, in Finland public health care services are financed by municipal taxes, state subsidies

and patient fees. The public health care services are operated by municipalities. The public health care services are supplemented by private health care services. The cost of private health care services are partly refunded to the patient by general sickness insurance, which is financed by the insured persons and state subsidy. In Norway the public health service is mainly financed by taxes or patient fees. The responsibility for ensuring public healthcare services is divided between municipalities, the counties and the state. The responsibility for health and medical care in Sweden is shared by the central government, county councils and municipalities. The Health and Medical Service Act regulates the responsibilities of county councils and municipalities, and gives local governments more freedom in this area. The role of the central government is to establish principles and guidelines, and to set the political agenda for health and medical care. Responsibility for providing health care is devolved to the county councils and, in some cases, municipal governments.

Patients' right to choose their healthcare service provider varies also slightly when compared by country.

In Denmark, every resident can choose once a year between two groups: One entitles to free medical treatment by a doctor who has joined the collective agreement with the Public Health Service. The other group entitles to free choice of medical practitioner - also among GPs who have not joined the collective agreement. The Public Health Service in this group only pays a part of the doctor's fee. Access to hospital is upon referral of a general practitioner or specialist. Danish have free choice of public hospital. Patients can also choose a private hospital in Denmark or abroad with agreement with the regional health authorities if the waiting time after referral to treatment in a regional public hospital is more than one month.

In Greenland, all residents are covered by universal public health care. Patients, who are referred for investigation, examination and/or treatment outside of Greenland, receive individual medical guidance and information on the reasons/assessment for the referral as well as the progress of the treatment outside Greenland. This very reason/assessment is made on the basis of decisions in the Visitation Committee, working out of the law and the instructions for obtaining services outside the country. If persons in the need of health care do not have residence in Greenland, the rules for temporary stay in Greenland applies. Greenland is not a member of EU, has not formally joined the EU Cross-border Healthcare Directive, but joins a general treatment obligation.

In Finland, patients have the right to choose among the health centre units for primary health care services. Once a year, patient may transfer from one health centre unit to another by giving a written notification. Each person may only be registered with one health centre unit at a time. Insofar as possible, the patient also has the right to choose the physician or other health care professional treating him or her. Those who need specialized medical care services in public hospitals can also choose to use any of the specialized medical care units. The treatment will be selected together with the referring physician or dentist.

In Iceland, there is also free choice of general practitioners and specialists. Residents are registered with a general practitioner employed in a health care centre or with an independent general practitioner. Hospitalization is upon referral by a doctor. In case of planned treatment the patient may have some choice.

In Norway, you are permitted to change your GP twice per calendar year. Opt-out possibility exists. In Norway you need to be referred by your doctor (GP) before you can receive medical care from the specialist healthcare services. As a patient of the specialist healthcare service, you have a right to choose your place of treatment.

In Sweden, there is free choice (fritt vårdval) of general practitioners and specialists in the public healthcare system and private practitioners affiliated to a county council or region. It is possible to freely apply for open specialist care without referral throughout the country, provided that the county council does not have a referral requirement. For examinations at only medical service units (X-ray and laboratories), referral is required. With a personal care request, the patient may submit a referral to a specialist in open minded (not including dental care), even outside the county, if the chosen reception offers this option. When the patient receives a referral to specialist care, it is possible to choose a county medical specialist at any hospital in the country. It is also possible to choose private practice specialist physician only if he has a care agreement with any county council. One condition is that the selected device or doctor has the opportunity to receive you. For hospital care, the same rules apply to the patient's free choice. It is the medical assessment that determines whether a patient should be referred to such care. Highly specialized care is such specialist health care that is usually not available at the county health care level.

Sources:

- Descriptions of National Healthcare systems in Nordic Countries provided by members of project group. Spring 2017
- The EU's Mutual Information System on Social Protection (MISSOC). <http://ec.europa.eu/social/main.jsp?catId=815&langId=en>. Read: 20.04.2017

Chapter 5

Statistics at the EU level and in the Nordic countries

5.1 Statistics on EU level

Statistics on patient mobility in accordance with Regulation 883/2004 is collected annually at the EU level. It should be noted that most of the care between citizens and residents of Nordic countries are not included in these statistics due to the Nordic agreements.

In 2015, some 48 700 E125 reimbursement forms were issued and 78 300 received in the Nordic countries (Table 5.1).

Definitions:

S1: (formerly E106, E109, E120 and E121 - still issued by some institutions). Certificate of entitlement to healthcare in the country of residence if person does not live in the country where insured. Useful for posted workers, cross-border workers, pensioners and civil servants and their dependents. Submit to any health insurance authority in the country of residents.

S2: (formerly E 112). Authorisation to obtain planned health treatment in another EU/EEA country is issued by the competent State and must be requested prior to the treatment. Person should be treated the same as a resident of that country - if one may have to pay a patient charge, the fees have to be same than for national citizens. The S2 form is submitted to the institution of the place of stay.

E125 (SED S080): Form E125 is an individual statement of the costs of the medical treatment a person has received in another Member State. It is used by the Member State who provided the treatment to claim the actual costs of medical treatment involved from the Member State where the person is insured.

Table 5.1.1 The number of E125 and SED S080 forms in the Nordic countries, 2015

	Denmark	Finland	Iceland	Norway ¹	Sweden	TOTAL
E125 forms issued	10 700	6 766	3 984	1 446	25 766	48 662
€	4 300 000	4 444 359	NA	6 508 838	21 739 517	36 992 714
SED S080 issued	0	0	0	0	0	0
€	0	0	0	0	0	0
E125 forms received	15 323	14 390	1 231	NA	47 361	78 305
€	8 100 000	NA	1 566 212	NA	23 635 634	NA
SED S080 received	0	8	NA	NA	NA	8
€	0	NA	NA	NA	NA	NA

1 When using EHIC

The numbers of issued and received S2 forms in 2015 were in total 348 (excluding Iceland) and 65 (excluding Sweden). Of these, 100/365 issued forms (29 per cent) and 18/65 received forms (28 per cent) were related to Nordic cross-border health care. In total, 195 S2 forms were refused issued of which 26 concerning treatment in another Nordic country (13 per cent).

The numbers of S1 forms issued and received in 2015, were in total 15 804 and 1 051 (table 3). Denmark and Finland did not issue any S1 forms for persons residing in other Nordic countries (as they are not required), but Iceland issued 27 forms (out of 184) to insured persons living in another Nordic country. Norway and Sweden did not provide any data.

There were even less data on received S1 forms: Finland reported no forms from other Nordic countries and Iceland reported 8 (out of 30) forms from other Nordic countries.

Table 5.1.2 The number of S1 forms in the Nordic countries, 2015

	Denmark	Finland	Iceland	Norway ¹	Sweden	TOTAL
S1 forms issued (E106, E109, E120, E121)	520	729	184	11 727	2 644	15 804
<i>Country of residents</i>						
Denmark ¹	NA	0	10	no info	no info	10
Finland	0	NA	0	no info	no info	0
Iceland	0	0	NA	no info	no info	0
Norway	0	0	7	NA	no info	7
Sweden	0	0	10	no info	NA	10
Nordic countries total	0	0	27			27
%	0.0	0.0	14.7			0.2
<i>Country of insurance</i>						
Denmark	NA	0	3	No info	No info	3
Finland	No info	-	0	No info	No info	0
Iceland	No info	0	NA	No info	No info	0
Norway	No info	0	0	NA	No info	0
Sweden	No info	0	5	No info	NA	5
Nordic countries total		0	8			8
%		0.0	26.7			0.8

Source: EU statistics

It should be notified that these statistics on the amounts of reimbursements are incomplete. First of all, not all countries have reported all the requested data to the EU. Second, the use of health care services by Nordic citizens is not included in these statistics due to the Nordic agreements.

For Denmark, the top three countries for reimbursements are Germany, Poland and Spain. In Finland, most reimbursement claims are received from Spain, Germany and Estonia, and most issued claims from Estonia, Germany and France. Iceland received most claims from Germany, Belgium and Spain, and issued most claims from United Kingdom, Germany and the Netherlands. Norway receives most claims and makes most reimbursements to Poland, Germany and Spain, and issues and send most claims to Germany, the Slovak Republic and the Netherlands. No data were available for Sweden.

Furthermore, EUROSTAT - the statistical office of the EU - collects information on patient mobility regarding inpatient hospitalisations. Member states are requested to provide the number of hospital discharges of non-resident patients according to place of residence (NUTS code for patient's place of residence according to four-digit NUTS code) and place of treatment (NUTS code for location of the treating institution according to four-digit NUTS code). The data have not been released yet, most likely due to low availability of data.

For example Finland can provide the statistics according to place of treatment with four-digit NUTS codes, but the data on place of residence are only available on the country level. It has been suggested that the data collection on patient mobility will not be included in the implementation regulation on non-expenditure health care statistics, which are to be decided in 2-3 years. This means that the countries

participating in the joint Eurostat-OECD-WHO data collection can provide this information voluntarily.

5.2 National statistics

Since the EU statistics on cross-border use of healthcare services are incomplete we explored the possibilities to get comparable data on use of hospital services in the Nordic countries. Denmark, Greenland, Finland, Åland, Iceland and Norway were able to provide some data, but the comparability was challenging. Finland and Åland provided only inpatient care. Åland had only data on patients while Norway provided data on episodes only (table 5.2.1).

The proportion of episodes by foreigners of the total number of episodes within outpatient or inpatient hospital varied between 0.1 per cent and 1.2 per cent of all episodes. The proportion of patients from other Nordic countries varied between 26 per cent and 46 per cent giving a total share between 0.0 per cent and 0.4 per cent of all episodes.

The proportion of foreign patients of the total number of patients within outpatient or inpatient hospital care varied between 0.6 per cent and 1.6 per cent of all episodes. The proportion of patients from other Nordic countries varied between 26 per cent and 41 per cent giving a total share between 0.1 per cent and 0.4 per cent of all episodes.

It should be noted that countries have different proportions of foreigners with missing information on their country of origin. Norway and Åland reported no episodes/patients with missing data. In Denmark, the share of foreigners with unknown country was 48 per cent for outpatient episodes and 35 per cent for inpatient episodes. For patients, the shares of missing data were 44 per cent for outpatient care and 35 per cent for inpatient care. In Iceland, the share was 27 per cent for inpatient episodes and for inpatients and 38 per cent for outpatient episodes (emergency care). Finland had incomplete information on the country of residence for 41 per cent of inpatient episodes and 45 per cent of patients in inpatient care.

Table 5.2.1 Hospital care episodes and number of patients for patients with foreign background in the Nordic countries, 2015

	Denmark	Finland	Åland	Iceland	Norway
	Outpatient hospital care				
Episodes					
<i>Nordic countries</i>	18 935	..	..	229	4 538
<i>Other EU/EEA countries</i>	9 301	..	..	821	5 240
<i>Other countries</i>	13 136	..	..	578	3 126
<i>Unknown</i>	38 549	..	..	933	0
<i>Total</i>	13 603 318	..	..	117 613	12 106 159
Patients					
<i>Nordic countries</i>	7 444	..	..	..	..
<i>Other EU/EEA countries</i>	6 850	..	..	..	..
<i>Other countries</i>	6 738	..	..	..	..
<i>Unknown</i>	16 511	..	..	..	..
<i>Total</i>	2 729 523	..	..	..	..
Proportions - episodes %					
<i>Nordic countries</i>	0.1	..	..	..	0.0
<i>Other EU/EEA countries</i>	0.1	..	..	..	0.0
<i>Other countries</i>	0.1	..	..	..	0.0
<i>Unknown</i>	0.3	..	..	..	0.0
<i>Total</i>	0.6	..	..	..	0.1
Proportions - patients %					
Nordic of all foreigners (Excluding unknown)	46	..	..	14	35
<i>Nordic countries</i>	0.3	..	..	..	..
<i>Other EU/EEA countries</i>	0.3	..	..	..	..
<i>Other countries</i>	0.2	..	..	..	..
<i>Unknown</i>	0.6	..	..	..	..
<i>Total</i>	1.4	..	..	..	..
Nordic of all foreigners (Excluding unknown)	35	..	..	..	..
Episodes					
<i>Nordic countries</i>	4 288	685	..	100	1 525
<i>Other EU/EEA countries</i>	2 143	900	..	62	2 011
<i>Other countries</i>	2 892	1 095	..	102	1 060
<i>Unknown</i>	4 982	1 849	..	97	0
<i>Total</i>	1 149 716	1 256 309	..	31 910	2 551 833
Patients					
<i>Nordic countries</i>	2 944	605	Total 82	99	..
<i>Other EU/EEA countries</i>	1 901	732		58	..
<i>Other countries</i>	2 420	951	12	101	..
<i>Unknown</i>	3 845	1 848	0	96	..
<i>Total</i>	695 515	710 736	4 971	..	..

Continues

Table 5.2.1 Hospital care episodes and number of patients for patients with foreign background in the Nordic countries, 2015, continued

	Denmark	Finland	Åland	Iceland	Norway
Outpatient hospital care					
Proportions - episodes %					
<i>Nordic countries</i>	0.4	0.1	..	0.3	0.1
<i>Other EU/EEA countries</i>	0.2	0.1	..	0.2	0.1
<i>Other countries</i>	0.3	0.1	..	0.3	0.0
<i>Unknown</i>	0.4	0.1	..	0.3	0.0
<i>Total</i>	1.2	0.4	..	1.1	0.2
Proportions - patients %					
Nordic of all foreigners (Excluding unknown)	46.0	26.0	..	38.0	33.0
<i>Nordic countries</i>	0.4	0.1	Total 1.6	1.0	..
<i>Other EU/EEA countries</i>	0.3	0.1		..	..
<i>Other countries</i>	0.3	0.1	0.2	..	..
<i>Unknown</i>	0.6	0.3	0.0	..	..
<i>Total</i>	1.6	0.6	1.9	..	..
Nordic of all foreigners (Excluding unknown)	41.0	26.0	..	26.0	..

Denmark

All patients in Danish public hospitals and most patients from the private hospitals are registered in the Danish National Patient Registry by their personal ID number and a code for their municipality (it is automatically for all citizens with an official personal ID number). Persons with residence outside Denmark, who do not have an official ID number, are manually coded with the code for municipality '9xx'.

We can see in the statistics that many have a municipality code '999' or missing information. The '999' code means residency 'unknown', but we do not know whether it is persons with residence outside Denmark or persons who lives in Denmark, but without of valid address (e.g. homeless people). In the forthcoming descriptive statistics, they are not presented. In an analysis, it is necessary to look further into this group and maybe do some standardization or imputation so the statistics will be sufficient.

Persons with residence outside Denmark are coded with a fictive personal ID for each case; they are given in hospital, so when you are counting numbers of patients, you often will count the same person several times, if the person has more than one case in hospital during a year. Therefore, when we count number of unique patients, the numbers of persons with residence outside Denmark might be overestimated.

In total 0.3 per cent of all outpatient visits are persons with residence outside Denmark, whereas the same number for inpatient is 0.8 per cent. If we look at the numbers of patients, please note the above reservation on counting numbers of patients. The numbers are 0.8 per cent of outpatient cases are persons with residence outside Denmark and 1.0 per cent are inpatients. These two groups combined: 0.9 per cent of persons in the Danish Public Hospitals have a residence outside Denmark, as we know of. There is a smaller amount of persons with residence outside Denmark in the group '999' or 'missings', this group overall are 0.9

per cent. Therefore, we can say that the share of persons with residence outside Denmark in Danish hospital is between 1.0 and 1.5 per cent of all patients.

When looking at the length of stay, we can see no significant difference between persons with residence outside Denmark and persons with Danish residence. Mostly persons with residence outside Denmark are male and younger when compared to persons with Danish residence. When looking at the distribution between 'acute' and 'elective', we can see that around half of the outpatient visits are acute. However, there is a variation between countries of origin.

Outpatient acute care for residence from Greenland and Faeroe Islands are less than ten per cent, which is less than the proportion of persons with residence in Denmark. Residents from Norway, Finland and EU/EEA countries: between 70 - 75 per cent of the outpatient visits are acute. For Sweden and other countries, it is between 40 - 50 per cent. Looking at inpatient care 70 per cent of residents in Denmark is acute, while for Greenland and Faeroe Islands it is only around 30 per cent. For other residents it is more than 85 per cent.

There are also interesting issues when looking at the main diagnosis: Greenland and Faeroe Islands is standing out. Many of the residents from here are treated for cancer ('svulster') this can explain some of, why so few of residents from these two countries are in acute care in Denmark. It is so that these two countries send their residents to Denmark for highly specialized treatment.

Greenland

The Department of Finance and Planning of Greenland provided detailed data on people living in Greenland who were treated in the Rigshospitalet in Copenhagen from January to October 2016. The number of episodes was 797, which equals approximately 960 episodes per year. The data included both planned care and acute care, as can be seen in the top ten diagnoses (table 5.2.2).

Table 5.2.2 The most common diagnoses of Greenlandic people treated in Copenhagen from January to October 2016

	Diagnose	Number	In %
1	I251 - Stable angina pectoris	40	5.0
2	C349 - Lung cancer, unspecified	35	4.4
3	I259 - Chronic ischaemic heart disease, unspecified	32	4.0
4	Unknown	28	3.5
5	N189 - Chronic kidney disease, unspecified	24	3.0
6	Z031 - Observation for suspected malignant neoplasm	23	2.9
7	Z950C - Presence of cardioverter-defibrillator (ICD)	23	2.9
8	I209 - Angina pectoris, unspecified	20	2.5
9	Z033 - Observ. for suspected nervous system disorder	14	1.8
10	C119 - Cancer in nasopharyngeal wall, unspecified	12	1.5
11	M480 - Spinal stenosis	12	1.5

Information on patients treated elsewhere in Denmark (104 patients in January-October 2016) or in Landspítali, Reykjavík (4 patients in January-October 2016) did not include information on diagnoses.

Additionally, there were 17 foreign tourists, who were treated in Greenland health care system in 2016. A care agreement exists for them to the extent that they were not from a country outside the EEA Agreement or in the Nordic Region.

Finland

Finland collects information on all people using Finnish health care services in the registers. The people not having residence in Finland can be identified with the municipal code '200'. If the clients or patients have a complete ID number, they are or have been Finnish citizens or have had permanent residency in Finland. If the ID number is lacking, the people can be visitors, health care service seekers, from countries with agreement of service provision, or recent migrants or asylum seekers.

The Finnish Hospital Discharge Register (HILMO Care register for health care and social welfare institutions) covers specialised health care and it is the only register, which includes a country code for foreigners with the municipal code '200'. For 31 per cent of discharges and 30 per cent of patients, the requested country code was, however, missing in 2014. This data cover only inpatient care and the data are not available for example for hospital outpatient care or for primary health care.

The proportion of foreigners is in small being 0.3 per cent of discharges, 0.2 per cent of hospital days and 0.4 per cent of patients (table 5.2.3). The five largest countries according to discharges and patients were Sweden, Russian Federation, Estonia, Germany and Spain.

Table 5.2.3 The number of discharges, hospital days and patients in Finland by their background in 2014

	Discharges	Hospital days	Patients
Foreigners	3 733	17 910	3 147
Unknown country	1 159	6 965	939
Nordic countries	779	2 777	657
Other EU/EES countries	965	4 455	829
Residence in Finland	1 260 398	8 986 278	714 858
Total	1 264 131	9 004 188	718 005
Foreigners, % of all	0.3	0.2	0.4

In 2012-2014, there were 2 291 discharges for 1 920 persons from the other Nordic countries. Most of the patients came from Sweden (87.4 per cent), and less often from Norway (9.3 per cent), Denmark (3.0 per cent) or Iceland (0.3 per cent). There were no patients from Faroe Islands or Greenland during these three study years (table 5.2.4).

Table 5.2.4 The number of discharges, hospital days and patients from other Nordic countries in Finland in 2012-2014

Country ¹	Discharges	Hospital days	Patients	Average length of stay	Discharges/patient
Denmark	63	285	57	4.5	1.1
Iceland	8	19	6	2.4	1.3
Norway	212	803	179	3.8	1.2
Sweden	2 008	7 125	1 678	3.5	1.2
Total	2 291	8 232	1 920	3.6	1.2

1. No patients from Faroe Islands and Greenland

In 78 cases (3.4 per cent) the diagnoses were missing, even though this is obligatory information and should always be reported. The most common main diagnoses and surgical procedures are given in Table 5.2.5.

