Borderwork and Cross-Border Health Policy in Europe

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Presented by Bruno Dupeyron, Ph.D. - bruno.dupeyron@uregina.ca
Assistant Professor, Johnson-Shoyama Graduate School of Public Policy, University of Regina Campus, Canada
Associate Researcher, Chaire de Recherche en Immigration, Ethnicité et Citoyenneté (CRIEC), Université du Québec à Montréal (UQAM), Canada
Member, Groupe de Sociologie Politique Européenne (GSPE), CNRS, UMR 7012, Université de Strasbourg, France

Introduction

The increasing cross-border patient flows in the European Union denote a need for clarifying and simplifying access and reimbursement for health care received in another EU member state (van Ginneken and Busse 2011). The process of health care policy coordination and supranational decision making has been tumultuous since the beginning of the 1970s: most of policy decisions have been held at the national level, with some notable exceptions, e.g., restricted set of Community norms, and decisions by the European Court of Justice (ECJ). Hence, health policy has shifted from decisions taken exclusively at the national level to decisions taken marginally at the Community (or "supranational") level (2001, 187-189).

In this European context of rising patient mobility (Glinos and Baeten 2006; Sevilla Perez 2009; Perez Jimenes and Ribeiro Nogueira 2009), border studies and health policy studies are two research fields that should gradually intersect. However, the growing literature on cross-border health care reveals a lack of dialogue among scholars in both research areas (Glinos and Baeten 2006; Perez Jimenez and Ribeiro Nogueira 2009; Legido-Quigley et al. 2011; Wismar et al. 2011).

First, the literature on cross-border health care includes too many practices and processes, e.g., from border workers who work in one country but reside in another one and use a geographically neighbouring health care system, to patients who go abroad for specialized care (Azzopardi Muscat 2010). In other words, "cross-border" is used here to describe all types of patient mobility within the EU, including cross-border mobility *stricto sensu* (mobility in a border region) and cross-national mobility (within the European territory). However, this dichotomy is too broad and superficial. More detailed and accurate typologies of European patients have been suggested (Hermesse, Lewalle and Palm 1997, 7-9; Glinos et al. 2010; EU directive 2011, in Legido-Quigley et al. 2011). Glinos and colleagues combine two dimensions in their typology of cross-border patient mobility, i.e., "types of patient motivations" and "types of funding"; the matrix they produce accounts for a variety of patient mobility, including the one in borderlands (2010). Besides, this corresponds to a categorization of European public action defined by the European Commission: for instance, in the most recent directive on this matter (Directive 2011/24/EU of March 9, 2011), cross-border healthcare is defined as "Healthcare provided or prescribed in a Member State other than the Member State of affiliation" (Officiel Journal of the EU, 4.4.2011, L 88/55). Health care scholars have thus accepted this category of public intervention without questioning the terms that are used, even if they conflict with identical terms used by the European Commission in the field of territorial cooperation, and

more specifically in the subfield of cross-border cooperation. In order to critically assess this categorization of public action (Dubois 2003), we would like to restrict in this paper the term "cross-border health care" to health care in a cross-border region, i.e., a region that "encompasses areas immediately beside a state's external border, or straddling it, and also administrative regions abutting a border whose centres are physically and socially distant from that border" (Anderson and O'Dowd 1999, 595).

Second, border scholars seem unable to convey to health care students recent approaches on borders: borders cannot be seen anymore as hard or soft lines that structure social interactions (Minghi 1991), but should rather be analysed as (re)bordering processes and social constructs (Paasi 1998; Newman 2006). Conversely, the legal and technical complexity of cross-border health care is not appealing to border scholars who seem reluctant to focus on this specific research topic, which is perceptible in selected works that cover briefly this issue (Diez Verdejo and Pinazo Hernandis 2005; Harguindeguy and Bray 2009) or in the latest border studies conferences, e.g., Association for Borderlands Studies or BRIT network, where cross-border health policy is generally absent. In sum, health care academics largely produce the literature on cross-border health care, while border researchers tend to overlook this topic.

