CAPÍTULO C 7: SANIDAD Y SERVICIOS SOCIALES

LÍNEAS GENERALES: se presentan las posibilidades de CTF en materia de sanidad y servicios sociales, incluyendo diversos tipos de actividades y ejemplos. Dichos ejemplos tratan una gran variedad de aspectos como el intercambio de información, creación de redes, formación, investigación y desarrollo, y la utilización y el aprovechamiento de recursos conjuntos.

PUNTOS CLAVE:

- Las regiones fronterizas, con frecuencia escasamente pobladas y con unos recursos sanitarios y servicios sociales comparativamente menos desarrollados, suelen tener dificultades para proporcionar una atención sanitaria y unos servicios sociales básicos a sus habitantes.
- La capacidad de una región fronteriza para proporcionar unos servicios de mayor calidad y más diversificados y rentables puede reforzarse en gran medida a través de la cooperación, concretamente mediante la utilización de recursos conjuntos (hospitales, unidades específicas, residencias de ancianos, ambulancias y servicios de emergencia).
- Los problemas de cooperación en la práctica suelen tener que ver con obstáculos legales y administrativos derivados de leyes, normativas y programas de ámbito nacional (p.e.: programas de planificación y seguridad social que sólo contemplan la cobertura de contribuyentes y ciudadanos nacionales, o diferencias de competencias).
- La elaboración de un inventario transfronterizo de servicios e instalaciones existentes en la región fronteriza, junto con la divulgación de información sobre estructuras, competencias y procedimientos administrativos y financieros constituye un primer paso muy importante para iniciar un diálogo sobre futuras medidas y proyectos de cooperación.

EJEMPLOS:

1. Investigación, estudios y estrategias de desarrollo

- Prevención de Accidentes en la Infancia (IE/UK)
- Atención primaria entre comunidades y fronteras (IE/UK)
- Investigación sobre la complementariedad de los sistemas de atención sanitaria (FR/BE)
- Estudio Comparativo sobre accesibilidad a servicios sociales y sanitarios (ES/PT)

2. Cooperación entre servicios de emergencia

- Programa de Formación Conjunta – Servicio de Ambulancias (IE/UK)
- Rescate de Montaña (FR/IT)

3. Cooperación entre otros servicios (p.e.: hospitales)

- Higiene y tratamiento dental en Grecia y Albania (GR/AL)
- Plan de Trabajo Flexible Transfronterizo (IE/UK)
- Radio-asistencia domiciliaria (ES/PT)
- Cooperación entre los hospitales de Selestat y Offenburg (DE/FR)

4. Desarrollo y CTF de instalaciones y servicios

- Institutos de Investigación TF sobre nuevas técnicas de rehabilitación (DE/NL)
- Centro para la determinación de características superficiales y celulares mediante análisis microscópicos y espectroscópicos (DE/NL)
- Creación de Centros Sanitarios Transfronterizos (GR/FYROM)
- Intercambio mutuo entre Servicios Sanitarios Públicos (SE/NO)
- Creación de un Centro Médico Transfronterizo (DE/CZ)
- CAWDT (Cooperation and Working Together) (IE-UK)
- Refbio - Red Biomédica de los Pirineos (ES/FR)
- Hospital Transfronterizo de la Cerdanya (ES/FR)

5. Redes

- *EurSafety HealthNet* (DE/NL)

6. E-Health

- Telemedicina en la Eurorregión Pomerania (DE-PL): la Red Pomerania

7. Medio ambiente y salud; 8. Otros proyectos de carácter social

9. Proyectos no europeos

- *Comitê binacional de Integraçao em Saúde Santana do Livramento-Rivera* (BR-UY)
- Hospital Transfronterizo entre Burkina Faso y Malí

1. GENERALIDADES

La cooperación transfronteriza (CTF) debería abarcar todos los aspectos de la vida de una persona: vivienda, empleo, ocio, comunicaciones, medio ambiente, etc. Además, es preciso conceder la misma importancia a la CTF social y cultural que a la cooperación en el ámbito de la economía o en el de las infraestructuras. Se da frecuentemente el caso de que la CTF en el terreno social y cultural crea las condiciones idóneas para que tengan éxito las actividades del sector económico.