Table 5.2.5 The ten most common main diagnoses and surgical procedures for foreigners in the Finnish Hospital Discharge Register 2012-2014

	Number	In %
Main diagnoses		
1 Pneumonia, unspecified ⁴	69	3.0
2 Atrial fibrillation and flutter	49	2.1
3 Other and unspecified abdominal pain	49	2.1
4 Acute nephritic syndrome	40	1.7
5 Chest pain, unspecified	37	1.6
6 Erysipelas	36	1.6
7 Otitis externa in erysipelas	36	1.6
8 Heart failure, unspecified	30	1.3
9 Spontaneous vertex delivery	29	1.3
10 Diarrhoea and gastroenteritis of presumed infectious origin	29	1.3
Surgical procedures		
1 Thorax X-ray examination	32	1.4
2 Inside imaging of coronary arteries	30	1.3
3 Internal fixation of fracture of ankle using wire, rod, cerclage or pin	28	1.2
4 CT of head and brain	22	1.0
5 Appendectomy	18	0.8
6 Physiotherapy	17	0.7
7 Extensive structural and functional ultrasound examination of heart	16	0.7
8 Cineangiography of both sides of heart	16	0.7
9 Assistance to normal delivery	12	0.5
10 Laparoscopic appendectomy	11	0.5

The main problem with these statistics is that there is no information why the patient had used the services in Finland: whether the person happened to be in the country, wanted to have the services in the country (for example Finns living in Sweden or in Spain), or the home country has a contract with country where the services were used. Additionally, Finnish people living elsewhere but are covered by Finnish health care as well as recent migrants and asylum seekers are included, but they cannot be distinguished from the current information system. Since 1 January 2017, however, the Hospital Discharge Register collects information on these inpatient and outpatient hospital care episodes, which have been provided under the Directive 2011/24/EU.

Åland Islands

ÅHS (Ålands hälso- och sjukvård) is in charge of public health care in Åland. It offers medical care to both the local population and visitors. This includes everything from preventive care to specialised hospital care given in the central hospital located in Mariehamn, in Turku/Åbo, Finland or in Uppsala, Sweden. In 2015, the share of outpatient visits was 25.6 per cent in Turku/Åbo and 2.5 per cent in Uppsala. For inpatient care, the shares of bed days were 20.8 per cent for Turku/Åbo and 10.0 per cent for Uppsala. The number of visits and inpatient days of people resident in Ålands Islands and treated in the neighbouring countries is shown in Table 9. Table 10

shows the number of referrals to and acute care episodes in the neighbouring countries by residents of Åland.

Table 5.2.6 Care of people resident in Åland Islands and treated in Finland or Sweden in 2015

	Visits, Number	Costs, €	Impatient days, Number	Costs, €	Cost/day, €
Turku/Åbo	2 165	726 702	1 504	1 922 199	1 278
Uppsala	214	241 083	721	1 946 136	2 699
Total	8 452	1 748 461	7 246	6 822 057	941

Table 5.2.7 The number of referrals to and acute care episodes in Finland and Sweden among people resident in Åland in 2011-2015

	Referrals		Acute care	
	Finland	Sweden	Finland	Sweden
2011	3 396	1 069	494	-
2012	2 690	870	520	1
2013	3 030	819	518	-
2014	3 299	975	685	-
2015	2 946	906	805	1

In 2015, the most common reasons for remission were neoplasms, i.e. cancers (C00-D48) with 995 referrals (25.9 per cent), diseases of the musculoskeletal system and connective tissue (M00-M99) with 449 referrals (11.7 per cent) and diseases of the circulatory system (I00-I99) with 354 referrals (9.2 per cent).

Of the 4 971 patients treated in Åland, 141 (2.8 per cent) were from Finland, 82 (1.6 per cent) from other EU/EEA-countries and 12 (0.2 per cent) from other than EU/EEA-countries. The shares of bed days were substantially lower: Of the 32 861 bed days, 201 (0.6 per cent) were for Finnish patients, 254 (0.8 per cent) for patients from EU/EEA countries and 17 for patients from other than EU/EEA countries. The distribution of patients and inpatient days by clinic is shown in Table 5.2.8.

Table 5.2.8 The number of hospital days and patients (net) by clinic in Åland Central Hospital in 2015

	Number of patients				
	Åland	Finland	Inside EU	Outside EU	Total
Emergency clinic	397	31	23	0	451
Children's and adolescents' clinic	316	6	10	2	334
Maternity and gynaecology clinic	855	26	4	5	890
Intensive care clinic					
Surgery clinic	1 412	27	28	0	1 467
Medical clinic	1 080	49	14	5	1 148
Psychiatry clinic	175	2	3	0	180
Rehabilitation and geriatrics clinic	501	0	0	0	501
- Ward 1a	70	0	0	0	70
- Ward 1b	155	0	0	0	155
- Ward 2a	169	0	0	0	169
- Ward 2b	107	0	0	0	107
Åland Central Hospital total	4 736	141	82	12	4 971
	Number of days of care				
	Åland	Finland	Inside EU	Outside EU	Total
Emergency clinic	283	12	22	0	317
Children's and adolescents' clinic	1 716	18	17	5	1 756
Maternity and gynaecology clinic	1 615	2	47	4	1 668
Intensive care clinic	394	0	0	0	394
Surgery clinic	4 067	68	55	0	4 190
Medical clinic	7 585	27	102	8	7 722
Psychiatry clinic	4 603	74	11	0	4 688
Rehabilitation and geriatrics clinic	12 126	0	0	0	12 126
- Ward 1a	2 141	0	0	0	2 141
- Ward 1b	3 425	0	0	0	3 425
- Ward 2a	5 345	0	0	0	5 345
- Ward 2b	1 215	0	0	0	1 215
Åland Central Hospital total	32 389	201	254	17	32 861
	Per patient				
	%/total	Days of care	Care episode	deaths	
Emergency clinic	1.0	0.7	1.1	0	
Children's and adolescents' clinic	5.3	5.3	1.2	0	
Maternity and gynaecology clinic	5.1	1.9	1.2	1	
Intensive care clinic	1.2				
Surgery clinic	12.8	2.9	1.2	15	
Medical clinic	23.5	6.7	1.4	62	
Psychiatry clinic	14.3	26.0	2.2	0	
Rehabilitation and geriatrics clinic	36.9	24.2	1.8	66	
- Ward 1a	6.5	30.6	1.3	7	
- Ward 1b	10.4	22.1	1.1	56	
- Ward 2a	16.3	31.6	1.6	3	
- Ward 2b	8.7	11.4	3.4	0	
Åland Central Hospital total	100.0	6.6	1.3	144	

Iceland

Iceland collects data on foreign users of health care services in the Directorate of Health. The data from Hospital Discharge Register shows that 20 per cent of discharges of foreigners are by people from the other Nordic countries (Table 5.2.9). By country, the largest number of patients came from the United States and Germany, but thereafter come Faroe Islands, Greenland and Denmark. The most common causes are injuries or acute health problems (Table 5.2.11).

Iceland has also statistics on foreigners who received emergency care in 2015. Of the 117 613 visits to the emergency departments of Landspítali and Akureyri Hospitals in 2015, in total 2 601 (2.2 per cent) were by foreigners. Of these, 229 were from the Nordic countries (8.8 per cent), 834 from EU/EEA countries (32.1 per cent) and 605 from other countries (23.3 per cent). For the rest - 933 visits, 35.9 per cent of all - patient's residence country remained unknown.

Table 5.2.9 Inpatient hospital care in Iceland by nationality, number of discharges 2012-2016

	Number	%
Nordic countries	365	20.2
EU/EEA	481	26.7
Other nationalities	516	28.6
Unknown	443	24.5
Total number of discharges (foreigners)	1 805	100.0

Table 5.2.10 Inpatient hospital care in Iceland by nationality, number of discharges, top 10 countries 2012-2016

	2012	2013	2014	2015	2016	Total
United States	29	41	41	45	62	218
Germany	34	36	30	40	39	179
Faroe Islands	62	44	21	21	15	163
Greenland	11	5	15	15	11	57
Denmark	16	10	7	10	8	51
United Kingdom	9	10	9	10	9	47
Canada	12	9	14	3	9	47
Norway	11	9	12	8	6	46

Table 5.2.11 The leading causes of hospitalisation among foreign patients in inpatient hospital care in Iceland 2012-2016

ICD-10 code	ICD-10 Name	2012	2013	2014	2015	2016	Total no. of discharges
S82	Fracture of lower leg, including ankle	31	36	31	44	56	198
S72	Fracture of femur	13	13	14	18	23	81
K35	Acute appendicitis	10	8	11	10	19	58
I21	Acute myocardial infarction	14	9	10	15	8	56
S22	Fracture of rib(s), sternum and thoracic spine	6	5	12	8	12	43
Z76	Persons encountering health services in other circumstances	18	18	2	1	-	39
S32	Fracture of lumbar spine and pelvis	6	3	9	5	7	30
S52	Fracture of forearm	2	4	7	6	6	25
J18	Pneumonia, organism unspecified	3	5	1	5	9	23
S06	Intracranial injury	2	-	7	9	5	23
S42	Fracture of shoulder and upper arm	2	5	3	7	6	23
I48	Atrial fibrillation and flutter	5	7	-	4	6	22
S02	Fracture of skull and facial bones	7	-	4	3	8	22
I63	Cerebral infarction	3	8	3	4	3	21
I10	Essential (primary) hypertension	7	3	3	2	5	20

Norway¹

Norway collects information, on specialised healthcare visits, for patients not having a residence in the country in the Norwegian Patient Register. Two variables can be used to identify such patients: municipal code and country of insurance. By using these variables, three groups of “foreigners” can be defined:

1. Patients with Norwegian municipal code, but other country of insurance than Norway. These patients include for example refugees and asylum seekers who are registered according to their Norwegian municipal of residence, but whose country of insurance is their original home country. Additionally, foreign citizens working in Norway and paying insurance are often coded according to their Norwegian municipal of residence and with their home country as their country of insurance.
2. Patient living in other countries or foreign citizens with other than Norway as their country of insurance. These patients include those coming from countries having agreement with Norway (e.g. EU/EEA countries), but also those, who come from other countries without such an agreement or from unknown countries.
3. Patients who have residence elsewhere, but who has Norway as their country of insurance. These patients, e.g. those moved to a new country for their retirement but who continues to have their insurance in Norway. They are excluded from the statistics presented here.

The quality of this data stemming from the specialised healthcare services remains unknown. There may be different practises to code the variables. There are no variables available that can indicate what regulation, directive or agreement the patient used when receiving the care in Norway

Table 5.2.11 shows the distribution of number of patient contacts for patient identified as foreigners using specialised health care services in Norway. The share of all visits among foreigners is 0.12 per cent. The most frequent main causes are injury, poisoning and certain other consequences of external causes (ICD-10: S00-T98, 34 per cent), factors influencing health status and contact with health services (Z00-Z99, 19 per cent) and symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99, 7 per cent), which contributes for 60 per cent of all visits by patients with other than Norwegian citizenship. For those patients living in Norway with foreign background according to their insurance status, the most frequent cases are factors influencing health status and contact with health services (Z00-Z99, 23 per cent), other (19 per cent, including missing) and mental and behavioural disorders (F01-F99, 13 per cent).

The number of inpatient care episodes, hospital days and their costs among patients from the other Nordic countries are shown in Table 5.2.12. The largest groups are people from Sweden, Denmark and Finland.

¹ Data from the Norwegian Patient Register has been used in this publication. The interpretation and reporting of these data are the sole responsibility of the authors, and no endorsement by the Norwegian Patient Register is intended nor should be inferred.

Table 5.2.11 The number of specialised health care visits in Norway 2015

	Foreign citizenship			Norwegian municipal, foreign background according to insurance status		
	Acute	Elective	Total	Acute	Elective	Total
Foreigners	12 051	5 449	17 500	1 496	3 830	5 326
Nordic countries	3 856	2 207	6 063	316	686	1 002
Other EU/EEA countries	5 539	1 712	7 251	346	308	654
Other countries	2 656	1 530	4 186	834	2 836	3 670
By country:						
Sweden	2 301	1 680	3 981	253	507	760
Denmark	1 244	314	1 558	48	134	182
Finland	164	155	319	6	29	35
Iceland	94	49	143	9	16	25
Faroe Islands	49	9	58	0	0	0
Greenland	4	0	4	0	0	0
Åland	0	0	0	0	0	0

Table 5.2.12 Inpatient care and its costs among Nordic patients in Norway 2015

	Days	Episodes	ALOS ¹	Costs, total (NOK)	Costs, per episode (NOK)
Foreign citizenship					
Nordic countries	2 890	983	2.9	57 127 422	58 115
Sweden	1 136	397	2.9	21 721 900	54 715
Denmark	267	66	4.0	3 015 448	45 689
Finland	160	42	3.8	2 367 273	56 364
Iceland	164	34	4.8	3 717 276	109 332
Faroe Islands	5	3	1.7	344 176	114 725
Greenland	0	0	..	0	..
Åland	2 890	983	2.9	57 127 422	58 115
Norwegian municipal, foreign background					
Nordic countries	812	138	5.9	8 889 121	64 414
Sweden					
Denmark	723	112	6.5	7 528 463	67 218
Finland	42	18	2.3	912 123	50 673
Iceland	43	7	6.1	407 240	58 177
Faroe Islands	4	1	4.0	41 296	41 296
Greenland	0	0	..	0	..
Åland	0	0	..	0	..

1 Alos = Average length of stay

Sweden

In the 1960's the National Board of Health and Welfare started to collect information regarding in-patients at public hospitals and from 1987 the National Patient Register (NPR) including all in-patient residential care (persons with personal identity number) in Sweden. Since 2001 the register also covers outpatient visits including day surgery and psychiatric care from both private and public caregivers. Primary care is not yet covered in the NPR.

All persons registered in Sweden receive a personal identification number. The personal identification number is given by the Swedish Tax Agency. People who have no known Swedish personal identity number or co-ordination number but need health care will get a reserve number (reservnummer) which is temporary and used only for the health care. The reserve number may change between hospital episodes, so there is no qualitative information on the number of non-resident patients in Sweden. There is no information on the country of origin in the Swedish NPR, and Sweden cannot make any reliable estimate on their proportion.

Chapter 6

Special issues relevant for this pre-study

6.1 Undocumented immigrants: Right to health care and challenges in the actual situation

The Nordic countries have been popular destinations for migrants for a long time. Not only Sweden but also Denmark and Norway have received large numbers of immigrants from countries outside Europe. The Nordic countries have also gained an international reputation as destination countries for humanitarian migration¹. Migrant flows to Finland and Iceland were relatively small until 2014. The situation in Finland changed radically in 2015, as Finland suddenly ranked fifth among EU-countries in the number of asylum applicants per population arriving from outside Europe.

The influx of immigration and changes in the political climate has been reflected in the tightening of legislation on residence permits in the Nordic countries. Similarly, legislation concerning the reunification of families has also been gradually tightened in the Nordic countries. The result is that even before the most recent wave of immigration it was estimated that there are tens of thousands of undocumented immigrants in the Nordic countries².

¹ For instance, in the OECD report Indicators of Immigrant Integration: Settling in 2015, Sweden, Norway, Denmark and Finland were described as “Destinations with significant recent and humanitarian migration” (p. 20, Figure 1.8 Classification of OECD and EU countries).

² Available estimates of the number of undocumented migrants were 18 100 in Norway in 2008 (NOU 2008:11), 31 200 in Sweden in 2010 (SOU 2011:15), and about 20 000-22 000 in Denmark according to the report Sundhedsytelser til uregistrerede migranter [Health care services for undocumented migrants] (2014). In the same year, Finland’s National Institute for Health and Welfare estimated in a report that there were about 3 000 undocumented migrants in the country.

Table 6.1.1 Asylum applicants in the EU - Top ten countries in 2015 with trends from 2011 onwards (Annual Report on the Situation of Asylum in the European Union 2015, European Asylum Support Office 2016)

	2011	2012	2013	2014	2015	% change 2014- 2015	Per million inhabitants in 2015
Hungary	1 690	2 155	18 895	42 775	177 135	+314	17 973
Sweden	29 650	43 855	54 270	81 180	162 450	+100	16 666
Austria	14 420	17 415	17 500	28 035	88 160	+214	10 280
Norway	8 990	9 675	11 930	11 415	31 110	+173	6 021
Finland	2 915	3 095	3 210	3 620	32 345	+794	5 911
Switzerland	23 615	28 400	21 305	23 555	39 445	+67	4 788
Luxembourg	2 150	2 050	1 070	1 150	2 505	+118	4 450
Malta	1 890	2 080	2 245	1 350	1 845	+37	4 297
Belgium	31 910	28 075	21 030	22 710	44 660	+97	3 967
Denmark	3 945	6 045	7 170	14 680	20 935	+43	3 699

As the discussions for specifying the mandate of the project group were under way, NOMESCO was notified of a letter from the Secretary General of the Nordic Council of Ministers (26 April 2016) in which the cooperation ministers stressed the importance of taking the wave of refugees into consideration in Nordic cooperation. It was considered that compiling national system descriptions regarding the right of undocumented migrants to health care was an appropriate job for the present project, since it was already planned to involve documentation of the legislative base concerning patient mobility and monitoring, including the compiling of statistics. It was also agreed that attempts would be made to gain recent estimates of the number of undocumented migrants in each country as the backlog of asylum applications from the huge influx of refugees was beginning to be processed in early 2017.

With a paperless person we refer to a person staying in the country without a residence permit and who does not come from an EU/EEA country or Switzerland. His or her residence permit has expired or the person's arrival to or stay in the country is illegal. Also those who have a residence permit on the basis of private health insurance, but insurance has expired or has no coverage any longer.

Refugees and asylum seekers are not undocumented migrants, if they have a residence permit or citizenship or if they have applied for asylum. They can, however, become undocumented migrants, if their residence permit has ended or their application for asylum or residence permit has not been accepted.

Undocumented migrants may come to pose a serious challenge for health care if legislation, resourcing for health care services and funding are not brought up to speed commensurate with the new situation. Undocumented migrants are in a vulnerable position with regard to making a living (labour market), exercising their human and civil rights (safety vs. crime), social relations (friends and family members) and health. Persons resident in the country illegally may not be entitled to health care services at all or have only limited access to health care. We will illustrate here how the right of undocumented migrants to health care is provided for in legislation in the Nordic countries by describing current legislation in Norway and

Finland (see next page). Similar descriptions for Denmark and Sweden, and documentation of arrangements in Iceland and Greenland, are given in Appendix 4.

6.1.1 Agreements between countries/regions/hospitals

According to national legislations, public health care shall always provide emergency care to anyone who needs it. The person pays himself or herself the cost of care if he or she does not have a domicile in the country, or the right to use the public health services on the basis of EU legislation or international social security agreement (asylum seekers). The payment is handled after the person has received emergency care. Other than urgent care can be given to undocumented migrants, but all costs are to be paid by the person himself or herself.

Several non-governmental organizations (NGOs) provide health care for undocumented migrants in the Nordic countries, such as The Church City Mission in Norway, the Global Clinic in Finland, and The Red Cross in Sweden.

In Sweden, county councils are obliged to offer care based on the individual's medical needs and in accordance with the priorities for health care, as well as in accordance with science and proven experience. This applies to anyone staying in Sweden who has a medical need for care. All children under the age of 18 must be offered health care and dental care to the same extent and under the same conditions as registered children living in Sweden.

Country descriptions of Norway and Finland

NORWAY

Healthcare for asylum seekers and undocumented migrants³

For the group of asylum seekers we refer to both those which are waiting for an answer to their application and those who have received a final rejection of their application.

