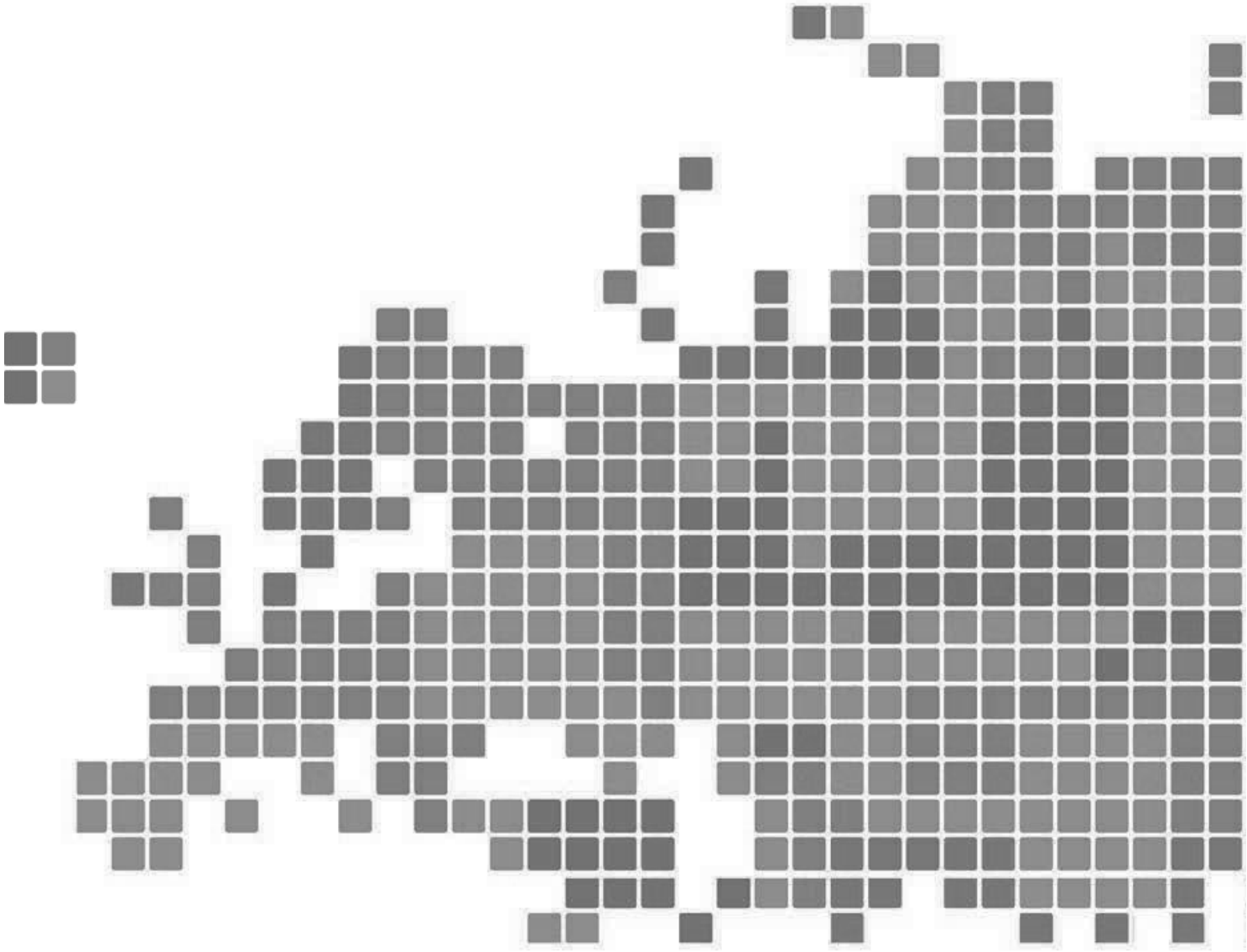
Hospitals and Borders

31
Observatory Studies Series

Seven case studies on cross-border collaboration and health system interactions

Edited by
Irene A. Glinos
Matthias Wismar



European Observatory on Health Systems and Policies
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SEVENTH FRAMEWORK PROGRAMME

Evaluating care across borders
ECAB
European Union Cross Border Care Collaboration

Hospitals and Borders

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

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Contents

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An overview of ECAB activities, partners and publications is available at www.ecabeurope.eu.

Irene A. Glinos and Matthias Wismar

List of tables, figures, boxes and maps

Tables

Figures

Boxes

Maps

List of abbreviations

CNAMTS	Caisse nationale de l'assurance maladie des travailleurs salariés (France)
CT	computerized tomography (scan)
DEH	district emergency hospital
DPHD	district public health directorate
DRG	diagnosis-related group
ECAB	Evaluating Care Across Borders
EEA	European Economic Association
EGTC	European Grouping of Territorial Cooperation
EHIC	European Health Insurance Card
ERDF	European Regional Development Fund
EU	European Union
EUH	European University Hospital
GDP	gross domestic product
GmbH	limited liability company
GP	general practitioner
MECSS	Maison d'enfants à caractère sanitaire et social (France)
MUMC+	Maastricht Universitair Medisch Centrum+ [Maastricht University Medical Centre] (the Netherlands)
NIHDI	National Institute for Health and Disability Insurance (Belgium)
OFBS	Observatoire Franco-Belge de la Santé [Franco-Belgian Health Observatory] (Belgium–France)
PET	positron emission tomography (scan)
RAD	radiation absorbed dose
SHI	social health insurance
UKA	Universitaetsklinikum Aachen [Aachen University Hospital] (Germany)
VHI	voluntary health insurance
ZOAST	zone organisée d'accès aux soins transfrontaliers [organized cross-border area for access to care] (Belgium–France)

List of contributors

Uta Augustin, Technical University of Berlin, Germany

Rita Baeten, Observatoire social européen, Belgium

Renate Burger, Gesundheitsmanagement, Austria

Reinhard Busse, European Observatory on Health Systems and Policies and Technical University of Berlin, Germany

Nora Doering, Maastricht University, the Netherlands/Karolinska Institutet, Sweden

Adriana Galan, National Institute of Public Health, Romania

Joan Gil, University of Barcelona, Spain

Irene A. Glinos, European Observatory on Health Systems and Policies, Belgium, and Maastricht University, the Netherlands

Ilmo Keskimäki, THL, National Institute for Health and Welfare, Finland

Régine Kiasuwa, Observatoire social européen, Belgium

Simo Kokko, Health authority of Northern Savo, Finland

Thomas Kostera, CEVIPOL and Institute for European Studies, Université libre de Bruxelles, Belgium

Riikka Lämsä, THL, National Institute for Health and Welfare, Finland

Hans Maarse, Maastricht University, the Netherlands

Victor Olsavszky, WHO Country Office, Romania

Dimitra Panteli, European Observatory on Health Systems and Policies and Technical University of Berlin, Germany

José Miguel Sanjuán, University of Barcelona, Spain

Cristian Vlădescu, University of Pharmacy and Medicine Victor Babes, Romania

Matthias Wismar, European Observatory on Health Systems and Policies, Belgium

Chapter 9

One hospital for the border region: building the new Cerdanya Hospital (Spain–France)

José Miguel Sanjuán and Joan Gil

Introduction

The cross-border Cerdanya Hospital project was the first European initiative to build a new facility aimed at providing health care services to patients from two different national health systems (France and Catalonia/Spain), bringing together patients, professionals, medical protocols, administrative procedures and laws from countries with deep institutional differences. This chapter describes and analyses the definition and construction stages of Cerdanya Hospital as a cross-border health care facility from its inception. It shows how the hospital has become a tool for fostering territorial cohesion, recognizing that part of its success results from a long history of political and institutional collaboration among stakeholders in the territory. The authors believe that Cerdanya Hospital represents a natural experiment worth further study, particularly into the wide array of problems and difficulties encountered when dealing with the construction of complex supranational institutions and organizations working at the European level.

