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Patient mobility in the Nordic Countries

Volume and obstacles

- Regulatory environment and main patterns of cross-border patient mobility at the EU-level
- Legislation, estimated numbers of patients and the barriers to patient mobility at a national-level
- Cross-border cooperation, patient mobility and barriers to greater patient mobility at a regional-level



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Report

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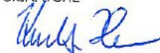
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ABSTRACT

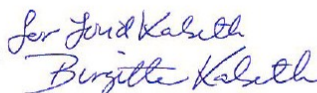
This study examines cross-border patient mobility between the four largest Nordic countries (Norway, Sweden, Denmark and Finland), focusing in particular on planned treatment within specialised healthcare services. It does this in three broad ways: (i) an examination of the regulatory environment and main patterns of cross-border patient mobility at the **EU-level**; (ii) an analysis of legislation, estimated numbers of cross-border patients and the barriers to patient mobility at a **national-level**; (iii) case studies presenting data on cross-border cooperation, the extent of patient mobility and barriers to greater patient mobility at a **regional-level**. The study concludes that despite increasing political interest in cross-border cooperation related to patient mobility, most patients' needs continue to be met within their national health systems. The actual numbers of patients crossing national borders to receive healthcare services were found to be very low.

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Executive summary

This study examines cross-border patient mobility between the four largest Nordic countries (Norway, Sweden, Denmark and Finland), focusing in particular on planned treatment within specialised healthcare services. The two regions Öresund and the North Calotte are investigated in particular.

We have shown that the number of patients who travel across national borders for planned hospital care financed by the public sector is very small in the Nordic countries. The patient flows that do exist are mainly due to a lack of highly specialised services (medical expertise and technology) in the patient's home country. To reduce waiting times most countries have established free choice of hospital systems to utilise the capacity within their own countries. There are also examples where patients can travel to another country when waiting lists for certain treatments become too long.

The small number (about 250 per year) of cross-border patients in the Nordic region appears to contradict studies that show a high level of hypothetical willingness to cross national borders for healthcare services. Therefore one can assume that the level of perceived need for cross-border care is currently not high, and that most patient needs are adequately met within national health systems.

The limited amount of patients crossing national borders for planned hospital treatment can be explained by:

- Lack of demand; the Nordic countries are largely self-sufficient regarding health services
- Lack of legal access to (public financed) treatment abroad
- Lack of support for cross-border care from healthcare workers in a patient's home country
- Distance or travel time
- Patient co-payment
- Individual reasons condition and functionality level, knowledge of, and connection to, the other country, language etc.

We can assume that willingness to travel is stronger for patients with serious and rare diseases, where treatment in the home country is limited or where expertise and/or equipment are inadequate.

Patient mobility across borders is not necessarily an end in itself. The Nordic countries are obligated to ensure capacity to treat common illnesses and injuries without patients having to travel too far.

North Calotte

In the case of North Calotte, a shared language and cultural affinity are important factors promoting cross-border patient mobility. Also, cooperation on primary healthcare has been gaining more significance because hospital care is increasingly centralised.

Öresund

Strong trade links have existed in the Öresund region for hundreds of years. This is reflected in the close social, cultural and linguistic similarities between populations on either side of the Öresund straight.

When viewed from a formal perspective, existing legislation grants patients the right to receive health services in another country if waiting time guarantees are breached or if services are not available in the patient's home country. Furthermore, legal barriers are becoming less significant with the introduction of new EU-regulations. However, some obstacles thought to inhibit patient mobility were identified. From a system-level perspective these include: administrative incompatibilities between the health systems in Denmark and Sweden (e.g. regarding patient co-payments, information systems); a lack of capacity on the other side of the border as well, inefficiencies in infrastructure connecting the region (in spite of the bridge); and differences in legislation (e.g. regarding pharmaceuticals). From a patient-level perspective obstacles identified include: insecurity over the unfamiliar; family connections; language and cultural barriers; transport costs and time; satisfaction with one's current circumstances.

Concluding remarks

While the projects, agreements and efforts outlined in this report may go some way to encouraging greater patient mobility, it is difficult to escape the conclusion that currently most patients perceive that their health needs are best met within their national system. Furthermore, patients demonstrate a strong preference to receive treatment as close to home as possible. Higher volume patient mobility is dependent of a number of factors, such as:

- a persistent asymmetry between health services offered on each side on the border, either in terms of capacity (waiting times etc) or expertise (competence, specialisation)
- the distance to health services in another country offers patients a comparative advantage to services offered within their own country
- financial incentives for both patients and health authorities
- readily available information about possibilities for patient mobility

In the absence of such factors, patient mobility is likely to remain limited to highly specialised ‘niche’ services or to the use of spare capacity in one national system to temporarily plug capacity gaps in another national system until such time as capacity can be strengthened.

Though there are legally few obstacles for patients seeking to access treatment abroad, the number of patients choosing this option is quite limited. One explanation implies that though national health services in each country may lack expertise or have long waiting lines, they are able to meet, to a great extent, the needs of its own inhabitants.

1 Background and project aims

During the last decades cross-border healthcare has gained increasing attention within the EU/EEA region. This reflects structural, cultural, economic and political changes. More people are staying in another country for shorter or longer periods to work, study or spend their retirement years. Cheap airline tickets have opened the world for broader segments of the population, and cultural and linguistic knowledge have also broadened, reflecting higher levels of education and increased international travel for both business and pleasure. In addition there is an increasing emphasis on patient rights and patient choice in many European countries. These and related trends contribute to an increased interest from policy-makers in cross-border patient mobility.

Within the EU/EEA region arrangements and regulations underpinning the free movement of services, goods, people and capital (four freedoms) are important underlying forces for EU health policy. Several EU court rulings have shown the need to clarify the rules for financial coverage of treatment in another country. In particular the balance between support of the EU's four freedoms on one side, and the protection of national social security systems and national health policy on the other, represent key legal and political challenges.

Cross-border healthcare is of particular relevance to people living in border regions, as the distances to health services in a neighbouring country are often shorter than to services in a patients' home country. A perceived need for access to healthcare across borders, however, is not enough for actual patient mobility to take place. The existence of structures and arrangements to facilitate patient mobility is also crucial.

The aim of this project is to map the extent of cross-border patient mobility in the Nordic countries and to highlight barriers or obstacles to increased patient mobility. The main questions of the study are:

- How many patients seek planned hospital treatment in other countries within the Nordic region (we call these patients cross-border patients)?
- Which diagnostic groups do the cross-border patients belong to, and what kinds of treatment do they seek?
- What are the reasons patients choose another Nordic country (waiting time, closeness, quality etc)?
- What difficulties do these patients face (administrative, logistical, cultural etc)?
- What are the obstacles to increased patient mobility?
- What regional and national guidelines exist for patient mobility in the Nordic countries?

The project focuses on planned treatment within specialist healthcare services and publicly financed healthcare – or to put it more simply, planned inpatient (hospital) care. This means that less emphasis is placed on patient mobility when it comes to primary care, private care and dental care. The two regions Öresund and the North Calotte are investigated in particular.

In this report patient mobility is viewed and analysed according to three different levels:

- The general EU-level
- The national-level
- The regional-level; focusing specifically on the border regions of Öresund (between Sweden and Denmark) and North Calotte (between northern Norway, Finland and Sweden).

While national and regional level policies are obviously significant in terms of patient mobility, EU policy and legal frameworks also apply to the Nordic countries and are therefore important to consider. In addition, a number of studies conducted within the EU have contributed valuable information regarding the scope and terms of patient mobility. Thus, experiences and knowledge from the whole EU region will be used as an important reference in this study.

1.1 Data and methodology

Data for this study was gathered using a combination of primary and secondary research.

Firstly, a review and analysis of regulatory documents was conducted. This included statutory and policy documents regarding patient mobility from the EU as well as from the four Nordic countries studied (Norway, Denmark, Sweden and Finland). A review of relevant literature was also conducted. This included previous academic research and reports examining the numbers, drivers, needs, obstacles and experiences of cross-border patients both within the Nordic countries and in Europe more broadly. Of particular importance was a feasibility study looking at the potential for an open market for health services in the Nordic countries published by the Nordic Innovation Centre in 2009 (see Mahncke, et al., 2009).

Secondly, contact was made with national and regional bodies involved in registering and administering cross-border patients. This included:

- Bodies responsible for processing patients' applications for overseas treatment and/or for administering financial settlement with the countries that treat patients.
- National patient registers.
- National health insurance bodies.
- Regional health authorities.

These authorities were asked to provide data regarding the extent of cross-border patient mobility between the Nordic countries, the drivers and obstacles of cross-border movements and the types of health services used by cross-border patients.

Thirdly, a patient questionnaire was sent out via the regional administrative authorities in Norway to Norwegian patients who had recently travelled abroad for healthcare services. The questionnaire was limited to Norwegian patients as they make up the largest group of cross-border patients in the Nordic region and because the availability of data from other Nordic countries was limited. In addition, the numbers of cross-border patients travelling from one Nordic country to another Nordic country for planned health services was found to be very low.

The questionnaire aimed to gather quantitative data regarding the type of treatment received, country of treatment, perceptions of quality, problems and/or challenges encountered, the cost of services, as well as various demographic data (see Appendix 1). Questions regarding the quality of health services were compiled from the NORPEQ patient experiences questionnaire (Olteidal, et al., 2007). The NORPEQ questionnaire is designed to gather comparative data on patient experiences of hospital care thus enabling data from this study to be compared with data gathered at a national level.

Finally, to map the perceptions and experiences of cross-border patient mobility and the plans or desires for increased patient mobility, key stakeholders were contacted by way of semi-structured and/or informal interviews. This involved phone and email interviews as well as face-to-face meetings with medical professionals, hospitals, national social insurance agencies and regional and national policy makers. Interviewees were selected firstly from recommendations provided by the Reference Group for this study (see Appendix 2) and secondly, via contact details published on health providers and administrative organisations' websites. The reference group also acted directly as informants, both in and between scheduled meetings.

1.2 Report structure

Chapter two and three lays the foundations for this research by exploring issues of patient mobility from a number of different perspectives. This involves an examination of different national health services; the regulatory environment and patients' rights to healthcare in another country; the different actors and institutions

affecting patient mobility; and the social, political, historical, geographical and economic factors that influence cross-border patient movements.

Chapter four then provides a detailed overview of patient mobility in Europe. It begins by analysing the formal cross-border arrangements within Europe before outlining the main cross-border movements. It then looks more closely at the Nordic countries, looking at existing literature on the numbers and experiences of cross-border patients and presenting key findings from the patient questionnaire.

Chapter five provides a detailed examination of patient mobility in the border regions of Öresund and North Calotte. The Öresund region is the largest and most densely populated area in the Nordic region with extensive medical research and specialised care facilities, while the North Calotte region is sparsely populated and does not have the same concentration of hospitals or research facilities. Thus, these two areas offer an interesting comparison in regards to some of the different incentives and challenges of patient mobility.

Finally, Chapter six brings the study to a close by briefly summarising the main points, a discussion of the findings and an estimate of the total cross border patient volume.

2 Cooperation between countries

Throughout the post-war period extensive cooperation has existed between the Nordic countries. The Nordic Council and the right of free movement for citizens within the Nordic countries (both coming into effect in 1952) demonstrate the significance and depth of this cooperation. The foundation of the current collaboration is the so-called Helsinki agreement of 1962, where the work methods and areas for the Nordic Council were established. During a revision of the agreement in 1971, the Nordic Council of Ministers was established as a governmental cooperative body. This led to formal cooperation in many fields. Today there are a range of national agreements regarding health and social welfare. The agreements mainly focus on crisis preparedness and Nordic citizens' rights when staying in another Nordic country. Travelling to another country for planned healthcare is not part of this. Patient rights and regulations within the EU and the Nordic countries are outlined in Chapter three. We have identified the following relevant agreements and institutions related to healthcare between the Nordic countries:

Agreements related to health and welfare between Nordic countries:¹

- 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 18 August 2003
- 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

Three institutions contributing to closer Nordic cooperation within the area of health and social care are:

- Nordic Welfare Center
- Nordic Institute of Dental Materials
- Nordic School of Public Health

¹ <http://www.norden.org/no/samarbeidsomraader/helse/avtaler>

3 Dimensions of patient mobility

To understand the experiences and obstacles facing cross-border patients in the Nordic region, it is important to firstly outline some of the main dimensions of patient mobility. Patient mobility can be described as a situation where a patient receives healthcare from providers located beyond his/her local catchment area. Cross-border patient mobility describes a situation where a patient has crossed a national border before receiving healthcare. The existence of cross-border patient mobility raises many questions. For example, why are patients seeking healthcare in another country? Why are the EU and its member nations interested in facilitating patient mobility? What are the factors affecting patient mobility? What are the effects of patient mobility?

While it is beyond the scope of this study to comprehensively answer all of these questions, this chapter aims to provide a short introduction to the subject of patient mobility based on existing knowledge. This entails an understanding of the driving forces behind patient mobility and the various regulations and health systems that govern or affect cross-border patient movements.

3.1 Types of care

Cross border patients can be categorised according to the types of care they receive. A key divide is between those patients receiving acute care and those receiving planned or elective care. Acute care can be broadly defined as healthcare in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery. This can involve either specialised (e.g. hospital) or primary (e.g. GP/family doctor) care. As the services used for acute care depend principally on the patient's location when requiring healthcare, it does not form part of this study.

Specialised elective healthcare can be further divided into five main categories: very specialised care (low frequency); ordinary/minor care (high frequency); research cooperation (treatment); dental care; and private treatment. In order to limit the scope of this study, dental care, research cooperation and private treatment are not included. Thus the focus of this study is on specialised elective care, including both very specialised and ordinary care. In practice this primarily means planned inpatient care. The focus of this study, at least for its quantitative parts, is shown in Figure 1 below.

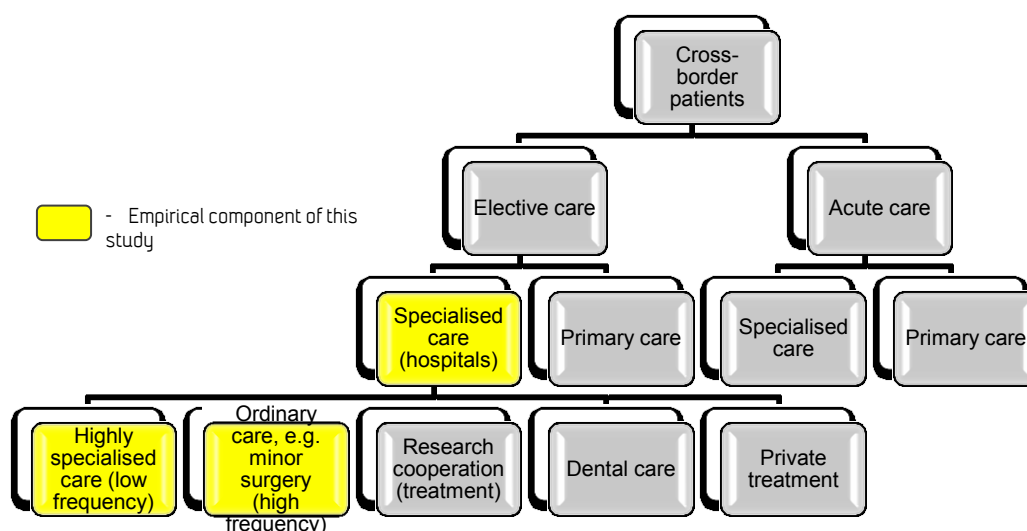


Figure 1: Types of cross-border health services and study focus areas

3.2 Factors affecting the extent of patient mobility

Cross-border cooperation and patient mobility can be driven by different factors; from factors at the individual level to factors at the regional, national or EU-levels.

Based on existing literature regarding cross-border patient mobility we emphasise four elements or groups of factors that must be taken into account when drivers and obstacles of cross-border patient mobility are analysed. Some of these factors contribute to a pushing effect and others have a pulling effect on patient mobility (Busse, Wörz, Foubister, Mossialos, & Berman, 2006; Glinos & Baeten, 2006; Kostera, 2007). These are presented schematically in Figure 2.

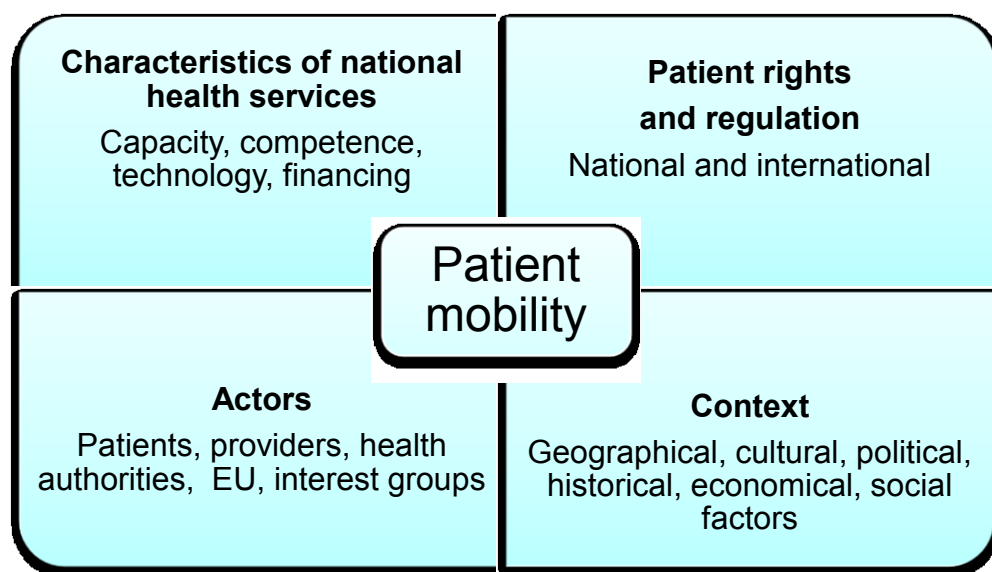


Figure 2: Four groups of factors influencing cross-border patient mobility

3.2.1 Characteristics of national health services

Weaknesses in the national health services can have a pushing effect on patient willingness to travel abroad for treatment (assuming this possibility exists). Long waiting times due to lack of capacity and/or deficiencies in technology or competence are the most usual reasons for patients or their providers to actively seek healthcare services in other countries. Differences in co-payment from patients can in some cases also act as an incentive to go abroad for treatment (see references in previous chapter).

In line with most western countries, Norway, Finland, Sweden and Denmark have experienced a substantial increase in costs related to the healthcare sector (Kittelsen, et al., 2009). Waiting times and prioritisation are however still important health policy issues and demands for increased capacity are persistent. Increased public purchase of healthcare from private providers has become more accepted as a solution to temporary backlogs of waiting lists. Sending patients to another country is, however, more restricted.