Undocumented persons refer to several different groups of people with no legal residence:

- a person who have entered the country without permission and without registering with the authorities
- a person with a visa or residence permit that has expired
- a person from countries that do not need a visa, who has been in the country longer than permitted

There are no exact estimates on how many undocumented migrants live in Norway.

A person is not automatically defined as an undocumented migrant if he or she does not have a domicile or a health insurance in Norway, e.g. a person insured in another EU/EEA member state or Switzerland, or a person registered as an asylum seeker. Excluded in this context are also those persons residing in Norway on short-term, such as tourists or business travellers.

³ This system description contains the general rules - it is not to be read a concise statement of all relevant legislation in the field.

The general rule is that you have rights to healthcare in Norway, and are covered under the National Insurance Act, if you have a legal domicile in Norway or are a member of the National Insurance Scheme. A person may be entitled to public health care services and/or reimbursement from the health insurance if EU legislation or international social security agreements require it. In such cases, no municipality or health insurance is required (Source: Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket).

Asylum seekers, who are waiting for an answer to their application, have the same healthcare rights as other people insured through the National Insurance Scheme in Norway.

Urgent cases

Anyone staying in Norway is entitled to urgent medical care from the municipal and specialised health services. Treatment must be provided as long as it is "an urgent medical necessity".

The person has to pay for the cost of care if he or she is:

- Not insured under the National Insurance Scheme, or has the right to use the public health services on the basis of EU legislation or international social security agreement
- Asylum seekers who are waiting for an answer to their application have the same healthcare rights and coverage as other people insured through the National Insurance Scheme in Norway
- Asylum seekers who have received a final rejection of their application is entitled to and have coverage for urgent medical care, until they leave the country

The payment is handled after the person has received the urgent medical care.

Non-urgent care

Some undocumented migrants may also need non-urgent care. The person is not entitled to use public health services if he or she is not insured under the National Insurance Scheme, or the EU legislation or international social security agreements does not apply for him or her. Asylum seekers who are waiting for an answer to their application have the same rights and coverage as other people insured through the National Insurance Scheme in Norway. Asylum seekers who have received a final rejection of their application are not entitled, under national legislation, to non-urgent public health services and/or reimbursement from the health insurance for such care. If an undocumented person is given care in the public health care he or she has to pay for all the costs. More information: Asylsøkere, flyktninger og familiegjenforente (in Norwegian).

The Church City Mission - Health Clinic

The Church City Mission is an open and inclusive organization and their work is amongst and with people who in different ways struggle with their everyday life. Their health clinic is aimed at all people who do not have legal residence in Norway. They offer a range of health services that allow patient to consult a nurse, doctor, psychologist and physiotherapist etc. The workers are health professionals, and as such, have taken a pledge of confidentiality. They can therefore guarantee that under no circumstances personal details will be shared with the police or the immigration authorities. More information: Bymisjonen - papirløse (in Norwegian).

FINLAND

Health care for undocumented migrants

With undocumented persons refers to several different groups of people who have different needs for health care services. It is estimated that there are about three thousand such people in Finland.

With a paperless person referred to in general:

- A person staying in the country without a residence permit and who does not come from an EU or EEA country or Switzerland. His or her residence permit has expired or the person's arrival to or stay in the country is illegal
- A person who comes to Finland for study purposes or for any other reason from a country other than an EU or EEA country or Switzerland. The person has received a residence permit on the basis of private health insurance, but insurance has expired or has no coverage any longer
- A person who has come from another country than an EU or EEA member state or Switzerland, and whose decision on domicile law is pending or unclear
- EU nationals residing in the country legally but do not have insurance coverage for any illness or medical care

A person is not automatically paperless if he or she does not have a domicile or a health insurance in Finland. With paperless is not meant in this context those persons residing in Finland in the short-term as tourists or who are in business trips (less than 3 months).

Who should be given care?

In Finland the Local Government Act

(www.finlex.fi/en/laki/kaannokset/2015/en20150410) determines whether public health services should be given for a person. Issues related to health insurance will be decided on the basis of the Health Insurance Act (www.finlex.fi/en/laki/kaannokset/2004/en20041224).

A person may be entitled to public health care services and/or reimbursement from health insurance if EU legislation or international social security agreement requires so. In such cases, no municipality or health insurance is required.

Urgent cases

According to the Health Care Act, the public health care always provides emergency care to anyone who needs it.

Emergency care includes:

- Immediate assessment and treatment of acute illness, injury, impairment of long-term illness or disability. In such cases, the care cannot be postponed without the disease worsens or injury hampers
- Acute oral and dental care, mental health care, care for substance abuse and psychosocial support

The person pays himself or herself the cost of care if he or she does not have a domicile in Finland, or the right to use the public health services on the basis of EU legislation or international social security agreement.

The payment is handled after the person has received emergency care.

Non-urgent care

Some undocumented people may also need non-urgent care. The person is not entitled to use public health services if he or she does not have a domicile in Finland or the EU legislation or international social security agreement does not apply to him or her.

If an undocumented person is given care in the public health care he or she has to pay for all the costs. More information: <http://stm.fi/sv/halsovard-for-papperslosa> (in Swedish).

Global Clinic

The Global Clinic is run by volunteers who provide health and dental care. Legal advice is also given by lawyers at the Clinic. The services are primarily meant for clients who are not entitled to public health care in Finland. Global Clinic is open to everyone, regardless of nationality or migration status. Help is given for free, anonymously and in strict confidence. All staff members have pledged full professional confidentiality. The annual number of patients' visits has varied between 300 and 500.

Global Clinics are located in Helsinki, Turku and Oulu. Various non-governmental organizations coordinate the Global Clinic, which forms a network that provides help and assistance for undocumented migrants.

More information:

testi.globalclinic.fi/files/documents/global_clinic_english_version1.pdf

Some Finnish municipalities, however, have decided to offer care of all undocumented migrants or some of them, such as for children and pregnant women.

6.1.2 Other Nordic countries

From the above descriptions of the situation in Norway and Finland, and on the basis of the country-specific reports in Appendix 4, Sweden stands apart in that it is the only country to have enacted a specific act on health care for undocumented migrants (2013)⁴. In Sweden, undocumented migrants are equated with asylum seekers as regards access to health care. Adult undocumented migrants are entitled to services the providing of which cannot be delayed without putting the patient at immediate risk. Services concerning maternity care, pregnancy termination and contraception are also included. Undocumented migrants who are children are entitled to the same services as permanently resident children. All adults and children seeking asylum in Sweden are offered a free health examination as soon as possible after a person's arrival in Sweden. If the person is paperless or is hiding, a health check will be offered at the health care centre.

In the other countries and autonomous regions, international conventions and recommendations on human rights, etc., are respected and taken into account when

⁴ The assessment is based on our own comparative analysis and to an article by researchers and experts at the National Institute for Health and Welfare (THL): Kuusio H, Nykänen E, Keskimäki I. Paperittomien oikeudet terveyspalveluihin Suomessa, Norjassa, Ruotsissa ja Tanskassa [Rights of undocumented migrants to health care services in Finland, Norway, Sweden and Denmark] (Sosiaalilääketieteellinen aikakauslehti 53: 3: 238-247, 2017 <https://journal.fi/sla/article/view/65567>).

providing for the right of undocumented migrants to health care⁵. However, the right of undocumented migrants to public health care services is restricted in various ways by the some governments, and for many services it is required that the undocumented migrants themselves must cover the patient fees and the costs of the service.

There has been a wide range of professional and political debate in the various countries, and national investigations have been conducted in recent years. In Finland THL National Institute for Health and Welfare has, at the request of Ministry for Social Affairs and Health examined health care for undocumented persons residing in Finland without a residence permit or health insurance in 2014. Undocumented people are offered not currently adequate health services in Finland. The study shows the need for further work including the undocumented persons identified in health care, the cost of reimbursed drugs in outpatient care and how from a public health perspective, major infectious diseases can be prevented and vaccinations provided. The report: Health care for undocumented migrants in Finland (in Finnish, Paperittomien terveystalvelut Suomessa).

In Denmark in the same year, the relevant ministry published the report Sundhedsydelser til uregistrerede migranter (Ministeriet for sundhed og forebyggelse 2014). In Norway a study was carried out already 2008 Developing methods for determining the number of unauthorized foreigners in Norway by Statistics Norway (NOU 2008/11). In 2014 Oxford Research published a report Et marginal problem? - Asylsökere, ulovlig opphold og kriminalitet conducted by UDI-utlendingsdirektoratet.

In Sweden, the Swedish Agency for Public Management (Statskontoret) has a mandate from the Government to monitor the implementation of new legislation. In 2015, the Agency published the interim report Vård till papperlösa - En uppföljning av lagen om vård till personer som vistas i Sverige utan tillstånd (Statskontoret 2015:10). The final report of the study, Vård till papperlösa - Slutrapport av uppdraget att följa upp lagen om vård till personer som vistas i Sverige utan tillstånd [Care for the undocumented - Final report of the project to review the Act on care for persons illegally resident in Sweden] (Statskontoret 2016:11), was published last year.

In Finland, in the previous electoral period (2011-2015) a Government proposal was submitted to Parliament concerning extending the right of undocumented migrants to health care services. The proposed act would have guaranteed undocumented migrants not only urgent care but also short-term health care services considered essential by health care professionals, including maternity care and childbirth services. Moreover, underage undocumented immigrants were proposed to be granted the same right to services as children permanently resident in Finland. The costs of the care were to have been borne by the undocumented migrants themselves, and ultimately as necessary by the government. The proposal gained widespread support when circulated for comment, and several parliamentary committees voted in favour of adopting it. However, the proposal was withdrawn because of political disputes before the general elections at the end of March 2015.

⁵ The most important of these are the UN International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the European Social Charter (revised).

It is estimated in various sources that the number of undocumented migrants must have increased considerably in all Nordic countries following the great refugee influx of 2015-2016. Their total number is estimated about 80 000 to 100 000, although such estimates are extremely difficult to make and are based on a variety of approaches and a combination of official data available⁶. Changed asylum rules for those who are allowed to stay in Sweden are likely to reduce the number of asylum applications and the number of unemployed or hidden will increase in the future. As the number of undocumented migrants increases, we may assume that their movement within the Scandinavian language area - between Denmark, Norway and Sweden - will increase. It is already being noted in Finland that some refugees who have been denied asylum go to Sweden.

Because of the evolving situation, the Finnish Government consulted key NGOs in autumn 2016 and talked to the Association of Finnish Local and Regional Authorities concerning ground rules for official cooperation regarding undocumented immigrants. In December 2016, the Government published an action plan for local authorities, *Laittoman maassa oleskelun ehkäisyyn ja hallintaan* (Preventing and controlling illegal residence). As noted above in the country description, the basic principle is that undocumented migrants are entitled only to urgent medical care, and at their own expense. Local authorities are instructed to charge the undocumented migrants receiving care for the cost of the care, and if they cannot pay, then the central government will compensate the local authorities. Local authorities are allowed to offer undocumented migrants services beyond urgent medical care, but in such a case the local authority is liable for the costs of the additional services.

The recommendations in the action plan include a requirement for officials to check with immigration authorities to verify whether a person has the right of residence and to refer undocumented migrants to the voluntary return system. This requirement is considered problematic vis-à-vis confidentiality provisions in social welfare and health care, because it would mean that a health care appointment by an undocumented migrant would have to be reported to the immigration authorities,

⁶ According to evaluation data we compiled, it was estimated that there are 4 000 to 5 000 undocumented migrants in Finland in early 2017. This is based on the previous report of the National Institute for Health and Welfare (THL) and two new publications (*Turvapaikka Suomessa* - [Refuge in Finland, University of Turku, 2017], *Kohti järkeviä ratkaisuja* [Towards reasonable solutions] Helsingin Diakonissalaitos 2017]. Also actual information received from the Ministry of the Interior supports this estimation: The whereabouts of about 2 000 of the 4 000 refugees denied asylum in 2016 are unknown; the majority of them are assumed to still be illegally resident in Finland. The figure for Denmark is found in status report 2016-17 from the Institut for Menneskerettigheder. The report refers to various sources, which estimates that the number unregistered migrants are between 20 000 - 40 000 depending on methods and definition. But the figures are some years old, and the mobility of refugees has been more massive the past years. The figure for Sweden 30 000-50 000, is given on the website www.fcs.se. The Swedish Migration Agency estimated in its budget proposal that in the near future as many as 46 000 persons who will probably be denied asylum will remain in the country (www.migrationsverket.se). Norway has an older estimation 18 100, which dated from 2010 and the uncertainties are the same as documented by the Danish Authorities (more information from Norway www.udi.no/globalassets/global/forskning-fou_i/beskyttelse/et-marginalt-problem---endelig.pdf).

in violation of confidentiality⁷. The minister in charge has made it clear in public that legislative precisions to clarify the situation are required.

In the present pre-study, we consider it justifiable that governments undertaking a legislative review with regard to health care for undocumented migrants should take account of studies carried out in other Nordic countries in this field in recent years. This is also the purpose of the documentation in the present chapter.

6.2 Cross-border regional patient mobility - Case North Calotte

Patient mobility and its prerequisites between the Nordic countries have previously been studied by Nordic Innovation in a report published in 2011 *Patient mobility in the Nordic Countries - Volumes and obstacles* (Oslo, June 2011). Cooperation in medical treatment between border regions became a topic of political discussion in a written question to the Council of Ministers by the Mittengruppen of the Nordic Council in September 2014, to which NCM responded the same autumn. A further question about the issue was posed by the Council's Finnish Member of Parliament, Katri Kulmuni in September 2015. The need for further clarification of the issue is particularly justified by the long distances between the northern parts of Finland, Norway and Sweden, and by the fact that hospitals in a neighbouring country might be located closer to human settlement in another country than in their own country.

The 2011 report partially applies a theoretical approach, which outlines the opening of the health service market and an increase in freedom of choice, and broadly references background work that was required by the EU's Cross-border Healthcare Directive approved in 2013. The focus of the project was patients who had sought and received special medical treatment in another Nordic country, and it collected information from different parties in the period 2009 to 2010 and carried out a small-scale patient survey. The final report rather comprehensively describes the cooperative structures, customer volumes, obstacles to mobility and different development projects in the largest area of patient mobility, Öresund/Øresund (see Chapter 5.1 in *Nordic Innovations 2011*).

In this project, it was considered appropriate to try and shed light on the present situation in the area of North Calotte, and to try to obtain updated information on medical treatment and healthcare cooperation, as well as possibly the latest statistical data on patient mobility in recent years. In this, we were encouraged by statistics produced on this by the Åland Islands based on the Finnish Hospital Discharge Register and health insurance reimbursement statistics, as a result of which the province was also able to shed light on patient mobility in the directions of both the Finnish mainland and Sweden by diagnostic group (see Chapter 5.2.4). Correspondingly, at the request of the Ministry of Social Affairs and Health, The Social Insurance Institute KELA planned a small-scale analytical test in which, by combining different health insurance and payment information, cross-referencing

⁷ Kuusio H, Nykänen E, Keskimäki I. Paperittomien oikeudet terveyspalveluihin Suomessa, Norjassa, Ruotsissa ja Tanskassa [Rights of undocumented migrants to health care services in Finland, Norway, Sweden and Denmark]. *Sosiaalilääketieteellinen aikakauslehti* 53: 3: 238-247, 2017 <https://journal.fi/sla/article/view/65567>.

was carried out about how, by combining information, it could be possible to glean new statistical data about patients treated abroad⁸.

Figure 6.2.1 Map of the North Calotte region



The joint political cooperation unit North Calotte Committee - Nordkalottkommitté was established in 1967 by the ministries of labour in Finland, Sweden and Norway. The purpose was to build closer regional cooperation and integrate political planning. Due to operational restructuring, the committee changed its name to the North Calotte Council - Nordkalotträdet in 1997. The Council can be characterised as a cross-border partnership between government and business. It consists of 12 regional representatives from Lapland/Finland, Norrbotten/Sweden and northern Norway (Counties of Nordland, Troms and Finnmark) and receives base funding from the Nordic Council of Ministers (www.nordkalottradet.org).

Region Norrbotten, Helse Nord RHF, Lapland Hospital District, Länsi-Pohja Hospital District and Oulu University Hospital concluded an agreement on cross-border cooperation in emergency medical treatment in September 2011. This agreement has been renewed and widened by a new cooperation partner Västerbottens läns landsting in September 2015 (see Appendix 5). It is based on an agreement concluded

⁸ From 2015, the test was able to identify 21 147 reimbursements concerning outpatient care (957 of which were dental care cases) and 30 356 visits in total. There were 2 457 hospitalisation cases (69 of which were maternal/natal cases) and 3 256 days of hospitalisation. There were 414 emergency care cases and 48 hospital transfers. Because of the few cases treated abroad in northern Finnish hospital districts, it was not necessary to carry out such a precise analysis, because the patient registers in Sweden and Norway cannot support the production of a joint analysis concerning the treatment that Finnish patients have received in the area of North Calotte.

by the governments of Iceland, Norway, Sweden, Finland and Denmark on 14 June 2002 on cooperation across national borders in medical treatment and healthcare, which aims to prevent accidents and to support other Nordic countries, for example in the event of accidents. It also observes a joint Nordic framework agreement on health care, and a particular objective is to improve the availability of emergency medical and hospital transport resources required by the local population of and visitors to border areas.

The secretary and office for coordination of this cooperation has been established the Region Norrbotten organisation (until 2016, Region Norrbotten). Through it, we conveyed a request to obtain up-to-date information on patient mobility. Previously in Chapter 5, we ascertained that national health data collection systems do not adequately support the supply of information about cross-border cases, and that it was also challenging for regional authorities to produce additional statistics on patient mobility.

Table 6.2.1 shows volume data for northern Finland (Lapland and Länsi-Pohja central hospitals in Rovaniemi and Kemi, respectively) based on Finnish hospital discharge register information (National Institute for Health and Welfare) about patients who originating from northern Sweden and northern Norway in the period 2012 to 2014. In Table 6.2.2, Helse Nord RFH has documented patients from Finland and Sweden (“social security nation”) in hospitals in North Norway.

Table 6.2.3 Norrbotten has documented patients who have gone or been sent abroad from northern Sweden in the period 2011 to 2015. In recent years, patient mobility to Denmark and Finland has stopped increasing, is minor to Norway and minimal to Iceland. The treatment diagnoses in Finland of northern Swedish patients are documented in the Appendix 7. We received similar information from the Region Skåne about patients who left their own area to seek treatment in other Nordic countries (we present them for purposes of comparison in Appendix 8).

At our request, based on the Åland example, Länsi-Pohja Hospital District was able to produce some volume data itemised into visits to emergency and hospitalisation (table 20). From Lapland Hospital District, we unfortunately did not receive any statistical information, even though the requests for information presented in this project were supported by several reminders by the Finnish Ministry of Social Affairs and Health.