Methodology

The authors collected data in three different stages during 2010 and 2011 to complete the study. They first searched all relevant documentation regarding the process of creating Cerdanya Hospital and the different institutions and stakeholders involved. They also performed a literature review, including local and regional newspapers mentioning Cerdanya Hospital and grey literature such as annual reports of the institutions involved in the process. To support this information they held several interviews with the general manager of Puigcerdà Hospital to obtain first-hand information on the new hospital's creation.

They then selected key stakeholders in order to capture the particularities of the actors involved and conducted semi-structured interviews, which they recorded. After the interviews, they asked respondents to cite other potential key actors; this allowed them to contact further stakeholders (see Annex 9.1 for interview details). The authors conducted all interviews face to face at the interviewee's place of work, whether on the Catalan or the French side. The interviews lasted between two and three hours and took place mainly in Catalan but also in Spanish.

The border region and health care context

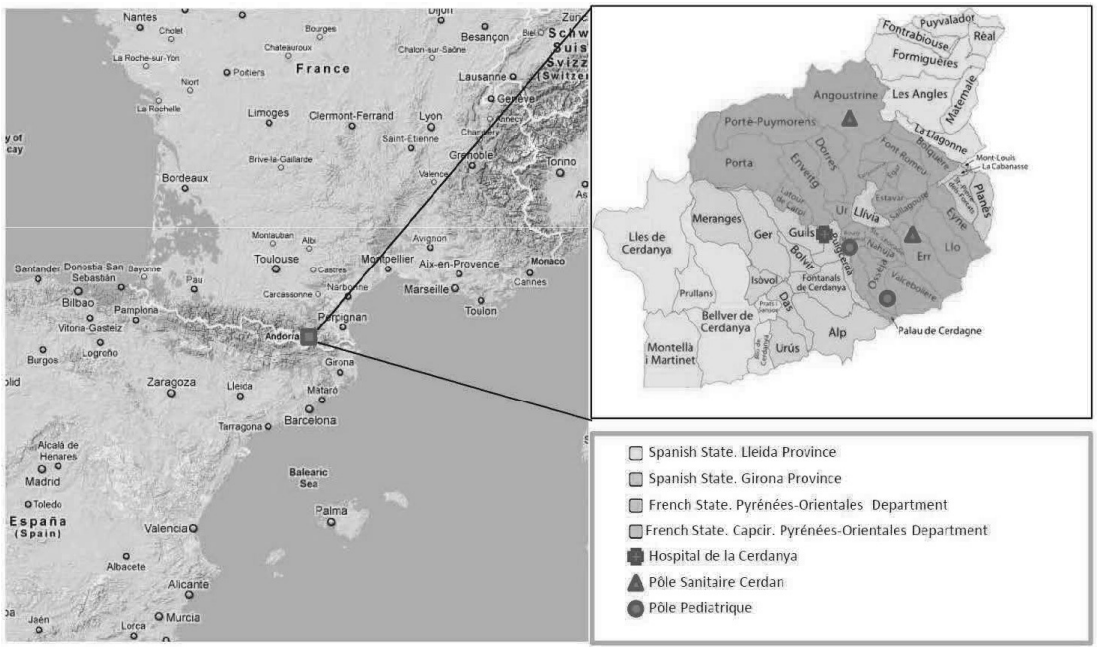
Geography

Cerdanya ("Cerdaña" in Spanish; "Cerdagne" in French) is an isolated valley with a large, high plateau set in the mountainous area of the Pyrenees. The region is divided into Upper Cerdanya (the northern part) in France and Lower Cerdanya (the southern part) on the Spanish side of the border (Map 9.1). Historically, the entire territory of Cerdanya was one of the counties of Catalonia and the split occurred as a result of the Treaty of the Pyrenees of 1659.

Today Lower Cerdanya (henceforth Cerdanya) is a Catalan county covering an area of 546.6 km^2 with a population of more than 18 500 inhabitants – a density of 33.9 inhabitants/km^2. The municipality of Puigcerdà, the county's capital since the twelfth century when it replaced Hix (now Bourg-Madame in France), has a population of more than 8 700 inhabitants: 47% of the whole county's population. Puigcerdà City Council is the largest in the valley and one of the most important in the Pyrenees. The area's main economic activity is tourism (mostly winter sports), with some services and livestock. Average gross domestic product (GDP) per capita in Cerdanya was €29 300 in 2006, 7.4% higher than that of Catalonia as a whole (Idescat, 2010). Puigcerdà Hospital is the most important employer in the region.

The French side, Upper Cerdanya, is part of the Pyrénées-Orientales department in the Languedoc-Roussillon region, with a population of 14 966 inhabitants within 540 km^2. Its most important municipalities are Font-Romeu-Odeillo-Via, Osséja (which has an important sanatorium), Bourg-Madame and Saillagose. Again, its main economic activity relies on the tourism sector, although the dairy industry is also important. Sanatoria, mostly built in the latter half of the nineteenth century and linked to the treatment of tuberculosis, have traditionally been another important source of income for the area. Over time many of these have been replaced by health spas as a result of the rise of so-called "health tourism", but the tradition of convalescence continues as modern-day recovery centres have a strong presence in the region.

Map 9.1. *Upper and Lower Cerdanya*



Source: Authors' elaboration based on figures extracted from Google Maps and i-Cerdanya.info.

GDP per capita on the French and Catalan sides of the border has evolved differently over the last two decades (Table 9.1). Interestingly, despite a lack of natural barriers, the historical artificial border between the two countries has separated the two communities for centuries, making them develop in different directions (Salvat et al., 1997). While these differences have remained during recent decades despite European integration, the fact that a significant proportion of the French population of Cerdanya speaks Catalan[1] has contributed to reinforcing political contacts among local stakeholders. These close ties have meant, for example, that some children from Puigcerdà go to school in neighbouring Bourg-Madame, citizens of Bourg-Madame visit Puigcerdà to participate in sports, and so on.

Table 9.1. *GDP per capita (euros), 1997–2008*

Area	1997	Index[a]	2008	Index
European Union	16 200	100	25 100	100
France	21 000	130	30 400	121
Pyrénées-Orientales	15 500	96	22 700	90
Catalonia	15 700	97	27 900	111
Girona[b]	16 100	99	27 200	108

Source: Eurostat data on GDP per inhabitant at current market prices by Nomenclature of Territorial Units for Statistics (NUTS) level 3 region.
Note: a Index European Union = 100, b Girona includes Catalan Cerdanya.

1 According to the Catalan government, 65% of the population of Upper Cerdanya understands Catalan, although this percentage decreases to around 50% among those aged 15 to 29. In contrast, Catalan is understood by 94.6% of the population across the border in Catalonia.

In 1991 the entire Cerdanya valley became part of the Pyrenees–Mediterranean Euroregion, which initially included Catalonia and the French regions of Languedoc-Roussillon and Midi-Pyrénées. In 2004 two more Spanish regions joined: Aragon and the Balearic Islands.