3.2.2 Patient rights and regulation

A key question for patients seeking healthcare in a country other than their own is whether there are adequate reimbursement schemes in place. Although health systems are still primarily the responsibility of member states, within the EU framework a common set of rules has been developed giving patients the right to be reimbursed for certain health services received in other member states. These regulations apply to all EU and EEA countries (with some exceptions for Switzerland) and hence also to all Nordic countries.

Current EU regulations regarding reimbursement for healthcare in another country

After World War II there was a desire to ensure peace through cooperation and integration between countries. This began with the establishment of the European Coal and Steel Community in 1951 and expanded in 1957 with the founding of the European Economic Community (EEC). The main intention of the EEC was to establish a common market for goods, labour, services and capital. In 1993 and the EFTA²-countries reached an agreement on economic cooperation, known as the EEA³- agreement. The same year the EEC was reconstituted and the EU was founded (Försäkringskassan, 2010). Martinsen and Blomqvist (2009) emphasise the importance of the single market as a driving force behind the integration of social policy in recent years.

Until 1998, access to foreign healthcare providers was regulated solely through the system for coordinating the social security rights of migrant workers (Regulation 1408/71). The right to immediate and necessary healthcare when staying in another EU or EEA member state was guaranteed through the E111 scheme granting prior authorisation for care. Today this scheme is replaced by the European Health Insurance Card E112. Unlike the E111 scheme, the E112 was later established so that EU citizens could also gain access to *planned* care in another member (or EEA) state. The E112 scheme provides a framework through which EU citizens can access planned healthcare abroad by applying for prior authorisation from their home country. However, experience shows there can be relatively large differences in countries' willingness to grant approval through the E112 form.

Fact box: Current EU regulations for planned non-hospital and hospital treatment

Non-hospital treatment is possible with or without authorisation.

Treatment without authorisation: The patient meets the costs themselves and may be reimbursed later on the basis of the rules in their home country. If the treatment costs more in the country of treatment than in the country of residence, it is up to the patient to pay the difference.

Treatment with authorisation: The costs of the treatment are met, with additional reimbursement if applicable. In the case of Switzerland this option is not available.

Hospital treatment in another EU country requires that patients obtain prior authorisation from the health authorities in their country of residence. The cost of the treatment is covered under the terms of the country of treatment. In some countries, this means that part of the treatment costs must be paid upfront by the patient, a cost that is later reimbursed (except in Switzerland).

A series of European Court of Justice (ECJ) rulings since 1998 (i.e. the cases Kohll and Decker, Smits and Peerbooms, Vanbraekel, Müller-Fauré/van Riet, Inizan and Watts) represented an important turning point in the development of EU-patients rights. Based on the principle of free movement of services, the rulings state that EU citizens may seek healthcare in other member states with the cost covered by their own health systems. In 2004, under articles 49 and 50 of the EC Treaty (now Articles 56 and 57 of the Treaty on the Functioning of the European Union - TFEU⁴), the Supreme Administrative Court ruled that healthcare is a service that can be sought across national borders. This means that EU citizens, entitled to subsidised healthcare in their own country, can also seek treatment in another EU/EEA country, pay medical costs themselves and subsequently apply for reimbursement from their home country.

The court rulings confirmed a need to clarify the rules relating to financial coverage of treatment in another country. In order to spell out patients' rights and the rules regarding patient reimbursement, an EU process aimed at developing a directive for patient mobility in the EU was initiated in 2006. The first draft proposal was introduced in 2008, but was subsequently rejected. Since then a long process has taken place to determine a set of rules and regulations that is acceptable to each EU member state. On 19 January 2011, an agreement was finally reached whereby the European Parliament approved a new directive on the application of patients' right in cross-border healthcare (Appendix 3). Each member state now has 30 months within which to make the required changes to their national legislation. The directive should therefore be fully implemented in the EU in

² European Free Trade Association

³ European Economic Area (Norway, Iceland and Lichtenstein included)

⁴ See European Union (2010).

2013.

The directive aims to stimulate cooperation on healthcare at a regional and local level as well as between neighbouring countries in border areas. Accordingly, it enables patients to receive treatment abroad and be reimbursed for this by their home country, provided that the type of treatment received is offered as a part of the home country's health system. Reimbursements for inpatient hospital treatment (with a stay of at least one night) and highly specialised treatment requiring expensive medical treatment, require prior authorisation from the home country. A state may refuse to give consent if the treatment can be provided within a medically acceptable timeframe in the home country or if the treatment is deemed to entail an unacceptable risk. Prior authorisation for non-hospital treatment is not required. Patients have the right to be reimbursed for an amount not exceeding that of the same treatment in the patient's home country. If treatment is less expensive abroad, the patient is eligible for reimbursement for the actual cost of treatment. Reimbursements for travel and accommodation expenses are not covered by the directive.

The directive also states that all countries should establish contact points to provide patients with information about cross-border healthcare so they can make informed choices. Contact points should provide information on patients' rights; the availability of various services and treatment in another country; quality and safety advice regarding health services; prices; complaints procedures; and compensation schemes.

Furthermore, the directive asks that the Commission support the further development of European networks between health service providers and reference centres/expert groups in member countries, particularly for rare diseases. The goal is that through such collaboration access to expert treatment and diagnosis will be improved for all patients who need specialised or highly specialised services in Europe. Through voluntary cooperation, the EU will also help member countries to obtain more objective evidence regarding the effects of different treatment methods. The Commission will therefore support cooperation on health technology assessments between national authorities and research groups working in order to prevent unnecessary duplication.

Finally, the directive states that when a drug or medical device is approved for marketing in one member country, patients that are prescribed this should also be able to access it in other member countries.

Reimbursement and patient rights in four Nordic countries

The Nordic countries are similar in terms of the main principles of health and welfare policy. Healthcare is financed through taxes and services are mainly owned and run by public organisations. The private sector has a limited but increasing role as service providers within the frame of publicly financed healthcare. There are also some differences between countries, for example, in the degree of decentralisation of authority in public healthcare management.

Norway: In Norway, specialist health services are owned by the state and administered by four regional authorities (regional health enterprises). Within each administrative region, health services are delivered by public health enterprises and a smaller number of private institutions and contracted specialists. There is a total financial separation between the administration of specialist health services (state responsibility) and primary healthcare (responsibility of the 430 municipalities). Primary care physicians in Norway are largely organised as private enterprises, but services are publicly managed and financed through contracts with municipalities. A minority of the physicians are employed directly by the municipalities.

Sweden: Responsibility for providing health services (including primary care physicians) in Sweden is decentralised to the 21 counties. 290 municipalities are responsible for community care. As county authorities have considerable autonomy in determining how healthcare should be planned and delivered, there is a great likelihood for regional differences in the organisation of services and the ways in which service providers are financed.

In Denmark responsibility for the health services is divided between the state level, five regions and 98 municipalities (Indenrigs og Sundhedsministeriet 2008). Hospitals, medical services (including primary care physicians) and psychiatric treatment are the responsibility of the regions. The municipalities have responsibility for community services and rehabilitation services.

Finland: The Finnish health system is the most decentralised and funding is more complex here than in the other Nordic countries. Most health services are organised and funded by Finland's 342 municipalities. Specialist health services are organised through 20 hospital districts (cooperation between municipalities) that own and fund the hospitals. For highly specialised care, groups of hospital districts cooperate at a larger regional level and treatment for rare diseases and highly resource-demanding treatments are offered at a state level. Centralisation of treatment for highly specialised and cost intensive care is also common for all countries.

The EU regulations on financial coverage for planned treatment abroad are common for the Nordic countries (through the EEA-agreement). Based on these rights, patients can be reimbursed or given prior authorisation through the national insurance system. In addition, patients can be granted access to treatment abroad through national regulations and reimbursements schemes. In the four countries included in this report, financial responsibility for patient treatment within specialised healthcare is, as described above, decentralised to counties (Sweden), regions (Denmark), health districts/municipalities (Finland) and regional health enterprises (Norway). On an independent basis these regional authorities can, within the frames of national legislation and regulations, give financial support for patient treatment abroad. However, the flow of patients out of each country is small (see chapter four).

The most important reason for granting cross-border treatment is a lack of competence or medical technology necessary to give patients the best available evidence-based treatment. Another is long waiting times. Finland, Sweden and Denmark have established general targets or guarantees for maximum waiting-times which include all patient groups for specialised healthcare (Kalseth, 2010). In addition, all countries (including Norway) have separate waiting-time guarantees for selected patient groups (for example cancer patients or patients in need of mental healthcare). There are relatively large differences in the length of waiting-time guarantees between countries. Denmark stands out with a very short waiting-time guarantee (one month⁵); Sweden has three months; while Finland has the longest waiting-time guarantee (six months in total).

Norway has a system of individual waiting-time guarantees for patients who have been granted priority status (meaning they are granted the right to necessary healthcare). Prioritisation guidelines have been developed to help physicians determine the appropriate waiting time for each patient. Such formalised prioritisation mechanisms related to waiting-times at the individual level are not used in the other Nordic countries.

Waiting-time guarantees are often combined with the right to free choice of hospital or provider. The right to choose a hospital for specialist health services has been introduced in Denmark, Norway (whole country) and Sweden (within counties). In Finland the possibility to choose has so far been restricted, but a new healthcare law (scheduled to be implemented from 2011) is expected to give patients extended rights. In Norway the choice also includes private hospitals with public contracts, and for Denmark patients can choose private hospitals after a waiting period of one month. If waiting-time guarantees are breached, patients in Norway and Denmark have the additional right to travel to another country for treatment; but only if the service cannot be provided by any other hospital in the home country within a given timeframe. Denmark has two private Swedish hospitals on their list of hospitals included in the free-hospital choice if waiting time of one month is breached.

⁵ If the waiting time is more than a month, the patient is entitled to treatment in a private hospital ("free choice of provider"). The general "treatment-guarantee is mainly within cancer and heart-diseases.

3.2.3 Actors in cross-border healthcare

Different types of actors can be advocates or opponents of different types of patient mobility and can thus influence efforts to facilitate cross-border patient mobility. Glinos and Baeten (2006) point out that patients, providers, purchasers, health authorities and middlemen are all important actors in regards to patient mobility. These actors can be situated at the local, regional, national or European levels and have different roles. For instance:

- *Stakeholders can be actively engaged with the medical aspects of patient mobility. This is invariably those receiving care (patients) and those providing it (hospitals or doctors).*
 - *Actors can be involved in setting up cross-border structures for patient mobility (e.g. contracts, agreements, procedures etc.). These administrative and organisational functions can be undertaken by providers, insurers, public authorities and middlemen.*
 - *Actors can be influential behind the scenes, where decision-making, priority-setting, allocation of budgets, signing of bilateral and multilateral international agreements and legislation concerning patient mobility is taking shape. These functions can be carried out at the management level of hospitals, in national parliaments, in local, regional or national governments and EU institutions etc.*
- (Glinos & Baeten, 2006, p. 20)

Most patients prefer treatment close to where they live, but special circumstances can motivate patients alone or through their doctors to seek health services abroad. According to a unified European model, patient organisations like EURORDIS (Rare Diseases Europe) can represent an important driving force for changes in patient rights. In border regions, local authorities and organisations often join forces to reduce barriers to patient mobility and cooperation related to national borders. Unlike public hospitals, commercial actors (for example for-profit hospitals) have few obligations towards the local population and thus can play an important role in offering treatment to patients/health authorities regardless of nationality. National health authorities, on the other hand, are often reluctant to extend patient rights to claim public financing for elective treatment abroad. This is based on their responsibility to plan and develop health services for the national population.

Why do patients seek cross-border treatment?

Glinos and Baeten (2006) separate between two main types of cross-border patients.

- Patients using cross-border care because they *are abroad at the time when the need for healthcare arises* (e.g. long-term residents, students, travelling professionals and tourists).
- Patients *going abroad to seek healthcare* either because they live in a region where cross-border care is more convenient, or because a perceived weakness in their national healthcare system relative to other countries pushes them to go abroad (such as waiting lists, lack of suitable treatment, or prohibitive prices).

The first group consists of patients who are staying in another country at the moment they need medical care. For the most part this is healthcare needed for unforeseen illness or injury, what is referred as acute care. If a person is staying in another country for a longer period she/he might also be in need of non-acute care.

The second group of patients travels from their own country to another for the purpose of receiving healthcare. The element of choice is more present among these patients. If we do not take into account the population living in border areas this is, in general, planned care (non-acute).

The degree of choice is important considering the development of national and international regulations on access to healthcare in other countries. The foundation of the EU regulations, concerning the reimbursement of expenses for medical services outside a person's own country, is to give access to necessary healthcare should the need for unplanned care arise while the person is staying in another country (EU/EEA-member state).

EU citizens can claim reimbursement for non-hospital healthcare services. For planned hospital services (inpatients), there is still a demand for pre-approval from the patient's home state. Several countries have

introduced a statutory right to free choice of hospital for planned treatment within the country (e.g. Norway, Denmark). The degree of freedom to travel to another EU country for hospital care and to have this covered by the home state without prior authorisation is an important issue related to the current EU Directive on patients' rights regarding cross-border healthcare.

In figure 3 we present healthcare schematically according to urgency level, threshold for reimbursement through EU regulations and reasons for seeking care in another country.

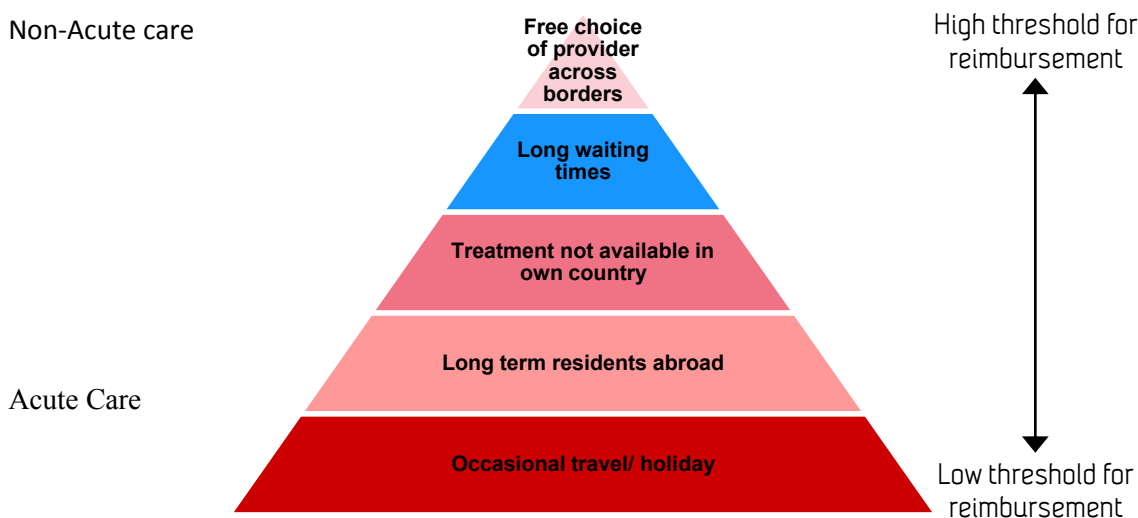


Figure 3: Urgency level, threshold for reimbursement and reasons for cross-border patient mobility

The bottom two fields in the triangle cover the first category of patients in the Glinos and Baeten (2006) typology. That is, patients already staying abroad at the time when the need for healthcare arises. Acute care for these patients is fully covered by existing EU regulations. The next two fields fall under the second category of patients, including those seeking healthcare across a national border or being sent abroad by their own health authorities due to lack of capacity and competence in own country. The threshold for granting patients this right can be different from country to country. On the top of the pyramid is the right to free choice of healthcare provider across national borders and to have this reimbursed by your own country. Although this is probably not a realistic scenario in near future, the current proposal for a new EU directive on cross-border healthcare will likely go a long way towards enhancing patient rights to healthcare across national borders. But it is still necessary to get an a priori approval before receiving hospital services.

One key reason for patient mobility not included in Figure 3 is *distance*. In some cases the distance to health services in another country can be closer than similar services in the patient's own country. This is one of the important reasons for cooperation in border regions.

According to the literature review by Glinos and Baeten (2006), five fundamental aspects of healthcare influence individual patients' decisions to go abroad. These are:

- Financial costs
- Availability
- Familiarity/proximity
- Quality
- (Bio)ethical legislation (e.g. privately financed fertilisation)

High financial costs can be an important obstacle for patients seeking health services abroad. Even if the patient has the right to have treatment costs covered by their health system, travelling costs or the requirement that patients pay up front before reimbursement may prove challenging. One important concern in regard to the EU directive on patients' rights in cross-border healthcare is that health services will not be equally accessible to all citizens and will instead favour wealthy citizens.

Poor availability is another important obstacle. One side of this is a lack of legal rights or finances. Another aspect is that a long journey to another country with another language can be a great physical and mental challenge for sick people, especially older people.

Information about quality of services/treatment is also a very important and challenging issue. Even though the development of quality indicators for monitoring purposes has been on the agenda in many European countries in recent years, it is challenging to establish valid and measurable indicators that can be used as a basis for hospital choice. Most patients sent abroad by their own doctors or health authorities would expect that the quality assurance is safeguarded for them. In the absence of guidance from medical professionals, one can assume that quality considerations are often based on the experiences of others, the media and general knowledge or assumptions about different countries. Most people will probably have the best knowledge of their neighbouring countries. Because the Nordic countries are quite alike culturally and economically, it is likely that patients expect the same quality of healthcare.

The professional perspective

Medical professionals can be patient advocates in striving for good and appropriate treatment and hence can be actively involved in finding help for individual patients. They can also be strong actors in developing shared, highly specialised treatment competencies and facilities that transcend national borders. On the other hand local healthcare personnel can sometimes be sceptical towards increased patient mobility, arguing that a lack of clarity surrounding medical and juridical responsibilities, and deficiencies in terms of coordinating health systems, can create certain risks.

System level motivations for cross-border care

National health authorities are obliged to help patients to appropriate and timely care within the framework of national health policy and legislation. First and foremost this means that each state must ensure sufficient resources, competence and personnel to build capacity within their own country. In some cases it might be very expensive to provide technology or to invest in developing expertise for the benefit of only a few patients. Hence it can be rational to buy treatment abroad. In other cases patients are sent abroad until expertise in the home country can be sufficiently developed. Another reason patients are sent abroad is to (temporarily) solve problems relating to long waiting lists for specific treatments. Extended waiting times can be related to new technologies/treatment as mentioned above, or due to a lack of capacity to handle high-volume treatments. In the period from 2000- 2002, for example, Norway spent one billion Norwegian kroner sending patients abroad due to long waiting times for national treatment.