Table 6.2.1 Volume data about patients from northern Sweden and northern Norway treated in Lapland and Länsi-Pohja Hospital Districts in the period 2012 to 2014

	Discharges	Patient days	Patients
Total numbers 2012-2014			
<i>West Bothnia</i>	39 068	154 754	20 346
<i>Lapland</i>	65 954	280 829	36 804
From Sweden to			
<i>West Bothnia</i>	57	150	45
<i>Lapland</i>	99	410	77
Of the total volume %			
<i>West Bothnia</i>	0.1	0.1	0.2
<i>Lapland</i>	0.2	0.1	0.2
From Norway to			
<i>West Bothnia</i>	..	..	..
<i>Lapland</i>	33	101	29
Of the total volume %			
<i>West Bothnia</i>	..	..	..
<i>Lapland</i>	0.1	0.0	0.1

Table 6.2.2 Volume data in 205 about patients from northern Finland and Sweden compared to other so called social security nations in hospitals of Helse Nord RFH

	Sweden		Finland		Other nations	
	Episode	Days	Episode	Days	Episode	Days
Hospitals						
Helgelandssykehuset HF	34	45	1		85	159
Finnmarksykehuset HF	131	99	151	96	191	398
Nordlandssykehuset HF	42	20	15	7	259	285
Universitetssykehuset i Nord-Norge HF	127	166	29	54	537	1 070
Total	334	330	196	157	1 072	1 912

Table 6.2.3 Patients living in the Region Norrbotten⁹ and healthcare provider countries 2011-2015

	2011	2012	2013	2014	2015	Total
Australia	-	-	-	1	1	2
Austria	11	9	24	17	10	71
Belgium	17	53	30	19	25	144
Bulgaria	4	2	1	4	7	18
Croatia	-	-	2	5	7	14
Cyprus	18	20	13	2	3	56
Czech Republic	13	18	4	10	17	62
Denmark	685	2 490	4 240	3 813	1 414	12 642
Estonia	26	26	21	18	14	105
Finland	763	703	628	545	683	3 322
France	56	44	39	27	42	208
Germany	229	179	195	136	199	938
Greece	9	17	17	20	26	89
Hungary	22	24	17	19	37	119
Iceland	-	3	1	-	1	5
Ireland	1	1	-	-	2	4
Italy	18	10	5	7	7	47
Latvia	23	42	12	12	23	112
Lithuania	2	9	10	23	34	78
Luxemburg	1	-	1	-	-	2
Malta	1	-	-	-	1	2
Norway	25	364	315	47	31	782
Poland	96	82	78	75	121	452
Portugal	3	7	10	2	9	31
Romania	5	7	5	9	4	30
Slovakia	1	6	2	1	3	13
Slovenia	4	1			1	6
Spain	189	217	212	167	294	1 079
Switzerland	4	6	6	2	3	21
The Netherlands	3	10	18	6	8	45
United Kingdom	15	34	22	40	51	162
Other countries	28	26	20	25	17	116
Total	2 272	4 410	5 948	5 052	3 095	20 777

⁹ County Council of Norrbotten, Sweden: The county has some 250 000 inhabitants. The County Council is in charge of health care services as well as for dental care for young people. Other responsibilities include regional cultural events, public transportation, regional development and education. From 1 January 2017 onwards the County Council took some tasks of the County Administration and changed its name to Region Norrbotten. There is one County Hospital in Sunderbyn, Luleå and four local hospitals in Kiruna, Gällivare, Piteå and Kalix. The number of health care centres is 32, of which 4 are private. The residents can choose any of these centres for their services. The County Council has some 7 500 workers, of which the most in working in health care.

Table 6.2.4 The care of foreign patient at Länsi-Pohja Hospital District and Central Hospital 2013-2015

	2013	2014	2015
Emergency visits			
<i>Sweden</i>	44	43	100
<i>Norway</i>	2	1	4
<i>Other countries</i>	45	34	298
Non-emergency visits			
<i>Sweden</i>	309	335	368
<i>Norway</i>	-	1	7
<i>Other countries</i>	123	99	186
Treatment periods, arrival type emergency			
<i>Sweden</i>	17	24	24
<i>Norway</i>	0	1	0
<i>Other countries</i>	23	13	75
Treatment periods, arrival type on-emergency			
<i>Sweden</i>	8	16	18
<i>Norway</i>	0	0	1
<i>Other countries</i>	12	6	19

The previous report by Nordic Innovation (2011) states that regionally, the hospitals on the Norwegian side and the hospital in Rovaniemi in Finland co-operate at an operational level, but the report was unable to present any patient health records. On the basis of official information from Northern Norway, the report states that, due to geography and settlement patterns, the patient flow (planned care) between Norway and Sweden in the North Calotte is rather small (Chapters 5.2.3.- 5.2.6 in Nordic Innovation 2011). The latest information available in tables 17- 20 confirms that the number of patients needing cross-border healthcare is only a few dozen in Norway and a few hundred in Sweden each year, when referring to the treatment provided by the Lapland and Länsi-Pohja Hospital Districts.

The scarcity or complete lack of patient mobility data is unfortunate, especially from the perspective of monitoring the access to treatment of the Sami-speaking people living in the North Calotte region. Local and regional authorities have conducted agreement-based cooperation for over a decade with the aim of safeguarding the access to health services of the Sami-speaking population in their native language, in particular. On the Norwegian side of the border in Karasjok, there are also certain specialised services (the Specialised Clinic and the Child and Adolescent Psychiatric Outpatient Clinic, see chapter 5.2.4 in Nordic Innovation 2011), which may also be utilised by the Sami people living on the Finnish side of the border (mainly in the Municipality of Utsjoki). Unfortunately, this fundamentally significant matter - for Sami identity and culture - still cannot be supported further with statistical data in the matter of regional cross-border patient mobility.

The agreement between the regional healthcare authorities in the North Calotte¹⁰ presented in Appendix 5 focuses on the organisation of emergency care and the shared use of medical transport resources, if necessary. Similarly, there is a long-standing agreement on crisis preparedness between the countries in the North Calotte region. In addition to cooperation on preparedness for disasters, the countries also have a strong focus on cooperation on these issues with Russia (chapter 5.2.2. Nordic Innovation 2011). Based on the additional information we have gathered, we can conclude that the cooperation in the North Calotte has developed to some extent in this decade¹¹ It is also able to meet at least two of the four objectives for cross-border healthcare presented in the theoretical section of the Nordic Innovation report:

- To increase cost efficiency by sharing resources for emergency preparedness, ambulances, etc., and
- To provide, to some extent, better access to healthcare for people located a long way from services in their own country

Due to the lack of data, we are unable to judge the success with the other two aims, or to what extent the cooperation to safeguard health services in Sami language can achieve the objective to “create a larger patient base to provide specialised services closer to patients”. Furthermore, due to low volumes, it cannot yet be claimed that cost-efficiency in hospital capacity has improved at any remarkable scale (“make services more cost-efficient by sharing hospital resources”, Nordic Innovation 2011, p. 18).

Upon request, the North Calotte healthcare coordination office provided us with their documentation on cooperation experiences, suggestions for improvements and development plans. Actors representing the northern Healthcare and Hospital Districts in Sweden, Norway and Finland have presented the following considerations, which the national authorities as well as Nordic cooperation should take into account:

- Preconditions for patient mobility, i.e. the obligation to inform patients of their right to use healthcare services in another country, have been decreed the duty of national authorities (such as the Försäkringskassan and National Board of Health and Welfare, Socialstyrelsen in Sweden and Social Insurance Institution, KELA in Finland). The laws on healthcare and medical care do not impose this kind of information provision obligation on regional authorities. As such, it is extremely unclear to clients what their right to treatment in another country means in practice. For example, in the care cooperation between Northern Sweden and Finland, residents of Northern Sweden have been surprised at the high private healthcare fees in Finland (such as € 200), compounded with the

¹⁰ The cooperation area is (see www.norkalottenradet.org) now larger than the traditional North Calotte, because Oulu University Hospital District in Finland and also Västerbottens läns landsting in Sweden (since September 2015) are partners.

¹¹ Already in September 2015 this cooperation has been enlarged and intensified by several special agreements: Agreement on cross-border cooperation - Healthcare providers in northern Norway, Sweden and Finland, Samverkan med ambulanshelikopter mellan Norge och Sverige, Procedures for Prehospital Emergency Medical Care (May 2016), Procedures for cooperation and interaction between Emergency Call Response Centers (May 2016), Administrative Procedures (May 2016).

travel costs. This together with the fact, that patient can receive reimbursement of cost afterwards. This has been considered not to be a fair precondition for people with low income

- There used to be wide-scale project-based primary healthcare cooperation in the Torne Valley between the cross-border municipalities, especially in terms of emergency activities (see Nordic Innovation 2011, chapter 5.2.5). In practice, primary healthcare and the current emergency treatment cooperation are difficult to implement due to different national regulations so this joint project effort ended in 2015. To solve the problems, the Ministries of Justice and Social Affairs and Health would truly need to put their heart in removing the obstacles to cooperation, so that the conflicting regulations, national guidelines and recommendations could be coordinated to sufficiently support the organisation of cross-border healthcare and medical care
- One concrete example on the Finnish side of the border that has been mentioned is that patient insurance issues have been found to complicate cooperation in the organisation of medical transport and emergency treatment. Transporting patients across national borders may jeopardise the patient's rights in cases of damage, leaving responsibilities and liabilities for damages ambiguous based on the current legislation. (This is also a problem for health care providers cross-over the board, e.g. dental care)

The actors representing the northern Healthcare and Hospitals Districts have drafted an ambitious strategic plan for cross-border collaboration in health care 2017-2019 (Appendix 9). It is being implemented by a coordination group under the supervision of the contracting parties Region Norrbotten, Västerbottens läns landsting, Helse Nord RHF, Lapland Hospital District, Länsi-Pohja Hospital District and Oulu University Hospital highest management. This aims to ensure that the practical development efforts move forward in the next few years.

Based on the received information our exploratory project can note that the development of national health data systems requires time-consuming and patient work (see more in chapter 7). This is why it is essential that, when national data systems do not yet support the systematic generation of follow-up data, regional authorities may also introduce development measures to better monitor and compile statistics on cross-border operations (the small-scale advanced analysis prepared by the Åland Islands for this project serves as an example). Finally, it is important that the primary health care services are included in the future data collections on cross-border health care services. Locally, their volumes are much higher than for the hospital care.

6.3 Nordic task forces in the field of patient mobility

During Finland's presidency in 2016, the sector programme of the Nordic Council of Ministers for Health and Social Affairs (MR-S) focused on implementing the recommendations put forward in Bo Könberg's report *Det framtida nordiska hälsosamarbeten*. Aside from the study on patient mobility, steps were taken to intensify current cooperation and introduce a number of new measures. To implement recommendation no. 2 of the report, a Nordic Group on Highly Specialized Care was appointed. To implement recommendation no. 3, a Nordic Network on Rare Diseases was established. Cooperation in eHealth (recommendation no. 9) initiated earlier was continued during Finland's presidency in the context of the Nordic eHealth Group.

Under the sector programme, all the four working groups were obligated to exchange information. To this end, hearings of the Finnish chairpersons of these working groups were held in connection with the kick-off meeting of the patient mobility project in Helsinki on 18-19 April 2016. The objective was to inform the working groups of their respective duties, verify the mandate interfaces, exchange information and identify potential areas of cooperation.

Nordic Group on Highly Specialized Care: Ministerial Counsellor for Health/Medical Affairs Timo Keistinen of the Ministry of Social Affairs and Health reported on the assessment of the progress made in respect of this recommendation presented in Könberg's report. Highly specialized care is most centralized in Denmark and Norway, followed by Sweden. The comparison between countries showed that this type of care is least centralised in Finland. Iceland has concluded special agreements with the Lund University Hospital and Rigshospitalet in Copenhagen.

Autonomous regions are in a special position in this respect because they need more extensive cross-border cooperation due to limited treatment capacity. Åland refers patients requiring specialised care to university central hospitals in Turku, Finland, and Uppsala, Sweden. The Faroe Islands and Greenland draw upon the resources of the National University Hospital of Iceland in Reykjavik and Rigshospitalet in Copenhagen for the care of patients in need of advanced medical care. Regional cooperation is carried out between some border areas such as northern Finland and Norway and North-Sweden (Norrland) Sweden and West-Bothnia Hospital District (Länsi-Pohja) in Finland (including primary health care cooperation between some border municipalities in the Torneådal).

The working group commenced its work in 2016 with an unofficial working meeting and seminar called Nordic cooperation regarding highly specialized treatment and clinical trial held in Vantaa, Finland, 25-26 August 2016. So far cooperation in highly specialized treatment has not yet materialized into any large-scale inter-governmental activity; instead, it is carried out on a needs-basis under agreements on cross-border care between service providers. In contrast, cooperation in clinical research between Nordic countries is being intensified. Accordingly, it is one of the priorities in the efforts to develop healthcare cooperation during Norway's Nordic presidency in 2017.

Nordic Network on Rare Diseases: The network was launched in March 2016 during Finland's presidency (Ministerial Counsellor for Health/Medical Affairs Jaakko Yrjö-Koskinen, Ministry of Social Affairs and Health). Based on Könberg's report, the Nordic Council of Ministers had financed a study called, Nordic networks on rare

diseases: Ideas for future cross-functional network (authored by Det Nationale Institut for Kommuner og Regioners Analyse og Forskning, KORA). EU has organised cooperation for its part within the framework of the Commission Expert Group on Rare Diseases. Nordic cooperation has longer traditions in this field: for example, the Nordic Conference on Rare Diseases was held in Copenhagen in September 2016 for the fourth time.

Rare diseases are diseases that affect a maximum of five people out of 10,000. Most rare diseases are even rarer than this. The network's objective is to share expertise as well as increase Nordic cooperation concerning the treatments for these diseases. The network has already recognized the need to gain a better understanding of the number of people suffering from various rare diseases in the Nordic countries. Improving psychosocial support has also been recognized as an important task.

In reality, there is very little mobility of patients with rare diseases between Nordic countries. Traditional consultations using the new telemedicine facilities, meetings between specialists and research cooperation also play an important part in the diagnosis and planning and implementation of treatment in the case of individual patients. Exceptionally, a patient may travel to another Nordic country or a specialist visit the hospital in which the patient is being treated to carry out highly advanced medical procedures. The network focuses primarily on the exchange of information, skills development of the staff treating patients with rare diseases as well as the sharing of human resources between Nordic countries.

The eHealth Group under the Nordic Council was established by ÄK-S in 2011 to ensure knowledge transfer between the Nordic countries and to help them strengthen their leadership position in the eHealth area. The work of the Group is a continuation of that of its predecessor, The Nordic forum for telemedicine founded in 2005 for the identification of barriers to cross-border health care in the Nordic countries, the scope of which was broadened to better accord with present political priorities at national levels and cross-border developments within the EU framework.

The Group has been a platform for joint formulation of strategic initiatives to enable communication of a Nordic view in a wider perspective particularly by offering a consolidated input in EU level bodies as there are a number of projects and actions with impacts on the practical implementation of the cross-border directive in the Nordic countries. Sweden and Finland are implementing their cross-border e-Prescription services aiming to go live early 2018 with Estonia.

The systematic eHealth indicator development activity under the umbrella of the Group has been recognized globally as a forerunner and has influenced the indicator development of OECD and WHO. The latest NCM indicator publication will be published in May 2017. In April 2016 a one-day seminar on "Digitalization and innovation culture" was co-organized with the Ministry of Social Affairs and Health of Finland in collaboration with the Finnish Society for Telemedicine and eHealth to highlight Nordic achievements in eHealth and telemedicine. The seminar had 150 participants. The Group also gave support to activities aiming at the harmonization of standards for personal connected health technology, which is a rising priority in all Nordic countries. The overall semantic harmonization and standardization of health record data used in patient summaries, etc., is an ongoing activity on both the EU level and globally. The developments are being closely followed by the Nordic Group

in order to support solutions that also facilitate other scenarios of secondary use in the cross-border setting such as statistics and research.

Towards the end of the pre-study, the Finnish team consulted the people in charge of the foregoing Nordic work groups. The results were discussed at the latest project meeting held in Copenhagen on 23 March 2017. In response to the assignment given to us, we wish to submit the following conclusions:

- The working groups have informed one another to a sufficient degree, the mandate interfaces have been verified and no duplicate work has been carried out by the working groups
- The additional statistical analyses carried out by regional authorities regarding cross-border patient mobility (see chapters 5.2 and 6.2) remain diagnostically too general in terms of classification systems to provide any genuine added value to the rare diseases network and the highly specialized care group. However, they do provide more accurate information on mobility volumes between northern Finland, northern Sweden and northern Norway and offer a description of the profiles of the patients referred from the autonomous regions
- If an actual and more extensive project to promote patient mobility or compile inter-Nordic statistics is launched, it is advisable that such a project engages in cooperation with these three more permanent Nordic working groups. A natural subject of the exchange of information is terminological and methodological issues. We do not expect a real need for this to arise until 5-7 years from now.

Chapter 7

Conclusions and recommendations for NOMESCO

The previous patient mobility study (Nordic Innovation 2011) found that cross-border healthcare only involved hundreds or at most thousands of patients per year. The foregoing sections show that current mobility volumes between the individual countries are, at best, a few tens of thousands. Compared with the total number of patients treated by each Nordic country, cross-border healthcare only accounts for a fraction of a per cent. It is difficult to estimate the extent of care provided for Nordic citizens by other Nordic countries: Under their reciprocal agreements, these countries do not invoice one another for the care provided for Nordic citizens in case of acute illness, which means that the actual patient numbers are unknown. Countries may be able to get statistics on those presenting their EHIC or identity card when receiving health care, but there are problems to get reliable data on those patients who are residing in one country, but insured in another Nordic country. There is a natural explanation for the low number of mobile patients: In keeping with the Nordic welfare state concept, the individual countries seek to offer the residents high-quality healthcare across the country. According to international comparative studies, the Nordic countries have succeeded in this in an exemplary manner (see OECD Health at a Glance: Europe 2016). As noted in the foregoing, a number of linguistic, cultural and administrative circumstances (such as reimbursement and payment systems) raise barriers to patient mobility across borders. They complicate the search for and access to healthcare in another country even in case of the countries speaking Scandinavian languages (Denmark, Sweden and Norway), not to say anything about native Finnish or Icelandic speakers seeking treatment in a neighbouring country (Nordic Innovation 2011). However, this pre-study shows that whenever there is a real need for cooperation in specialized medical care, it can be organised on a contract basis between the Nordic countries and, more specifically, the autonomous regions and their relevant partner countries¹.

¹ Sections 5.2.2-52.5 provide a description of the cooperation in patient volume numbers between Iceland and the Lund University Hospital and Rigshospital in Copenhagen; cooperation between the Faroe Islands and Greenland with Iceland; Åland's cooperation in specialized healthcare with the university hospitals in Turku and Uppsala; as well as cooperation in the circumpolar region. Additionally, a description is provided of cooperation in the Öresund/Øresund region in Nordic Innovation-report 2011, see also Appendix 8).

The Nordic societies are characterized by advanced democracy and a decision-making process that is close to the citizens. This also holds for the healthcare system where the services are normally provided by municipalities and municipal consortiums as well as counties and regions. Moreover, local and regional service providers have for a long time developed and maintained healthcare IT and patient data systems independently. Given that national data policies are still a relatively new development, all Nordic countries have not yet been able to create standardised national systems that would make it easy to monitor patient mobility across national borders.

To develop healthcare data systems, facilitate international cooperation and promote research cooperation, the OECD has issued OECD Recommendations on Health Data Governance. The meeting of health ministers organised by the OECD in January 2017 was also attended by Nordic ministers when it adopted these recommendations. The OECD framework and the work carried out within the EU provide a uniform basis for future efforts by the Nordic countries in developing their universal health data architectures. At the same time, the data gathering solutions required for international patient mobility statistics can be more easily integrated into the efforts to develop the data systems.

Under the EU Cross-border Healthcare Directive, Member States are obligated to reimburse the cost of cross-border medical care up to the maximum amount that the Member State would have had to pay if care had been provided in its own territory. The reimbursement model applied by Finland covers the costs as provided in the Health Insurance Act (1224/2004) (compensation paid by the Social Insurance Institution of Finland Kela without prior permission obtained from another EU/EEA state or Switzerland). The EU finds that the limitation applied by Finland is not fully consistent with the EU Cross-border Healthcare Directive. According to the Commission, the costs should be reimbursed in such a way that the amount payable by the patient is identical to the amount the patient would have had to pay for the same care when provided by the Finnish healthcare system. Finland argues that the Cross-border Healthcare Directive should be interpreted with due regard to the structure and inherent characteristics of the national system of each Member State. Consequently, care provided by another EU Member State is equated to the care sought outside the municipality of residence responsible for the provision of care in Finland. This practice is based on the existing multi-channel healthcare financing system.

Finland is currently preparing a comprehensive social and healthcare reform. It foresees a transition from the existing decentralised system (involving close to 300 municipality-based healthcare service providers) to a system of 18 regional units (counties) responsible for providing integrated social and healthcare services. The reform will enter into force at the beginning of 2019. At the same time, people's freedom of choice will gradually be extended during 2018-2020. Finland's social and healthcare reform will facilitate patient mobility. As part of the reform, the healthcare financing system will be overhauled and a uniform, nationwide healthcare data system put in place. All these steps make it possible for Finland to review the legislation for the implementation of the EU Cross-border Healthcare Directive and plan further measures for improving the monitoring and statistics on patient mobility.