Third, cross-border health care policy cannot be seen only as a top-down process initiated by EU member states, the European Commission or the ECJ: other players should be included, for instance health care practitioners, patients or sub-national governments, who play an increasing role in challenging current health care in Europe. One of the best viewpoints can be found in cross-border regions, where a re-articulation of existing norms and processes is claimed by cross-border patients, e.g., in the French-German-Swiss Rhineland borderland, several social movements have raised health care problems[1].

In this paper rooted in border research (Balibar 1998, 2004; Scott 1999; Beltran Garcia 2007; Blatter 2004; Newman 2006; Perkmann 2003, 2007; Harguindeguy and Bray 2009; Blatter et al. 2010; Hamman 2011), I suggest that the approach in terms of 'borderwork' is relevant to analyse European cross-border health policy. Chris Rumford considers "the role of citizens (and indeed non-citizens) in envisioning, constructing, maintaining and erasing borders. Such activities I here term 'borderwork'" (Rumford 2008). Indirectly, this perspective may be useful to foster interactions between border and health care scholars. To do so, I focus on a case study located on the French-Spanish border, namely the Cerdanya Joint Cross-Border Hospital (CJCBH). The creation of this hospital has been a bottom-up process that has started in 2003 (the hopital is still in construction[2]), and involved several levels of governance. This case study also echoes what Rumford describes as the "cosmopolitanization of border": first, borders are used as instruments of connectivity; second, the work of bordering is not entirely in the hands of the state; finally, borders offer opportunities for claims-making (Johnson et al. 2011).

From a methodological perspective, I use primary and secondary sources. Several scholars stress that problems are numerous in collecting and merging data related to European cross-border health care, e.g., existence of different national standards, byzantine typologies, and probable underestimation of patient flows (van Ginneken and Busse 2011). In order to minimize

[1] Association de citoyennes et citoyens en région frontaliere. 2011. *Santé - Quelques exemples de situations problématiques.* http://www.frontaliers.net/sante_sit_probl.htm (accessed May 2, 2011).

[2] Generalitat de Catalunya. 2011. *Comunicat referent a les obres de l'Hospital de la Cerdanya.* http://www.gencat.cat/salut/depsalut/html/ca/premsa/doc35020.html (accessed May 2, 2011).

possible ethnocentric biases and diversify perspectives, secondary sources are selected in several languages, e.g. Catalan, English, French, and Spanish. To complement this initial research, semi-structured interviews with a range of key informants will be conducted by phone over the summer 2011 (Appendix 1). Those interviews will supplement a few ones that had been done previously in the Eastern French-Spanish border area, i.e., the 'Euroregion Pyrenees-Mediterranean' (Herranz Loncan 2002; Diez Verdejo and Pinazo Hernandis 2005; Dupeyron 2008).

Two sections will articulate this paper: the first one will show how conflicting categories of public action in France, Spain and at the Community level explain enduring cross-border health care problems in Cerdanya. The second section will show how health borderwork is painfully done, due to several factors that still persist.