To create more robust and highly specialised services and to provide better quality and access to treatment, it can therefore be cost effective for neighbouring countries to cooperate over healthcare provision (economies of scale). Giving patients better access to healthcare in border regions by cooperating with hospitals across a national border can have the same effect.

Even if there are many reasons for national authorities to be positive towards cross border patient mobility, there are also reasons to restrict permission to travel out of the country and to limit access from other countries to a nation's health system. Some of these are as follows:

- Cost (expensive to reimburse services abroad).
- Planning of capacity and education of personnel in own country.
- Avoid prioritisation between own citizens and citizens from other countries'.

- Continuity of care and responsibility for complications.

3.2.4 Contextual factors

A range of factors not directly related to health services or to the patients themselves can be important drivers of cross-border patient mobility. These can be geographical, cultural, political, historical, economical or social factors. In border regions, for example, geographical proximity, similarities in language and culture and shared history are likely to impact patients' perceptions of cross-border healthcare.

Border regions are especially suited for cross border patient mobility

There is an important distinction between patients living in border regions (often more familiar with and willing to use foreign healthcare facilities) and patients travelling abroad because of lack of timely, accessible and/or appropriate care in the national system.

Border areas are special settings where, depending upon the location of services on either side, patients can benefit from access to both acute and non-acute care across the border. Geographical proximity can also include a range of other factors promoting cross-border mobility. As Glinos and Baeten (2006, p. 20) write:

“Some of these border regions are poles of intense cross-border flows and activities in a variety of areas, including healthcare. One can speak about multi-dimensional proximity in these regions as culture, language, traditions, history and habits often contribute to a feeling of closeness between the local communities despite the existence of an international border... In other cases, there is no such proximity and the borders constitute a more physical separation between the countries. These characteristics suggest the distinction between what could be termed as fluid borders and rigid borders.”

Hence, in many cases border regions have natural advantages for cross-border cooperation and patient mobility due to closeness and familiarity. In these areas it is also common to find frontier-workers who live on one side of the border and work on the other. The Schengen Agreement has made borders more permeable. Some border regions have agreements with their neighbouring counterparts and, according to Kostera (2007), patients will be more motivated to cross the border if there is a liberal approach to granting the necessary E112 authorisations. Rosemöller et al. (2006, p. 181) found that:

“The examples in which care is provided to a population that straddles a national frontier provide many interesting experiences. These have often emerged from grass-roots cooperation based on local agreements between providers and purchasers, as seen in the cases of Belgium, France, Ireland and Slovenia. These forms of cooperation are often within a broader framework of cross-border cooperation, often supported by EU Interreg funds (or in Ireland, Peace and Reconciliation Programme funds). These projects often seek to achieve optimal use of capacity on both sides of the border, with patients and health professionals crossing in both directions”.

To summarise, cooperation in border regions can:

- Create a larger patient base to provide specialised services closer to patients.
- Give better access to healthcare for people located a long way from services in their own country.
- Make services more cost-efficient by sharing hospital resources.
- Increase cost efficiency by sharing resources for emergency preparedness, ambulances, etc.

Border area arrangements are often pragmatic solutions to specific local problems. However, according to Rosenmöller et al. (2006), in many cases the lack of a sound legal basis can cause problems in implementing cooperative initiatives. They also found that lack of quality assurance, continuity of care, information sharing, compliance with regulatory systems, ownership and legal authority can create difficulties in cooperation.

3.3 Arrangements for patient mobility

Patient mobility can be arranged in a variety of different ways, including different methods of payment. At times patients can be sent abroad by their national health authorities, while other times patients may act on their own initiative.

Busse et al. (2006) group arrangements under four broad headings; each of which reflects different underlying rationales, involves different types of actors, and affects different groups of patients. These are as follows:

- Border area emergency coordination arrangements: emergency plans, etc.
- Arrangements among providers (typically hospitals located in border areas).
- Arrangements between insurers/purchasers (in one country) and providers (in another) due to waiting lists.
- Administrative arrangements designed to facilitate access to care abroad, but not actually involving the purchase or provision of care.

4 Patient mobility within Europe and the Nordic countries today

So far there is little systematic documentation on the actual cross-border mobility of patients in Europe. The need for better data has been strongly emphasised in publications on the subject (e.g. Busse, et al., 2006; Glinos & Baeten, 2006; Mahncke, et al., 2009; Rosenmøller, et al., 2006). In some cases, estimates relating to the extent of mobility in or out of countries have been made, but the literature more often describes examples of patient mobility and cross-border arrangements to facilitate mobility (permanent arrangements or projects) than the actual volume of patients. In the Nordic countries the data situation is similar. Access to treatment abroad can go through various agencies and have different sources of funding and are hence rarely systematised. This chapter starts with a description of patient mobility in Europe based on existing literature. We then look more specifically at the Nordic countries and finally the border regions of Öresund and North Calotte.

4.1 Europe

Busse et al. (2006) provide a general outline of obstacles to cross-border healthcare in Europe. The authors believe some of the obstacles (primarily geographical and organisational) can be alleviated through greater European integration. In their 2006 study of ten European countries⁶ they identified over 130 cross-border arrangements promoting access to healthcare. In most cases these arrangements were based on formal agreements. As shown in Table 1 Belgium, Netherlands and Germany dominate in terms of the number of arrangements.

Table 1: Cross-border arrangements identified by countries involved - 2006

	<i>UK</i>	<i>PL</i>	<i>HU</i>	<i>AT</i>	<i>NL</i>	<i>IT</i>	<i>IE</i>	<i>FR</i>	<i>DE</i>	<i>BE</i>
BE	0	0	0	0	31	0	0	16	7	
DE	0	3	4	15	14	4	0	9		
FR	0	0	1	1	0	5				
IE	13	0	0	0	0	0				
IT	0	0	0	6	0					
NL	0	0	0	0						
AT	0	0	6							
HU	0	0								
PL	0									
UK										
Other EU	1	4	3	5	0	2	0	3	5	1

Source: Busse et al. (2006).

Most of the arrangements involved cooperation between insurers and providers and between separate providers. Although far fewer in number, cooperation among emergency services, intergovernmental cooperation, health insurance card projects and support and advice were other forms of cooperation. The number of patients involved in the arrangements was difficult to identify. Based on data from the European Commission they found that the number of bills for inpatient cases using the E112-scheme increased by approximately 100 per cent between 1998 and 2004. However, according to the authors the figures must be treated with caution.

⁶ The Health ACCESS project has investigated access issues arising from the experience of ten EU member states: Austria, Belgium, France, Germany, Ireland, Italy, Poland, Hungary, The Netherlands and the United Kingdom (especially England and Northern Ireland)

Figure 4 shows the increase in the number of formal cross-border structures existing in Europe between 1970 and 2006.

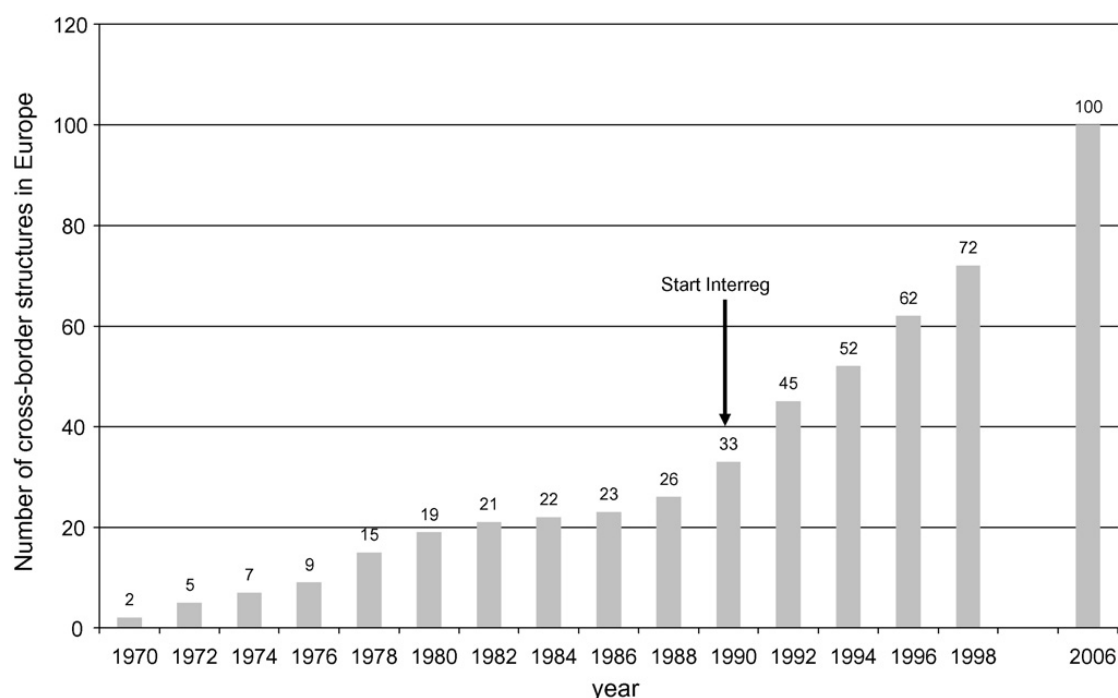


Figure 4: Development of cross-border structures in Europe

Source: Brand et al. (2008)

The rapid rise in the number of such structures beginning in 1990 demonstrates the significant role of the EU's Interreg programme in encouraging cross-border collaboration. The Interreg programme is funded by the European Regional Development Fund and aims to promote regional integration in European border regions. The broader vision underpinning the ERDF is to meet the challenges of a single EU market by eliminating barriers to trade and communication and reducing local time-distance barriers.

A recent project co-funded by the Public Health Programme of the European Union evaluated cross-border collaboration in healthcare using written surveys carried out with the Joint Secretaries of the 53 Interreg areas as well as within 67 Euregios (cross-border regions in Europe) (see Brand, Holleder, Ward, & Wolf, 2008). The final project report identifies 37 Euregios involved in at least one cross-border health-relevant activity and evaluates the results of 122 health projects being carried out in these regions. The authors found that the primary aims of health projects were to make cross-border healthcare easier for citizens living in the border regions and to improve healthcare systems and institutions according to the needs of health professionals and politicians. Specific objectives identified in these projects were to:

- Provide healthcare close to the patient's place of residence.
- Reduce waiting times.
- Improve the quality of medical care.
- Facilitate the joint use of existing resources.
- Balance the use of existing capacities.
- Provide immediate care in emergencies.
- Reduce health risks.
- Avoid health-risking behaviours such as tobacco and alcohol consumption as well as abuse of illegal drugs.

The report concludes that there is an evident lack of research, information and evaluations from the cross-border health projects in the Euroregions and cooperation in healthcare remains underdeveloped in many regions. According to the authors the most active Euroregions are found in the north-west of Europe:

“Euroregions which are very active in the health sector are in the north-west of Europe the Rhine-Waal and Meuse-Rhine Euroregions as well as the EUREGIO located on the German-Dutch and on the German-Dutch-Belgian border with many years of experience in cross-border cooperation. On the border between Ireland and Northern Ireland, the organisation “Cooperation and Working Together” which initiates and carries out a great number of health-relevant projects has been set up. In Northern Europe, the Finnish-Russian Karelia Euroregion, the Danish-Swedish Öresund Committee as well as the Finnish-Swedish-Norwegian North Kalotten Council are active cross-border structures. In Southern Europe, on the other hand, a great example, recorded along the border between Spain and Portugal” (Brand, Hollederer, Ward, et al., 2008).

Based on information gathered from responsible project bodies, Brand et al. 2008 identify 10 main factors that were thought to hinder projects related to cross-border healthcare. These are shown in Figure 5.

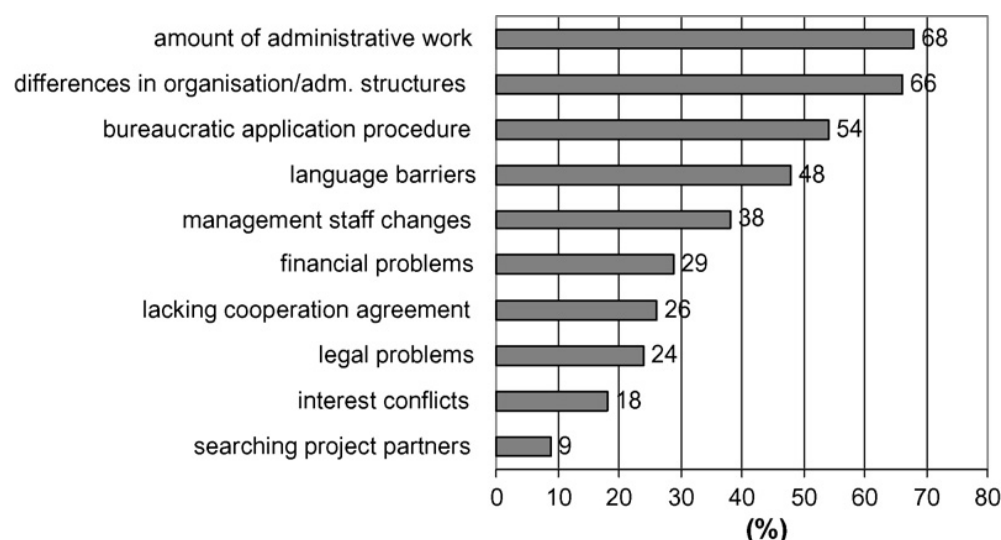


Figure 5: Main appearance of hindering factors in the view of the responsible project bodies (multiple nominations are possible, N= 122)

Source: Brand et al. (2008)

Conversely, 12 main factors thought to promote cross-border projects were also outlined. These are presented in Figure 6.

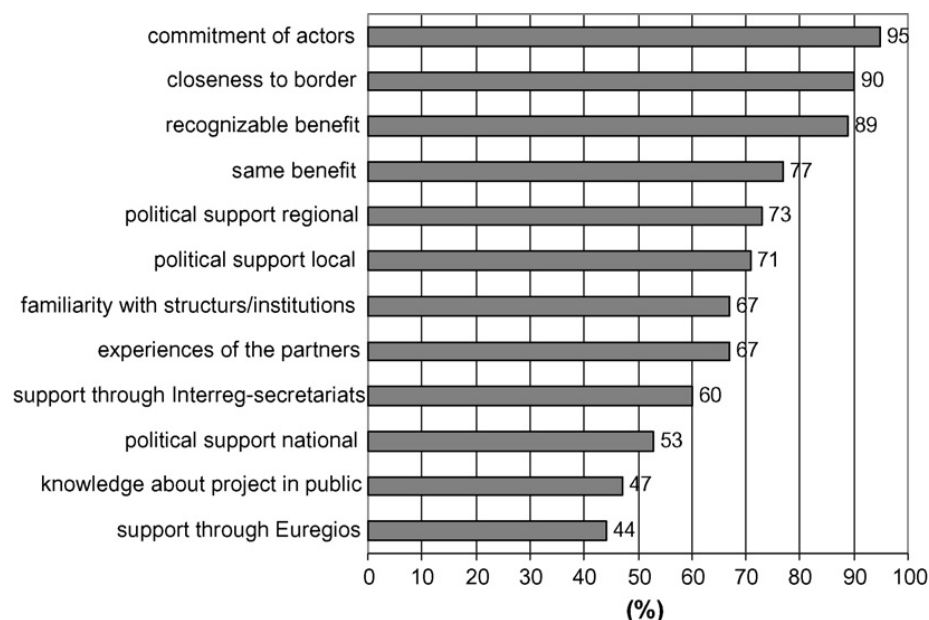


Figure 6: Main appearance of promoting factors in the view of the responsible project bodies (multiple nominations are possible, N= 122)

Source: Brand et al. (2008)

In their 2006 review, Glinos and Baeten (2006) distinguish between two broad categories of cross-border mobility settings. The first category involves patient mobility within the *border areas* and the second involves patient mobility that takes place due to *circumstances in national healthcare systems*. Given that the best availability of appropriate healthcare in border regions is often found across a national border, patient mobility in these areas often involves regional or local collaboration or projects. Closeness, familiarity and language are seen to be important facilitating factors. The authors of the review identify 15 such border regions in Europe. These are between the following countries:

- Sweden – Denmark
- Denmark – Germany
- Germany – The Netherlands
- Germany – The Netherlands – Belgium
- Belgium – The Netherlands
- Belgium – Germany
- The Netherlands – Belgium - Germany
- Germany – Austria
- Germany – Switzerland
- Belgium – France – Luxembourg
- France – Belgium
- France – Italy
- France – Spain
- Estonia – Latvia
- Northern Ireland – Republic of Ireland

Patient mobility outside of border regions, on the other hand, tends to be driven by circumstances in national health systems. According to Glinos and Baeten (2006) the main factors pushing these patients to go abroad are as follows:

Patient mobility due to availability shortcomings (Waiting Lists, lack of competence or lack of capacity).

Examples:

- **Denmark » EU**
- **Norway » EU**
- **EU » Sweden (Stockholm)**
- Malta » the UK
- UK NHS patients » Germany/ France/ Belgium
- Republic of Ireland » Northern Ireland/ UK
- Spain » Portugal

Patient mobility due to differences in prices or co-payments (Often dental care or plastic surgery). Examples:

- **Germany/ Denmark/ the UK » Poland**
- **Finland/ Sweden » Estonia**
- Austria (for example) » Hungary (for example)
- Austria/ Italy » Slovenia

Patient mobility due to perceived lower quality and dissatisfaction with the system. Examples are found in:

- Italy
- Greece

4.2 Patient mobility in the four Nordic countries

The following overview of patient mobility in the Nordic countries is based primarily on existing figures for outbound patients. However, in some cases these figures are supplemented by numbers of incoming patients. Data are collected from a number of sources including: national health insurance agencies; national bodies responsible for processing patients' applications for overseas treatment and/or for administering financial settlement with the countries that treat patients; and national patient registers.

4.2.1 Norway

In their 2009 Annual Report, the National Network for Foreign Treatment (NNFT) notes that the number of Norwegian patients being sent abroad for treatment has decreased steadily in recent years. Table 2 provides a breakdown of these cross-border patients and the countries in which they received treatment in 2009. It shows that of the 211 applications for treatment abroad granted in 2009, 121 (57 per cent) of these patients received treatment in another Nordic country (Nasjonalt Nettverk for Utenlandsbehandling, 2009).

Table 2: Patients sent to another country by the National Network for Foreign Treatment in 2009

<i>Country</i>	<i>Number of patients</i>
Sweden	96
Denmark	18
Finland	7
Germany	31
England	13
Austria	10
France	5
Other countries in Europe	22
USA	9
Total	211

Source: Nasjonalt nettverk for utenlandsbehandling (2009).

In general the National Network for Foreign Treatment approves applications for treatment abroad if the required services are not available in Norway due to a lack of competence. In these situations Norwegian patients are granted the right to receive health services in another country at the state's expense.