Health care system and patient flows

A duality affects the whole Cerdanya border region. As well as the hospital at Puigcerdà the next closest Catalan hospital is in Manresa, which is 100 km to the south and connected by well-maintained main roads. The French side, however, is relatively isolated. Prades, which has a small health centre, is 59 km away, while the hospital at Perpignan (capital of the Pyrénées-Orientales department) is 103 km away, but the road is sinuous and the heavy weather conditions in winter can result in a lengthy trip or even an impassable route. As a result the French population began to use services provided by Puigcerdà Hospital.

Three types of health care institution coexist across the region: French family doctors, French recovery centres and Puigcerdà Hospital. On the French side family doctors are independent professionals operating privately under market conditions. The 14 public and private health centres (see Annex 9.2) specialize in recovery care and continuous assistance; these are highly subsidized, following either the former concept of the "Participant au Service Public Hospitalier" model, for which they receive a fixed yearly amount, or the "Objectif Quantifié National" model, for which they receive funding depending on the number of patients treated. A seemingly high rate of underutilization characterizes these centres, which had over 800 beds among them in 2003.

On the Catalan side the main health care provider is Puigcerdà Hospital, operated by a private foundation that is part of the Xarxa Hospitalària d'Utilització Pública (the public hospital network), overseen by the Catalan Health Service. Unusually, the mayor of Puigcerdà is the president of the foundation and is involved in the management of the hospital. Puigcerdà Hospital Foundation provides three types of service: primary care (via the health centres of Puigcerdà and Bellver), hospital care (with 30 acute care beds, 19 outpatient beds, 2 operating rooms and 1 delivery room) and a skilled nursing home (with 130 beds for long- and medium-term stays). It is the most important organization in Cerdanya in economic terms.

It is important to note that while Catalan health policy relies on a model of local hospital networks, in France hospitals are more geographically concentrated with networks of thematic health clusters and with heavy reliance on patient transport. The practice of offering long recovery periods in specialized centres

is also more widespread in France (Harant, 2006; Bourret and Tort i Bardolet, 2003).

To give an idea of the magnitude of patient flows, between 2007 and 2011 Puigcerdà Hospital treated a total of 7401 French patients (Table 9.2). Of those, about 48% were outpatients, 40% emergency cases, 8% in receipt of other hospital services and 3% maternity patients. French payments represented roughly 5% of the Catalan hospital's total revenue in 2008 (last information available).

Table 9.2. *French patients admitted to Puigcerdà Hospital, 2007–2011*

Department	2007	2008	2009	2010	2011
Outpatients	696	586	777	814	676
Emergency	491	502	772	654	568
Other hospital services	114	104	116	161	132
Maternity	51	50	41	58	38

Source: data provided by Puigcerdà Hospital.

Evolution of the new hospital: a chronological perspective

Background: 1980s to 2002

The idea of building a new cross-border hospital dates back to the 1980s. It arose partly in response to the need of the population of Upper Cerdanya to have access to certain health services (including birth and emergency care) when, especially under adverse weather conditions, the time taken to reach the nearest French hospital in Perpignan could cause or exacerbate serious health problems. Although Puigcerdà Hospital was easily accessible, at the beginning of the 1990s visits from French patients were few, as it seems cultural barriers and distrust of the Catalan/Spanish health system meant that only the most severe cases sought assistance at the hospital.

Although according to several sources an initial draft of a cross-border hospital proposal developed by the Catalan administration existed, nobody took the project seriously until the mid-1990s. The relationship between the manager of Puigcerdà Hospital at that time and the mayor of Puigcerdà from 1995 to 2003, who was also a doctor at Puigcerdà Hospital (and who went on to become minister of governance and public administration of the Catalan government in 2003–2006), helped to resurrect the old idea. They observed an increase in the number of visits by French patients to the hospital, although without reimbursement from French insurance funds (Glinos and Baeten, 2006). Between 1997 and 2002 the number of French patients hospitalized

or admitted for emergency care at Puigcerdà almost tripled (from 68 to 190), while payment remained unsettled in 50% of cases (Tobar Pascual, 2003).

The stakeholders solved this problem by setting up an agreement in 2002 between Puigcerdà Hospital, Perpignan Hospital and Languedoc-Roussillon Regional Health Agency to organize reimbursement for the provision of emergency services to French patients retrospectively from 2001. A second agreement with the same actors followed in 2003, precisely regulating procedures for emergency and birth care at Puigcerdà Hospital. This evolved satisfactorily over time as French doctors and patients gained confidence in the Catalan health system. For instance, in obstetrics assistance evolved from visits covering the last weeks of pregnancy to broader monitoring of the patient (currently following up future mothers from the seventh month) (Interview 2).

According to one interviewee, these agreements were possible because of the existence of previous political, economic and personal links across the border, especially among the local mayors, which facilitated reconsideration of the old project (Interview 8). In fact, the hospital was not the first or only cross-border initiative undertaken in the area: in 1993 parties on both sides drew up an agreement to share a sewage treatment plant, which is still operational. A previous agreement managed by mayors from France and Spain regulating the international water channel of Cerdanya even dates back to 1866. According to the mayor of Bourg-Madame there have been talks about setting up a cross-border secondary school based in Bourg-Madame, and a project to create a cross-border slaughterhouse in Ur (on the French side) (Interview 9). A recent ambitious project aims to teach graduate odontology courses within Puigcerdà Hospital jointly with the Universities of Vic and Paul Sabatier of Toulouse, sharing students between Toulouse and Puigcerdà (Interview 7). The ultimate objective of these extended cross-border collaborations is to transform the area to avoid the region's constant loss of human capital and high dependence on the tourism sector.

First steps: 2002–2003

In 2002 the mayors of Puigcerdà and Bourg-Madame jointly initiated the first moves to gain the French government's support for the project to build a cross-border hospital. With the help of a local French member of parliament they went to Paris to contact a well-placed politician in the cabinet of the French Ministry of Solidarity and Social Cohesion, Ministry of Health and Ministry of Social Affairs – a native of the region and supporter of regional integration, as well as a key figure in the Languedoc-Roussillon Regional Health Agency. Together they agreed the idea of (partially) financing the future cross-border hospital with funding from the European Regional Development Fund (ERDF).

At the same time the presidents of the Catalan government and Languedoc-Roussillon signed a letter of intent to prepare a feasibility study for a new cross-border hospital in Cerdanya. The feasibility project was the result of an agreement between the government of Catalonia, the Languedoc-Roussillon Regional Health Agency, the Conseil Régional du Languedoc-Roussillon, the Conseil Général des Pyrénnées-Orientales and the Puigcerdà Hospital Foundation. The study drew four main conclusions (Rodríguez and Conill, 2003).

- The project would be viable if the administrative agencies in charge of planning and funding public health (the Languedoc-Roussillon Regional Health Agency and Catalan Health Service) co-owned the new cross-border hospital. A juridical formula should be found to enable this.
- The new hospital should replace the existing Puigcerdà Hospital and offer assistance to acute patients across the whole Cerdanya region.
- It should be located in Puigcerdà and integrate the current health networks of the two different public administrations.
- It should also respect the cultural and health particularities of both countries.[2]

Once the feasibility report confirmed the project's viability and gave general outlines, responsibility passed to the institutions in charge of developing it: the Catalan Health Service and Languedoc-Roussillon Regional Health Agency. According to the current operations director of the Pyrenees Health Region, the project was a courageous one and its initial success resulted from its relevance to larger political initiatives in France and Catalonia (Interview 4). On the Catalan side, for instance, the government's policy of creating networks of local hospitals (as with the health regions of the Alt Pirineu i Aran: Vall de Aran in 1985, Seu de Urgell in 1992 and Pallars in 1993) dates from the 1980s. In consequence, the idea of a new hospital financed by European funds to replace the one dating from the seventeenth century perfectly fits within this policy. On the French side, the project would offer a better health service to the isolated Upper Cerdanya, and the decision to fund a new hospital also occurred in the middle of an initiative to restructure the French health care sector.