While the efforts to develop this type of national systems will take years, it is possible - already at this point of the pre-study - to present a number of measures taken to promote patient mobility and improve monitoring:

- *Iceland has begun to apply the EU Cross-border Healthcare Directive:* It is of fundamental importance that Iceland (independently of the present project) was able to prepare and pass legislation on the implementation of the EU Cross-border Healthcare Directive effective as of 1 January 2017
- *In Finland, the Social Insurance Institution KELA has introduced a system-based compilation of patient mobility statistics.* As of 2017, Finland adopted a special benefit system for processing right-to-care issues. Previously, in the absence of such a system, the statistics based on manual data gathering were unofficial. Now with the new system, the data will be migrated to Kela data store and detailed, up-to-date statistics on the right to care will be published²
- *Reference to EU Directive included in the entries to the Finnish Hospital Discharge Register.* At the beginning of 2017, the National Institute for Health and Welfare (THL), which maintains the register, created a data item indicating whether the care provided for a foreign national is due to the EU Directive (in order to provide additional information on the domicile of patients residing outside Finland which used to be uncertain and often lacking)
- *Åland adopted ePrescription:* As of 2017, Åland adopted the ePrescription system which was joined by all major healthcare providers in this autonomous region. Fully integrated with the Finnish prescription system, the ePrescription, as a system solution, should be compatible with the Swedish system. Previously a pilot project had been carried out in the context of cross-border cooperation in the Haaparanta/Haparanda-Tornio/Torneå in 2014. This cooperation is possible to start again, when a larger European project will be launched in 2018 including these partners and Estonia (information received from the Nordic eHealth Group)

Finally, patient mobility can also have consequences for other health issues. For example, newcomers' health examinations for increases health care costs. It should be explored if this can be followed by health expenditure data. Further, the morbidity patterns may be changed by time. This could be interesting to follow. However, this requires that also the morbidity statistics other than infectious diseases and cancer is improved in the Nordic countries.

² The purpose of the right to care is to ensure access to necessary care for people staying in an EU/EEA Member State, Switzerland and other signatory country to the Social Security Agreement. The right-to-care decisions define the benefits that the person involved is entitled to. Benefits available in Finland under the EU social security legislation are public healthcare services as well as medical care reimbursements paid and rehabilitation benefits provided by Kela. The basic data on the right to care to be published include decisions, rights to care, those entitled to care and right-to-care documents. The statistics on background variables to be published include the right-to-care status (e.g. employee working at the border, family member, pensioner), level and type, country (country of residence, country of origin, host country, country where working, state responsible for the cost of care) and the partner country, as well as right-to-care documents and type of form including demographic data on the person entitled to care.

7.1 Recommendations

The project issues the following recommendations for further action regarding the monitoring of patient mobility and compilation of statistics:

1. Countries should provide more complete data on patient mobility provided to EU. This data could be used as a base for Nordic statistics
2. The statistics provided for EU could be developed by initiating Nordic collaborative projects and studies. Based on the Könberg Report, it would be interesting if the countries could agree on the Nordic level how the individuals using other countries' health services could be identified. This might facilitate the contacts between different healthcare providers for these patients. The Könberg Report also suggests that the cooperation between the Nordic countries should be expanded, for example, for highly specialized care. In future, we may expect an increased patient flow between the Nordic countries. Even in these contexts, an identification of the patient is required. It would be extremely interesting if you could solve this issue at the Nordic level
3. Information on country of residence should be added to national health care registers to cover the care, which are not included in the EU statistics
4. It should be discussed whether Health Statistics for the Nordic countries should include a table on patient mobility (hospitalisations, prescriptions) in the future. This requires that the national health information systems are substantially more developed than now
5. The system description of legislation, practices and statistics should be published at the internet homepage by NOMESCO, and they should be updated regularly, and always after major changes
6. We were also mandated to determine whether it was advisable to launch a more extensive project to develop the compilation of statistics on patient mobility and if so, when. It is our considered opinion that no study be commenced until 5-7 years later because it takes time to develop the national systems (the time interval is identical to the period of time that elapsed from the previous study released by Nordic Innovation in 2011). Over the next few years, steps can be taken to implement the EU recommendations more suitable for all the Nordic countries for data gathering for the purpose of monitoring compliance with the EU Cross-border Healthcare Directive

Appendix 1

Table describing the national rules and regulations on patient mobility in the Nordic countries

	Denmark	Finland	Iceland	Norway	Sweden
Institution in charge	The Danish liaison body: Danish Patient Safety Authority, International Health Insurance For issuance of EHIC and other E-forms: Udbetaling Danmark, International Health Insurance Note: Residents of the other Nordic countries (Finland, Iceland, Norway and Sweden) need only to show a valid national ID card to prove eligibility for public healthcare in Denmark	Kela Social Insurance Institution Note: Residents of the other Nordic countries (Denmark, Iceland, Norway, Sweden) need only to show a valid national ID card to prove eligibility for public healthcare in Finland	Icelandic Health Insurance Note: Residents of the other Nordic countries (Denmark, Iceland, Norway, Sweden) need only to show a valid national ID card to prove eligibility for public healthcare in Iceland	Helse Norge.no e-service Note: Residents of the other Nordic countries (Denmark, Iceland, Norway, Sweden) need only to show a valid national ID card to prove eligibility for public healthcare in Norway	1177 Vårdguidene-service Note: Residents of the other Nordic countries (Denmark, Iceland, Norway, Sweden) need only to show a valid national ID card to prove eligibility for public healthcare in Sweden
Emergency	Call 112	Call 112	Call 112	Call 116 117	Call 112
Contact	In an emergency the patient can go to the Accident and Emergency (A&E) department (skadestue or akut modtagelse/akut klinik) of any public hospital. In some regions, one must call before going to the A&E department. Treatment is free of charge. The patient advises in each of the five regions in Denmark also provide specific guidance for insured persons from other EU/EEA-countries, who are looking for treatment in Denmark	Kela, a local municipal health centre or hospital in the region		Take contact to an accident and emergency department (legevagt) or a general practitioner working for the public healthcare system. In an emergency one can get treatment in the nearest public hospital	Nurses at 1177 will answer the questions, determine the need for further care, provide advice and/or recommend other healthcare assistance

	Denmark	Finland	Iceland	Norway	Sweden
Treatment, coverage, costs	In some regions one must call before going to the A&E department. Treatment is free of charge		Co-payment in Iceland varies as stated under "Treatment, coverage and costs", depending on what type of medical treatment and what group an individual belongs to: children under the age of 18, state pensioners, those receiving disability benefits	Valid card: one will pay a subsidised fee for the treatment on the same basis as a person living in Norway. Charges are not refundable and may vary	Private healthcare is in general not covered by the card
Pre-authorisation	In some cases prior authorisation of the treatment have to be applied (admitted overnight, the treatment requires special planning, the use of highly specialised and expensive equipment, there is a list of requiring pre-auth.)	Not necessary	No information	Not necessary	No information
Deadline for the claim	No information	Six months	4 years	Six months	No information
Doctors	Consultations and treatments by GP's and specialists, who are working under a contract with the public health insurance scheme, are free of charge. Treatment by a specialist normally requires a referral from a GP. Treatments by other health professionals such as chiropractors, psychologists and physiotherapist are partly paid by the public health insurance, however for treatment by a psychologist or physiotherapist only after referral	EHIC entitles to treatment at any public healthcare facility. Client fees according to a fixed scale of charges. Under 18 years, treatment is free of charge during normal office hours (outside office hours there is a client fee based on a fixed scale of charges). If using private services: claim reimbursement later from the social insurance institution Kela	Treatment is free of charge for children under the age of 18. Adults: standard fee, non-refundable in Iceland, but one can seek reimbursement once returned back home		Provided to have a valid card one is entitled to pay a subsidised fee for medically necessary treatment on the same basis as a Swedish residents. Charge are not refundable and may vary. Patients under 20 are treated free of charge in most areas

	Denmark	Finland	Iceland	Norway	Sweden
Dentists	Contact a dentist, who have a contract with the public health insurance scheme. The public health care reimburses up to 40% of costs for certain treatments. No reimburse for dentures, crowns etc.	Age under 18 years, public dental treatment is free of charge during normal office hours (outside office hours there is a client fee according to a fixed scale of charges) Adults: the municipal health centre will charge a client fee based on a fixed scale of charges (according to residents) or if using private services: reimbursement from Kela	Children under the age of 18, state pensioners and those receiving disability benefits are eligible for partial reimbursement. One must provide proof of eligibility. Generally, a standard fee is charged, non-refundable in Iceland, but one can seek reimbursement once returned back home	Have to pay the full cost of any dental treatment; usually non-refundable in Norway, except for children	Most dentists can provide treatment under the public healthcare scheme. Provided one has a valid card: pay the full cost up to SEK 3 000. From SEK 3 001 to SEK 15 000
Hospital outpatient care	Treatment in public hospitals is free of charge. Hospital treatments require a referral from a GP, a specialist or other licensed health professionals, except in case of an emergency. Emergency hospital treatment is free of charge for any person staying in Denmark	A referral from a doctor is needed. Client fees according to residents or if using private services: reimbursement from Kela. Dialysis, oxygen and chemotherapy treatments: in advance contact the healthcare unit (hospital)	A fee for hospital treatments with no hospital stay will be charged, non-refundable in Iceland, but one can seek reimbursement once returned back home. EHIC covers the provision of oxygen, dialysis and chemotherapy. One should arrange and pre-book medical treatment (a state-funded healthcare provider) before arriving to Iceland. Treatments carried out by private healthcare providers are not covered by EHIC	One have to be referred by a doctor and one must pay the applicable standard fees	For out-patient care: a subsidised fee. Charges are not refundable and may vary. Specialist healthcare is charged
Hospital inpatient care	In non-acute cases a referral is required. Certain hospital treatments need to be arranged before arrival in Denmark e.g. dialysis, oxygen or chemo therapy needed during the stay in Denmark must be arranged with the relevant local public hospital. Public hospitals may refuse to arrange treatment because of capacity problems	A daily client fee for hospital in-patient treatment. Age under 18 years: no need to pay the daily fee for more than seven days during the same calendar year. Client fees according to residents or if using private services: reimbursement from Kela	Generally, there is no charge for treatment provided during hospital stays	The treatment, including any medication needed, is free of charge	In-patient treatment is generally free, except for a non-refundable standard daily fee

	Denmark	Finland	Iceland	Norway	Sweden
Prescription	Reimbursement is calculated on the basis of the actual annual consumption of medicines on prescription. No reimbursement of annual costs below a fixed limit (in 2017: DKK 950). However, 60% reimbursement for children under 18. Foreigners will get a special card with a unique number the first time they buy medicine in Denmark. The card must be showed at any time they buy medicine in Denmark. The card must be presented at any further purchase of medicine for calculation of the reimbursement	At the pharmacy one pay the full cost of the medicine. Reimbursement is calculated on the basis of the actual annual consumption of medicines on prescription	To show prescription and European Health Insurance Card, which proves the eligibility for state healthcare. Prescription charges range from 0% to 100% of the price according to standard prescription categories. Prescription charges are non-refundable in Iceland, but one can seek reimbursement once returned back home	Medicines can be collected at any pharmacy. Charges may vary	To present a valid European Health Insurance Card at the pharmacy in order to pay the subsidised price. Charges may vary
Ambulance	Acute necessary ambulance transport is free of charge	Client fee of EUR 25	A standard non-refundable fee is charged for ambulance services	Free of charge in emergencies	Free of charge in most areas

Appendix 2

Country descriptions of cross-border health issues

Greenland¹

Healthcare

The general rule is that you have rights to healthcare in Greenland, if you have a legal domicile in Greenland²:

Residents of Greenland are entitled to healthcare in Greenland and hence in the member states of the European Union cf. Council regulation (EEC) No 1408/71 of 14 June 1971 Article 22 (1) (a), cf. Council regulation (EEC) 1661/85 of 13 June 1985 Article 3, cf. Council regulation (EC) 883/04 of 29 April 2004 Article 90 (b). Furthermore, a residence certificate serves as documentation for these persons right to healthcare cf. Council Regulation (EC) No 574/72 Articles 21 and 23.

Citizens outside of Greenland are during a temporary stay entitled to health care under the following rules³:

For persons without residence in Greenland it is in general the regulation for temporary stay (less than 6 months of duration) in Greenland that is to be followed. Please note that depending on whether the stay is work related other rules may apply. Furthermore, in general, a travel health insurance is strongly recommended.

The rules are different whether the persons are from Denmark and Faeroe Islands:

- Documentation for rights to health care in home country necessary (e.g. EU Health Insurance Card). There is a right to urgent health care according to specifications
- Different types of transportation are not covered

Nordic Countries (Norway, Sweden, Finland or Iceland):

- Documentation for rights to health care in home country necessary (e.g. EU Health insurance care). Without documentation persons will be required to pay the full cost of health care
- There is a right to urgent health care according to specifications
- Different types of transportation are not covered

¹ This system description contains the general rules - it is not to be read a concise statement of all relevant legislation in the field

² Landstingsforordning nr. 15 af 6. november 1997 om sundhedsvæsenets ydelser m.v.
<http://lovgivning.gl/lov?rid={62CB910D-6B43-4789-A631-8881C63A842B}&#>

³ Borgere udenfor Grønland har under midlertidigt ophold her i landet ret til sygehjælp efter følgende regler, Departementet for Sundhed/Peqqissutsimut Naalakkersuisoqarfik, Government of Greenland.
<http://www.peqqik.gl/Emner/Patientinformation/Sygehjaelp-ved-rejse/Midlertidigt-ophold-i-Groenland>

EU/EEA countries (Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Switzerland and United Kingdom:

- Documentation for rights to health care in home country necessary (e.g. EU health insurance card). Without documentation persons will be required to pay the full cost of health care
- There is a right to urgent health care according to specifications

Other Countries:

- Greenland is not covered by international agreements with the wider world. This means that people coming from a country outside the EU and the Nordic countries have to pay for all health care and transportation home from Greenland

The legislation behind rules for persons temporarily in Greenland:

- Home Rule Regulation no. 15 of 6 November 1997 on health care services, etc., §2, section 2⁴
- The Home Rule Executive Order no. 5 of 15 February 2006 on the services and user fees in health care, § 1, section 3⁵
- Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community: Article 22. 1 point a) and Article 22. section 3, which regards healthcare rights of temporary stay in another EU/EEA State⁶

⁴ Landstingsforordning nr. 15 af 6. november 1997 om sundhedsvæsenets ydelser m.v.
<http://lovgivning.gl/lov?rid={62CB910D-6B43-4789-A631-8881C63A842B}&#>

⁵ Hjemmestyrets bekendgørelse nr. 5 af 15. Februar 2006 om ydelser og brugerbetaling i sundhedsvæsenet.
<http://lovgivning.gl/lov?rid={AEDB0389-4813-407C-8C82-81DC611EA86A}&#>

⁶ Rådets forordning (EØF) nr. 1408/71 af 14. juni 1971 om anvendelse af de sociale sikringsordninger på arbejdstagere og deres familiemedlemmer, der flytter inden for Fællesskabet <http://eur-lex.europa.eu/legal-content/DA/TXT/?uri=celex:31971R1408>

Finland

Legislation

Legislation related to cross-border healthcare system in Finland includes the Act on Cross-Border Health Care (1201/2013), Health insurance Act (1224/2004) and the Health Care Act (1326/2010). A National Contact Point for Cross-Border Health Care operates in the Social Insurance Institution (Finnish acronym: Kela).

Finns receiving care abroad

Medically necessary treatment during a temporary stay abroad:

- Patients have the right to obtain treatment in another EU/EEA country or in Switzerland when they need care during their stay. With the European Health Insurance Card (EHIC), the costs will be the same as they would be for the local residents. The EHIC is accepted in the public healthcare or in a private service provider who has an agreement with the public health care sector
- Patients who fall ill during a temporary stay outside the EU/EEA-area or Switzerland can from Kela retrospectively get reimbursements of the costs of treatment provided. The rules of procedure and the reimbursement rates are the same as they would have been if the patient would have received private healthcare services in Finland

Scheduled treatment

Without prior authorization:

- Patients can travel abroad with the purpose to receive both primary healthcare and specialized medical care or care for a chronic condition without prior authorization. Kela reimburses retrospectively the costs of treatment provided on the same basis as private healthcare services in Finland. In order to get the reimbursement, the treatment must be included in the range of services available in the Finnish healthcare system. Types of treatment and levels of reimbursement are based on legislation. The reimbursement is based on a schedule of fixed charges and is in practice around 20-24 per cent of the actual costs. It should also be noted that Finland has not opted to use to prior authorization system stipulated in the Cross-border Healthcare Directive

With a prior authorization:

- Prior authorization according to the EU-regulation 883/2004 can be used in the public healthcare system of another EU/EEA country or Switzerland. When deciding on prior authorization, the applicant's current state of health and the likely course of the illness are taken into consideration. Authorization is always granted when the following conditions are met: the treatment is medically justified, the treatment in question is provided by Finnish public healthcare system and the public healthcare provider is unable to arrange for treatment within a medically justifiable time period. However, prior authorization can be granted in all other cases when the public health care provider determines that the treatment is medically justifiable for the person in question and concurs with the applicant. With prior authorization, the patient will pay the same client fee for the treatment as a resident in the country in question. Patient's municipality

of residence is responsible for the rest of the costs of treatment provided abroad. Kela is responsible for the application process. If the conditions in the national legislation are met, Kela will reimburse also the costs of travel, an escort and accommodation retrospectively. It is also possible to apply for prior authorization retrospectively. No reimbursements are paid for costs of scheduled treatment outside the EU/EEA-area or Switzerland

Moving to other country

When a person moves to another EU/EEA country or Switzerland to work, the responsibility for the health care costs will primarily be transferred to the country in which he/she works. Patients who work in Finland but are living abroad in another EU/EEA-country or Switzerland (e.g. Frontier workers) are primarily health insured in Finland. It should also be noted that according to the EU-legislation the Finnish responsibility to pay for the patient's health care costs can also remain even if a patient works abroad (posted workers).

When a person moves abroad for less than a year (e.g. holiday, exchange study), the coverage of the Finnish health system usually remains. When a person lives abroad more than a year, he/she usually loses the right to Finnish health insurance coverage (with some exceptions of pensioners, workers and students). However, it should be taken into consideration that according to EU legislation or international agreements Finland can remain responsible for the patient's health care costs even if the patient, who is moving to another EU/EEA-country or Switzerland, no longer is health insured in Finland (e.g. pensioners who receive a pension only from Finland).

Finland receiving patients abroad

Medically necessary treatment during a temporary stay in Finland:

- All foreign patients have always the right to receive urgent treatment in Finnish public healthcare. According to EU-legislation, international agreements or national legislation a patient might also have the right to receive health care which is not considered urgent. Patients from another EU/EEA-country or Switzerland have for instance the right to obtain medically necessary treatment during their temporary stay in Finland. By showing their European Health Insurance Card (EHIC) the costs will be the same as they would be for the local residents in Finland. Finland also has international bilateral agreements that contain cross-border health care provisions with Australia, Quebec, Israel, Chile and the Nordic countries. The personal scope and the health care rights concerned vary between the agreements

Scheduled treatment

A person covered by health insurance in another EU country can freely travel to Finland with the purpose to receive treatment in Finland's public or private healthcare. He/she needs to contact treatment providers personally in order to determine the opportunities for treatment, waiting times and treatment costs. Information can be requested also from the Finnish contact point for cross-border healthcare. A referral is required for specialized medical care and it can be written in another EU country.

Healthcare service providers are obligated to accept patients from other EU countries in the same manner as patients from Finland. This obligation does not yet

apply to persons from EEA countries or Switzerland, although the service providers can offer services if they have available capacity.

As a rule, a patient is responsible for the costs of the treatment, as well as arranging interpretation, translating documents and other related costs. According to the Cross-border Healthcare Directive he/she can retrospectively apply for reimbursements in the competent Member state. If the patient according to the EU-regulation 883/2004 has been granted a prior authorization by the competent Member State the costs for the patient will be the same as customer fees for Finns in the public healthcare or the same reimbursements as Finns would get for the private health care services. It is to be noted that the reimbursements for private health care services are not granted directly but has to be applied for from Kela.