Waiting time guarantees

Another group of patients are those whose waiting time guarantee has been breached and no national hospital can offer a timely service. The situation for Norwegian patients experiencing violations of their waiting time guarantees is an issue examined in more depth in a recent thesis published by the University of Oslo (see Louwerens, 2009). Using statistics from the Norwegian Health Economics Administration (HELFO) it shows that between 2004 and 2008 a total of 23 patients sought healthcare services abroad following a breach in their waiting time guarantee. Of these, four received treatment in Sweden and two received treatment in Denmark. In 2009, despite there being approximately 150,000 breaches of waiting time guarantees⁷, none of these patients received healthcare abroad. As of mid-2010 HELFO representatives claim that only one or two patients have received treatment abroad due to breaches in waiting time guarantees. They also said that they had received 1,572 requests from patients seeking their services because of waiting time breaches. The overwhelming majority of these patients therefore received healthcare at home.

Diagnostic groups

The NNFT states that in general terms the largest group of patients travelling from Norway to another country for health services do so to receive highly specialised treatment for various forms of cancer that are not found in Norway (Nasjonalt Nettverk for Utenlandsbehandling, 2009). Other common patient groups include:

- Patients requiring orthopaedic surgery.
- Patients receiving treatment for neurological conditions.
- Patients receiving treatment for heart and cardiac diseases.
- Patients receiving treatment for congenital deformity.
- Patients receiving treatment for various syndromes.
- Children (patients under the age of 18 make up approximately 25 per cent of all cross-border patients).

4.2.2 Sweden

Patients that travel from Sweden to another country for planned health services fall into two main categories: those that receive prior authorisation (under the E112 arrangement) for planned treatment abroad; and those that seek reimbursement (under articles 56 and 57 of the TFEU) after having received medical services abroad.

In the first category, Table 3 shows that from 2004 to 2009 only a small number of prior authorisation requests for planned care abroad (1,382) were received by the National Social Insurance Board. Of these an average of 97 were granted and 137 rejected each year.

⁷ Source Norwegian Patient Register. See chapter 3.2.2 for description of waiting time guarantees.

Table 3: Requests for prior authorisation (under the E112 arrangement) of planned care in another country from 2004 to 2009

<i>Year</i>	<i>Accepted</i>	<i>Rejected</i>	<i>Total</i>
2004	88	36	124
2005	116	62	178
2006	87	76	163
2007	115	165	280
2008	78	203	281
2009	96	260	356
Total	580	802	1,382

Source: National Social Insurance Board

Data gathered between February 2005 and January 2007 suggests there are three main types of treatment these patients received: treatment for pregnancy-related disorders; treatment for various forms of cancer; and treatment for circulatory diseases. The numbers of cross-border patients per diagnostic group are presented in Figure 7 below. Please note that these are patients financed by the National Insurance Board and not by the counties.

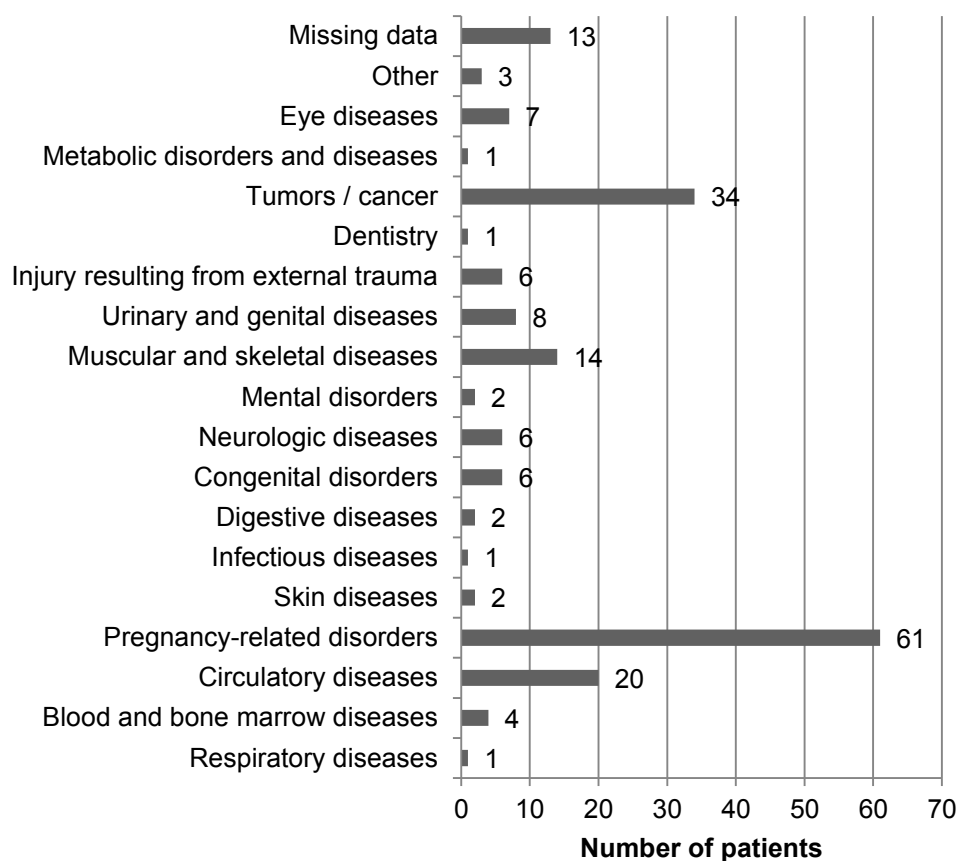


Figure 7: Number of patients granted prior permission to receive health services abroad by diagnostic category between February 2005 and January 2007 (n=192). Source: National Social Insurance Board

As Table 4 shows, in 2009 a total of 26 patients travelled from Sweden to another Nordic country under the E112 scheme. Of these, 5 travelled to Denmark, 15 to Finland and 6 to Norway. Patients were asked to provide

the reasons for travelling abroad. Although many did not answer, the patients that did answer most commonly cited a relation to the country as the primary reason for travelling abroad for healthcare services.

Table 4: Applications for health services in another Nordic country (under the E112 scheme) in 2009

Country	Rejected	Accepted	Total
Denmark	17	5	22
Finland	39	15	54
Norway	10	6	16
Total	66	26	92

Source: National Social Insurance Board

Table 5 presents data on the second category of cross-border patients – those that requested reimbursement after having received health services abroad. It shows that between 2004 and 2009 7,798 requests for reimbursement were received by the National Social Insurance Board. Of these 1,396 were rejected and 6,402 were accepted.

Table 5: Requests for reimbursement (under articles 56 and 57 of the TFEU) of planned care in another country from 2004 to 2009

Year	Accepted	Rejected	Total
2004	147	26	173
2005	954	83	1,037
2006	1,868	169	2,037
2007	1,175	301	1,476
2008	1,186	361	1,547
2009	1,072	456	1,528
Total	6,402	1,396	7,798

Source: National Social Insurance Board

Although this appears to be a fairly large total, many of these patients fall outside the scope of this study – either receiving health services outside the Nordic region or receiving acute care or dental services. In 2009, for example, 500 of the 1,072 patients whose applications for reimbursement were accepted (47 per cent) received dental services. Furthermore, 573 out of the 1,072 successful applications for reimbursement in 2009 (53 per cent) were for treatment in a non-Nordic country. Thus the number of cross-border patients travelling from Sweden to other Nordic countries for health services is low.

An indication of this can be seen in Table 6. It shows the number of applications for reimbursement for patients receiving health services in another Nordic country in 2009. A total of 499 such applications were accepted in 2009, of which 456 received services in Finland, 30 in Denmark and 13 in Norway. The most significant patient group are those travelling to Finland.

Table 6: Applications for reimbursement for services received in another Nordic country (under articles 56 and 57 of the TFEU) in 2009

Country	Rejected	Accepted	Total
Denmark	15	30	45
Finland	125	456	581
Norway	16	13	29
Total	156	499	655

Source: National Social Insurance Board

4.2.3 Denmark

Table 7 shows the numbers of patients referred by Region Hovedstaden for specialised treatment abroad, the types of treatment they received and the cities in which this treatment was received. Again, this shows that only

a very small number of patients (17) were sent abroad for treatment, with most of these receiving experimental treatments in Stockholm.

Table 7: Patients referred (Copenhagen) for treatment in the Nordic countries – 2009

<i>Place</i>	<i>Category</i>	<i>Type of treatment</i>	<i>No. of patients</i>
Stockholm	Research or experimental treatment	Post-polio	10
Göteborg	Highly specialised treatment	Oncology/ Brachytherapy	1
Lund	Highly specialised treatment	Urology	1
Lund	Highly specialised treatment	Ear-nose-throat	1
Örebro	Highly specialised treatment	Oncology/ Brachytherapy	1
Malmö	Highly specialised treatment	Plastic surgery/ear reconstruction	2
Stockholm	Highly specialised treatment	Gastroenterology	1
Total			17

Source: Hovedstaden Region

In addition to the above patients sent abroad by the Capital Region, the Danish Government also sent patients abroad. According to Nikolaj Blomberg at Region Hovedstaden, in 2008 33 patients were sent to Sweden for treatment and 1 was sent to Norway. The Danish Ministry of Health did not have the resources to clarify the numbers of patients sent abroad in 2009.

Furthermore, each region can enter into an agreement with foreign hospitals for a number of specific treatments. Zealand region has not entered into agreements with hospitals in Sweden or Norway, despite significant interest in such an agreement from a private hospital in Sweden. The cost of transportation, however, meant that their proposal was too expensive (due to limited patient mobility, transport is a major cost when selecting hospitals relatively far from the patient's residence). Region Zealand patient advisors reported that within the past six years Zealand has referred and paid for approximately 4-5 patients to seek treatment in Stockholm via Rigshospital in the Capital Region. Patient advisors have also indicated that there have been times when critically ill patients have sought relief in hospitals in Lund and Malmö when Rigshospital has reached peak capacity. In the past some cancer patients have received radiotherapy in Norway or Sweden due to a lack of national capacity. However, Denmark has since built up sufficient capacity

4.2.4 Finland

According to data gathered by Kela (the Social Insurance Institution of Finland), only a very small number of Finnish patients access planned health services in another country. As shown in Table 8, between 2000 and 2009 Kela recorded just 71 patients accessing health services abroad, of which 42 accessed services in Sweden and the remainder accessed services in other European countries.

Table 8: Patients from Finland accessing planned health services in another country between 2000 and 2009 (only those cases that Kela is aware of)

<i>Country</i>	<i>Number of patients</i>
Netherlands	2

Belgium	2
Spain	1
France	8
Sweden	42
Germany	10
United Kingdom	1
Estonia	5
Total	71

Source: Kela

This compares to a total of 443 foreign patients using planned health services in Finland during the same period. Of these, 10 came from Norway, 85 came from Sweden, 2 came from Denmark and the remainder came from other EU countries. This is shown in Table 9.

Table 9: Patients from other countries seeking planned health services in Finland between 2000 and 2009 (only those cases that Kela is aware of)

<i>Country</i>	<i>Number of patients</i>
Norway	10
Sweden	85
Denmark	2
Other EU	346
Total	443

Source: Kela

No data was available to indicate the types of treatment these patients received.

4.3 Patient experiences/perceptions of cross-border healthcare

A Flash Eurobarometer report published in 2007 is one of the few major studies to have examined EU patient mobility from a patient perspective (see The Gallup Organization, 2007). The study surveyed more than 27,200 individuals from across the 27 EU member states on their experiences of cross border health services and their willingness to cross national borders to access health services. However, rather than surveying people in the process of seeking or receiving healthcare services, it instead surveyed people at random on their previous experiences with patient mobility and their *hypothetical* willingness to travel across national borders to receive healthcare services. Thus the data should be viewed with some caution. The following tables present some findings of relevance to this study.

Table 10 presents the numbers of respondents indicating that they had received medical treatment in another EU member state during the 12 months prior to being surveyed. Overall less than four per cent of respondents claimed to have received healthcare in another EU country during this time. While there is some variation among the Nordic EU member states, the extent of patient mobility nevertheless remains very low, with 6 per cent of respondents from Denmark, 2.4 per cent of respondents from Finland and 1.5 per cent of respondents from Sweden indicating that they had received medical treatment abroad during the specified period.

Table 10: Responses to the question: *Have you received any medical treatment in another EU member state in the last 12 months?*

	<i>Total No.</i>	<i>% YES</i>	<i>% No</i>	<i>%DK/NA⁸</i>
EU 27	27,228	3.6	96	0.4
Denmark	1,018	6.0	93.9	0.1

⁸ Don't know/not applicable

Finland	1,000	2.4	97.3	0.3
Sweden	1,003	1.5	98.5	0.0

Source: The Gallup Organization (2007).

Although the proportion of the general population accessing health services abroad therefore appears to be very small, the majority of respondents expressed a hypothetical willingness to receive health services in another EU country. As Table 11 shows, 53 per cent of respondents across the 27 EU countries indicated that they might be willing to travel to another EU country for medical treatment. Respondents from Denmark and Sweden expressed an even higher degree of willingness (78.1 per cent and 60.8 per cent respectively). This was not the case in Finland, however, with only 26 per cent of respondents indicating that they might be willing to travel to another EU country to receive medical treatment.

Table 11: Responses to the question: *Would you be willing to travel to another EU country to receive medical treatment?*

	Total No.	%YES	%No	%DK/NA
EU 27	27,228	53	42.2	4.8
Denmark	1,018	78.1	18.6	3.3
Finland	1,000	26	69.9	4.1
Sweden	1,003	60.8	34.4	4.9

Source: The Gallup Organization (2007).

Looking at the reasons why respondents might be prepared to travel abroad for healthcare can provide a clue as to the patient-level drivers of patient mobility. As is shown in Table 12, of those indicating that they would hypothetically be willing to travel abroad for treatment, ‘receiving treatment unavailable in the patient’s home country’ was seen as the most important reason to do this. Other important reasons were to ‘receive treatment more quickly’ and to ‘receive better quality treatment’, while ‘receiving treatment from a renowned specialist’ and ‘receiving cheaper treatment’ were seen as relatively less important reasons to travel abroad for medical treatment.

Table 12: Responses to the question: *For which of the following reasons would you travel to another EU country to receive medical treatment?*

	<i>Total N Those saying yes</i>	<i>To receive treatment more quickly</i>	<i>To receive cheaper treatment</i>	<i>To receive better quality treatment</i>	<i>To receive from a renowned specialist</i>	<i>To receive treatment that is not available</i>
EU 27	14,437	63.8	47.5	77.5	68.6	91.3
Denmark	795	90.4	37	81.4	69.7	93.4
Finland	260	65.7	37.7	60.1	33.5	89.6
Sweden	609	80.8	46.9	70.1	79.3	95.3

Source: The Gallup Organization (2007).

Similarly, examining the reasons why respondents might not be willing to travel across national borders to receive health services can help to identify some of the barriers towards greater patient mobility. Table 13 shows that while a lack of information about cross-border healthcare, language difficulties and financial concerns were seen to be important reasons not to travel to another country for medical treatment, they were comparatively less important than the fact that respondents were satisfied with health services in the home country and a perception that it is more convenient to receive medical treatment in one's home country.

Table 13: Responses to the question: *Which of the following reasons would you not travel to another EU country to receive medical treatment?*

	<i>Total N Those saying no</i>	<i>Satisfied with healthcare at home</i>	<i>More convenient to be treated near home</i>	<i>Not enough information about availability and quality of medical treatment abroad</i>	<i>For language reasons</i>	<i>Cannot afford it to receive medical treatment abroad</i>
EU 27	11,486	82.6	86.4	60.6	49.4	46.6
Denmark	190	81.9	78.4	46.7	42.4	34.3
Finland	699	89.8	84.8	60.6	42.0	36.6
Sweden	345	88.6	91.1	64.8	44.5	33.1

Source: The Gallup Organization (2007).

Other studies

Among the existing studies on the use of free choice of hospital and similar schemes for patient choice (such as choice of doctor/GP) in the Nordic countries, the consensus is that these arrangements are only used to a very limited extent (e.g. Christensen & Hem, 2004; Vrangbaek, Østergren, Birk, & Winblad, 2007; Winblad & Ringard, 2009). A study from Norway from 2004, for example, found that only 1.6 per cent of all elective patients selected hospitals themselves (Christensen & Hem, 2004). The limited use of the scheme has also been featured in the Nordic media (e.g. Dagens Medicin, 2009; Nordjyske, 2008).

With the exception of Godager & Iversen (2009), Botten et al. (2003), Johnsen & Paulsen (2001), Johnson (2002) and Mahncke et al. (2009), there are few studies and analyses of barriers to patient mobility across-borders in the Nordic countries. The following section examines some of the barriers and challenges faced by patients when accessing health services abroad.

4.4 Patients experience (Norway)

An important aspect of this project was to map or identify the experiences of cross-border patients, paying particular attention to the obstacles or challenges they faced when accessing services in another Nordic country. Using information from the Norwegian Network for Foreign Treatment, this study identified two key groups of patients that travelled from Norway to another Nordic country for health services – those that travelled to Denmark and those that travelled to Sweden. A postal questionnaire was then sent out to these patients to seek information about their experiences.

Studies had also been planned in the other Nordic countries, but either the actual number of patients were found to be too small, (Denmark, Finland) or the practical challenges to establish contact with patients were found to be too great (Sweden). Nevertheless, in our view this survey of Norwegian patients gives a picture of the actual experiences from cross border patients.

Survey, population and response-rate

The questionnaire was carried out among Norwegian patients who travelled to either Denmark or Sweden for planned health services between January and September 2010. A total of 43 questionnaires were sent out via the Health Regions (of which 21 were sent from Helseregion Sør-Øst, 12 from Helseregion West and 10 from Helseregion Midt-Norge). Two questionnaires were returned unopened, as the patient was not known at the address provided. Thus 41 patients received the questionnaire⁹.

By the due date (15 November 2010), 26 responses had been received from which the following results are presented. Although a small total, this nevertheless represents 60 per cent of the Norwegian patients known to have received planned treatment in either Denmark or Sweden between January and September 2010 and thus it gives us some indication of patients' experiences when accessing planned care in a foreign health service.

Of the respondents 15 (58 percent) were women, and four of the patients were under the age of 18 (figure 8). Only two of the patients reported that they had bad health (figure 9).