Creating agreement: 2004–2010

From 2004 to 2007 the two administrations entered a period of negotiation. An unparalleled number of local, regional and national elections slowed the process as the individual actors involved in the discussions changed frequently, but in July 2007 the French and Catalan health ministries signed an agreement to fund Cerdanya Hospital. In March 2009 ERDF funding of €18.6 million

2 Data from the authors' conversations with X. Conill, co-author of the feasibility study (Interview 3).

was approved through the POCTEFA 2007–2013 programme, which finances economic and social integration of the cross-border regions of Spain, France and Andorra through ERDF funds amounting to €168 million (POCTEFA, 2008).

Once both parties agreed the general outline of the project and its funding, the process of negotiating the statutes of the new hospital lasted until the spring of 2010 (BOE, 2011; Box 9.1). Although negotiations took place mainly between the Catalan Health Service and the Languedoc-Roussillon Regional Health Agency, the central governments of Barcelona, Madrid and Paris had to make or ratify some of the decisions.

Box 9.1. *Setting up EGTC Cerdanya Hospital*

EGTC Cerdanya Hospital – the largest EGTC constituted to date – is the legal instrument adopted to manage the new cross-border hospital (BOE, 2011; European Commission, 2011). Created on 26 April 2010, it involves the Catalan government on the Spanish side and the Languedoc-Roussillon Regional Health Agency, national health insurance fund Caisse nationale de l'assurance maladie des travailleurs salariés (CNAMTS) and French Ministry of Health on the French side.

The EGTC replaced the Fundació Privada Hospital Transfronterer de la Cerdanya, which had been in charge of the construction of the hospital since 2006. The main reason for its adoption was the Treaty of Bayonne, by which the French and Spanish administrations are bound, which states that they cannot manage foreign funds and that only institutions at the same level can sign agreements.[3] The EGTC formula was the optimal juridical solution to overcome such limitations. In addition, the new instrument can receive and manage ERDF funds, govern the hospital and bring together foreign institutions at different levels.

From the beginning EGTC Cerdanya Hospital was set up to construct and manage the new hospital within the jurisdiction of European law, using Spanish law when the broader approach was not applicable. It is also responsible for purchasing health services from providers in both countries. EGTC Cerdanya Hospital is subject to the accounting rules and supervisory bodies of Spain, which will transfer the information to their equivalents in France. It has four governing bodies.

- The board of directors approves and supervises the management of EGTC Cerdanya Hospital, sets policy and appoints the executive commission. It comprises 14 members: eight from Catalonia, elected by the Catalan health minister, and six from France, elected by the Languedoc-Roussillon Regional Health Agency. Catalan members include the mayor of Puigcerdà and the president of the county council, a local administrative body grouping the county's mayors. French members include four representatives of the

3 Thus, for example, city councils can sign agreements with other city councils but not with regional bodies.

French government, the director of the Languedoc-Roussillon Regional Health Agency and a representative of CNAMTS. The director of Cerdanya Hospital is also a (non-voting) member of the board. Every two years the presidency and vice-presidency alternate between the two countries (Catalonia currently holds the presidency and France the vice-presidency). The board takes its decisions based on a simple majority of voting members.

- The executive commission is the purchasing body, which deals with day-to-day decision-making, advises the board of directors and decides the outline of EGTC Cerdanya Hospital management. It comprises five representatives: three from Catalonia and two from France.
- The consultative body or advisory council is composed of local mayors and relevant stakeholders. It scrutinizes the decisions taken by the board of directors and its role is to express its opinion, although without voting rights. It comprises 14 members: eight from the Catalan and six from the French side.
- The director of EGTC Cerdanya Hospital, appointed by the board of directors as advised by the executive commission, acts as CEO, applying the decisions of the board and executive commission.

Source: BOE, 2011.

Three main critical issues appeared during the negotiation phase (Interview 4).

- A new instrument, the European Grouping of Territorial Cooperation Hospital de la Cerdanya (EGTC Cerdanya Hospital), became the governing body of the new hospital. It represented both administrations but the French government did not agree to share responsibility with a regional government, wanting an agreement between Spain and France, not between Catalonia and France. Eventually the Spanish Ministry of Health became involved in the project, thus solving the problem.
- The next issue concerned responsibility for funding the day-to-day costs of Cerdanya Hospital. The negotiations ended in an agreement that the French side would finance 40% and the Catalan side 60% during the first five years (2012–2017), following which a new agreement should take into account the number and proportion of French patients served by the new hospital. The underlying purpose of this arrangement was to unify prices, under the principle that the same tariff should apply for every patient, whether paid by the Catalan Health Service or the Languedoc-Roussillon Regional Health Agency.
- Another initial proposal was that the governing body would include local mayors, an idea grounded in an established tradition in Catalonia that

favours close monitoring of the provision of certain public services by local politicians. The Catalan government was in favour of this move but the French government disagreed. The negotiations ended with the creation of a "consultative body", which included local politicians, within the EGTC.

In parallel, the French government had to overcome another important political issue. Upper Cerdanya contained a network of health centres focused mainly on the recovery of patients with respiratory illnesses. This network had become unsustainable over time, and in the 2000s the French government aimed to rationalize the sector, forcing the centres to collaborate and optimize resources. The government thus faced the difficulty of explaining to its constituents the decision to close local recovery centres while funding a new hospital in Catalan Cerdanya.

To help rationalize the region's resources a new cross-border care project emerged, initially put forward by the feasibility study. This entailed the creation of two new health facilities on the French side of the border – a "pôle gériatrique" (geriatric health centre) in Err and a "pôle pédiatrique" (paediatric health centre) in Bourg-Madame – as a way of rationalizing the surplus of French health care professionals by integrating some of the French recovery centres into the orbit of the services needed for Cerdanya Hospital.[4] The new health centres offer services not provided by the hospital: long-, medium- and short-term geriatric and paediatric care (Interviews 5 and 6). Table 9.3 summarizes the provisional investment funding sources for each facility.

Table 9.3. *Provisional investment plan*

Facility	Funding		Investment (€ million)	Proportion (%)	Total (€ million)
Cerdanya Hospital	France		4.7	16	30.7
	Catalonia		7.4	24	
	ERDF		18.6	60	
Geriatric health centre	EGTC Cerdanya Hospital	France	1.1	8	14.1
		Catalonia	0.5	4	
	Local recovery centres		9.5	67	
	ERDF		3.0	21	
Paediatric health centre	France		0.4	4	10
	Catalonia		0.19	2	
	Local recovery centres		8.2	82	
	ERDF		1.2	12	

Source: Boix, 2011 (figures for the health centres are forecasts).

4 These health centres will legally take the form of a "groupement de coopération sanitaire", a legal instrument facilitating cooperation between private and public health professionals and institutions.

The internal structure of the health centres is still under consideration, with the involvement of the Languedoc-Roussillon Regional Health Agency and Catalan Health Service. One of the first steps will be the creation of a mobile geriatric health care team to lend support to Cerdanya Hospital, composed of French and Catalan staff. The next stage will probably be to unify criteria, establishing a joint tariff and an information technology system that supports both the hospital and the health centres.