1. The clash of French and Spanish health care systems: conflicting categories of public action

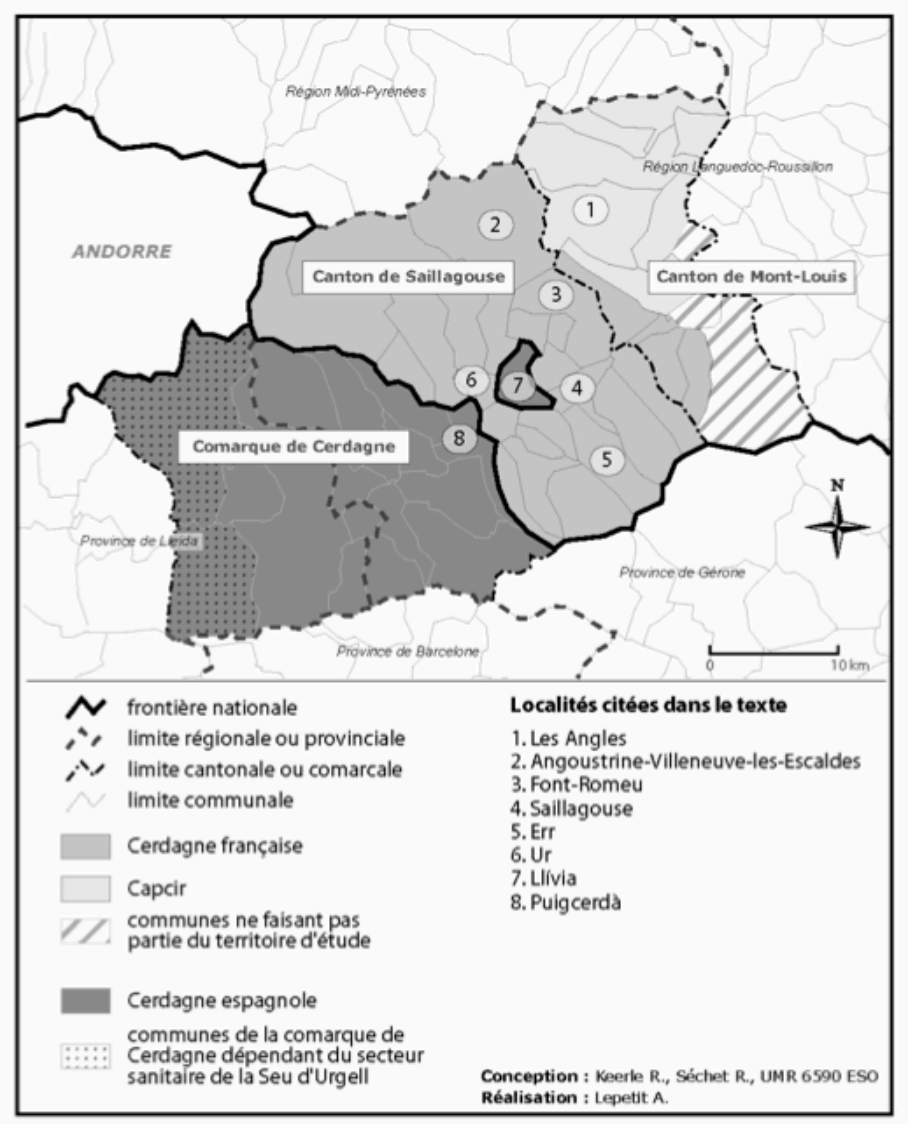
We have emphasized in the introduction that the European Commission had been able to impose a specific category of public action ("cross-border health care"). Now, it is useful to understand how specific categories of public health care intervention are accepted in Spain and France, how they are redefined and eventually are conflicting in Cerdanya.

Cerdanya is a geographically delimited plateau in the Pyrenees, on the Eastern side of Andorra, whose isolation has been reduced by the creation, in 1987, of road infrastructures that improve mobility to Barcelona (2 hours). In 1659, the Treaty of Pyrenees divided Cerdanya into two areas, the Spanish Lower Cerdanya and the French Upper Cerdanya. Several administrative reforms further separated this region on both sides, e.g., *cantons* in France, *comarcas* in Spain. Demographically, the population grew from 25,000 in 1990 to 32,000 in 2006. This touristic area now attracts up to 150,000 people in the winter and summer. Due to simpler access (infrastructures and European freedom of movement), this border region is also visited over the weekends by people who may own a second residency. This flow of population is also visible in the annual variation of emergencies at the Puigcerda hospital, with peaks in August and between December and March (Sechet and Kerle 2010).

The Puigcerda hospital, on the Spanish side, is the only one that performs surgery and has an obstetrics branch. Nevertheless, this facility is not accessible to Upper Cerdanya inhabitants, due to differences in health care systems. In Spain, provinces are responsible for public health (Spanish Constitution 1978); in Catalunya, the social protection model is a Beveridge one (funded by taxes and provided by the governement). However, in France, the system follows the Bismarck model, supported by employees and employers payment deductions.

On the Catalan side, at the beginning of 2000, Catsalut, the organization that plans, funds and assesses the public sector, can also make contracts with the private sector, often non-profit organizations. This is actually the case with regards to the Puigcerda hospital, managed by a foundation. Care is provided on the basis of a principle of geographic proximity, implemented by 470 (2006) *Centres d'atencio primaria* (CAP); two additional levels of administration allow the coordination of those CAPs, health sectors that are merged into seven health regions. Lower Cerdanya belongs to the Alt Pireneu i Aran health region, and to two of its subdivisions, the sector areas of Cerdanya and Alt Urgell.