Age

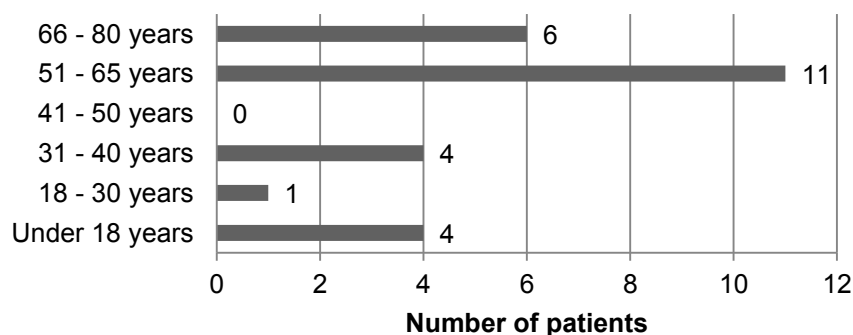


Figure 8: Age of respondents (n=26)

⁹ Thanks to the contacts from each of the four health regions for sending out questionnaires to patients. In particular thanks to Harald Platou, leader of the Office for Foreign Treatment in Helse Sør-Øst, for help in organising the survey.

Health

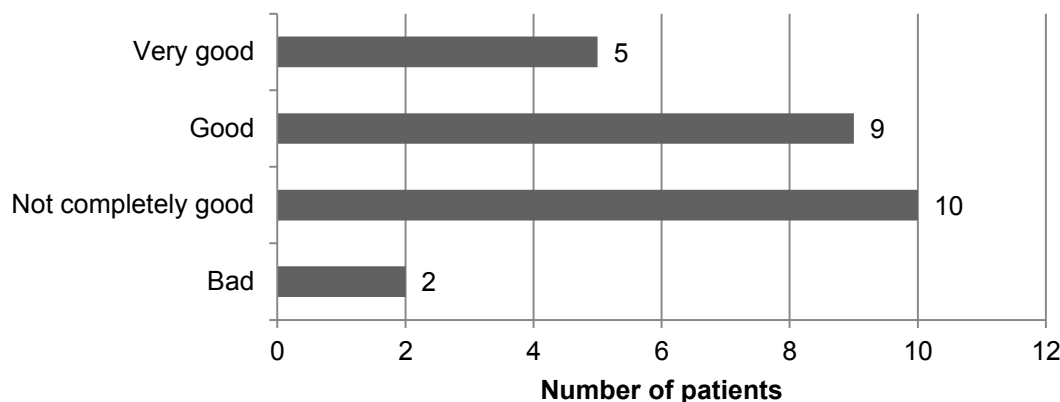


Figure 9: Perceptions of health of respondents

Country of treatment

Of the 26 responses, seventeen (65 per cent) came from patients who received services in Sweden, and eight were from patients that travelled to Denmark for health services. One respondent left this question unanswered.

Type of healthcare service received

Only four of the patients surveyed travelled abroad for diagnostic purposes, while the remaining patients received some form of treatment. Types of healthcare service received are presented in Figure 10 below. The two patients that accessed diagnostic services did so in Sweden, while the patients that received some form of treatment, travelled to either Sweden or Denmark.

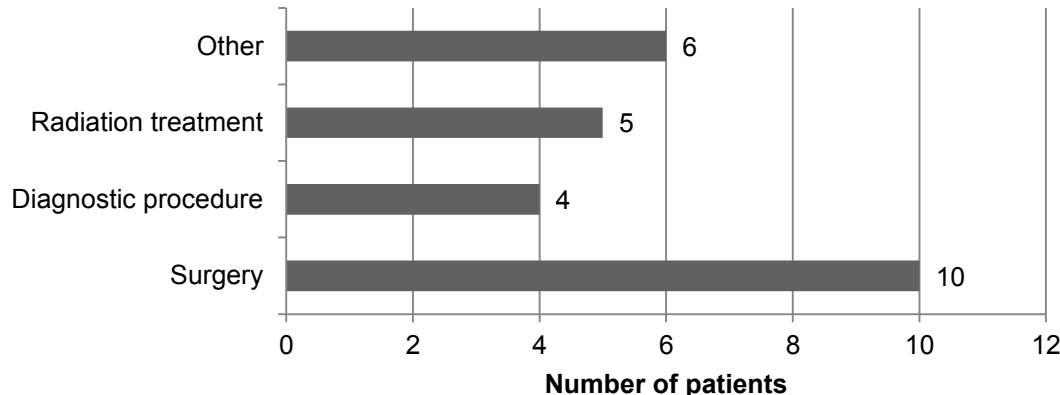


Figure 10: Type of healthcare service received by Norwegian patients. (n=26)

Quality of service

As is shown in more detail in Figure 11, at an aggregate level respondents expressed a high degree of satisfaction with their experiences using cross-border healthcare services. When asked the extent to which they were satisfied with their overall treatment at the foreign hospital 24 (92 per cent) indicated that they were to “a large” or “very large” extent satisfied, while the remaining two indicated that they were “to some extent” satisfied with their experience.

This generally positive experience is also reflected in more specific quality indicators. For instance, 96 per cent of patients (25) expressed confidence to a “very large extent” in the doctors’ professional knowledge and 89 per cent in the nurses’ professional knowledge. Furthermore, 91 per cent of patients were either satisfied to “a large”

or “very large” extent with the care provided by nurses; the interest shown by doctors and nurses in the patient’s case; and the information received prior to examinations.

Despite the differences in language, only a few patients experienced problems communicating with doctors. When asked the extent to which doctors were easy to understand, 25 patients (96 per cent) answered to “a large” or “very large” extent. Only one patient felt that their doctors were to “a limited extent” easy to understand.

On a less positive side, one patient was only confident “to a limited extent” in the doctor’s professional knowledge and one patient believed to “a large extent” that s/he had received the wrong medical treatment. 11 patients also experienced problems or complications upon returning home from their treatment, although it is not known whether these complications are unusual or whether they require the patient to return to the foreign hospital.

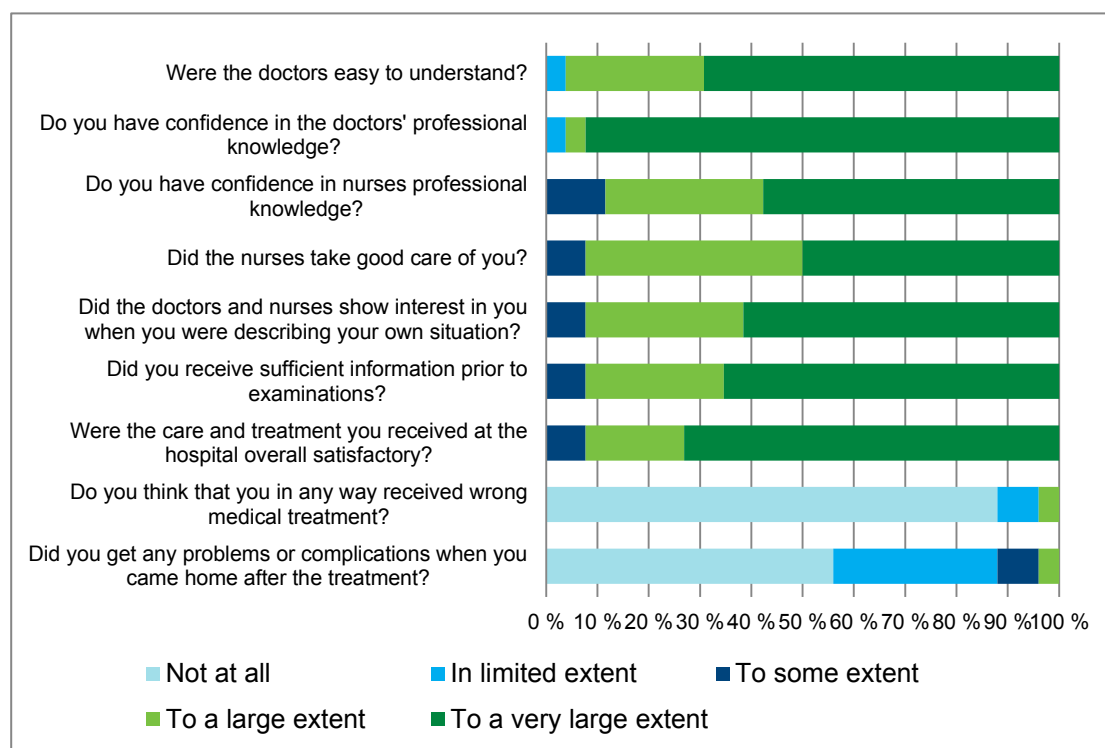


Figure 11: Experiences of treatment received by Norwegian patients. (n=26)

Finally, a useful indicator of patient satisfaction is the number of patients that would select the same hospital if given the choice in the future. All of the 26 patients indicated that they would select the same hospital again, which suggests that the standard of services received met their expectations.

Challenges met by the patients

The challenges that respondents faced before, during and after their stay abroad can give us an indication of the most common obstacles cross-border patients meet. Figure 12 shows the main challenges identified by survey respondents. Although six patients indicated that they faced no significant problems during and after their hospital stay, the remaining patients identified a total of seven obstacles. These ranged from problems associated with being in a new and unfamiliar place; to language and travel difficulties; to administrative problems and/or problems with the communication and cooperation between healthcare providers and professionals.

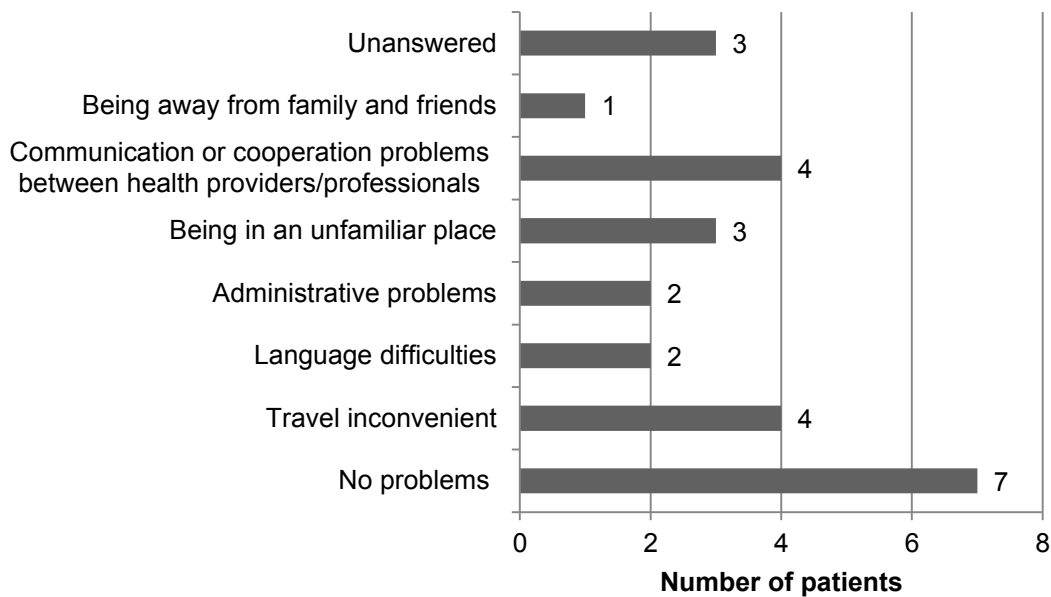


Figure 12: Challenges patients faced when receiving healthcare in a foreign country. (n=26)

While the above challenges provide some idea of the obstacles that patients may encounter when trying to access planned health services in another Nordic country, all of these patients nevertheless managed to successfully apply for, and complete, travel to another country for health services. Thus other important obstacles may not have been identified.

Means of transport

Twenty four (92 per cent) of the patients receiving healthcare services abroad travelled to the destination country by air. A number of these patients also completed part of their journey by car (8), taxi (11), train (10) or bus (4). The NNFT was involved in the arrangement of travel for 20 (77 per cent) of the patients, while the local hospital assisted a further nine patients. Seven of the patients (27 per cent) indicated that they arranged their travel themselves.

Travel cost

The cost of patients' travels ranged from NOK 750 to 10,000, with the average travel cost being NOK 4,200. None of the respondents paid these travel expenses themselves.

Travel time

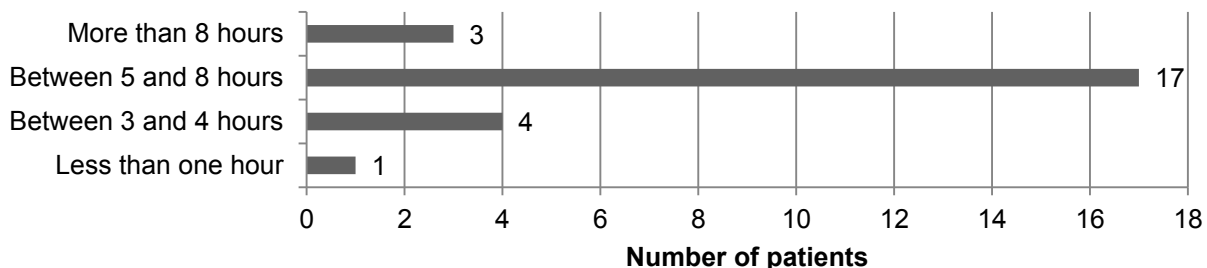


Figure 13: Time spent travelling to destination hospital. (n=25)

As Figure 13 shows, the majority of the cross-border patients spent between five and eight hours travelling to the destination hospital. Only a very few patients recorded a travel time of more than eight hours.

5 Border regions Öresund and North Calotte

In this chapter we look at two border areas in the Nordic countries on the basis of the special circumstances that make them particularly relevant for cross-border healthcare. The reasons are however very different for the two areas. An important difference is the population and settlement structure. As Figure 14 shows, the variation in population density across Europe means that the starting point for cross-border cooperation varies significantly.

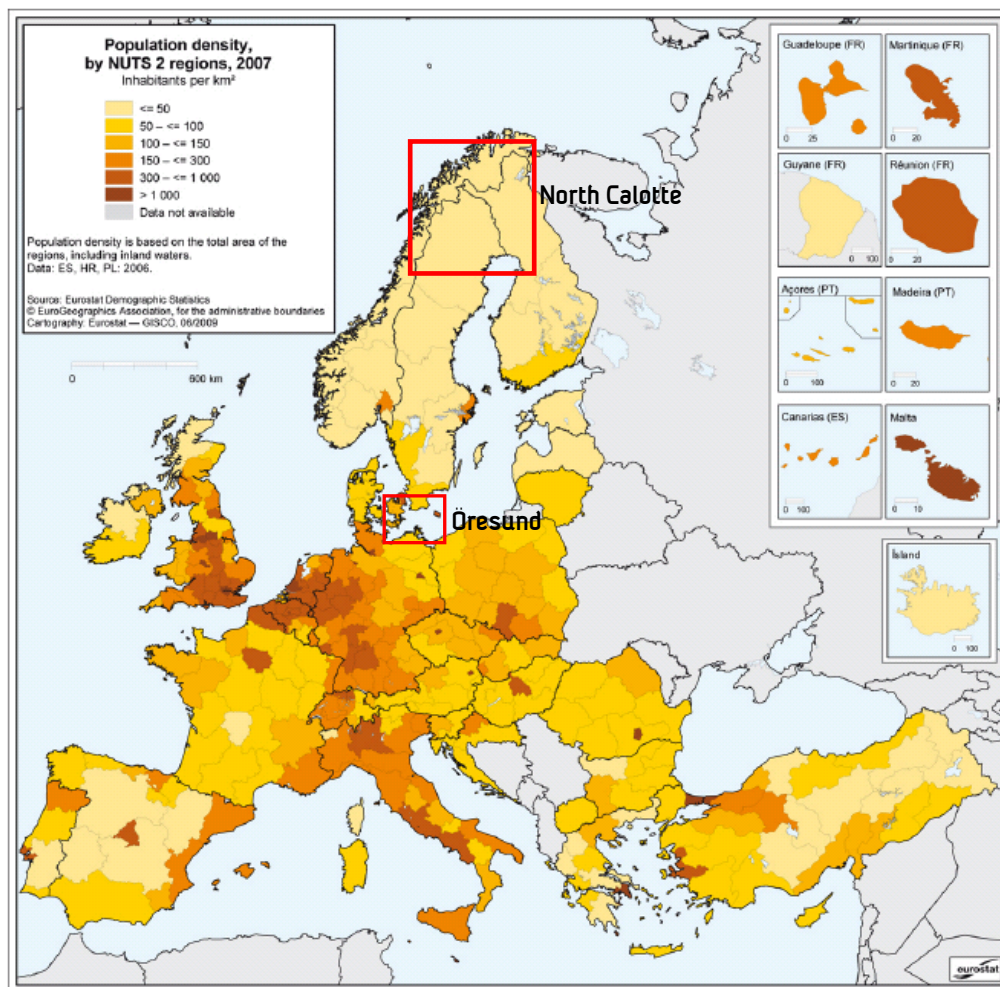


Figure 14: Map of Europe showing population density¹⁰

This is particularly true of the two border regions examined in this study. The first (Öresund) is a small, but densely populated region and as a result has extensive medical research and specialised care facilities. The second (North Calotte), being sparsely populated, with fewer hospitals and healthcare facilities spread over a large geographical area, is in many respects the exact opposite of the Öresund region. The healthcare challenges, incentives for seeking cross-border care and the obstacles standing in the way of greater cross-border patient mobility are therefore likely to be somewhat different in the two regions.

¹⁰ http://sedac.ciesin.columbia.edu/wdc/map_gallery.jsp?show=population

5.1 Cooperation in the Öresund region

The Öresund region (Øresund in Danish) is a transnational region encompassing the Danish islands Zealand, Lolland-Falster, Møn and Bornholm and the Swedish county of Skåne. The region has approximately 3,732,000 residents, 2,501,000 of whom live on the Danish side and 1,231,000 on the Swedish side. Spread across a total land mass of 21,203 square kilometres, the density of the population varies from the relatively thinly populated rural areas in Lolland and in eastern Skåne to the highly populated urban areas such as Copenhagen and Malmö. Population density is shown in Figure 15.