These broader ideas of care delivery show how both administrations have shifted their perspectives, and since 2007–2008 have started to talk of a wider territorial project instead of just the setting up of a new hospital. The success of the two health centres and of Cerdanya Hospital will depend on their managing to attract patients who currently seek health care outside the valley.

Current status of Cerdanya Hospital

Building work on the new hospital started in 2008 and was close to completion in 2012. The hospital expects to begin activity in 2013. It will have 64 beds, 11 day hospital places, 13 emergency beds, 13 dialysis stations, 4 operating rooms and an MRI scanner. Of the €31 million investment (see Table 9.3), the total cost of equipment is forecast to be €10 million, of which €3 million is earmarked for information technology (Actualitat la Cerdanya, 2012). The hospital plans to employ 201 professional staff members (Table 9.4). This is a rise of 46% on personnel numbers at Puigcerdà Hospital; in particular, the number of doctors will rise from 36 to 50 and the number of nurses and midwives from 43 to 58 (Fundació Privada Hospital de Puigcerdà, 2010; Boix, 2011).[5]

Table 9.4. *Staff numbers forecast at Cerdanya Hospital (initial stage)*

Role	Number
Doctor	50
Nurse/midwife	58
Technical personnel	42
Management – administration – patient care	30
Other staff	21
Total	**201**

Source: Boix, 2011.

5 The most recent information provided to the authors is that EGTC Cerdanya Hospital, the governing body of the new hospital, will purchase the necessary health services mainly from those institutions available within the region (Puigcerdà Hospital, Perpignan Hospital, and so on).

The annual budget of Cerdanya Hospital will amount to about €17.5 million (Table 9.5). This must provide the necessary financial means for the new hospital to start its cross-border care activities, which both administrations will examine after the first five years. In order to become viable, the new hospital needs to attract, during this initial period, about 5500 hospital admissions from Upper Cerdanya that currently visit other French health centres for treatment.

Table 9.5. *Estimated operating costs of Cerdanya Hospital*

Category	Cost (€ million)
Purchasing	3.845
Outsourcing services	1.350
Taxes	0.040
Human resources	10.130
Financial expenses	0.025
Exceptional expenses	0.025
Depreciation and amortization	2.000
Total	**17.415**

Source: Boix, 2011.

Needs and incentives

The necessity that sparked the creation of Cerdanya Hospital was local need: French patients needed faster access to hospital services, since under certain circumstances they were at considerable risk. Upper Cerdanya's low population density and lack of large villages meant that the region could not build a new local hospital under the French government's health policy, which promoted large geographically concentrated hospitals. On the Catalan side, even taking into account the important floating population associated with tourism in the area (some years reaching more than 100 000 people) and the Catalan policy of small networked hospitals, investment in a new health care facility was not a priority because a local hospital already existed. Nevertheless, the old Puigcerdà Hospital could not accommodate the expansion of services resulting from increased numbers of French patients, so the area needed a new hospital, ideally with updated and improved facilities to continue to attract more cross-border patients.

The institutions involved thus began to collaborate primarily because, even though both sides needed improved local hospital facilities, they could not undertake the cross-border health care project independently. As a result they established a win–win relationship. A project of this scale inevitably at some point develops its own momentum: this section analyses each institution's

internal incentives to collaborate, the obstacles that arose and the solutions developed to overcome them.

For Puigcerdà Hospital the collaboration offered opportunities to expand its activities and gain a new and modern hospital, to incorporate experienced French professionals into an already established team, and to rethink the services the hospital should provide (Interviews 1 and 2). For Puigcerdà City Council the new hospital was a chance to diversify the city's economic activity by expanding a sector with high added value. As a result the staff of both organizations were deeply involved in the project and prepared themselves over the seven years of its development to face the challenges that becoming part of the new cross-border hospital would entail, by learning French or dealing with the legal and administrative problems of the management of the cross-border collaboration. This may also explain why the mayors of Puigcerdà and Bourg-Madame did not accept the new de facto situation when they lost control of the project around 2004 (when the Catalan and French governments took over). The words of the current mayor of Puigcerdà – "We do not want the result of moving the hospital one kilometre away to be that the management is hundreds of kilometres away" (Interview 7) – reflect the desire to maintain control over an institution that had always been managed locally. Inclusion of local governments in the consultative body of EGTC Cerdanya Hospital was a way of calming the waters, for the moment.

Conversely, the 2002 agreement solved the French government's specific problems with the delivery of health services in Upper Cerdanya. Analysis of the information provided suggests that an additional incentive for the French side to participate in the cross-border hospital project was that it could contribute to solving the problem of their seemingly underused recovery centres. Transforming them into the two new geriatric and paediatric health centres would integrate them into a larger cross-border area of service provision. Although the 2003 feasibility study first considered this option, it did not take shape until 2008 and is still being refined.

The delay suffered by the new hospital seems to be a consequence of dealing with multiple stakeholders, as is the case in Upper Cerdanya where there are many little villages. The Joseph Sauvy Centre led the process of establishing the geriatric health centre on the French side, forming a partnership with the Centre des Escaldes and EGTC Cerdanya Hospital, mainly because it is part of a larger association with 26 health centres in the department. The two partner recovery centres see the project as a way to ensure their survival and remain in the region.

It is also noteworthy that, according to one interviewee, the ultimate objective of the extended regional collaboration is to transform the territory to avoid the loss of human capital and high dependence on the tourism sector (Interview 7).

Future outlook: problems and solutions

To understand how Cerdanya Hospital will evolve in the future it is necessary to consider the problems encountered during its inception as these have shaped its subsequent development. Fundamentally, the establishment of the cross-border hospital means that three key groups of actors who previously had very little interaction will suddenly need to start cooperating closely. The relationships within and between these groups will change as they have to adopt new roles (Figs. 9.1 and 9.2).