Figure 1 Territory of the Puigcerda hospital



Source: Sechet and Keerle 2010, 539.

On the French side, several legislative and administrative reforms in the 1990s have considerably altered the health care regional background. For instance, the regional level has become a powerful player in hospital care, with the creation, in 1996, of *Agences regionales de l'hospitalisation* (ARH). ARHs prepare and implement *schemas regionaux d'organisation sanitaire* (SROS). One of the most important aspects of those reforms is related to necessity of welcoming regional patients, which excludes non-regional patients; now, this is a problem in Cerdanya, as four out of five patients in Cerdanya come from the Languedoc-Roussillon region, e.g. sanatoriums. In Languedoc-Roussillon, SROS adjustments have been made to balance the supply and demand of health care goods and services, which has led to the closure or drastic transformation of sanatoriums and similar socio-health care centers, and to the concentration of services in urban areas (Perpignan), far from the Cerdanya plateau.

2. Borderwork: the construction of cross-border health care problems in Cerdanya

Borderwork can take various forms: it can be an act of support for a particular public policy, e.g., public support for a securitization of borders and criminalization of illegal immigrants (Vaughan-Williams 2008), but it can also be an act of resistance to a national or European public policy (Hamman 2010b). In the case of the CJCBH, borderwork rather represents a mixed work of support, resistance and innovation against existing health care problems in Cerdanya.

In 1986, Spain joined the European Communities. In spite of the improvement of the French-Spanish bilateral relations, and despite the implementation of EC norms, health care remained a problem in Cerdanya. In other words, the existing normative opportunities for European member states[3] have not solved present problems in Cerdanya, due to several obstacles: French patients who used the Spanish hospital of Puigcerda were not reimbursed (an authorization is required in order to get an E111 or E112 form; in 2002, the European Health Insurance Card replaces both forms and other EXXX- forms, but it is not automatic and does not cover all types of treatments); the Puigcerda hospital could not recover the funds used to provide care to French patients. However, the number of patients was then fairly limited. At the end of the 1990s, the closure of a maternity centre in Prades forced pregnant women residing in Cerdanya to go to Perpignan, which may take 90 minutes instead of 40 (without mentioning difficult weather conditions).

This problem led to a 2001 agreement, signed by the ARH, the Perpignan hospital and the Puigcerda hospital, in order to allow French Cerdanya patients to acces the Puigcerda hospital for emergency and obstetric care. A second agreement, signed in 2003, allowed French patients to be reimbursed for care obtained at the Puigcerda hospital. Following the implementation of those agreements, in the middle of 2000s, one third of the 300 annual births at the Puigcerda hospital are for French women; emergencies for French patients reach 10%. This new cross-border health care landscape, where a strong minority of the population is concretely crossing the border to have access to hospital care, will justify the creation of a cross-border hospital. Another argument that should be mentioned briefly and explains the joint view with regards to the need of a joint hospital is the sociological and cultural proximity of the population in this cross-border area (Sabate i Guasch 2009); conversely, the relative distance of the political centers, i.e., Paris/Montpellier and Madrid/Barcelona, may explain the borderwork instigated in this area.

In 2003, the *Conseil regional de Languedoc-Roussillon* and the *Generalitat de Catalunya* sign a memorandum of understanding that sets the foundations for a feasibility study concerning the creation of joint hospital, in Cerdanya. The institutional framework used to shape this MOU is the Euroregion Pyrenees-Mediterranean, supported by INTERREG funds, in collaboration with the ARH, Catsalut, and the Puigcerda hospital. On the Catalan side, this operation reveals a regional preference for the Puigcerda hospital, instead of its main competitor, the Seu d'Urgell hospital. This initiative is supported by local elites that instrumentalize the cross-border agenda to reinforce their position. On the French side, a new SROS recommends that the supply of health care in border regions should also be taken into account, which leads to the study of the Cerdanya plateau, surprisingly not in terms of hospital care, but more broadly, in terms of cross-border health care network. In fact, the ARS considers that its study will complement the cross-border one on the joint hospital.