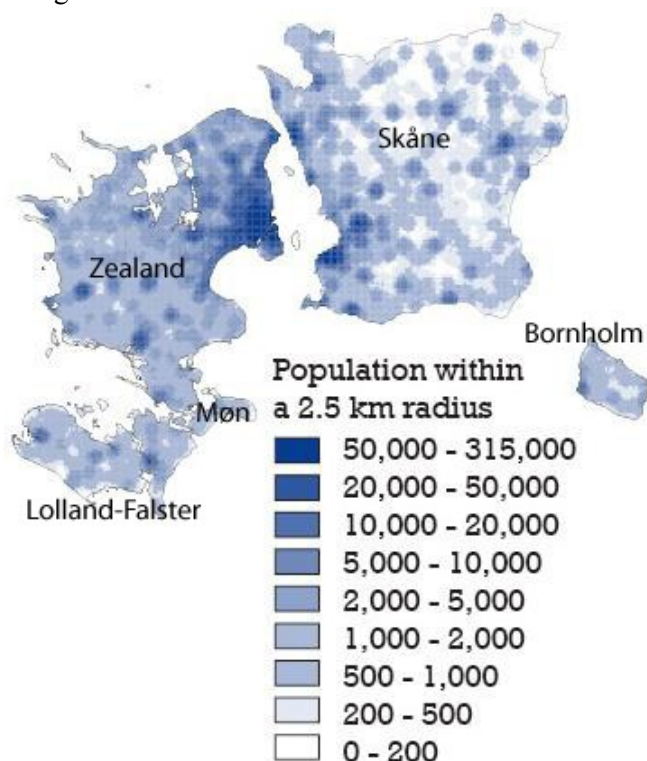


Figure 15: Map of the Öresund Region showing population density (source: Öresund Committee, 2010)

The region is dominated by the greater metropolitan regions of Malmö and Copenhagen which, when combined, constitutes the largest and most densely populated urban area in Scandinavia. Hence, this area is also home to some of the largest and most advanced healthcare facilities and medical research institutions, including the Medicon Valley Alliance; an association of universities, hospitals and companies aiming to establish Öresund as a world class life science region that was established in the mid-1990s.

Medicon Valley in numbers:

- Biotech and pharma companies: > 150
- Medtech companies: > 200
- Employees in the private life science sector: 44,000
- Universities: 11, of which 5 offer life science degree courses
- Students: 155,000
- Life science students: 45,000
- New life science graduates each year: 9,000
- Hospitals: 33, of which 11 are university hospitals
- Science parks with a focus on life science: 9
- Contract research organisations and contract manufacturing organisations: 50+

Source: www.mediconvalley.com

5.1.1 Regional cooperation in the Öresund region

Cross-border administrative cooperation has a relatively long history in the Öresund region. In 1964 the Öresund Council was established to support cooperation between local politicians on both sides of the border. While this was seen as an important step towards greater regionalisation, differences in national interests and systems often hindered cooperation. Key obstacles were the strong tradition of centralisation in Sweden (which discouraged devolution of decision-making responsibilities) and the perceived dominance of Copenhagen in regional negotiations.

In 1973 the Danish and Swedish governments reached an agreement to construct a fixed link bridge joining the two metropolitan areas of Copenhagen and Malmö. The following year an organisation called the Öresund Contact was also formed to assist businesses in establishing operations in the region (Møller, 2010; OECD, 2010). However, with the oil crisis and economic down-turn of the late 1970s little progress was made until the mid-1980s when efforts by the European Round Table of Industrialists, the European Commission and the Scandinavian Link Consortium revived ideas of regionalisation.

In 1991 the Swedish and Danish governments reached a new agreement to build a fixed link bridge across the strait. Anticipating greater regional integration as a result of the bridge, a new regional administrative body, the Öresund Committee, was formed in 1993. The Öresund Committee has since become the primary regional political institution in Öresund. The aim of the Committee is to facilitate joint project management/implementation, networking and representation and joint administration of regional integration and environment programmes, and to provide a forum for discussing political questions of regional relevance (Møller, 2010).

The fixed link bridge was finally completed in 2000 and was expected to greatly enhance functional integration in the region. While it has undoubtedly increased the level of cross-border activity (see Figure 16), research suggests that functional trans-Öresund links remain weak and underdeveloped (Matthiessen, 2004). This is in spite of the fact that greater cross-border integration appears to have strong regional support at both a political level and among individual citizens (Matthiessen, 2004).

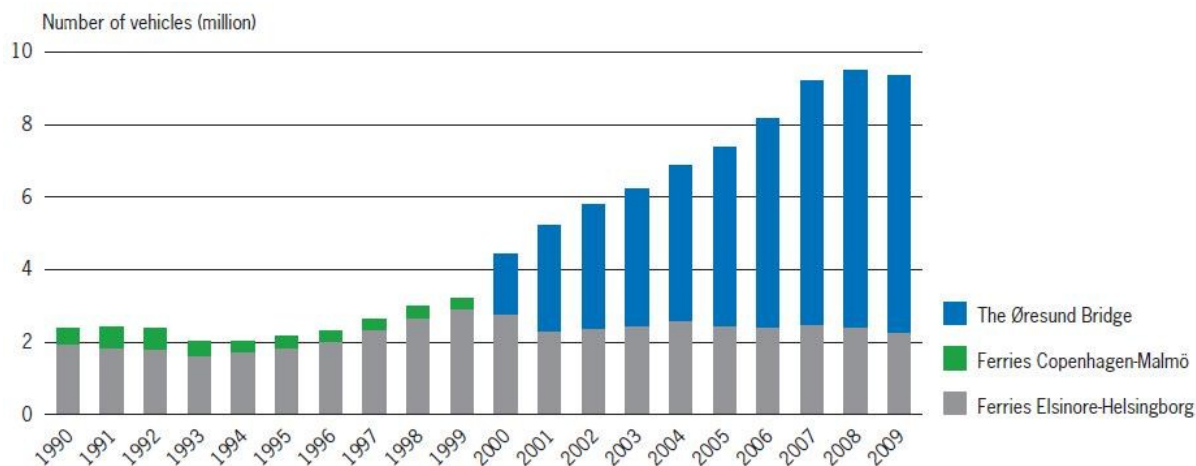


Figure 16: Cross-border traffic in the Öresund region (Source: Shippax and Öresund Bridge)

5.1.2 Interreg projects involving cross-border cooperation in healthcare

Since 1996 a key task of the Öresund Committee has been to administer various projects co-funded through the EU's Interreg programme. According to an OECD Territorial Review published in 2003, the EU has come to see Öresund as “a privileged testing ground” in the push to achieve a “Europe of the regions” (OECD, 2003, p. 75).

The Interreg programme in Öresund has evolved through three phases: the first phase (Interreg 11A) lasted from 1996 to 2001 and attracted EUR 29 million in ERDF funding; the second phase (Interreg IIIA) operated between 2000 and 2006 with an ERDF budget of EUR 31.26 million, and the most recent phase (Interreg IVA) is scheduled to run between 2007 and 2013, during which time the ERDF has allocated EUR 52.5 million for Öresund region and a further EUR 10.5 million for projects that extend cooperation beyond Öresund to include the Kattegat-Skagerrak region between Norway, Denmark and Sweden. Between 2008 and 2010 37 full-scale projects and a number of smaller projects were approved for Interreg funding. Included are two major projects involving cross-border patient mobility, the Prohip project and the Reprosund project.

Prohip

The project contributes to fulfilling Interreg priority 2 - Tying the region together.

This priority focuses on creating a physically and organisationally homogeneous region, while making it easier to cooperate and share resources.

Lead Partner: University College Zealand

Partners: Ortopedklinikken ved Lunds Universitetshospital, Sverige og Ortopædkirurgisk afdeling i Slagelse/Ringsted, Sygehus Syd, Region Sjælland

Project Period: 1 Apr 2010 - 1 Apr 2013

Total Budget: 1,493,984.40 EUR

EU Grant: 746,992.20 EUR

Source: www.interreg-oks.eu/en

The Prohip project is designed to improve the choice and flexibility of hip surgery patients by developing an e-information and booking system. Specific aims of the project are to:

- Promote the common development of health services for citizens across the entire Öresund Region as well as reducing citizens' experiences of border obstacles.
- Enable citizens from both sides of the border to have more flexibility, a clearer view of waiting lists and more choices amongst more and better forms of treatment on both sides of the border.
- Enable citizens to better compare health services on both sides of the border.
- Enable citizens to choose one's own health professional and/or any follow up treatment (Prohip, 2010).

Reposund

The project contributes to fulfilling Interreg priority 2 - Tying the region together.

This priority focuses on creating a physically and organisationally homogeneous region, while making it easier to cooperate and share resources.

Lead Partner: Öresundsuniversitetet/Lunds Universitet

Partners: UMAS Malmö (Reproduktionsmedicinskt Centrum samt Urologiska Kliniken), Lunds Universitet (institutionen för laboratoriemedicin), Herlev Hospital (Urologisk klinik), Rigshospitalet, Københavns Universitet (Afdeling for Vækst og Reproduktion, Fertilitetskliniken samt Reproduktionsbiologisk Laboratorium), Bispebjerg Hospital (Arbejdsmedicinsk klinik) och Öresundsuniversitetet/ RUC

Project Period: 1 March 2010 - 28 Feb 2013

Total Budget: 1,785,080 EUR

EU Grant: 892,540 EUR

Source: www.interreg-oks.eu/en

The Reposund project focuses on infertility treatment and aims to create a new structure for building and mixing specialist competences in Sweden and Denmark. It also aims to prepare and open up treatment for increased patient mobility so that the optimal treatment is available irrespective of which side of the border the treatment is offered (Interreg IVA, 2010).

5.1.3 Other forms of cooperation

In addition to these projects, the Skåne Region estimates that there are approximately 20 contractual arrangements and 20 or more informal arrangements currently governing healthcare cooperation in the Öresund region. The Öresund Committee list the following forms of cooperation governed by contractual arrangements:

- Research cooperation (such as formalised scientific exchanges).
- Education, (including the exchange of physicians undergoing further training).
- The exchange of personnel.
- Cooperation over specific health services. For example, dental care, coordination of intensive care beds, mammography, hiring laser equipment, analytical cooperation, transplantation, surgical treatment of mandibular joints and patients with eye diseases.

Much of the informal cooperation stems from long-established contact between specialists. Examples of informal arrangements listed by the Committee include cooperation in education and information exchange as well as cooperation regarding research and commissioned training. There are also examples of provisional cross-country cooperation with Danish patients being sent to Sweden for heart surgery due to long waiting lists. To facilitate communication, hospitals have also translated information materials to ensure that patients are informed about examination and treatment as well as any necessary follow-up procedures or rehabilitation. This is particularly true of hospitals in Sweden.

In October 2009 the Capital Region of Denmark and the Skåne region produced a joint declaration of intent to establish more effective cooperate in order to mutually benefit from the capacity to reduce waiting times for non-urgent patients. This resulted in the establishment of a joint working group charged with identifying potential

areas for cooperation, highlighting the legal, economic and quality aspects of cooperation and developing a draft agreement for use in future projects. The agreement concluded between Skåne and Copenhagen will be ready summer 2011. There have been some difficulties in standardizing patient rights. Also the questions of who should pay compensation for mistakes have been discussed. Patient compensation in Denmark is more generous than in Sweden

As of early 2010, the working group had identified some potential areas for cooperation based on the length of waiting times and had appointed a special project team to oversee possible collaboration. Areas for possible cooperation included, patients waiting for urological surgery and patients requiring surgery for inguinal hernia, urinary tract stones or benign prostatic hyperplasia. The working group had also begun developing a template for future agreements between the Capital Region of Denmark and Region Skåne and models for the purchase of services from one region to the other.

Despite an expressed desire and intention from a political perspective to increase cross-border patient mobility and despite a significant reduction in the time-distance barrier as a result of the Öresund link bridge, only a few patients cross the strait to receive planned hospital treatment each year. In 2009, for example, Skåne province received 83 applications for reimbursement for health services received abroad of which 55 were accepted. During the same year Skåne province received 48 applications for prior treatment under the E112 arrangement of which only 11 were accepted.

Although two private Swedish hospitals - Spenshult sjukhus and Österlenkirurgin¹¹ - also have an agreement with Danish health authorities in regard to Danish patients' "free choice of hospitals", the actual number of Danish patients in these hospitals remains minimal. Spenshult, for example, reports that only one or two Danish patients were treated in 2009.

5.1.4 Barriers/obstacles

System level barriers

Under certain conditions, EU regulations offer patients the opportunity to seek treatment in another country and, as detailed above, there are also a number of regional initiatives intended to smooth the way for greater patient mobility. This research demonstrates that for eligible patients groups the purely formal obstacles to cross-border patient mobility in Öresund are small.

According to a representative from Capital Region of Denmark, the main system-level obstacles preventing increased patient flow across the sound are structural differences between each country's health systems. In Denmark, for example, the longstanding tradition has been for patients to visit a permanent primary doctor when addressing initial medical questions. In Sweden, on the other hand, it has been more common to visit a 'vårdcentralen' in which the patient is not linked to any single doctor.

In addition to administrative incompatibilities such as this, Mahncke et al. (2009) cite a lack of capacity on both sides of the border, inefficiencies in infrastructure connecting the region (notwithstanding the fixed link bridge) and differences in pharmaceutical legislation as important system-level barriers to greater patient mobility.

Patient level barriers

Although significant investments have been made in promoting greater regional integration in the Öresund Region, the pace of change has been slower than some analysts expected (Matthiessen, 2004), making this a very uncommon activity.

¹¹ Se Sygehusvalg.no: <http://www.sygehusvalg.dk/geoomraade.aspx?type=geoomraade&id=122445>

A number of recent studies have sought to identify some of the personal-level barriers to greater regional integration (e.g. Matthiessen, 2004; Öresundskomiteen & Øresunddirekt, 2003). Some of these are thought to play an important role in the health sector. A report into commuter experiences with cross-border health services published in 2003 found that, “the barriers that meet those involved in health care are the same as those that stand in the way of others who take the initiative for increased integration” (Öresundskomiteen & Øresunddirekt, 2003, p. 14).

In relation to cross-border employment one such study identified five key individual-level barriers. These are:

- Insecurity over the unfamiliar.
- Family connections.
- Language barriers.
- Transport costs and time.
- Satisfaction with one’s current circumstances.

According to a representative from Capital Region of Denmark, cultural differences - in particular differences in language - are important barriers. Although, people from the two countries have few difficulties understanding each other, being a patient can put one in a vulnerable situation which demands full understanding between patient and healthcare professional.

5.2 Cooperation and patient mobility in the North Calotte region

Although it is not an area with clearly demarcated geographical boundaries, the North Calotte region essentially refers to the area of Scandinavia north of the Arctic Circle. This includes the counties of Nordland, Troms and Finnmark in Norway, the Lapland region (from 2010) in Finland and Norrbotten in Sweden (see Figure 17).



Figure 17: Map of North Calotte region

The area is very sparsely populated, containing only five per cent of these countries population (approximately 900,000) but covering 30 per cent of their total land mass. The majority of the residents in North Calotte live in northern Norway (approximately 460,000). This compares to approximately 184,000 in northern Finland and 250,000 in northern Sweden. North Calotte is also the most important Sami centre. Of the approximately 79,000 Sami people, 50,000 live in Norway, 20,000 in Sweden and 7,000 in Finland and about 2,000 on the Kola Peninsula.

Given the sparse population in the far north, municipalities in all four countries are generally much larger than they are in the more densely populated areas of the south. This is especially true of Finnmark in Norway; the northernmost parts of Lapland in Finland; and the Swedish municipalities in Norrbotten located in the Norwegian border. The distance between border areas, local municipal centres and specialist health services can

therefore be great. The border areas between Norrbotten, Nordland and Troms County, for example, consist largely of uninhabited mountainous terrain and thus for the vast majority of citizens in Norrbotten, the distance to specialised health services in Sweden is nearer than the distance to services in Norway. In some of these areas of northern Finnish Lapland bordering on Norway, it is shorter for Finnish citizens to seek specialised health services on the Norwegian side than on the Finnish side.

In addition, border regions often display strong elements of a shared cultural and linguistic community. This is true of a number of border regions between Finland and Sweden, among others along the long Torne Valley. The last 150 km down the Gulf of Bothnia Torne River forms the border between the two countries. In the far south, it is only the river separating the cities of Haparanda (Sweden) and Tornio (Finland).

5.2.1 Supranational bodies under the auspices of national governments

In 1967 the ministries of labour in Finland, Sweden and Norway established the North Calotte Committee (Nordkalottkomite) for the purposes of building closer regional cooperation and integrating political planning. Due to operational restructuring, the Committee changed its name to the North Calotte Council¹² (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, Norrbotten and northern Norway and receives base funding from the Nordic Council of Ministers.

There is also an agreement on crisis preparedness between the countries in the region. Locally, the hospitals on the Norwegian side and the hospital in Rovaniemi in Finland cooperate at an operational level. In addition to cooperation on preparedness for disasters in Norway, Sweden and Finland, the countries also have a strong focus on cooperation on preparedness for crisis/disasters with Russia.

5.2.2 Health cooperation under the auspices of the Barents Euro-Arctic Council, BEAC

Barents Euro-Arctic Council (BEAC) is the forum for inter-governmental cooperation in the Barents Region (see Figure 18).

¹² [Http://www.nordkalottradet.nu/omnordkalottraadet.html](http://www.nordkalottradet.nu/omnordkalottraadet.html)

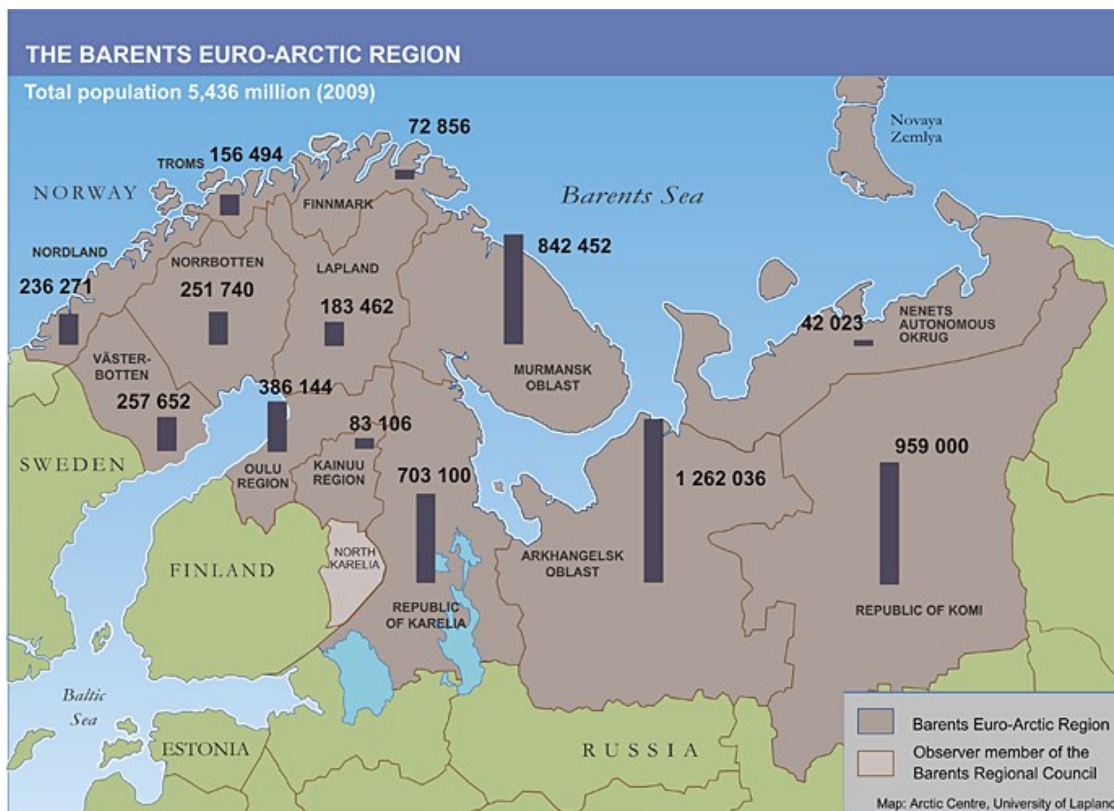


Figure 18: Map of the Barents Euro-Arctic Region. Source: <http://www.barentsinfo.org/?DeptID=7022>

BEAC was established in 1993 in order to support and promote cooperation and development in the Barents Region (BEAC, 2010). The same year the Barents Regional Council (BRC) was also formed, uniting the 13 member counties and an indigenous representative from the northernmost parts of Finland, Norway, Sweden and north-west Russia. Cooperation within the healthcare field is focused on supporting activities that will improve health and health care in the countries. However, thus far there is no specific focus on patient mobility.