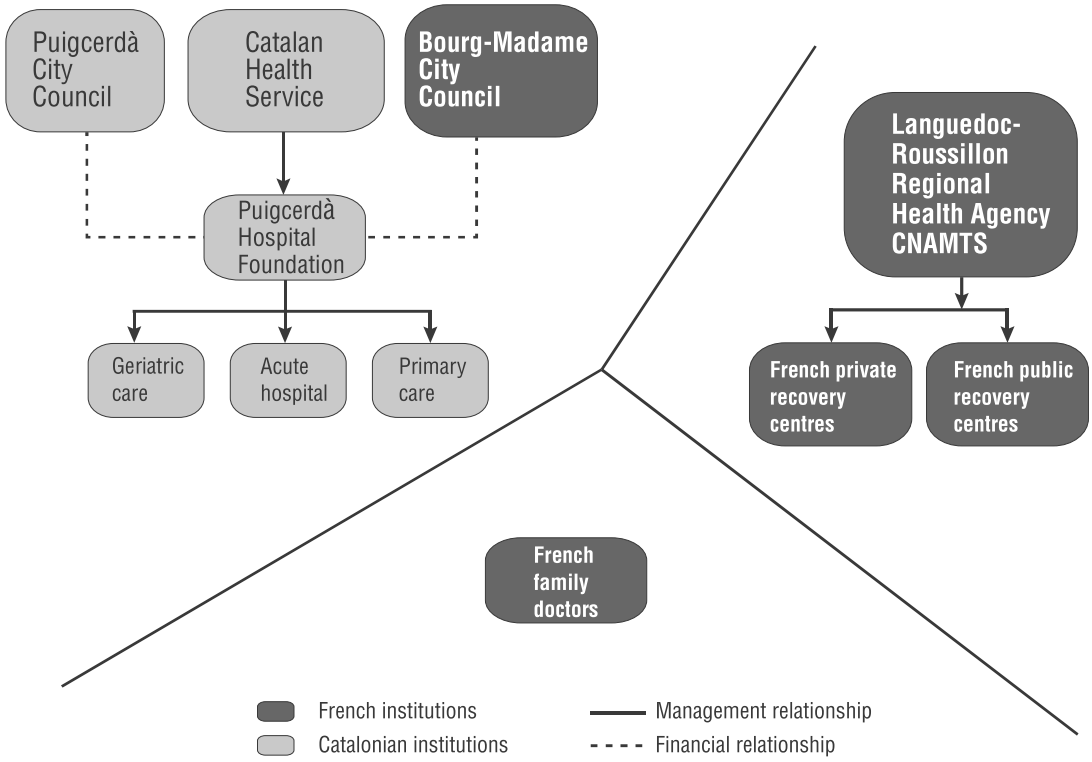
EGTC Cerdanya Hospital will become the main supplier of health services in the territory, financed by the French and Catalan governments (see Table 9.2). Puigcerdà Hospital Foundation will transform, shifting its activity to the new Cerdanya Hospital. Puigcerdà City Council, which had a high degree of control over the management of the old Puigcerdà Hospital, will lose part of this influence over the new hospital to the Catalan Health Service and Languedoc-Roussillon Regional Health Agency. Some of the French recovery centres in Upper Cerdanya will need to convert their activities to support the region's new geriatric and paediatric health centres. Finally, the French family doctors will have to deal with a new health system context that could reduce their workload.

All these different stakeholders will have to establish new formal and informal relationships as interaction becomes the norm. The following subsections analyse issues that have arisen and consider some of the strategies developed to overcome this potentially conflictive situation and create equilibrium between the various parties.

Patients and health professionals

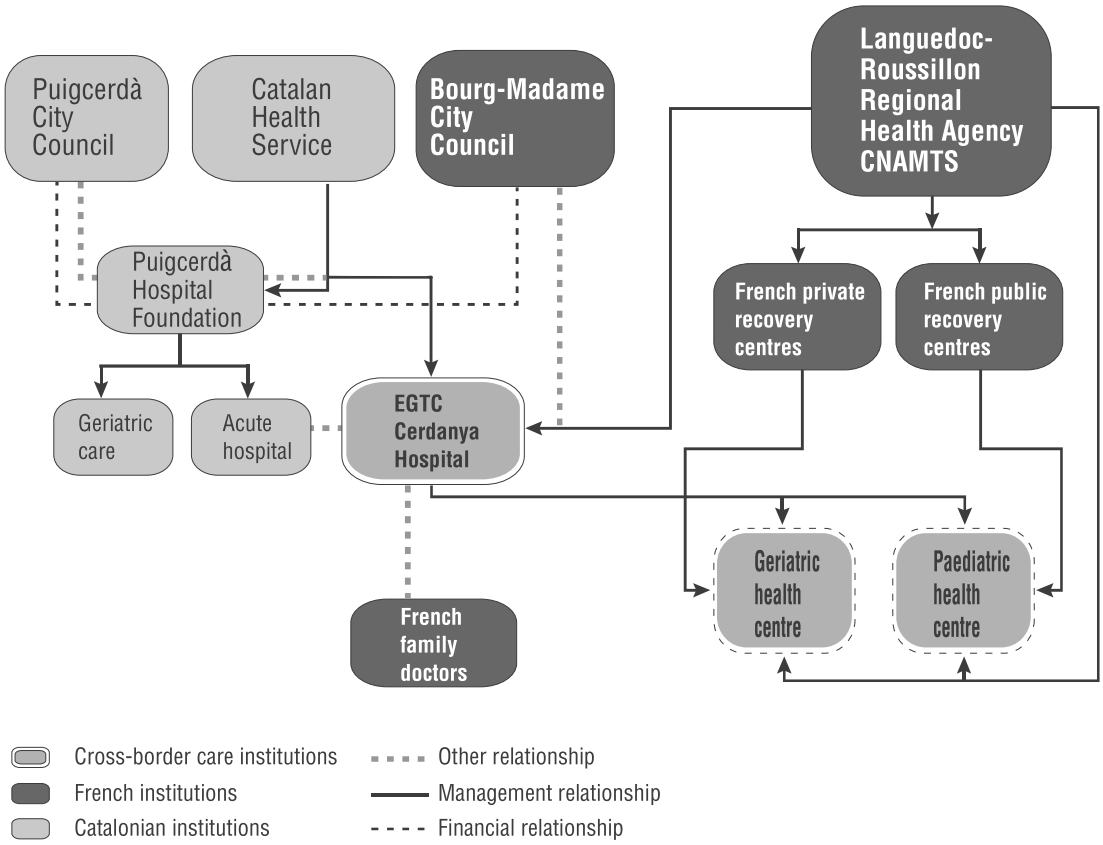
Patients are the cornerstone that will make the cross-border collaboration project viable. Catalan patients will see few differences at Cerdanya Hospital as the staff will initially consist mainly of local professionals. French patients, on the other hand, will face significant changes, including the need to opt out of their own health system (Interviews 5 and 6), which may well give rise to natural concerns. Doubts may also develop from the uncertainties associated with the cross-border hospital project; for example, will patients be able to choose which hospital they attend, and will they have the choice of going to Prades instead of Puigcerdà if they call an ambulance? French patients are used to having a great degree of freedom to choose their health care provider, so it is essential for the new hospital to "win them over". Some of the local population may remember that wealthy Catalan patients historically chose to visit French health centres rather than the local hospital when they encountered a medical problem;

Fig. 9.1. *Key stakeholders before establishment of Cerdanya Hospital*



Source: Authors' compilation based on stakeholder interviews.

Fig. 9.2. *Key stakeholders once Cerdanya Hospital is operational*



Source: Authors' compilation based on stakeholder interviews.

this may also exacerbate such concerns and make acceptance of the reverse situation where French patients have to seek health care in Catalonia difficult (Interviews 5 and 6).

The key to attracting French patients to Cerdanya Hospital is clear: the hospital's future success, in the opinion of both French and Catalan managers, depends on the recruitment of personnel from both countries. The underlying idea, therefore, is not to simply close Puigcerdà Hospital and open a new version of it, but to create a real cross-border health facility. To accomplish this objective, from the very beginning a significant proportion of the staff (not only doctors but all personnel) must come from the French side (Interviews 1, 2, 3, 5, 6 and 10). This policy serves a further purpose: Cerdanya Hospital will offer employment opportunities for French professionals who wish to work within the framework of the EGTC. The new hospital needs to attract a certain number of admissions from the territory in the first five years, as well as admissions from the non-resident floating population, to ensure viability.

This strategy relies on understanding the cultural differences between the French and Spanish health care systems (Interview 4). For instance, in France family doctors providing primary care closely assist patients (recommending, for instance, when they should go to hospital or which hospital they should attend), while in Spain general practitioners (GPs) do not follow up with the patient throughout the process. Patients in France also spend longer in hospital, while the Spanish health care system tends to favour shorter stays using home care services as an alternative. Other minor differences include the more formal or polite relationship French patients and doctors are used to, compared to a more direct form of contact in Spain. If the hospital applies Spanish standards rigidly the authors are inclined to believe that French patients could be somewhat disappointed with the service. In addition, Cerdanya Hospital will need to gain the confidence of French patients without interfering with the usual practice of the French doctors it needs to refer those patients to its services; this means that the hospital must provide the medical tests and services not available on the French side to avoid competition with French health professionals. Another potential problem not mentioned by the stakeholders could be dealing with differences in patients' rights, as Spanish law gives patients legal rights vis-à-vis their medical doctor whereas French patients have quasi-legal rights (Nys and Goffin, 2011).