La calidad de la asistencia sanitaria y de la prestación de servicios sociales constituye un atributo fundamental de las políticas de sanidad y bienestar social. Sin embargo, la sanidad y los servicios sociales dependen de las autoridades estatales y de normativas nacionales en mayor medida que otros sectores, aunque cada vez hay más casos de competencias descentralizadas (subsidiariedad).

Las fronteras entre estados han dado lugar a leyes y normativas diferentes en relación con los servicios sociales, impuestos, sistemas de aseguración sanitaria, etc. Muchas regiones fronterizas siguen afrontando dificultades de desarrollo y se encuentran en zonas periféricas y alejadas respecto del resto de la nación, caracterizándose a menudo por su escasa población, por una alta emigración entre la juventud y una mayor población dependiente (niños y ancianos). Las áreas rurales y las zonas que experimentan un declive demográ-fico suelen tener un sector de servicios sociales precario en el que la insuficiente demanda limita algunos de los servicios.

Debido a estas circunstancias, algunas regiones fronterizas pueden tener dificultades para garantizar unos servicios sociales y unas instalaciones de atención sanitaria adecuadas. La apertura de las fronteras internas abrió nuevas oportunidades para la cooperación en asuntos sociales y el sector de servicios vinculados. Con el fin de mantener el nivel y la calidad de los servicios sanitarios y sociales en las regiones periféricas, es preciso adoptar soluciones creativas y adecuadas en las regiones fronterizas.

2. PROBLEMAS

Las leyes y normativas nacionales que regulan la sanidad y los servicios sociales y su tradición histórica impiden en gran medida encontrar soluciones generales válidas para todas las regiones fronterizas, especialmente en países con numerosos vecinos que, a su vez, tienen sistemas muy distintos. Los obstáculos legales ocasionan problemas de orden práctico para la CTF en materia sanitaria y de servicios sociales, como por ejemplo:

- La ***distinta atribución de responsabilidades*** (servicios de emergencia y ambulancias, policía, etc.).
- El hecho de que las ***áreas de planificación e influencia de los servicios e instalaciones sociales*** y sanitarias (áreas de salud) se detengan en las fronteras.
- Las ***aportaciones financieras nacionales*** para los sistemas de seguridad sanitaria y social, al tratarse de contribuciones nacionales, sólo pueden ser empleadas en dicho ámbito.

A modo de ejemplo, el número de camas en los hospitales de las regiones fronterizas se planifica únicamente para las necesidades nacionales. Es decir, estas camas están únicamente disponibles para el contribuyente nacional. Aunque exista una normativa europea para viajeros que puedan necesitar servicios médicos y hospitales en el extranjero en caso de enfermedad y accidente, los sistemas de aseguramiento sanitario suelen tener una actitud muy restrictiva sobre estos temas en las regiones fronterizas. La utilización de servicios médicos, hospitales, etc., en las áreas fronterizas por parte de residentes fronterizos está sujeta a controles muy estrictos y las dificultades suelen surgir a la hora de abonar los gastos: ciertos costes por el período de estancia hospitalaria y por los servicios prestados son puestos en cuestión o reembolsados sólo en parte.

Por todo ello, en muchas regiones fronterizas se realizan acuerdos privados entre hospitales de manera que las plazas hospitalarias puedan utilizarse en casos especiales. Esto suele ser así en los casos de utilización de unidades de cuidados intensivos para pacientes cuyas vidas estén en peligro o requieran una atención especializada urgente. Si la capacidad de las camas hospitalarias es ocupada con excesiva frecuencia por pacientes de un país vecino y no quedan camas disponibles para la población nacional, surgen a su vez problemas de provisión a los pacientes nacionales y reclamaciones.