Finnish public healthcare may limit the reception of patients seeking treatment from abroad when it is necessary to ensure healthcare services for the residents of a municipality (e.g. waiting times are exceeded). The limitation is temporary and it must be reported to Finnish authorities. Currently, Finland does not have any limitations.

Residing or working in Finland

When a person has a place of domicile/ municipality of residence in Finland, he/she can use all public healthcare services. If the person is health insured in Finland he/she has the right to receive reimbursements for cost occurred in the private health care sector in Finland or at pharmacies. Also travel costs related to illness can be reimbursed. It is to be noted that Finland might not be responsible for the health care costs occurred. If another country is responsible for the costs Finland will claim the costs from the competent country.

According to EU legislation, international agreements or national legislation a person may also have the right to receive public health care services even if he or she does not have a municipality of residence in Finland. This concerns for instance persons working in Finland.

If a person moves to Finland permanently, he or she can request the inclusion in the Finnish residence-based social security system providing for example partial refund of the cost of private health care services. Persons working in Finland are insured in Finland from the first working day if conditions concerning working hours and wages are met and if they are working in Finland a minimum of four months.

Residents of other Nordic countries

Residents of other Nordic countries have a right to medically necessary treatment in Finnish public healthcare. They are also entitled to use their own language (Finnish, Swedish, Norwegian, Danish and Icelandic) within public healthcare. The treatment provider will arrange for an interpreter, if needed.

Frontier workers

Frontier workers working in Finland and living in another country are entitled to use all public healthcare services at the same price as the residents of the municipality in Finland. They are also covered by the Finnish health insurance.

Sources: www.choosehealthcare.fi

Iceland

Legislation

In Iceland, individuals do not pay special premiums for their social insurance. Employers pay premiums to the State Treasury on all paid wages, the use of which includes financing of social insurance. The national institution administrating these matters is Sjúkratryggingar Íslands (Icelandic Health Insurance, IHI).

Legislation related to cross-border healthcare system in Iceland includes act on health insurance no. 112/2008, regulation no. 442/2012 on the coordination of social security systems (EU regulation no. 883/2004), regulation on urgent medical treatment abroad when necessary treatment cannot be provided in Iceland no. 712/2010, regulation on reimbursement of expenses due to sickness or accidents abroad no. 281/2003, and regulation no. 484/2016 on patients' rights in cross-border healthcare.

Icelanders receiving care abroad

Medically necessary treatment during a *temporary* stay abroad:

Countries within EEA and Switzerland:

- With the European Health Insurance Card (EHIC), used due to illnesses or accidents during a temporary stay in countries within EEA and Switzerland, insured Icelanders pay the same as insured residents. The EHIC does not cover additional cost, such as changes in travel plans or repatriation. Individuals who qualify for insurance in Iceland but have citizenship from a country outside the EEA are not entitled to the EHIC, but can receive a confirmation of insurance from the IHI. The EHIC is only accepted in public healthcare systems, and not for scheduled treatment. In emergency cases, IHI may accept treatment in private health care within EEA. (<http://www.sjukra.is/heilbrigdisthjonusta/rettindi-millilanda/evropska-sjukratryggingakortid/almennar-upplysingar-/>). If an insured individual receives private medical services during a temporary stay, cost is reimbursed by IHI as if the services had been provided in Iceland

Other countries

If an insured person requires medical services in other countries than those within EEA or Switzerland, the insured must apply for reimbursement retrospectively. Overall, this applies to health care services due to sudden illness or accident, but for all necessary health care for students.

For cost base the individual pays the same as if treated in Iceland. Infant and maternity services are not covered.

For excess cost the reimbursement rates are:

- Expenses up to 75 000 Icelandic Kronas (650 €) are reimbursed 50 per cent (75 per cent for pensioners, students or their family)
- Expenses beyond 75 000 are reimbursed 75 per cent (90 per cent for pensioners, students or their family)
- Expenses beyond 10 000 000 are reimbursed 90 per cent (100 per cent for pensioners, students or their family)

Patient transport to Iceland is not paid, with a possible exception when cost would be greater for the IHI to keep the patient in hospital abroad (prior authorization required) (Regulation no. 281/2003).

Scheduled treatment in countries within the EEA or Switzerland

Without prior authorization:

- In June 2016, Directive 2011/24/EU on patients' rights in cross-border healthcare was implemented in Iceland, allowing insured individuals to seek services from another country within the EEA. Reimbursement equals what the services would have cost in Iceland, if the services are usually covered by the IHI. Travel and living expenses are excluded. (Regulation 484/2016)

IHI may deny reimbursement if:

- Services would have been available within acceptable waiting time (medically evaluated)
- Patient's health or the general public's health is threatened by the treatment
- Minimum requirement of quality and safety is not fulfilled

Only evidence-based medical treatment is covered. If the individual wishes to be treated at a different place than suggested by the IHI, only the amount that would have been charged at the place selected by the IHI will be reimbursed (Regulation 712/2010, 4. gr.).

With prior authorization

In general, an insured resident of Iceland can seek scheduled health care services within the EEA without prior authorization. However, prior authorization from IHI is required when:

- Treatment requires hospitalization for at least one night or continued treatment for more than 24 hours
- The treatment is hazardous for the individual or the general public
- Concerns arise about quality of services

When authorized beforehand, both treatment and travel expenses (in some instances also for an accompanying person) may be covered by IHI - if appropriate health care services cannot be provided in Iceland within acceptable waiting time (the Director of Health has defined 90 days as the maximum acceptable waiting time). However, that does not guarantee that IHI will accept treatment abroad. When applying for scheduled treatment abroad, the patient's physician sends an application to a specialized committee. The committee assesses the need for the hospitalization abroad, whether required conditions are fulfilled, and where the insured person is to be hospitalized. Confirmation of day of registration to a waiting-list in Iceland must be provided and arguments on how severe the consequences of waiting may be for the patient. Only evidence based treatment at certified hospitals is accepted, and the treatment must generally be covered by national health insurance in that country. If an insured individual seeks prior authorization and service cannot be provided within a medically justifiable time frame (according to an objective medical assessment, patient's medical history, and likely progress of the disease, pain and obstructive effects of the sickness), IHI may not deny the application. (11. gr.).

<http://www.sjukra.is/heilbrigdisthjonusta/rettindi-milli-landa/laeknismedferd-erlendis/langur-bidtimi-eftir-medferd-a-islandi/>

Moving to another country

When domicile is moved from Iceland, the individual loses the right of insurance by IHI. However, students who study abroad may remain registered in Iceland and will continue to be insured, as well as their partners and children.

Civil servants located abroad (such as embassy employees) remain insured in Iceland <http://www.althingi.is/lagas/nuna/2008112.html>

Insured individuals who reside in Iceland but work in EEA or Switzerland are most often insured in the country of work. Those who work in other countries may remain insured in Iceland, if the employer is located in Iceland and tax of wages is paid in Iceland (acceptance from the IHI is first valid for one year with possible extension of four more years). <http://www.sjukra.is/heilbrigdisthjonusta/rettindi-milli-landa/flutningur-milli-landa/stadfesting-a-rettindum-s1-vottord/>

Iceland receiving patients from abroad

Medically necessary treatment during a temporary stay in Iceland:

- Insured citizens of EEA countries are entitled to benefits which become necessary on medical grounds during a temporary stay in Iceland, taking into account the nature of the benefits and the expected length of the stay.
- Excluding those insured in the other Nordic countries (who only need proof of residence), individuals from the EEA must present the EHIC and their passport to be charged the same fee as those insured in Iceland. If the EHIC card is not presented, the individual will be charged the full costs of the treatment according to tariffs.
- Those who are not covered by EEA regulations can obtain medical assistance but must pay in full. They can then seek reimbursement from their own insurance in their country of origin or from their private insurance, according to rules and regulations applicable in their insurance country

Scheduled treatment

Hospital authorities are not aware of any patients who have received scheduled treatment in Iceland.

Residing or working in Iceland

Citizens insured in their previous country within the EEA or Switzerland obtain the right of insurance from IHI as soon as they have registered their domicile in Iceland. However, when moving to Iceland following residence in countries outside the EEA/Switzerland, the individual first comes part of the social insurance system six months after moving his/her domicile to Iceland. Until then, medical assistance must be paid in full by the individual (the IHI recommends private health insurance during the first six months). <http://www.sjukra.is/heilbrigdisthjonusta/rettindi-milli-landa/hverjir-eru-sjukratryggdir/um-busetu-og-logheimili/>.

Foreign workers from EEA or Switzerland, temporarily working in Iceland, may remain insured in their home country, but have the same rights as those insured in Iceland (with the S1 certificate).

Residents of other Nordic countries

Health care costs between the Nordic countries are waived. Residents of the other Nordic countries do not need the EHIC, only a confirmation of residence. IHI may also cover extra cost regarding transport to their home country, such as requiring stretchers. Iceland further has an agreement with all the other Nordic countries regarding rehabilitation http://www.sjukra.is/media/skjol/log_og_reglugerdir/Rgl-osjukratryggdir.pdf.

Souces:

<http://www.sjukra.is/heilbrigdisthjonusta/rettindi-milli-landa/>

<http://www.laeknabladid.is/tolublod/2016/12/nr/6154>

<http://www.landlaeknir.is/um-embattid/frettir/frett/item29708/Vidmidunarmork-um-bidtima-eftir-heilbrigdisthjonustu>

https://www.velferdarraduneyti.is/media/Rit_2013/Vidmidunarreglur_flottamannnefndar_Mai2013.pdf

Norway

Legislation

Legislation related to the cross-border healthcare system in Norway includes:

- Norwegian National Insurance Act (Folketrygdloven). The Act implements Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare
- Regulation (EC) No 883/2004 of the European Parliament and of the Council on the coordination of social security systems
- International social security agreements (e.g. the Nordic convention)
- The Patients' Rights Act (Pasient- og brukerrettighets loven)
- The Norwegian National Contact Point for Cross-Border Healthcare is operated by Helfo

Norwegians receiving care abroad

Medically necessary treatment during a temporary stay abroad:

- When a person stays abroad for less than a year (e.g. holiday), the coverage of the Norwegian health system usually remains. During this temporary stay in another EU/EEA country, or Switzerland, the European Health Insurance Card (EHIC) entitles patients to medically necessary healthcare affiliated with the state-provided health service in the country in which they are staying. Patients are entitled to coverage on the same terms as the country's nationals and must pay the same user fees as the country's nationals. Patients who fall ill during a temporary stay outside the EU/EEA-area or Switzerland are not covered by any legislation under the National Insurance act, and will therefore need private travel

Scheduled treatment

Without any prior authorization:

- Patients referred to for examination or treatment in Norway may receive their healthcare in another EU/EEA country (not Switzerland). They must pay for the healthcare out of pocket. If the terms and conditions are met, they will be eligible for subsequent reimbursement. The reimbursement is limited to the amount that the equivalent health service would have cost the Norwegian public health system if the health service had been received in Norway. Travel expenses are covered only to a limited extent. Process time for reimbursement claims is within 12 weeks.

Those who are assessed as entitled to necessary healthcare from the specialist health service within a certain time limit - may apply for prior notification before travelling abroad for treatment. Process time for a prior notification is within 4 weeks.

With prior authorization

- Prior authorization according to the EU-regulation 883/2004 can be used in the public healthcare system of another EU/EEA country or Switzerland. When deciding on prior authorization, the applicant's current state of health and the likely course of the illness are taken into consideration. Authorization is granted when the following conditions are met: the treatment is medically justified, the

treatment in question is provided by the Norwegian public healthcare system and the public healthcare provider is unable to arrange for treatment within a medically justifiable time period

- With prior authorization, the patient will pay the same client fee for the treatment as a resident in the country in question. It's also possible to apply for prior authorization retrospectively. Process time for prior authorization is within 4 weeks. No reimbursements are usually paid for costs of scheduled treatment outside the EU/EEA-area or Switzerland. If the patient is applying for in-patient treatment abroad or reimbursement thereof due to lack of adequate medical services in Norway, the patient may be granted this treatment according to the Norwegian Patients' Rights Act. A patient could also be entitled to treatment abroad following an expiry of the time limit set for his/her treatment

Residing or working

When a person lives abroad for more than a year, he/she usually loses the right to Norwegian health insurance coverage (with some exceptions of pensioners, workers and students). However, it should be taken into consideration that according to EU legislation or international agreements Norway can remain responsible for the patient's health care costs even if the patient, who is moving to another EU/EEA-country or Switzerland, no longer is health insured in Norway (e.g. pensioners who receive a pension only from Norway).

Within the EU/EEA-area, or Switzerland the person working or residing is entitled to health care services and/or reimbursement from the health insurance in the country of work or residents on equal terms with those residing there, this includes the payment of the same client fee for the treatment as a resident in the country in question. The treatment must be received in the public healthcare system in that country.

Persons residing or working in a country outside the EU/EEA area may be entitled to reimbursement for healthcare costs according to the Norwegian National Insurance Act. To be entitled for reimbursement the person has to be insured in the Norwegian social security scheme as a person working or residing outside of Norway. This applies primarily to pensioners, full-time students studying abroad, or persons stationed abroad by their Norwegian employer.

Patients from abroad receiving care in Norway

Medically necessary treatment during a temporary stay in Norway

Anyone staying in Norway is entitled to urgent medical care from the municipal and specialized health services. Treatment must be provided as long as it is "an urgent medical necessity".

During a temporary stay in Norway patients insured in another EU/EEA country, or Switzerland are entitled to coverage of medically necessary healthcare affiliated with the state-provided health service during their stay. This right is documented by the European Health Insurance Card (EHIC). Patients are entitled to coverage on the same terms as persons insured under the Norwegian National Insurance Act, and must pay the same user fees as the country's nationals.

Patients from outside the EU/EEA-area or Switzerland, who fall ill during a temporary stay in Norway, will need to cover all healthcare received themselves or through a private travel insurance, unless there is an international bilateral agreement giving the person entitlement to coverage.

Norway has international bilateral agreements that contain cross-border health care provisions with Australia, Quebec and the Nordic countries.

Scheduled treatment

Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border health care, entails that citizens from other EEA countries can come to Norway for treatment, both in the public and private healthcare system. These patients must pay out of pocket, and may later seek reimbursement from their home country depending on national legislation.

For a number of treatments in Norway, the waiting lists are long. The patient will have to join the same queue for healthcare as anyone else in Norway. A given hospital cannot reject the patient because he/she is from another EEA country. A patient can only be rejected when this can be justified by overriding reasons of general interest.

In Norway, the healthcare system requires everyone to have a referral from a medical professional in order to consult and be attended by the specialist health service. This will also apply to a resident of another EEA country. If the patient according to the EU-regulation 883/2004 has been granted a prior authorization by the competent Member State, the costs for the patient will only be the same user fees as the country's nationals. Patients from outside the EU/EEA-area or Switzerland will have to cover all healthcare treatments in Norway themselves.

Residing or working

If a person settles and works in Norway, the person usually becomes a member of the Norwegian National Insurance Scheme. This means that necessary health care expenses in the public health care system will be covered, and the person will only have to pay user fees for treatment.

A cross-border worker (a person that works in Norway, but live in another country) will also be entitled to health care services, including planned treatment, in both Norway and the country of residence. This includes persons insured in the Norwegian social security scheme, which works or resides outside the EU/EEA-area, or Switzerland.

According to EU legislation or international agreements a person may remain insured in another country's National Insurance Scheme, or another EU/EEA country or Switzerland may be responsible for the patient's health care costs, even if the patient works or resides in Norway. These persons will be entitled to health care services and/or reimbursement from the health insurance in Norway on equal terms with those residing, this includes the payment of the same client fee for the treatment as a resident in Norway. The treatment must be received in the public health system.

Sources:

<https://helsenorge.no/>

<https://oslo-universitetssykehus.no/dine-rettigheter/utenlandsbehandling>

Sweden

Beskrivning av gränsöverskridande hälso- och sjukvård i Sverige

Med gränsöverskridande vård avses sådan hälso- och sjukvård som tillhandahålls eller förordnas i en annan medlemsstat än försäkringsmedlemsstaten. En EU/EES-medborgare kan ha rätt till både nödvändig och planerad vård i ett annat EU/EES-land eller Schweiz. Vid behov av vård tar den enskilde kontakten med vården.

I Sverige är kostnadsansvaret för utomlandsvård fördelat mellan Försäkringskassan och landsting- och kommuner. Inför beslut om ersättning samråder Försäkringskassan med kundens hemlandsting. Eventuella kostnader regleras mellan Försäkringskassan och hemlandstinget. När EU/EES-medborgare får vård i Sverige och använder ett intyg för vårdförmåner reglerar Försäkringskassan kostnaderna med behörig institution i det land där kund är försäkrad för vårdförmåner. Försäkringskassan utfärdar Europeiskt sjukförsäkringskort samt andra intyg som berör gränsöverskridande vård.

Grundregeln är att om man blir sjuk vid ett tillfälligt besök i Sverige har man alltid rätt till nödvändig vård det vill säga akut vård eller vård som inte kan vänta tills man kommer hem igen. Vad som ska räknas som "vård som inte kan anstå" måste alltid avgöras i det enskilda fallet av den behandlande läkaren, tandläkaren eller annan ansvarig vårdpersonal.

Den som vistas tillfälligt i Sverige och är försäkrad i ett annat EU- eller EES land har rätt till nödvändig hälso- och sjukvård. Med det avses att man inte ska behöva avbryta en planerad vistelse här och återvända till sitt hemland av medicinska skäl. Den behandlande läkaren avgör vilken vård som ska anses vara nödvändig. För att få vård till vanliga patientavgifter ska patienten kunna visa upp det europeiska sjukvårdsförsäkringskortet (EU-kortet). Den som saknar försäkring får själv bekosta sin vård.

EU-medborgare kan även resa till Sverige för att få så kallad planerad vård. Då måste de först ha ett tillstånd för vårdinsatsen från hemlandets socialförsäkringsinstitution, som ska betala för vården.

En person ifrån ett annat EU/EES-land kan också vända sig direkt till en vårdgivare i Sverige för vård och sedan ansöka om ersättning i efterhand enligt bestämmelserna i den nationella lag som berört medlemsland tillämpar som en följd av patientrörlighetsdirektivet. I dessa fall skall patienten själv betala hela vårdkostnaden direkt till berörd vårdgivare. Den svenska Försäkringskassan blir därmed inte involverad i arbetet med att administrera finansieringen av denna vård.

Länkarna nedan komplettera texten med ytterligare uppgifter från dessa publikationer:

- SKL - vård av personer från andra länder
<http://webbutik.skl.se/bilder/artiklar/pdf/7164-992-8.pdf?issuusl=ignore>
- SoS vård
- <http://www.socialstyrelsen.se/vardochomsorgforasylsokandemedflera/halso-ochsjukvardochtandvard/vilkenvardskaerbjudas>
- FK - gränsöverskridande vård
- https://www.forsakringskassan.se/sjukvard/internationell_vard/gransoverskridande_vard_inom_eu

<http://www.regeringen.se/contentassets/2b09159f65cb42c6ad7f4bdde12b53f4/patientrorlighet-i-eu---forslag-till-ny-lag-ds-20126>

- Vård för papperslösa
<https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19381/2014-2-28.pdf>

Lagstiftning

Det är framför allt dessa lagstiftningar som är styrande:

- Hälso- och sjukvårdslag (1982:763)
http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-1982763_sfs-1982-763
- Tandvårdslag (1985:125)
https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/tandvardslag-1985125_sfs-1985-125

Nationella kontaktpunkter

Det svenska kontaktpunktsuppdraget är tvådelat mellan två myndigheter - Försäkringskassan och Socialstyrelsen.

National Contact Points for Cross-Border Health Care in Sweden:

- The National Board of Health and Welfare (Socialstyrelsen) for EU citizens intending to use Swedish healthcare.
- (Försäkringskassan) for Swedish insured persons seeking healthcare in the EU

Socialstyrelsen ansvarar för att informera om hälso- och sjukvård till personer som är försäkrade för vårdförmåner i en annan medlemsstat och andra medlemsstaters myndigheter och kontaktpunkter.