Fact Box: Cooperation programme on health and related social issues in the Barents Euro-Arctic Region 2008-2011 (BEAC, 2007)

Scope and priorities:

The extension of the Programme should be based on the previous programmes. With reference to the public health and social situation in the Barents region the priority areas shall be the following:

- *Prevention and combat of communicable diseases*
- *Prevention of lifestyle-related health and social problems, and support to children and youth at risk*
- *Development of primary health care, public health and social services.*

In all the priority areas special attention should be paid to:

- *Gender mainstreaming*
- *The UN Convention on the Rights of the Child and improvement of the health and social wellbeing of children and young people*
- *Effective coordination and public health aspects*

The target groups should be the vulnerable groups in the population. Furthermore, the special problems of indigenous people as well as the special problems of sparsely populated areas should be part of the planning whenever relevant.

5.2.3 Cooperation between regional health authorities

From 2008 the regional health authorities in Finnish Lapland, Finnish Västerbotten, Norrbotten County in Sweden and Northern Norway Regional Health Authority also established contact to facilitate cooperation on healthcare issues other than preparedness for crisis and disaster. Several areas of cooperation were identified:

- Crisis and disaster preparedness: procedures for crisis and disaster exist, but can be strengthened through developing closer relations at a personal level.
- In situations involving high potential strain on businesses personal knowledge and understanding of each other's capabilities and organisation as well as knowledge of appropriate contact channels can be important. Forms for such cooperation should be further developed.
- Cooperation in everyday medical care: the parties will identify potential areas of interest to develop cooperation between two or all parties in relation to everyday care.
- IT development: all parties see the transfer of information between care providers as an issue of growing importance.

So far, no concrete cooperation has taken place, but the representatives from the authorities have meetings and this work is continuing.

5.2.4 Cooperation between Norway and Finland in the border areas between Finnmark and Lapland

In the mid-1980s, as a result of initiatives from Sami communities and the work of a Norwegian-Finnish ad hoc working group, an agreement was reached for cooperation between the Lapland Central Hospital and The Specialist Clinic in Karasjok. The Child and Adolescent Psychiatric Outpatient Clinic, Karasjok also reached an agreement at this time for the sale of outpatient services to Finland. The agreements enabled doctors in some Finnish municipalities to refer patients to outpatient clinics in Karasjok (primarily Sami people, although other groups were also eligible). Invoices for consultations were initially sent to the hospital in Rovaniemi, before being forwarded to the patient's home community. Later, after an amendment to the regulations in 1994, it became possible for Finnish municipalities to buy specialist services directly. However, Utsjok was the only municipality interested in such arrangements.

From 2002 to 2004 a high-profile Finnish-Norwegian project known as Grenseløs i nord (borderless in the north) was initiated with the purpose of identifying and helping to break down structural barriers to cross-border mobility. Project participants included the three Sami border municipalities of Utsjok, Enontekiö and Inari in Finland and the municipalities of Storfjord, Kåfjord, Nordreisa, Kautokeino, Karasjok, Tana, Porsanger, Nesseby and Sør-Varanger in Norway. The final report from the first stage of the project, published in 2004 (see Regjeringen Norge, 2004) emphasised the need to develop further cooperation between the two countries. Health services were seen to be an important part of this. The report outlined a need for cooperation in several areas of the healthcare system, such as midwifery and health services for newborn, emergency cooperation, rescue services and a range of specialist services within psychiatric and somatic health services.

Although cooperation between the two countries had existed for a long time, the report identified a need to establish a more formalised framework for cooperation. This was also partly due to structural reforms in both countries. In Finland the financing of health services had become increasingly decentralised with responsibility largely devolved to the municipalities. Norway, however, had developed in the opposite direction where the ownership of specialised health services was transferred from county to state level in 2002. This created a period of confusion over responsibilities and financing, resulting in less cooperation (Fylkesmannen i Finnmark, 2006). Between 2005 and 2008, the County Governor of Finnmark took responsibility for continuing the "Grenseløs i nord" project. This was also supplemented by a similar project undertaken by Utsjok municipality between 2005 and 2007. These initiatives contributed to the realisation of an agreement on cooperation between Lapland Health Districts and the Helse Finnmark (health enterprise in Finnmark) over specialist services. The agreement states that the signatories will:

"Further improve services for border residents, primarily the Sami population, who may have special needs and preferences in relation to culture and language. All border residents should be able to receive treatment over the borders, based on language/cultural needs, or because of proximity to the service"
(translated from the original)

The combination of long distances to services and linguistic/cultural considerations are therefore seen to be important factors supporting the need for cooperation in border areas between northern Norway and Finland. There are already several health services with Sami-speaking staff in both primary care (e.g. midwives and health services for the newborn) and specialist health services (e.g. for several somatic and psychiatry services in Karasjok) on the Norwegian side of the border. For Finnish residents the distance to the nearest hospital in Finland is in Rovaniemi can be up to 4,600 km away.

According to a representative for Helse Finnmark (Health enterprise), the number of registered patients within specialised care is small, and may be caused by lack of knowledge of the agreement and lack of proper registration in the registry system. In the period from 2007 to 2010 Helse Finnmark paid approximately 0.5 million NOK to Rovaniemi hospital for treatment, mainly for psychiatric issues and issues to do with substance abuse (approximately 10 patients). Annually, Helse Finnmark provide outpatient treatment to about 5-10 Finnish patients at the specialist clinic in Karasjok. In addition, a few Finnish patients have been given hospital treatment in Kirkenes and Hammerfest.

5.2.5 Cooperation in the area of Torne Valley (Tornedalen)



The Torne Valley Council

Founded in 1987, the Torne Valley Council (Tornedalsrådet) is based on cooperation between the municipalities of Tornio, Ylitornio, Pello, Kolari, Muonio and Enontekiö in Finland; Haparanda, Övertorneå, Pajala and Kiruna in Sweden; and Storjford, Kåfjord, Nordreisa and Kautokeino in Norway. The purpose of the Council is to cooperate within the areas of business, labour, education and culture in the Torne Valley. In regards to healthcare, cooperation around primary care is seen as the most important issue. The Torne Valley Council sees the need to ensure and develop quality and competence in primary care in the area, partly because of increasing centralisation of specialist care. Due to the long distances and small population involved, primary care must have more specialised/qualified personnel in the future (Tornedalsrådet 2009).

The Torne Valley has 20,000 inhabitants on the Swedish side and 40,000 on the Finnish side. There is a common cultural and linguistic tradition in area. The local Sami-inspired language meänkieli is spoken on both sides of the border in addition to Sámi, Finnish and Swedish. On the Finnish side this is regarded a Finnish dialect. People travel daily across the border to work and study, and there is widespread cooperation in healthcare. Ambulances and x-

rays regularly cross the national border. The health centres in Övertorneå (Sweden) and Ylitornio and Pello (Finland) share responsibility for emergency care. The public dental clinic in Karesuando treats both Swedish and Finnish patients. For three decades there has been cooperation regarding social services, ambulance services and emergency care and diagnostic and dental services. Cooperation within primary healthcare is particularly important for cross-border workers who live on one side of the border and work on the other. Emergency care is

also an important and well-established area for cooperation as each municipality is very small (e.g. the municipalities of Övertorneå and Ylitornio).

The role of the Tornedalen Council is to support and contribute with knowledge on cooperation across borders. On this basis, an application for funding from the EU through the Interreg IVA programme resulted in the project "Fritt Vårdval i den funktionella regionen Tornedalen" (Free choice of care in the Torne Valley region), with the working title "Gränslös vård" (Borderless Care).

Borderless Care in the Torne Valley

The project contributes to fulfilling Interreg priority 3 - to enhance regional functionality and identity.

This priority focuses on enhancing regional unity by strengthening transnational links and contacts to facilitate information transfer and the movement of persons, services and goods.

Lead partner: County Council of Norrbotten

Project partners: Municipalities of Tornio, Ylitornio, Pello, Kolari, Muonio and Enontekiö

Project period: 10 Jan 2009 – 30 June 2011

Total project budget: 1,013,872.00 EUR

EU grant: 607,715.00 EUR

Source: www.interregnord.com

The aim of the project is to further deepen cooperation between local health services in Finnish and Swedish Torne Valley in order to achieve the right quality of care and choice for patients in the region (Norrbottens Läns Landsting 2009). The project is being carried out in two phases. The objective of Phase 1 (now completed) was to map the current situation to determine how health cooperation functions today and to identify potential areas for future cooperation. It focused on the following areas:

- Patient (free choice of health provider).
- Logistics (ambulance helicopter, disaster and crisis preparedness etc.).
- Work methods (emergency preparedness, work plans etc.).
- Diagnostics (laboratory, radiology, ultrasound etc.).
- Education (terminology, networks, etc.).
- Information- and technology of communication.
- Legislation and reimbursement schemes.

The project identified a number of obstacles to cooperation. These included:

- Reimbursement (Finnish municipalities are not reimbursed for cross-border workers).
- Insurance (uncertainty over who is insured in some cross-border cases e.g. when an ambulance is required to cross the border).
- Legislation (only cross-border workers are included. The law applies to emergency treatment or planned specialist health services (not planned primary care). There are also different interpretations of the law among experts in the countries).
- Patient co-payment (differences between countries).
- Plans for emergency situations (communication systems are not always compatible).
- Work methods / duty rota (patients treated differently because working arrangements are different).
- Unable to communicate and share patient information (various IT systems that do not communicate with each other in terms of patient related information).

Part of Phase I of the project also involved a survey carried out among people in the Torne Valley. The survey found that a large proportion of respondents would be willing to seek treatment on the other side of the border (66 per cent of the Finnish participants and 69 per cent of the Swedish). When asked which services they would like better access to (across the border), primary care was the most important, while dental services and hospital care were also mentioned by many. Responses are shown in Figure 19.

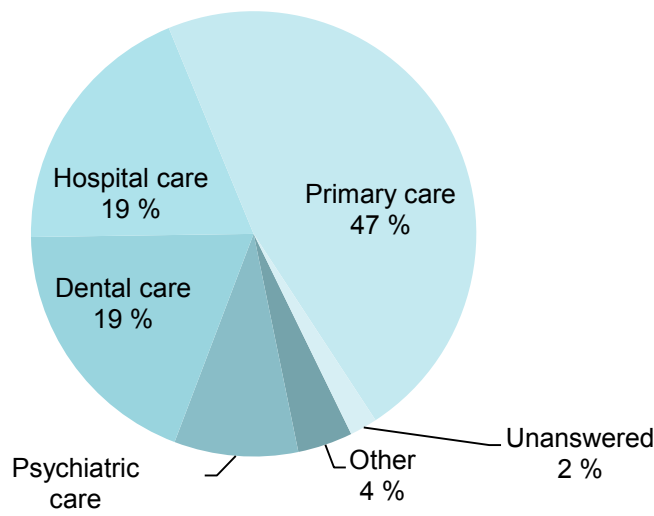


Figure 19: Services respondents from Torne Valley: “would like to have access to on the other side of the border?” (Source: Borderless Care in the Torne Valley)

The aim of Phase II of the project is to try to address some of the key problems identified in Phase I. The main focus is currently on:

- Using web cameras to facilitate cross-border consultations.
- Logistics relating to ambulance services and emergency. Including:
 - Quality assurance plans for emergency preparedness.
 - Joint disaster exercise.
- Electronic transmission of X-rays.
- Collaboration on competence.

Creating effective networks and collaboration with Norwegian partners is also an important goal in phase II of the project.

Summing up, the cooperation in the Tornedalen area is first and foremost directed towards primary health care and is focused on:

- Patient rights to freely choose health care provider.
- Make health services more accessible for patients through use of technology (e.g. e-Health).
- Sharing costs.
- Sharing competence.

5.2.6 Documentation on Patient mobility in the North Calotte Area

By contacting health authorities, patient registries and national insurance funds, we have tried to get a picture of the extent of patient mobility across borders¹³. As previously discussed (see Chapter four) there are no systems for developing statistics on the total scale of cross-border patients in the Nordic countries. Our investigations show that the scale in general is very small in terms of specialist consultations and hospital treatment.

Norrbotten County have figures that show only 16 registered admissions for Finnish citizens in the Norrbotten hospitals in 2009 and 15 from Norway. The number of consultations, however, was far higher, with 488 from Finland and 819 from Norway. However, these figures include primary care and dental visits which fall outside

¹³ The National Patient Registers do not have information on the Country of origin for patients from other countries.

the scope of this study. A representative from Norrbotten Council says that in principle patients are referred to other hospitals in Sweden if required and a small number of lung patients are sent for treatment in Copenhagen.

From The Finnish FPA (insurance fund), we have figures showing that in the period 2000-2009 reimbursement was paid for only 42 Finnish patients who had scheduled treatment in Sweden. For Swedish patients in Finland the figure was 85 and from Norway the figure was 10. It must be noted that the actual number of cross-border patients in this regions is probably somewhat higher because on an independent basis hospital districts in Finland can send patients out of the country. Figures from Norrbotten, however, indicate that patient mobility related to planned specialist healthcare is relatively modest. Representatives from the Norrbotten Health Authorities confirm that cross-border health care is mainly directed towards primary healthcare and that there is less need for cooperation between countries within specialist services.

As described in section 5.2.4 the number of patients crossing the border between Finland and Norway is very limited, but very important for the patients as alternative travel times can be long. As a representative from the hospital in Narvik stated, due to geography and settlement patterns the patient flow between Norway and Sweden in the North Calotte area (planned care) is almost “non-existent”.

6 Summary and conclusions

Drawing on data gathered from previous research, interviews with key personnel and a quantitative survey among Norwegian cross-border patients, this study has investigated the patient flow between the Nordic countries. Our starting point was a study on patient mobility for planned specialised healthcare (predominately inpatient care). We have also attempted to identify some of the important obstacles preventing patients from accessing healthcare services in other countries. This included a review of the regulatory framework governing patient movements within the EU and between the Nordic countries, as well as case studies of cross-border cooperation and patient mobility in the Öresund and North Calotte regions.

6.1 Small patient flows at the national level

This study has focused on situations in which patients travel to another country specifically for the purpose of receiving healthcare services. Hence, less attention is placed on patients who for various reasons are already in another country when requiring healthcare services, irrespective of whether this is for a longer or shorter period of time. We have shown that the number of patients who travel across national borders for planned hospital care financed by the public sector is very small in the Nordic countries. The patient flows that do exist are mainly due to a lack of highly specialised services (medical expertise and technology) in the patient's home country. To reduce waiting times most countries have established free choice of hospital systems to utilise the capacity within their own countries (most limited in Finland). There are also examples where patients can travel to another country when waiting lists for certain treatments become too long.

Available data on cross-border patient movements in the Nordic countries is incomplete (see Mahncke, et al., 2009). However, the data that is available suggests that the number of cross-border patients granted prior authorisation for planned health services in the Nordic countries is small. Although these figures must be treated with caution, they nevertheless provide some indication of the approximate number of cross-border patients. Table 14 summarises these flows using both aggregate data (figures averaged over a number of years) and annual data (figures for a specific year).

Using data gathered by the Danish Ministry of Health in 2008, we can see that a total of 34 Danish patients crossed a national border to receive health services (33 to Sweden, 1 to Norway). The main reasons for this were to receive experimental or research treatment, or highly specialised treatment. Based on 2009 data from the National Network for Foreign Treatment, 121 Norwegian patients were found to have travelled to another Nordic country for treatment in 2009 (18 to Denmark, 7 to Finland and 96 to Sweden). The primary reason for this was a lack of national competence, with domestic hospitals and professionals referring patients abroad for treatments not adequately provided for in the national system. Using figures for cross-border patient movements collected by the Social Insurance Institution of Finland between 2000 and 2009, we can see that the average annual number of patients receiving prior approval for treatment in another Nordic country is just four (all to Sweden). Finally, using figures collected by the National Social Insurance Board of Sweden between 2004 and 2009, we can see that the average number of patients receiving prior approval for treatment in another Nordic country is 88 (6 to Denmark, 79 to Finland and 3 to Norway).

Table 14: Approximate numbers of Nordic cross-border patients granted prior authorisation for planned health services in another Nordic country annually (based on actual and aggregate data)

From	To				Total
	Denmark	Finland	Norway	Sweden	
Denmark ¹⁴	-	0	1	33	34
Finland ¹⁵	0	-	0	4	4
Norway ¹⁶	18	7	-	96	121
Sweden ¹⁷	6	79	3	-	88
Total	24	86	4	133	247

The small number (about 250 per year) of cross-border patients in the Nordic region appears to contradict studies that show a high level of hypothetical willingness to cross national borders for healthcare services (e.g. The Gallup Organization, 2007). Therefore one can assume that the level of perceived need for cross-border care is currently not high, and that most patient needs are adequately met within national health systems.

The limited amount of patients crossing national borders for planned hospital treatment can be explained by:

- Lack of demand; the Nordic countries are largely self-sufficient regarding health services
- Lack of legal access to (public financed) treatment abroad
- Lack of support for cross-border care from healthcare workers in a patient's home country
- Distance or travel time
- Patient co-payment
- Individual reasons condition and functionality level, knowledge of, and connection to, the other country, language etc.

We can assume that willingness to travel is stronger for patients with serious and rare diseases, where treatment in the home country is limited or where expertise and/or equipment are inadequate.

6.2 Greater patient mobility an end in itself?

Patient mobility across borders is not necessarily an end in itself. The Nordic countries are obligated to ensure capacity to treat common illnesses and injuries without patients having to travel too far.