The construction of Cerdanya Hospital and probable diminution or closure of facilities in French recovery centres could appear to be moving good jobs from France to Catalonia, which might endanger the likelihood of French health professionals collaborating in the project. Moreover, potential resistance by some French professionals "could emerge in case of working in Spain if they consider it might mean a loss of social rights" (Interview 10). Trade unions

are particularly concerned with how the new hospital would absorb French staff, especially when social security contributions by French workers are about double those of their Catalan counterparts. Similarly, wage differences are considerable, especially in the early stages for certain professions, favouring French workers. This could cause a problem for recruitment and retention and infringe EC regulations;[6] trade unions defend the position that health professionals should not accept a dual wage scale.

Medical protocols

Both sides recognized, perhaps surprisingly, that unification of medical protocols was the easiest issue to arrange. Stakeholders attended bilateral meetings to learn how the two systems worked and French and Catalan counterparts agreed on the medical equipment needed at Cerdanya Hospital. In general differences in protocols were rapidly resolved using scientific criteria, resulting in the following areas of agreement (Interview 2).

Pharmaceuticals

The French health system permits the use of drugs outside the international drug consensus, according to interviewees (Interviews 2 and 3). The solution is for the new hospital to use generic products under Spanish law.

Services and protocols

Several in-depth discussions took place on how to manage within Cerdanya Hospital certain treatments or services currently practised differently on each side of the border. Significant differences in treatment occur in the field of nephrology, for example, as French doctors use autodialysis with some patients while in Catalonia haemodialysis is more common (this solution is still under discussion). Actors agreed to use Catalan protocols for obstetrics as these tend to follow the patient more intensively, and decided to use French protocols for radiology services as these are more exigent than the Catalan equivalent. Where a medical service is only available on one side of the border, as in the case of orthopaedic surgery, the solution agreed is to follow the protocols of the country providing the service. The ultimate objective is that Cerdanya Hospital will offer a full array of health care services as provided by both the French and the Catalan health care systems.

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6 Regulation (EEC) No 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community. *Official Journal of the European Union*, L 257: 2–12 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=DD:I:1968_II:31968R1612:EN:PDF, accessed 9 July 2013).

Primary care

As noted earlier different systems exist in each country. The French health care system uses a model based on private family doctors who follow up with patients throughout their lives. In Catalonia family doctors working in primary health care centres and multidisciplinary teams tend to act as gatekeepers, referring patients to specialists. In this particular case, the aim is to achieve equilibrium on a win–win basis so that no parties feel they are losing "their" patients. The hope is that French doctors will refer patients to Cerdanya Hospital instead of Perpignan.

Clinical records

These are very similar in both countries and are unlikely to give rise to problems. In fact, the new hospital plans to connect the Catalan and the French system of clinical histories. The remaining outstanding question concerns how to protect the data.

Administration and management

The first and most important issue in this category relates to merging "two cultures, two administrations and two countries with different political agendas" (Interview 4). The obstacles represented by the continual political changes in both countries clearly reflect this difficulty. In the last two decades there have been more than 30 elections in the territory, leading to several changes in the personnel of the administrations involved in the collaboration. They have resulted, for example, in three different mayors in Puigcerdà, four different governments in Catalonia and three in France, quite apart from internal changes within the French health care administration leading to the transformation of the regional hospital agency into several regional health agencies. These frequent changes in political agenda are, in the opinion of most stakeholders, the reason the hospital has postponed its opening so often. Adoption of the EGTC legal formula has partly dissociated Cerdanya Hospital from this problem, as it has gained a certain amount of autonomy to work independently from the administrative and political changes in each country.

Another example relates to the issue of purchasing – of medical equipment, for example. In principle, since the hospital is located in Catalan territory, such acquisitions should take place within the framework of local public law and through the centralized department of the Catalan Health Ministry. Instead of following this procedure, however, out of respect for the French collaboration partners the hospital management decided to use a more complex legal option consisting of calling for open tenders, thereby allowing French companies to

bid for equipment supply contracts. Similarly, the design of new information technology for the hospital not only had to work with three languages but also needed to provide specific accounting information according to both Spanish and French laws. For this reason the hospital's investment in information systems represents a third of the total investment in equipment (Interview 4).

Other minor problems will also emerge as the stakeholders gain inaugural experience of the day-to-day operation of a cross-border care facility. These will be important and varied and may include issues such as the repatriation of deceased French patients' bodies and concerns surrounding people sent to the hospital under police arrest (since the French gendarmerie cannot carry weapons in Spanish territory). A Spanish or French doctor's decision to disqualify a patient on the grounds of mental health may not be recognized by their juridical counterpart, and even small details such as how to deal with ambulances that display different warning lights need to be addressed. Admittedly, none of these issues is entirely unforeseen, but different stakeholders perceived these specific problems as insurmountable obstacles during the course of the project and addressed them regularly in interviews.

Actors are, nevertheless, continually finding solutions to problems seen as insuperable even less than a year earlier. For instance, the issue of the nationality of French babies born at Cerdanya Hospital (in Catalonia) was partially solved by opening an office specifically to deal with the juridical process associated with neonates while a new law was approved (Renyé, 2011; Assemblée Nationale, 2011). (Deliveries by French women in Puigcerdà Hospital were not historically a problem because of the low numbers affected.)

One problem still under discussion is co-payments. While in France there is a broad system of co-payments, in Spain these are mainly restricted to certain prescribed medicines, so should Cerdanya Hospital apply them only to French patients and not Spanish ones? The floating population exacerbates this issue (BOE, 2011): if the hospital applies co-payments only to patients from France does this give rise to a discriminatory issue?

In summary, however, it is clear that stakeholders on both sides of the border have created initiatives to ensure the continuation of the project, overcoming the obstacles and solving the problems as they arise.

Conclusion

Two distinct periods are discernible in the development of the Cerdanya cross-border hospital. In the beginning local administrations took the joint initiative to build a new hospital as they could not meet their evolving health service requirements

independently. Patients in Upper Cerdanya needed faster access to hospital services because of the difficult journey to the nearest French hospital in some conditions. Catalan Cerdanya needed new health facilities but its administration did not deem the investment worthwhile because of the scarcity of population during much of the year. At the same time the Catalan administration was seeking an opportunity to expand activities with higher added value and better-quality jobs. The history of cooperation between the two sides of the Cerdanya region undoubtedly facilitated the idea of constructing a cross-border hospital.

The second phase of the project began after the feasibility study of 2003, once it received approval from national and regional institutions. Administrations on both sides of the border included the hospital in territorial plans that sought to consolidate deeper changes within the region. Other cross-border initiatives such as the paediatric and geriatric health centres, a cross-border slaughterhouse, a water purification plant, and initiatives on higher education reinforced these changes, although many of them remain at the planning stage.