Försäkringskassan ansvarar för att tillhandahålla information till personer som är försäkrade för vårdförmåner i Sverige om deras rättigheter och möjligheter vid nödvändig och planerad vård i andra EU/EES-länder eller Schweiz och villkoren för ersättning för den sökta eller planerade vården.

Swedish receiving care abroad

Medically necessary treatment during a temporary stay abroad

I Sverige ansvarar landsting och regioner för hälso- och sjukvården. Om man kommer från ett annat land och blir sjuk vid ett tillfälligt besök i Sverige har man alltid rätt till nödvändig vård. Det kan till exempel vara akut vård eller sådan som inte kan vänta tills man kommer hem igen. Försäkrade i andra EU - länder har vid tillfällig vistelse rätt till nödvändig vård. Denna rätt innebär att de försäkrade under trygga medicinska omständigheter ska kunna vistas här den tid de planerat. De ska inte behöva avbryta en planerad vistelse och återvända till sitt hemland pga. medicinska skäl. Med nödvändig vård avses också vård som orsakas av kronisk sjukdom. Det inkluderar även provtagningar, medicinska kontroller, förebyggande mödra- och barnvård samt förlossning. Om vården kan vänta tills patienten kommer tillbaka till sitt hemland betraktas den inte som nödvändig. Det är behandlande ansvarig vårdgivare som i det enskilda fallet avgör vad som ska anses vara nödvändig vård. Rätten till nödvändig vård ger inte möjligheter till vård om syftet med resan till Sverige är att söka vård.

When a person moves to another EU/EEA country or Switzerland to work, the responsibility for the health care costs will primarily be transferred to the country in which he/she works. When a person moves abroad for less than a year (e.g. holiday, exchange study), the coverage of the Swedish health system usually remains. When a person lives abroad more than a year, he/she usually loses the right to Swedish health insurance coverage (with some exceptions of pensioners, workers and students).

Sweden receiving patients abroad

Medically necessary treatment during a temporary stay in Sweden

All foreign patients have always the right to receive urgent treatment in Swedish public healthcare. According to EU-legislation, international agreements or national legislation a patient might also have the right to receive health care which is not considered urgent. Patients from another EU/EEA-country or Switzerland have for instance the right to obtain medically necessary treatment during their temporary stay in Finland. By showing their European Health Insurance Card (EHIC) the costs will be the same as they would be for the local residents in Sweden.

Sweden also has international bilateral agreements that contain cross-border health care provisions with Australia, Quebec, Israel, Chile and the Nordic countries. The personal scope and the health care rights concerned vary between the agreements.

Scheduled treatment

A person covered by health insurance in another EU country can freely travel to Sweden with the purpose to receive treatment in Sweden's public or private healthcare. He/she needs to contact treatment providers personally in order to determine the opportunities for treatment, waiting times and treatment costs. Information can be requested also from the Finnish contact point for cross-border healthcare. A referral is required for specialized medical care and it can be written in another EU country.

Healthcare service providers are obligated to accept patients from other EU countries in the same manner as patients from Sweden. This obligation does not yet apply to persons from EEA countries or Switzerland, although the service providers can offer services if they have available capacity.

Residing or working in Sweden

When a person has a place of domicile/municipality of residence in Sweden, he/she can use all public healthcare services. According to EU-legislation, international agreements or national legislation a person might also have the right to receive public health care services even if they do not have a municipality of residence in Sweden. This concerns for instance persons working in Sweden.

If a person stays more than a year, he/she can request the inclusion in the Swedish social security system. Persons working in Sweden can be insured in Sweden from the first working day if conditions concerning working hours and wages are met and if they are working in Sweden a minimum on four months.

Residents of other Nordic countries

Residents of other Nordic countries have a right to medically necessary treatment in Swedish public healthcare. They are also entitled to use their own language (Finnish,

Swedish, Norwegian, Danish, and Icelandic) within public healthcare. The treatment provider will arrange for an interpreter, if needed.

Frontier workers

Frontier workers working in Sweden and living in another country are entitled to use all public healthcare services at the same price as the residents of the municipality in Sweden. They are also covered by the Swedish health insurance.

Source:

DIREKTIV EUROPAPARLAMENTETS OCH RÅDETS DIREKTIV 2011/24/EU av den 9 mars 2011 om tillämpningen av patienträttigheter vid gränsöverskridande hälso- och sjukvård

<http://eur-lex.europa.eu/legal-content/SV/TXT/PDF/?uri=CELEX:32011L0024&from=SV>

NATIONAL CONTACT POINTS

http://ec.europa.eu/health/sites/health/files/cross_border_care/docs/cbhc_ncp_en.pdf

Bryssel den 4.9.2015 COM(2015) 421 final RAPPORT FRÅN KOMMISSIONEN TILL EUROPAPARLAMENTET OCH RÅDET Rapport från kommissionen om tillämpningen av direktiv 2011/24/EU om tillämpningen av patienträttigheter vid gränsöverskridande hälso- och sjukvård

https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/2015_operation_report_dir2011_24eu_sv.pdf

Sveriges Kommuner och landsting (SKL) Vård av personer från andra länder (sjunde omarbetade upplagan)

<http://webbutik.skl.se/bilder/artiklar/pdf/7164-992-8.pdf?issuusl=ignore>

Statskontoret: Vård till papperslösa En uppföljning av lagen om vård till personer som vistas i Sverige utan tillstånd (2015:10)

<http://www.statskontoret.se/upload/Publikationer/2015/201510.pdf>

Statskontoret: Vård till papperslösa Slutrapport av uppdraget att följa upp lagen om vård till personer som vistas i Sverige utan tillstånd, Slutrapport 2016:11

<http://www.statskontoret.se/globalassets/publikationer/2016/201611.pdf>

SINTEF: Patient mobility in the Nordic Countries, 2011-06-07

http://www.nordicinnovation.org/Global/_Publications/Reports/2011/2011_patientMobility_report.pdf

Regeringens proposition 2012/13:109 Hälso- och sjukvård till personer som vistas i Sverige utan tillstånd

<http://www.regeringen.se/contentassets/dd981e89c9574cdf9031c3797e883dc1/halso--och-sjukvard-till-personer-som-vistas-i-sverige-utan-tillstand-prop-201213109>

Appendix 3

Outpatient and inpatient care in Denmark 2012-2016 by country and residence

	OUTPATIENT CARE - VISITS							INPATIENT CARE - EPISODES						
	2012	2013	2014	2015	2016	Total	%	2012	2013	2014	2015	2016	Total	%
Greenland	7 104	7 775	7 698	7 406	8 125	38 108	18.3	1 468	1 551	1 406	1 484	1 402	7 291	16.0
Faroe Islands	4 710	5 233	5 562	5 274	5 816	26 595	12.8	1 166	1 229	1 154	1 153	1 191	5 893	12.9
Iceland	175	168	230	208	336	1 117	0.5	57	37	52	43	42	231	0.5
Norway	1 996	1 904	2 233	2 030	2 248	10 411	5.0	803	773	864	766	750	3 956	8.7
Sweden	3 569	6 407	5 216	3 828	4 615	23 635	11.3	764	851	827	787	742	3 971	8.7
Finland	187	157	181	189	204	918	0.4	57	48	68	55	44	272	0.6
Other EU/EES countries	8 405	8 459	8 283	9 301	9 647	44 095	21.2	1 900	1 956	1 972	2 143	2 244	10 215	22.4
Other countries	11 121	11 520	11 408	13 136	16 276	63 461	30.5	2 427	2 503	2 480	2 892	3 432	13 734	30.1
Total foreigners	37 267	41 623	40 811	41 372	47 267	208 340	0.3	8 642	8 928	8 823	9 323	9 847	45 563	0.8
Without or unknown address	30 888	31 395	34 906	38 549	40 005	175 743	0.3	4 615	4 537	4 739	4 982	5 135	24 008	0.4
Residence in Denmark	11 698 562	12 225 080	13 094 649	13 523 397	13 639 326	64 181 014	99.4	1 143 283	1 139 804	1 154 191	1 135 411	1 117 166	5 689 855	99.8
Total care in Denmark	11 766 717	12 298 098	13 170 366	13 603 318	13 726 598	64 565 097	100	1 156 540	1 153 269	1 167 753	1 149 716	1 132 148	5 759 426	100

	OUTPATIENT CARE - PATIENTS							INPATIENT CARE - PATIENTS						
	2012	2013	2014	2015	2016	Total	%	2012	2013	2014	2015	2016	Total	%
Greenland	1 561	1 535	1 682	1 676	1 854	8 308	7.8	778	730	765	765	780	3 818	10.8
Faroe Islands	1 113	1 110	1 092	1 041	1 240	5 596	5.3	736	811	700	733	793	3 773	10.7
Iceland	126	127	163	150	268	834	0.8	43	31	40	38	36	188	0.5
Norway	1 565	1 491	1 717	1 548	1 686	8 007	7.5	714	688	786	687	659	3 534	10.0
Sweden	2 763	4 921	4 162	2 876	3 187	17 909	16.9	632	707	688	675	629	3 331	9.4
Finland	156	129	143	153	135	716	0.7	47	46	51	46	42	232	0.7
Other EU/EES countries	6 280	6 151	6 184	6 850	7 244	32 709	30.8	1 702	1 781	1 774	1 901	2 018	9 176	25.9
Other countries	5 696	5 633	6 264	6 738	7 802	32 133	30.3	1 977	2 080	2 098	2 420	2 762	11 337	32.0
Total foreigners	19 260	21 097	21 407	21 032	23 416	106 212	0.8	6 629	6 874	6 902	7 265	7 719	35 389	1.0
Without or unknown address	11 706	12 233	15 278	16 511	17 279	73 007	0.6	3 554	3 523	3 686	3 845	3 943	18 551	0.5
Residence in Denmark	2 489 092	2 521 145	2 656 027	2 691 980	2 717 812	13 076 056	98.6	684 611	682 593	688 845	684 405	677 893	3 418 347	98.4
Total care in Denmark	2 520 058	2 554 475	2 692 712	2 729 523	2 758 507	13 255 275	100	694 794	692 990	699 433	695 515	689 555	3 472 287	100

Please note the uncertainties of registration of residential code for other than Danish residents. So the numbers cannot be quoted exact.

Appendix 4

Country reports for care of undocumented migrants in the Nordic countries

Denmark

(Summary of the report, Ministeriet for sundhed og forebyggelse, 2014)

Det danske sundhedsvæsen tilbyder sundhedsydelser efter regler, som er fastsat i dansk lovgivning samt i medfør af EU-retten. I den danske lovgivning er det nærmere fastsat, hvilke persongrupper der har adgang til vederlagsfri eller tilskudsberettigede sundhedsydelser. Samtidig er Danmark også forpligtet til at overholde internationale konventioner som fx FN's konvention om økonomiske, sociale og kulturelle rettigheder og Den Europæiske Socialpagt vedtaget af Europarådet.

Ydelser efter sundhedsloven er som udgangspunkt betinget af bopæl, dvs. registrering med bopæl i Danmark i CPR-registret. Sygehusydelser og en række primære sundhedsydelser, herunder behandling hos alment praktiserende læge og specialelæge ydes vederlagsfrit, mens der ydes tilskud til behandling hos fx tandlæge, fysioterapeut m.fl. samt til medicin. Personer, som opholder sig i landet uden at være bopælsregistreret, herunder uregistrerede migranter, har ret til sundhedsydelser i et begrænset omfang (akut behandling).

Forskellig terminologi anvendes om persongruppen, som opholder sig i Danmark uden lovligt opholdsgrundlag. "Illegale indvandrere" har tidligere været en almindelig betegnelse. Europarådet anvender betegnelsen "irregular migrants", og denne terminologi vinder også frem i EU¹. På linje hermed vil betegnelsen uregistrerede migranter blive anvendt i denne analyse.

Praksis vedr. tilbud om sundhedsydelser til uregistrerede migranter

Regionerne yder akut sygehusbehandling til alle, som har behov herfor, uanset personernes opholdsgrundlag.

Der blev i 2011 etableret et privat tilbud i form af en sundhedsklinik for uregistrerede migranter ("udokumenterede udlændinge") i København og i 2013 en tilsvarende klinik i Århus. Sundhedsklinikkerne er primært baseret på frivillig arbejdskraft, som alle har en autoriseret sundhedsfaglig uddannelse. Den daglige leder er ansat af Røde Kors. Sundhedsklinikkerne tilbyder sundhedsydelser, som ikke tilbydes uregistrerede migranter i det offentlige sundhedsvæsen. Derfor behandler sundhedsklinikkerne som udgangspunkt ikke akutte og livstruende tilstande, da disse tilbydes i det offentlige sygehusvæsen. Klinikernes ydelser omfatter bl.a. behandling af smitsomme sygdomme, tandproblemer, problemer med bevægeapparatet, undersøgelser af gravide kvinder, fysioterapi samt henvisning til speciallæger, der yder frivillig hjælp.

¹ Søvig, Karl Harald: Provision of Health Services to Irregular Migrants with a Special Focus on children. European Journal of Health Law 18 (2011), s. 43-54.

En stor del af klinikkens patienter er udlændinge, der er kommet til Danmark for at søge arbejde eller blive familiesammenført. Patientgruppen omfatter således også udlændinge, som i visse tilfælde evt. kan være berettiget til sundhedsydelse efter fx forordning 883/2004.

Greenland

In particular regarding asylum seekers:

The Immigration Office in Denmark, to which these matters for Greenland at the time being still belong, has no information on textent of asylum seekers in Greenland. This seems to have little practical importance in particular in relation to health care and the load on the health care system as “it is difficult to reach Greenland without having been, for example, in Denmark, Iceland or Canada first. These countries have signed - and comply with the Refugee Convention”². While this number may be unclear, the Greenland Law Enforcement reported 2 undocumented migrants in 2016.

Iceland

Healthcare in Iceland for immigrants

The Icelandic Red Cross provides service to asylum seekers, safeguarding their rights, according to an agreement with the Ministry of the Interior. This entails the Icelandic Red Cross provides asylum seekers with consultation and safeguards their interests during case procedure by the authorities. According to service agreements between certain municipalities and the Directorate of Immigration, the applicant is guaranteed housing, meals and other basic service, including medical service.

The Icelandic Red Cross and certain municipalities further provide services to refugees invited by Icelandic authorities. They are entitled to more support and services than the asylum seekers, including financial support for the first year of stay and all necessary healthcare services available.

Non-urgent care healthcare

Refugees

Refugees invited by Icelandic authorities and those with residence permit on humanitarian grounds are covered by the Icelandic Health Insurance from the day they arrive in Iceland (with confirmation from the Directorate of Immigration). (Act 112/2008).

Primary health care services, as well as pharmaceuticals, glasses and hearing aids are without cost for refugees during their first six months of residence in Iceland. They are also entitled to dental services for decays and necessary dental mechanics.

Two years after their arrival in Iceland, they are encouraged to undergo interviews with a psychologist in their municipality, without cost.

² Redegørelse om udlændingeområdet, http://naalakkersuisut.gl/-/media/Nanoq/Files/Publications/Arbejdsmarked/DK/Redegoerelse_om_udlaendingeomraadet_DK_211013.pdf, page 25

Asylum seekers

According to contracts between The Directorate of Immigration and municipalities, asylum seekers are entitled to general health care and medicines, as well as maternal and infant health care. Pregnant women should immediately be referred to maternal health care. Asylum seekers should also be offered treatment for conditions such as post-traumatic stress disorder.

Medical examination

When applying for residence or permission to work, individuals from certain countries must undergo medical examination, verification of immunizations, and tests for infectious diseases. This should be paid by the individual or the employer (who should pay if specially requesting an examination). These examinations as well as the treatment of notifiable infectious diseases are free of charge by the individual.

The Directorate of Immigration provides individuals seeking asylum or quota refugees with this medical examination and the general immunizations in Iceland.

Urgent healthcare

As stated before, refugees invited by Icelandic authorities and those with residence permit on humanitarian grounds are parts of the governmental health insurance from the day of arrival.

Certain emergency health care for asylum seekers is included in a service contract between municipalities and The Directorate of Immigration. However, division of cost is somewhat unclear overall.

Sweden

Landstingen är skyldiga att erbjuda vård utifrån den enskildes medicinska behov och i enlighet med de prioriteringsgrunder som gäller inom hälso- och sjukvården samt i enlighet med vetenskap och beprövad erfarenhet. Detta gäller alla som vistas i Sverige och som har ett medicinskt behov av vård.

Lagstiftning

Vård till papperslösa enligt lagen (2013:168) om hälso- och sjukvård är vissa personer som vistas i Sverige utan tillstånd.

Sedan den 1 juni har den som har sökt asyl och fått ett beslut om avvisning eller utvisning har inte längre rätt till boende och dagersättning från Migrationsverket.

Den 21 juni fattade riksdagen beslut om en lag som begränsar asylsökandes möjligheter att få uppehållstillstånd och möjligheten för den sökandes familj att få komma till Sverige. Lagen gäller från och med den 20 juli och tre år framåt.

Vård för asylsökande och personer som saknar tillstånd för att vistas i Sverige (papperslösa)

I enlighet med hälso- och sjukvårdslagen (1982:763) är landstingen skyldiga att erbjuda fullständig hälso- och sjukvård till alla som är bosatta i landstinget. Landstingen har också en skyldighet att erbjuda de som vistas i landstinget omedelbar vård, det vill säga akut vård, om de behöver det.

Den hälso-, sjuk- och tandvård som landstingen enligt lag är skyldiga att erbjuda asylsökande och vissa personer utan uppehållstillstånd (papperslösa) skiljer mellan vuxna och barn. Idag omfattas alla barn av samma rättigheter till vård som de barn

som är folkbokförda. Landstingen kan erbjuda vård i större omfattning än vad som anges i regelverken.

Vem är papperslös?

Utredningen om vård för papperslösa m.fl. (SOU 2011:48) och Socialstyrelsen använder begreppet papperslösa för att beskriva målgruppen för den nya lagstiftningen. Termen papperslös är ursprungligen en direkt översättning av franskans sans papiers, som betyder "utan identitetshandlingar". Man behöver inte helt sakna identitetsdokument för att räknas som papperslös. Papperslösheten är med andra ord en definition av personens juridiska status vad gäller att vistas i Sverige.

Vem kan få vård?

Lagen om vård till papperslösa innebär att landstingen också är skyldiga att erbjuda papperslösa över 18 år hälso- och sjukvård och tandvård som inte kan anstå samt läkemedel som förskrivs i samband med sådan vård. Skyldigheten omfattar även mödrahälsovård, vård vid abort samt preventivmedelsrådgivning. Landstingen ska också erbjuda papperslösa en hälsoundersökning om det inte är uppenbart att det inte behövs.

Vård som inte kan anstå - vilken vård ska erbjudas?

Det är svårt att beräkna hur många papperslösa och gömda människor som finns i Sverige. Enligt ungefärliga beräkningar från 2010 uppehåller sig mellan 10 000 och 35 000 papperslösa personer i Sverige och av dessa är uppskattningsvis 2-3 000 barn.

Det framgår av lagen och propositionen 2012/13:109. Hälso- och sjukvård till personer som vistas i Sverige utan tillstånd att landstingen vid behov ska erbjuda hälso- och sjukvård och tandvård till papperslösa, som kan sammanfattas enligt följande:

- akut vård och behandling (omedelbar vård)
- vård och behandling som är mer än omedelbar vård, det vill säga lagen omfattar inte bara akut vård
- vård och behandling av sjukdomar och skador där även en måttlig fördröjning kan innebära allvarliga följder för patienten
- vård som kan motverka ett mer allvarligt sjukdomstillstånd
- vård för att undvika mer omfattande vård och behandling
- vård för att minska användningen av mer resurskrävande akuta behandlingsåtgärder
- vård som är följdinsatser av vård som getts (inklusive psykiatrisk vård)
- mödrahälsovård
- preventivmedelsrådgivning
- vård vid abort
- läkemedel som omfattas av lagen om läkemedelsförmåner
- smittskyddsinsatser
- en hälsoundersökning (om den enskilde inte redan har fått det)
- hjälpmedel vid funktionshinder (om inte patienten kan få tillgång till sådana på annat sätt)
- sjukresor eller transport i samband med vårdtillfället
- tolk i samband med vårdtillfället

Denna vård omfattar alla typer av vård: somatisk och psykiatrisk hälso- och sjukvård samt tandvård. Vård för personer med särskilda behov (som utsatts för tortyr, allvarliga övergrepp eller trauma) bör bedömas särskilt omsorgsfullt.