The possibilities for planned treatment abroad can be considered from several perspectives. One of these is a state perspective, whereby the primary objective is to provide citizens with care consistent with a state's perceived mandate. In certain circumstances, for instance if services are not offered within the country, the state may choose to send patients out of the country for treatment. The fundamental point of this perspective is that access to treatment abroad is regulated by the need to supplement the health services that are available in a patient's home country.

¹⁴ Figures based on 2008 data from the Danish Ministry of Health.

¹⁵ Figures based on average cross-border patient movements between 2000 and 2009. Source: Kela – the Social Insurance Institution of Finland.

¹⁶ Based on 2009 data from the National Network for Foreign Treatment.

¹⁷ Figures based on average cross-border patient movements between 2004 and 2009. Source: The National Social Insurance Board of Sweden.

Another perspective is a freedom of choice perspective, whereby a patient's right to choose healthcare providers is regarded as a significant end in itself. In an international context, the right of free choice of provider within a country has become more common. This right has increasingly been linked to the quality of services. As a result there has been strong pressure to develop quality indicators that patients can use as the basis for selection in addition to waiting time information. This is part of a general trend in the health sector in many western countries where market-style mechanisms are used as a tool for promoting greater efficiency in healthcare systems. As also shown in this report, experience suggests that only a small number of patients currently exercise their rights to free choice of hospital at a national level. However, from a rights perspective, it is the right itself that is important, not the extent of mobility per se. From this perspective greater patient mobility may also be desirable in order to exploit spare capacity and to temporarily relieve bottlenecks until capacity can be strengthened. The complexity of implementing such schemes between the countries is demanding.

Within the framework of the EU's four freedoms, countries must support free flow of labour and services, including in healthcare. Through cases brought before the European Court attention on cross-border healthcare services has shifted from a concern with the rights of citizens who for various reasons stay in another country, to include a patient's right to leave the country for the purpose of receiving health services. Implementation of a new directive on cross-border healthcare (from 2013) will also make it easier for some patients to obtain treatment abroad. An important point in the new directive (adopted in the EU-Parliament in January 2011) is that patients are entitled to treatment in another country when the waiting time is unreasonably long in their own country. The situation regarding waiting time guarantees in the Nordic countries today varies significantly. Norway has moved away from general waiting-time guarantees and currently has a system based on individual assessments of waiting times. Low-priority patients with mild disorders are not granted waiting time guarantees. A key challenge in the future may be to harmonise national priority mechanisms with global EU rights.

Update: As this report is being printed, a new report has been published from European Observatory on Health Systems and Policies (Wismar, Palm, Figueras, Ernst, & van Ginneken, 2011). This book explores the trends of cross-border healthcare and also looks at the legal framework for cross-border care as well as examining some of the uncertainties surrounding it at the EU-level.

6.3 Border regions; both common and different challenges regarding healthcare

Border regions are of special interest in terms of cross-border patient mobility. The population in these areas is more likely to have a special interest in accessing health services in neighbouring countries. This may be for a number of reasons, the most obvious being their potential physical proximity to services in another country.

North Calotte

In the case of North Calotte, a shared language and cultural affinity are important factors promoting cross-border patient mobility. This is particularly true for the Sami population as is demonstrated by the cooperation between the municipalities of Finnmark and Lapland. In the Torne Valley area there has historically been a close relationship between the populations living on either side of the border; both in regard to business and in terms of social and culture life. Similar circumstances are often found in other border areas in Europe. The concern is therefore not only on patients' rights to cross-border services, but also on system level cooperation to maintain and develop good quality services, in particular related to primary health care in sparsely populated areas. Sharing of costs and personnel to run services and sharing of patient information are important issues. Cooperation on primary healthcare has been gaining more significance also because hospital care is increasingly centralised. Cooperation between municipalities in the Torne Valley area currently occurs largely around primary healthcare and the right to "free choice" across the border. In this context there is a need for greater integration at the system level through access to patient information etc. Changes in EU regulations from May 2010 state that it is possible to be reimbursed for certain non-hospital services in another EU/EEA country without prior-approval. This gives patients in border areas easier access to primary health services in the neighbouring country. One of the obstacles experienced throughout the Torne Valley has been that rights have

been in place for cross-border workers, but have not been available to the same extent for other citizens. Furthermore, you can only receive services that you normally would have access to in your own country. Different rules for services covered and different levels of co-payment represent challenges in the work for borderless access to healthcare in the border regions. An example would be patients from the country with the highest patient fees looking across the border in an effort to save money (e.g. in the case of dental care). Travel costs are typically a smaller obstacle in the border areas than elsewhere because of proximity. In general, one can conclude that health system and administrative incompatibilities between the countries are seen as obstacles just as much as formal access.

Öresund

Strong trade links have existed in the Öresund region for hundreds of years. This is reflected in the close social, cultural and linguistic similarities between populations on either side of the Öresund strait. Although the Öresund region has no common governing body, there is a long-standing tradition of cross-border administrative cooperation with regional administrative bodies being established as early as the 1960s. Following the decision to build a bridge linking the Capital Region of Denmark and the Skåne province of Sweden in 1993, the Öresund Committee was established as the most significant forum for cross-border cooperation in the region.

The opening of the Öresund link bridge in 2001 was heralded as the beginning of a more integrated approach to the region and was expected to significantly increase cross-border flows of labour and services. Although the bridge undoubtedly made it quicker and easier to travel between the two countries, patient and system-level needs for cross-border health services were unaltered. Thus contrary to some expectations, the number of cross-border patients has remained low. The largest group of cross-border patients currently consists of Danish people who live in Sweden and are treated in Swedish hospitals.

When viewed from a formal perspective, existing legislation grants patients the right to receive health services in another country if waiting time guarantees are breached or if services are not available in the patient's home country. Furthermore, legal barriers are becoming less significant with the introduction of new EU-regulations. However, some obstacles thought to inhibit patient mobility were identified. From a system-level perspective these include: administrative incompatibilities between the health systems in Denmark and Sweden (e.g. regarding patient co-payments, information systems); a lack of capacity on the other side of the border as well, inefficiencies in infrastructure connecting the region (in spite of the bridge); and differences in legislation (e.g. regarding pharmaceuticals). From a patient-level perspective obstacles identified include: insecurity over the unfamiliar; family connections; language and cultural barriers; transport costs and time; satisfaction with one's current circumstances.

Some of these obstacles are actively being addressed – notably through two key projects supported by the EU's Interreg Programme. Within specified patient/service groups, these projects aim to encourage:

- greater and easier choice for certain patients
- improve patients' access to information better enabling them to compare treatment options
- build specialist/research cooperation at a professional level and
- promote the common development of health services to ensure compatibility between health services on either side of the border.

A formal agreement between Capital Region and Skåne province is expected to be signed during 2011 with the aim of facilitating cross-border patient movements.

6.4 Concluding remarks

While the projects, agreements and efforts outlined in this report may go some way to encouraging greater patient mobility, it is difficult to escape the conclusion that currently most patients perceive that their health needs are best met within their national system. Furthermore, patients demonstrate a strong preference to receive treatment as close to home as possible. Higher volume patient mobility is dependent of a number of factors, such as:

- a persistent asymmetry between health services offered on each side on the border, either in terms of capacity (waiting times etc) or expertise (competence, specialisation)
- the distance to health services in another country offers patients a comparative advantage to services offered within their own country
- financial incentives for both patients and health authorities
- readily available information about possibilities for patient mobility

In the absence of such factors, patient mobility is likely to remain limited to highly specialised ‘niche’ services or to the use of spare capacity in one national system to temporarily plug capacity gaps in another national system until such time as capacity can be strengthened.

Patient mobility across borders is not necessarily an end in itself. The Nordic countries are obliged to ensure capacity to treat common illnesses and injuries for their own population without patients having to travel too far for treatment.

The objectives and possibilities for planned treatment abroad can be considered from the perspectives of the patients (possibility to choose), from the professional perspective (give services to more patients) or from the political perspective.

Patient perspective

EU regulations offer selected patient groups the opportunity to receive treatment in another country. One of the few major studies to have examined EU patient mobility from a patient perspective found a high-level of *hypothetical* willingness to make use of this opportunity. However, very few patients currently seek planned medical treatment in another country (approximately 250 per year were identified in this report). This shows that in practice closeness is the most important factor for patients and this observation is in line with other studies (see Chapter 4.3).

Political perspectives; National Health authorities and EU

One of the national states primary objectives is to provide citizens health care consistent with a state’s perceived mandate. Secondly, ideas of patient rights and patient choice appear to be increasingly important organising principles in the deliver of health care. The manifestation of this thinking is the implementation of a new directive on cross-border health care adopted in the EU-Parliament in January 2011. Key to the new directive is the principle that patients are entitled to treatment in another country, for instance when waiting times become unreasonably long in their own country. The fundamental point is that access to treatment abroad is regulated by the need to supplement the health services available in the patient’s home country.

The professional perspective

The health services in each country have their own motivations in seeking cooperation outside national borders. In order to give good health services to all of the patients, it is sometimes necessary to send patients to other hospitals for a limited number of patients. These hospitals may be in another country.

Because of rapid medical development and increasingly specialisation it is necessary and rational that not all hospitals treat all types of patients. For some more rare and specialised cases it is not cost-effective to build up competence and capacity in several places. The Nordic health cooperation is influenced both from the top-down level (The Nordic Council) and bottom-up, from the actors in the health services itself. Although the most extensive cooperation is within the plans for emergency preparedness (as the example of treatment of fire injured at Haukeland hospital in Bergen), some cooperation exists for elective care in another Nordic country.

However, implementing cooperative arrangements for cross-border treatment raises a number of challenges involving professional responsibility for each stage of the health care process. For instance:

- information dissemination both for patients and for health care workers

- legal responsibility
- quality control
- rehabilitation and patient follow-up

Should the authorities aim to stimulate increased patient flow between the Nordic countries? One should be aware of the costs of sending patients to another country; Costs for patients, to the health-service and to public authorities (i.e. national insurance). If the costs are obviously lower than national services, one should consider treatment abroad. Another obvious reason for sending patients to another country is when the health services at home are lacking the relevant competence to treat the patient. It would then be very rational to use service from other countries. The experience from Norway is that such a system could be quite efficient, but that the number of relevant patients and type of treatment is small.

In the case of long waiting lists in a patient's own country and short waiting list and excess capacity in another country it might be a good idea to offer treatment abroad. However situations such as this only seldom occur and when they do, rarely occur for a prolonged period of time. The situation is more often that waiting times for certain types of health services are long at both side of the border, and thus potential benefits from sending patients abroad is small - both for the patients and for the health systems itself.

Though there are legally few obstacles for patients seeking to access treatment abroad, the number of patients choosing this option is quite limited. One explanation implies that though national health services in each country may lack expertise or have long waiting lines, they are able to meet, to a great extent, the needs of its own inhabitants.

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Appendix 1: Patient questionnaire

SINTEF Tecnology and society

Postal address:
Pb 124, Blindern, 0314 Oslo

Telephone:
22 06 73 00 (Oslo)
Fax:
22 06 79 09 (Oslo)

Foretaksregisteret:
NO 948 007 029 MVA

Oslo, September 2010

To those that have received hospital treatment in a foreign country

SINTEF is conducting a survey on patient experiences with hospital care in another Nordic country. The study is funded by the Nordic Council of Ministers and the Nordic Innovation Centre. As the Nordic countries are sending some patients to other countries in order to provide better health care they now want to identify lessons learned from this scheme. We must therefore ask the patients themselves.

The regional foreign office has sent you this questionnaire as they have recorded you as patient that has received healthcare services abroad during the last year. We ask you to please fill out this questionnaire and return it to SINTEF in the enclosed reply envelope as soon as possible, preferably within a week. Postage is already paid. Participation in this survey is optional, but to get the best data possible it is important that as many patients as possible answer.

Questionnaires are returned anonymously to SINTEF and we will not be informed of the name or any other identifying information about the individual patient. All participants in this project have complete confidentiality and SINTEF will also treat all data confidentially.

If you have any questions about this study please contact: Karl-Gerhard Hem, Ph. (+47) 930 05 019, email: hem@sintef.no.

Thank you in advance for your help!

Kind regards,

Inger H. Scheel
Research leader

Karl-Gerhard Hem
Researcher

About hospital treatment and choice

1. In which country did you receive treatment?

Sweden

☐

Denmark

☐

2. What form of treatment did you seek/receive in the foreign country?

Operation (surgery)

☐

Examination (diagnostic)

☐

Radiotherapy

☐

Other

☐

4 Experiences during hospitalisation

To what extent ...

Not at all To a limited extent To some extent To a large extent To a very large extent

a Were the doctors easy to understand?

☐☐☐☐☐

b Do you have confidence in the doctors' professional knowledge?

☐☐☐☐☐

c Do you have confidence in the nurses' professional knowledge?

☐☐☐☐☐

d Did the nurses take care of you?

☐☐☐☐☐

e Did the doctors and nurses show interest in you when you were describing your situation?

☐☐☐☐☐

f Did you receive sufficient information prior to examinations?

☐☐☐☐☐

g Was the overall care and treatment you received at the hospital satisfactory?

☐☐☐☐☐

h Do you think that you in any way received the wrong medical treatment?

☐☐☐☐☐

i Did you experience any problems or complications after you returned home from treatment?

☐☐☐☐☐

What is your opinion on?

kroner.

5. Would you consider being treated in the same hospital again?

Yes ☐ No ☐

Travel to the hospital

6. How did you get to the hospital?

(Select more than one box if necessary).

Private car ☐ Bus ☐
Train ☐ Plane ☐
Taxi ☐ Boat/Ferry ☐

7. Who arranged the travel?

(Select more than one box if necessary)

Myself ☐ Foreign Office ☐
Hospital ☐ General practitioner ☐

8. How long did it take you to travel from your home to the hospital?

Under 1 hour ☐
Approx. 1-2 hours ☐
Approx. 3-4 hours ☐
Approx. 5-8 hours ☐
More than 8 hours ☐

9. How much did you personally pay?

kroner.

10. What was the approximate total cost of travel to and from the hospital (before any rebates)?

11. What would you say has been the biggest challenge when receiving hospital treatment abroad?

Background information

The information below will be used to investigate whether different patient groups have different experiences with hospital treatment. It is therefore important that you answer questions.

12. Sex

Male ☐ Female ☐

13. Age

18-30 ☐
31-40 ☐
41-50 ☐
51-65 ☐
65-80 ☐
81 or older ☐

14. In general, would you say that your health is:

Bad ☐ Not completely good ☐ Good ☐ Very good ☐

15. In which country do you have citizenship?

Sweden ☐ Denmark ☐
Finland ☐ Norway ☐
Other country ☐

Please put this form in the envelope provided and post it as soon as possible. Postage is already paid.

Thank you for your help!

Appendix 2: Reference group

Jonathan Olsson, Försäkringskassan, Sweden
Eilsabeth Eero, Norrbottens Läns Landsting, Sweden(/Finland)
Siri Björvig, Nasjonalt senter for samhandling og telemedisin, Norway
Nicolaj Fasmer Blomberg, Region Hovedstaden, Denmark
Marcus Zackrisson, NICE
Johan Englund, NICE
Karl-Gerhard Hem, SINTEF, Norway
Birgitte Kalseth, SINTEF, Norway

Appendix 3: EU Draft directive concerning the application of patients' rights in cross-border Healthcare.

COUNCIL OF THE EUROPEAN UNION

Brussels, 13 September 2010

13535/10. PRESSE 239

The draft directive aims to facilitate the access to safe and high-quality cross-border healthcare and to promote cooperation on healthcare between member states. The compromise reflects the Council's intention to fully respect the case law of the European Court of Justice on the patients' rights in cross-border healthcare while preserving member states' rights to organise their own healthcare systems. The draft directive provides clarity about the rights of patients who seek healthcare in another member state and supplements the rights that patients already have at the EU level through the legislation on the coordination of social security schemes (regulation 883/04).

More specifically, the Council's position contains the following provisions:

- as a general rule, patients will be allowed to receive healthcare in another member state and be reimbursed up to the level of reimbursement applicable for the same or similar treatment in their national health system if the patients are entitled to this treatment in their country of affiliation;
- in case of overriding reasons of general interest (such as the risk of seriously undermining the financial balance of a social security system) a member state of affiliation may limit the application of the rules on reimbursement for cross-border healthcare; member states may manage the outgoing flows of patients also by asking a prior authorisation for certain healthcare (those which involve overnight hospital accommodation, require a highly specialised and cost-intensive medical infrastructure or which raise concerns with regard to the quality or safety of the care) or via the application of the "gate-keeping principle", for example by the attending physician;
- in order to manage ingoing flows of patients and ensuring sufficient and permanent access to healthcare within its territory a member state of treatment may adopt measures concerning the access to treatment where this is justified by overriding reasons; member states of treatment will have to ensure, via national contact points, that patients from other EU countries receive on request information on safety and quality standards on their territory in order to enable patients to make an informed choice;

The draft directive continuing..

- the cooperation between member states in the field of healthcare is strengthened, for example in the field of e-health and through the development of European reference networks which will bring together, on a voluntary basis, specialised centres in different member states;
- the recognition of prescriptions issued in another member state is improved; as a general rule, if a product is authorised to be marketed on its territory, a member state must ensure that prescriptions issued for such a product in another member state can be dispensed in its territory in compliance with its national legislation;
- sales of medicinal products and medical devices via internet, long-term care services provided in residential homes and the access and allocation of organs for the purpose of transplantation fall outside the scope of the draft directive;
- with regard to the member state of affiliation (which concerns in particular the reimbursement of healthcare costs of a pensioner living in the EU outside their home country and receiving healthcare in a third member state), the Council's position provides that as a general rule the member state competent to grant a prior authorisation according to regulation 883/2004 (i.e. the member state of residence) reimburse the cost of cross-border healthcare of pensioners. If a pensioner is treated in his country of origin, this country would have to provide healthcare at its own expenses.
- concerning healthcare providers, the Council's position seeks to ensure that patients looking for a healthcare in another member state will enjoy the quality and safety standards applicable in this country, independently of the type of provider; furthermore, the Council agreed that member states may adopt provisions aimed at ensuring that patients enjoy the same rights when receiving cross-border healthcare as they would have enjoyed if they had received healthcare in a comparable situation in the member state of affiliation.



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Nordic Innovation

Nordic Innovation

Nordic Innovation is an institution under the Nordic Council of Ministers facilitating sustainable growth in the Nordic economies.

Our mission is to stimulate innovation, remove barriers and build relations through Nordic cooperation. We encourage innovation in all sectors, build transnational relationships, and contribute to a borderless Nordic business region.

We work with private and public stakeholders to create and coordinate initiatives which help Nordic businesses become more innovative and competitive.

Nordic Innovation is located in Oslo, but has projects and partners in all the Nordic countries.

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