After 2004 when the project began to take shape and national and regional institutions became involved, local organizations progressively lost control over it. A side-effect of this was that once the larger administrations took over the project slowed down as a result of continual changes associated with the electoral cycle. In this phase the project faced multiple obstacles associated with adapting the different medical protocols, administrative laws and managerial systems or regulations to which both administrations are subject. Surprisingly, the differences in medical protocols were, relatively, the easiest to solve. Above all, it became clear that patients were the crucial element of the project and that the hospital's sustainability would depend on its ability to attract French patients and to respect the internal equilibrium of the health systems on each side of the border. The new hospital will need the support of all relevant stakeholders.

Building the cross-border hospital means that key groups of actors with little previous interaction will suddenly have to start cooperating closely, developing new roles and relationships; these changes are not always easy to accept, not least in a context where the health care sector is an important employer on both sides of the border. In Catalonia, the existing Puigcerdà Hospital Foundation will shift its activity to the new EGTC Cerdanya Hospital and Puigcerdà City Council, which for years had an important role in co-managing the old hospital, will transfer significant powers to the Catalan Health Service and Languedoc-Roussillon Regional Health Agency. In the words of one interviewee, the new hospital may be local, but its management has moved hundreds of kilometres away. On the French side recovery centres, currently struggling with underutilization, will need to convert their activities to support the new geriatric and paediatric health centres that will serve the whole region. To

become truly cross-border the new hospital will have to appeal to local French patients, who are accustomed to choosing their health care providers freely. It thus plans to recruit both Catalan and French staff; this has the added benefit of absorbing personnel who may be made redundant by the rationalization of older recovery centres. French family doctors will also have to deal with a new context that could reduce their activity levels. Cerdanya Hospital has to gain their confidence and avoid any competition, not least because they will be instrumental in referring the French patients it needs to avoid making a financial loss. Creating a cross-border hospital is thus an ambitious, long-term project which extends far beyond the building of a new facility.

This study contributes to the existing literature on cross-border care experiences in Europe. The authors believe that one of the most important policy implications derived from the evidence is that the cross-border hospital has ushered in a new stage of political relationships based on mutual trust across the border, mainly between the regional administrations (see Figs. 9.1 and 9.2). The border is, nevertheless, a permanent fixture in the minds of many people in the region: even though the European process of political and economic integration has led to convergence between the two communities, they are still separate and distinct entities with their own rules, institutions and logic. Differences between the two health systems also reinforce the border.

The significant financial role played by the European Union (EU) was decisive for the project as without the ERDF funds it would not have got off the ground, but the EU had no involvement in either managing or helping to solve the political and legal problems that arose. European institutions could develop clearer leadership, providing legislative and political instruments in order to facilitate the implementation of cross-border care facilities. A roadmap and clear EU leadership could have avoided two major problems faced by the new hospital: the continual change of actors resulting from political elections and the lack of a clear vision of the final administrative, legal and managerial structure of the hospital.

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Annex 9.1 Interviews conducted

Number	Date	Interviewee	Institution
Interview 1	4 May 2011; 7 June 2011	Dr Jordi Boix, General Manager; member of the board of directors of EGTC Cerdanya Hospital	Puigcerdà Hospital
Interview 2	25 November 2011	Dr Franzina Riu, Medical Director and Dr Enric Subirats, Head of Internal Medicine	Puigcerdà Hospital
Interview 3	6 September 2011	Dr Xavier Conill, Co-author of the viability study	Calella Hospital
Interview 4	3 November 2011	Dr Felip Benavent, Operations Director of the Pyrenees Health Region; member of the board of directors of EGTC Cerdanya Hospital	Catalan Health Service
Interview 5	23 September 2011	Ms Rose de Montellà, President of Association Joseph Sauvy; member of the consultative body of EGTC Cerdanya Hospital	Joseph Sauvy Centre
Interview 6	23 September 2011	Mr Jacques Arevalo, Director of Association Joseph Sauvy	Joseph Sauvy Centre
Interview 7	30 September 2011	Mr Albert Piñeira, current Mayor of Puigcerdà; Secretary of the Puigcerdà Hospital Foundation; member of the consultative body of EGTC Cerdanya Hospital	Puigcerdà City Council
Interview 8	16 September 2011	Mr Joan Planella, former secretary of Puigcerdà Hospital; former Alderman and Mayor of Puigcerdà 2007–2011	Puigcerdà City Council
Interview 9	30 September 2011	Mr Jean-Jacques Fortuny, Mayor of Bourg-Madame 1995–2011; member of the consultative body of EGTC Cerdanya Hospital	Bourg-Madame City Council
Interview 10	14 June 2011	Mr Ricard Bellera, Responsible for the international policy of the Catalan section of CCOO Trade Union	CCOO – Catalan section

Annex 9.2 French recovery centres in Upper Cerdanya, 2003

Name	Age group treated	Private/ public	Type of recovery	Location	Beds
Clinique du Souffle la Solane	Adults	Private	Chronic respiratory illness	Osséja	68
Le Soleil Cerdan	Adults	Private	Pneumology and recovery	Osséja	80
Charles et Madona	Adults	Private	Psychiatric recovery	Osséja	60
Val Pyrène	Adults	Private	Alcohol and drug recovery	Odeillo	52
Centre des Escaldes	Adults	Public	Respiratory and polyvalent recovery	Les Escaldes	150
Via sol	Children	Private	MECSS	Font Romeu	40
Castel Roc	Children	Private	MECSS	Font Romeu	40
Les Ailes d'Éole	Children	Private	MECSS	Font Romeu	40
Les Petits Lutins	Children	Private	MECSS	Font Romeu	40
Le Nid Soleil	Children	Private	MECSS	Font Romeu	40
Le Mas Catalan	Children	Private	MECSS	Font Romeu	40
Les Touts Petits	Children	Private	MECSS	Bourg-Madame	40
La Perle Cerdane	Children	Public	MECSS	Bourg-Madame	115
Joseph Sauvy Centre	All ages	Private	Rural Clinic	Err	22
Total					**827**

Source: Rodríguez and Conill, 2003.
Note: MECSS stands for Maison d'Enfants à Caractère Sanitaire et Social.

The European Union (EU) Directive on the application of patients' rights in cross-border health care explicitly calls for Member States to cooperate in cross-border health care provision in border regions. Given that most cross-border collaboration in the health care field involves secondary care, the legal text places hospitals close to national frontiers at the centre of attention. But how do hospitals interact with each other and with other health care actors across borders? Why does cross-border collaboration take place? Who actually benefits from it? And when does it work? These are the questions at the heart of the present volume.

Seven case studies examine the circumstances under which cross-border collaboration is likely to work; the motivations and incentives of health care actors; and the role played by health systems, individuals and the EU in shaping cross-border collaboration. The study is original in that it produces qualitative and analytical scientific evidence on aspects of cross-border collaboration involving hospitals from a geographically diverse selection of cases covering 11 EU and non-EU countries (Austria, Belgium, Bulgaria, Denmark, Finland, France, Germany, the Netherlands, Norway, Romania, and Spain).

This book is of interest to decision-makers and field actors engaged in or considering cross-border collaboration. Questions on feasibility, desirability and implementation are at the core of the analysis. The book puts forward policy conclusions directly linked to the EU Directive on patients' rights and proposes a "toolbox" of prerequisites necessary to start or maintain cross-border collaboration in health care. In addition to its deliberate policy perspective, it is relevant to observers and students of the intersection between the EU and domestic health systems known as *cross-border health care*.

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The editors

Irene A. Glinos is Researcher at the European Observatory on Health Systems and Policies.

Matthias Wismar is Senior Health Policy Analyst at the European Observatory on Health Systems and Policies.

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