Statskontoret (The Swedish Agency for Public Management)

Statskontoret har haft regeringens uppdrag att följa upp landstingens skyldighet att erbjuda hälso- och sjukvård till personer som vistas i Sverige utan tillstånd.

Regeringen gav den 16 april 2014 Statskontoret i uppdrag att analysera det nya regelverket som trädde i kraft den 1 juli 2013 och som innebär att personer som vistas i Sverige utan tillstånd ska erbjudas samma hälso- och sjukvård som asylsökande. I uppdraget ingår att analysera hur det nya regelverket har implementerats och hur det tillämpas.

Delrapport:

<http://www.statskontoret.se/upload/Publikationer/2015/201510.pdf>

Slutrapport:

<http://www.statskontoret.se/globalassets/publikationer/2016/201611.pdf>

Statskontorets övergripande slutsats är att de flesta papperslösa som söker vård också erbjuds hälso- och sjukvård, tandvård och läkemedel i enlighet med vad lagen föreskriver. Vår uppföljning visar samtidigt att det finns vissa hinder och brister i vården till papperslösa. Den största risken för att papperslösa inte erbjuds vård i enlighet med lagstiftningen är att vårdpersonalen har bristande kännedom och kunskap om lagen.

Frivilligorganisationer:

Röda korset

Redan för många år sedan uppmärksammades bristen på tillgång till sjukvård för papperslösa i Sverige. Bland annat startade organisationen Läkare i världen den första mottagningen för papperslösa redan 1995, där frivilliga läkare och annan medicinsk personal tog hand om svårt sjuka människor som nekades hjälp av den offentliga vården. Efter att den första kliniken öppnades i Stockholm har flera andra mottagningar öppnats. Bland annat driver vi i Röda korset sedan år 2006 en vårdförmedling för papperslösa i Stockholm och sedan år 2008 har Röda Korset ett samarbete med Rosengrenska stiftelsens vårdförmedling i Göteborg. Tusentals papperslösa i behov av vård har under åren sökt sig till vårdförmedlingarna och fått hjälp. Sedan år 2008 ingår Röda Korset i ett nätverk av 60-talet andra organisationer och förbund som alla står bakom kravet om rätt till vård på lika villkor som övrig befolkning.

Appendix 5

Avtal om gränssamverkan inom prehospital akutsjukvård

1. Avtalsparter

Sverige: Norrbottens läns landsting, Västerbottens läns landsting

Norge: Helse Nord RHF

Finland: Lapin sairaanhoitopiiri (Laplands sjukvårdsdistrikt),
Länsi-Pohjan sairaanhoitopiiri (Västerbottens sjukvårdsdistrikt)
och Oulun yliopistollinen sairaala (Uleåborgs universitetssjukhus)

2. Nordiskt hälsoberedskapsavtal

Regeringarna i Danmark, Finland, Island, Norge och Sverige har den 14 juni 2002 tecknat ett avtal inom hälso- och sjukvårdsområdet om samarbete över gränserna i syfte att förebygga och bistå varandra med assistans vid exempelvis olyckshändelser. Syftet är därför att förbättra tillgängligheten av prehospitala akutsjukvårdsresurser för befolkningen och besökare i gränsområdena.

3. Omfattning

De resurser som anges i detta avtal är bemannade vägambulanser och ambulanshelikoptrar samt övriga resurser inom prehospital akutsjukvård.

Avtalet omfattar både stora olyckor, där de befintliga resurserna inte räcker till, och livshotande sjukdomstillstånd hos en enskild medborgare, där en resurs på den andra sidan nationsgränsen bedöms ha kortare insatstid.

De medicinska åtgärderna omfattar säkerställande av vitala funktioner samt stabilisering enligt de medicinska direktiv som tillämpas inom den egna nationens organisation.

Gränssamarbetet omfattar det geografiska området mellan Norrbottens län i Sverige, Västerbotten län i Sverige, Nordland, Troms och Finnmark i Norge och Lappland och Västerbotten i Finland och berör i första hand resurser i gränsområdet. Search & Rescue (SAR) och fjällräddning ingår inte i detta avtal.

4. Avtalstid

Ursprungliga avtal från 2012-01-01, reviderat 2015-09-17. Avtalet gäller tillsvidare med ett års uppsägningstid.

5. Utalarmning

Larmcentralerna, SOS Alarm i Sverige, R-AMK Tromsø, i Norge och Hätäkeskuslaitos (Häke) i Finland, bedömer behovet och begär hjälp hos berörd larmcentral som därefter ansvarar för utalarmering av den egna nationens resurser enligt gällande rutiner.

6. Prehospitala resurser

Vägambulanser och ambulanshelikoptrar ska bemannas med sjukvårdspersonal som har den kompetens som den egna organisationen beslutat om. Detsamma gäller den sjukvårdsutrustning som används vid insatsen.

Patienten ska transporteras till närmaste vårdinrättning i hemlandet. Det kan det vid något tillfälle innebära överflyttningar mellan två resurser.

Beroende på patientens tillstånd kan transporten behöva ske till närmaste akutsjukhus eller sjukhus med tillgång till adekvat specialistkompetens, se bilaga till avtalet. Beslut om detta fattas i samråd mellan sjukvårdspersonalen, larmcentralen och ansvarig läkare.

7. Medicinskt ansvar

Respektive organisations medicinskt ansvarige läkare har ansvar för åtgärder som den egna sjukvårdspersonalen utför.

8. Organisation på skadeplats och sjukdomsplats

Den biträdande nationens resurser är underställd organisation och ledning i det land där sjukvårdsinsatsen äger rum.

9. Dokumentation

Sjukvårdspersonalen ska dokumentera ärende- och patientuppgifter samt medicinska uppgifter som bedömningar och åtgärder i den egna organisationens journalhandlingar. Nödvändig dokumentation ska alltid medfölja patienten. I händelse av anmälningsfall ska journalen kunna bifogas som underlag i den andra nationens utredning.

10. Försäkringar och tillstånd

Avtalsparterna ansvarar att den egna sjukvårdspersonalen har de försäkringar och tillstånd som krävs vid tjänstgöring på den andra sidan nationsgränsen. Avtalsparterna ansvarar för att patientförsäkringen även gäller i de fall omhändertagandet och åtgärder genomförs av sjukvårdspersonal från den andra nationen.

11. Begränsningar

I de fall den hjälpande nationens resurser är upptagna kan insatserna försenas eller i sämsta fall utebli.

12. Ekonomi

Detta avtal följer principerna i det Nordiska hälsoberedskapsavtalet. Parterna ersätter varandra enligt gällande taxor för de faktiska kostnader som uppkommit vid insatsen.

Kostnaderna faktureras motparten efter varje uppdrag och specificeras med tidpunkt och plats för händelsen samt de kostnader som är förenade med hjälpinsatsen.

Patientavgift kan debiteras enligt avtalsparternas egna regelverk.

13. Samverkan

Parterna kan tillsammans etablera arbetsgrupper som får i uppdrag att bl.a. följa upp avtalet, utveckla rutiner samt hantera avvikelser. Det är värdefullt att samverkan även sker med berörda larmcentraler.

14. Överlåtelse

Avtalsparterna kan efter överenskommelse, med samma villkor i avtalet, överlåta utförandet till anlitaad entreprenör.

15. Tvist

Tvist med anledning av detta avtal ska i första hand avgöras av avtalsparterna. Om parterna inte kan enas hänskjuts frågan till berörd politisk nivå.

Detta avtal är upprättat i ett gemensamt dokument på svenska, norska och finska, i sex likalydande exemplar, ett till varje avtalspart.

(Redaktionellt tillägg: Detta avtal har daterats och undertecknats av parterna den 17/9, 22/9 och den 1/10 2015.)

Appendix 6

Norrbottnen och Finland, diagnoser och volymer 2007-2015

	2011	2012	2013	2014	2015	Totalt
Ögonsjukdom	204	213	154	144	192	907
Öronsjukdom	20	21	23	10	12	86
Rörelseorganens sjukdomar	133	99	94	72	65	463
Andningsorganens sjukdomar/skador	18	23	13	12	16	82
Blod- & immunsjukdomar	2			2	1	5
Hjärt- och kärl sjukdomar	23	20	10	5	11	69
Fertilitetsbehandlingar	1	2	6	7	1	17
BB-Gynekologi	2	3	6	2	4	17
Hudsjukdomar	23	19	28	26	45	141
Infektionssjukdomar	24	24	16	10	13	87
Matsmältningsorganens sjukdomar	9	7	7	4	6	33
Medfödda missbildningar	-	1	1	-	-	2
Nackskador	3	-	3	8	6	20
Neurologiska sjukdomar	12	14	8	6	12	52
Psykiska sjukdomar	14	18	8	9	20	69
Urin- eller könsorganens sjukdomar	43	47	37	28	47	202
Skador/yttre våld	7	5	5	4	1	22
Tandvård	4	5	10	7	7	33
Tumörer/cancer	8	4	1	1	1	15
Ämnesomsättnings- körtelsjukdomar	6	3	3	1	4	17
Övrigt	61	51	76	88	108	384
	4	4	3	6	4	21
Summa	621	583	512	452	576	2744

Appendix 7

Länsi-Pohja healthcare district: diagnoses for foreign patients - Sweden and the other countries, 2015

Länsi-Pohja's central hospital										
	Emergency appointments and inpatient bed-days				Other appointments and inpatient bed-days					
Speciality	Consulting appointments		Bed-days			Consulting appointments		Bed-days		
	Sweden	Other countries	Sweden	Other countries		Sweden	Other countries	Sweden	Other countries	
	Men			5	146	17		22	4	9
	Women				42	13		14	4	1
Internal disease ward		0	0	5	188	30	36	8		10
	Men					1				
	Women									
Anaesthesiology and intensive care unit		0	0	0	0	1	0	0		0
	Men	61	160			7	9			
	Women	31	120			4	2			
Accident and emergency		92	280	0	0	11	11	0		0
	Men		3	6	55	41	19	2		6
	Women	1	3	5	11	13	12			6
Surgery		1	6	11	66	54	31	2		12
	Men						1			
	Women									
Neurosurgery		0	0	0	0	0	1	0		0
	Men						1			
	Women	6	9	27	19	53	48	30		28
Obstetrics and gynecology		6	9	27	19	53	49	30		28
	Men			9	10	4	3	17		1
	Women				12		1	2		2
Pediatrics		0	0	9	22	4	4	19		3
	Men	1	2			5	2			
	Women					12	1			
Eye diseases		1	2	0	0	17	3	0		0
	Men		1			23	0	1		
	Women					7				
Otorhinolalngology		0	1	0	0	30	0	1		0
	Men						1			
	Women					3				
Oral and dental diseases		0	0	0	0	3	1	0		0
	Men					2	4			
	Women					1	4			
Dermatosis diseases		0	0	0	0	3	8	0		0
	Men					3				
	Women									
Cancer diseases		0	0	0	0	3	0	0		0
	Men					55	4			
	Women		3		188	54	12			
Psychiatry		0	3	0	188	109	16	0		0
	Men									
	Women		1			1	0			
Youth psychiatry		0	1	0	0	1	0	0		0
	Men						9			
	Women									
Child psychiatry		0	0	0	0	0	9	0		0
	Men			2	9	8	2			5
	Women			6	1	1	1			
Neurology		0	0	8	10	9	3	0		5
	Men									
	Women						2			
Child neurology		0	0	0	0	0	2	0		0
	Men					10	11			4
	Women					1				
Respiratory system diseases		0	0	0	0	11	11	0		4
	Men					15	6			
	Women					14	2			
Physiatrics		0	0	0	0	29	8	0		0
All together		100	302	60	493	368	193	60		62

Appendix 8

Statistics Region Skåne -Personer bosatta i Skåne som sökt vård i nordiskt land enligt SFS 2013:513

Den planerade vården i nedanstående sammanställning är i huvudsak utförd hos privata vårdgivare i vårdlandet.

2014 Planerad vård

Vårdland	Antal	Kvinnor	Män	Födda år	Vårdområde
Danmark	866	470	406	1922-2013	Hyperhidrosbehandling (788), Ögon (40), Kardiologi (16), IVF (7), Ortopediska operationer (4) + enstaka vårdtillfälle hjälpmedel, Urologi, Rehabilitering, Endokrin, Neurologi, kirurgi, tandvård, ÖNH och Kvinnosjukvård
Finland	6	5	1	1939-1977	IVF (3), Ortopedi (2) och Urologi (1).
Island	2	1	1	2007-10	Tandvård

2015 Planerad vård

Vårdland	Antal	Kvinnor	Män	Födda år	Vårdområde
Danmark	876	470	406	1922-2013	Hyperhidrosbehandling (366), Kardiologi (27), ADHD (23), Ögon (8), Ortopediska operationer (6), IVF (5), + enstaka vårdtillfälle Kvinnosjukvård, Urologi, Thorax, Kirurgi, Läkemedels-förskrivning, Handkirurgi, Onkologi och Neurologi
Finland	6	4	2	1939-1992	Onkologi (3) + enstaka vårdtillfälle Ögon, Psykiatri och IVF
Norge	5	4	1	1947-94	Mödravård, Hudsjukvård, Onkologi och Ortopedi

2016 Planerad vård

Vårdland	Antal	Kvinnor	Män	Födda år	Vårdområde
Danmark	549	293	256	1932-2004	Hyperhidros behandling (462), ADHD (39), Kardiologi (25), Ortopediska operationer (13), IVF (4), + enstaka vårdtillfälle Urologi, Thorax, Kirurgi, Handkirurgi, Rehabilitering och Neurologi
Finland	9	4	5	1938-1976	Onkologi (8) + Urologi (1)
Norge	3	1	2	1951-90	Enstaka vårdtillfälle Neurokirurgi, Psykiatri och Urologi

2017 Planerad vård

Vårdland	Antal	Kvinnor	Män	Födda år	Vårdområde
Danmark	247	131	116	1939-2003	Hyperhidros behandling (199), ADHD (34), Kardiologi (7), Ortopediska operationer (4), IVF (4), + enstaka vårdtillfälle IVF, Ögon och Kirurgi
Finland	1		1	1931	Onkologi

Appendix 9

Strategic plan for cross-border collaboration in health care, 2017-2019

Background

The need for medical care is increasing throughout northern Europe, at the same time as organisations are under constant pressure to streamline costs and efficiency. Furthermore, the regional level plays an increasingly important role due to requirements for increased collaboration between municipalities and county councils and also internationally.

Care providers in northern Norway, Sweden and Finland have a long tradition of cross-border collaboration and a joint task to improve the population's health and the quality of health and medical care. Health and medical care providers and the municipalities in the northernmost districts/counties also face the same major challenges in the form of demographic changes, difficulties with the provision of skills and an ageing population, particularly in rural areas.

The population in the border areas often have a common, cross-border identity that is characterised by the meeting of the four cultures; Norwegian, Swedish, Finnish and Sami. The historical collaboration and participation culture of the Northern counties represents a unique opportunity for the joint development of health and medical care in both border and rural areas. Based on the specific characteristics of the border areas collaboration can create added value for patients and be beneficial to business. The implementation places major demands on the care providers' ability to actively support new ways of working in order to meet future needs and challenges at the same time as employee creativity, commitment and energy are utilised.

Aims

Improve the health of the population in rural and border regions in northern Norway, Sweden and Finland

- In addition to the quality of health and medical care
- Based on equal and patient-centred care

Success factors

Certain conditions for achieving this aim require that the cross-border collaboration:

- Is anchored within the respective organisations
- Actively supported at management level
- Based on an awareness of a long-term approach and perseverance

Focus areas: rural and border areas

New demands are placed on health and social care in rural and border regions as a result of an increasingly ageing population and its demographic development, in combination with difficulties securing the skills supply and a strained economy. Collaboration within the local community and across national borders can make it

possible for the elderly and ill to continue living in their homes and make it easier for health and medical care to cope with their assignment. In addition to the collaboration, there is the need for continued development of the concept of rural medicine and the implementation of technical solutions. Helse Nord RHF, Region Norrbotten, Västerbotten County Council, the hospital districts of Lapland, Länsi-Pohja and Oulu University Hospital all face similar challenges. Nevertheless, they have reached different stages in development - especially in primary care and distance solutions. Through the transfer of knowledge and skills between organisations, an exchange of good examples is possible, and if necessary new methods can be developed.

Furthermore, there is the opportunity for universities and health sciences programmes in northern Norway, Sweden and Finland to increase their collaboration in the field of rural medicine. The collaboration between care providers also creates opportunities for solid cooperation in the border regions through agreements for the purchase of health care services. With a declining population in the border regions, as well as to ensure the care of the Sami population, such solutions can lead to more efficient operations and higher level of service.

Below is a description of the possible themes for continued collaboration as well as a model for how the joint development work can be realised.

Themes

Management

- Develop distance solutions in the first instance in primary care, emergency medicine and medical specialities
- Work for solving obstacles to cross-border collaboration
- Develop and follow up on the collaboration/cooperation agreements between the health and medical care in the border regions
- Guarantee the correct transfer of written information and documentation across international borders and between care providers in pre-hospital care
- Cooperate and follow up activities within the framework of the Co-operation Programme on Health and Related Social Issues in the Barents Euro-Arctic Region

Research and education

- Support and encourage research and development of rural medicine and cross-border collaboration
- Develop acquisition of knowledge and exchange of experience in a Nordic context, for example by using comparative data and methods to measure quality and costs.
- Promote development and exchange of skills in rural medicine through collaboration between universities/higher education institutions in northern Norway, Sweden and Finland
- Develop the potential for nurses and doctors in northern Norway, Sweden and Finland to exchange their experiences and work tasks in order to increase knowledge and interest in rural medicine

Good care and best practice

- Develop methods for care and treatment based on the needs of the population
- Ensure good and equal care of elderly people in rural areas
- Press for greater patient influence and self-care
- Ensure fast and safe provision of care in the border regions
- Work for good patient safety and secure patient insurance
- Promote skills development in primary care and adult psychiatry
- Enable agreements for purchasing services from SANKS

Implementation

Cross-border collaboration in health and medical care within and between the Nordic countries has been ongoing for many years. In order to avoid parallel efforts and take advantage of previous experiences, ongoing or planned partnerships should be identified and compiled in a report.

Stage 1

The Directors decide to initiate collaboration within a priority area. Together with the party responsible for the project implementation, goals and a schedule are established. All involved parties appoint participants for a common project group. In order to clarify the scope and thereby avoid future ambiguities concerning the level of ambition and responsibility, the scope should be clearly stated before work begins.

The project group will compile a general description of the priority area in each health care district. The summary should include:

- A brief description of the current situation
- Good examples of completed development work
- Identified new development areas that, as a result of cross-border collaboration, lead to business benefits or added value from the patient's perspective

Proposals for improvements can be anything from measures that are possible to implement directly in daily operations or that require joint development work, e.g. project. The conclusions must be documented and reported to the directors, who decide on any further work and in what form.

Stage 2

When making decisions on continued collaboration the Secretariat together with the appointed representatives of the parties, are instructed to submit an action plan/project plan to the directors. A working/project group are appointed to work according to the established project plan. The work must be reported to the directors at least twice a year.

Administration and follow-up

Personnel costs and other expenses for participation in the working groups are financed by the parties themselves, from the common budget or external financing.

The secretariat annually compiles a written follow-up of the work conducted by the groups, which is presented each financial year.

Network

In addition to the common development work, there is a need to establish networks between experts in medical specialities or between those responsible for areas of expertise. Channels of communication between colleagues allows for early warning, as well as the exchange of knowledge and experience.