[note to self: the key players and their network on the Catalan side are not clearly identified – as opposed to the French ones who have obvious allies in the central government (ministers and

[3] e.g. *Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community.*

senior civil servants), which allows sometimes to avoid complete freeze of the project and save face]

Some aspects of the CJCBH project are easier to achieve than others. The medical aspect of the project is constructed by a network of local health care paractitioners in both countries: the hospital should have a dual purpose, on the one hand, serving permanent residents of the plateau, and on the other, serving tourists' populations. However, other facets of the project are more difficult to address, more exactly regulatory and administrative issues, as well as funding mechanisms. The factors that explain this complexity can be found in the systemic differences between France and Spain, but also in the management of the operation on both sides. For instance, between 2004 and 2005, after examining administrative and funding obstacles, a joint technical committee suggests using the 1995 French-Spanish Treaty of Bayonne - a proposal that is supported by a joint French-Spanish declaration, in 2005. However, six months later, in 2006, French authorities declare that this bilateral agreement cannot be used in this health matter. A few months later, a solution is found: in July 2006, the Catalan and French ministers of health sign a convention (Sabate i Guasch 2009) that outlines the construction of the Puigcerda hospital within a new legal framework, the European Cross-Border Cooperation Grouping (ECCG) that enjoys legal capacity (Regulation (EC) No 1082/2006). Another problem is the number of players involved (Table 1), which is not unusual in an INTERREG operation (Dupeyron 2009), without mentioning the complex regulations of the project stated by the European Commission.

Table 1 Organizations involved in the CJCBH

French entities	**Spanish entities**	**Joint French-Spanish entities**
Agence Régionale de l'Hospitalisation Languedoc Roussillon (ARH)	Ayuntamiento de Puigcerda	Fundación Privada Hospital Transfronterizo de la Cerdaña (Spanish Law)
Ministère de la Santé et de Solidarité	Consejo Comarcal de la Cerdaña	European Cross-Border Cooperation Grouping (French Law)
	Departamento de Salud de la Generalidad de Cataluña	
	Servicio Catalán de la Salud	
	Ministerio de Sanidad y Polí-tica Social de España	

Scholars note that tiny but persistent problems subsist for patients and health care practitioners who ignore in majority how to swim in troubled waters (Groene et al. 2009), for instance regarding the non-automatic applicability of the new European Health Insurance Card, the slow reimbursement of health claims, and the determination of the newborns' nationality. Moreover, future issues might be related to professional skills needed by healthcare practitioners in order to provide care to European patients (professional and linguistic skills), as well as the law governing possible labour and liability problems (Harant 2006). Finally, French and Spanish legislations and regulations do not necessarily match, e.g., ambulance, mortuary, and judicial assistance (Sabate i Guasch 2009), and will have to be harmonized in the future, either at the bilateral or Community level.

Concluding comments

The new directive 2011/24/EU, published in April 2011, may contribute to the construction of a European health care system (Greer 2008; Hermesse, Lewalle and Palm 1997, 4-6; Sevilla Perez 2009), although it only synthesizes existing Community norms and ECJ decisions. Within this new legal framework, it is not clear if and how EU member states will transpose this text by October 25, 2013 (art. 21, paragr. 1), and therefore be applicable, including exceptions recognized by the ECJ (ECJ December 4, 1974 Van Duyn). [note to self: read legal doctrine that will be published soon about this directive].

It is clear, though, after a brief analysis of the creation of the Puigcerda hospital, that EU member states face more challenges that those enumerated in the directive. However, the Puigcerda hospital borderwork may have contributed, as well as other border regions initiatives (Glinos and Baeten 2006, 24-58), to the labour of health care harmonization, in a public policy field that remains strongly in the hands of EU member states.

Appendix 1 Framework used for future semi-structured interviews (summer 2011)

	Supra-National Level		National Level	Cross-Border Level	Regional Level	Local Level	Patients and Healthcare Providers
	DG for Health and Consumer Policy (SANCO)	DG for Employment, Social Affairs and Equal Opportunities (EMPL)					
France							
Spain							
EU							
Other							
Total							

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