Los obstáculos para el uso de instalaciones sanitarias al otro lado de la frontera se basan principalmente en los cálculos de costes, ya que difieren marcadamente entre países, y al hecho de que las aseguradoras no puedan estimar qué gastos y en qué proporción se generarían si se diera una utilización generalizada de servicios al otro lado de la frontera. Por ello, existe un rechazo hacia las normativas de carácter general y ***las aseguradoras sólo están preparadas para tratar casos individuales de forma pragmática***. De hecho, se intentó que las cuestiones relacionadas con los pacientes transfronterizos fueran incluidas en la Directiva de la UE sobre *Servicios de Carácter General*, lo cual generó el rechazo de distintos sectores. Al final, hubo que elaborar una directiva específica, durante cuyo debate y trámite se pusieron en evidencia la multitud de condicionantes y obstáculos fruto de unas políticas genuinamente "nacionales". A pesar de su publicación en 2011, la ***Directiva 2011/24/EU de 9 de marzo de 2011 del Parlamento Europeo y del Consejo sobre la aplicación de los derechos de los pacientes en la atención sanitaria transfronteriza***, está lejos de haber cumplido sus objetivos, siendo muchos sus elementos que aún no han podido ser desarrollados apropiadamente.

Por otra parte, ***las instalaciones y servicios sociales se rigen por distintos fundamentos sujetos a condiciones que difieren profundamente de un país a otro***. Hay ejemplos de hospitales en los que las subvenciones públicas no se incluyen en el cálculo de costes de la administración del hospital. En el otro lado de la frontera ocurre precisamente lo contrario: las subvenciones y fondos públicos deben ser tenidos en cuenta por los hospitales al calcular las tarifas diarias. Esto lleva a unas ***proporciones de gasto muy distintas y variadas*** que, por razones obvias, no pueden ser financiadas por las compañías aseguradoras.

También surgen dificultades en relación con la respuesta a emergencias transfronterizas por parte de los servicios de ambulancia y bomberos. Por ejemplo, la proporción de personal y vehículos de emergencia se calcula generalmente para las exigencias nacionales y la utilización de personal y equipos para la dotación de servicios de emergencia al otro lado de la frontera provoca nuevamente brechas en el abastecimiento nacional que han de ser consiguientemente subsanadas. Afortunadamente, muchas regiones transfronterizas disponen desde hace tiempo de protocolos TF de emergencia y reacción a catástrofes, que se encuentran, en muchos casos, en el propio origen de la CTF en esas regiones.

El uso transfronterizo de residencias de ancianos, clínicas de rehabilitación, colegios, clínicas, etc., provoca dificultades similares. También en este caso se calcula la capacidad sólo para las necesidades nacionales en primera instancia y la financiación de las instalaciones es nacional.

En las ***áreas rurales fronterizas periféricas*** surgen otros problemas concretos en cuanto al mantenimiento de una población que haga viable la dotación de servicios tales como hospitales, residencias de ancianos, colegios, servicios sociales y especializados (como algunos sistemas de ambulancias más sofisticados). Un problema típico de estas zonas periféricas es la posibilidad de acceder a las mismas mediante transporte público local, problema que podría solventarse mediante la utilización transfronteriza de un helicóptero y de otros servicios de emergencia.

Otro factor que no debe descuidarse es la ***falta de información***, a ambos lados de la frontera, acerca de los servicios, sistemas o estructuras administrativas existentes en materia de atención sanitaria, servicios sociales, policía, servicios de emergencia, etc.

3. SOLUCIONES

Como suele ser habitual en la CTF, es preciso ***dejar de pensar en términos de fronteras nacionales para crear nuevas áreas de influencia*** que sean adecuadas, basar la viabilidad de las instalaciones y servicios sociales en un nuevo concepto transfronterizo, y evitar que las áreas rurales, especialmente aquellas en una situación fronteriza periférica, se "desvitalicen". Deben aplicarse ***soluciones bilaterales y trilaterales específicas*** para determinadas regiones y ***aprovechar las TIC*** para aumentar enormemente la eficacia de estas medidas.

Una medida básica consiste en ***divulgar información*** sobre las instalaciones, estructuras, procedimientos administrativos, condiciones de partida, etc., de los servicios sociales y el sistema sanitario del país vecino. Para esto, en primer lugar es necesario ***elaborar un "inventario" transfronterizo***, contando con la participación de todas las partes afectadas a ambos lados de la frontera. Se trata de un requisito previo para poder iniciar el diálogo y establecer acuerdos sobre medidas prácticas dentro del servicio sanitario y los servicios sociales que sean posibles y necesarios a ambos lados de la frontera, a pesar de las diferencias y dificultades.

Durante los últimos veinte años las regiones fronterizas europeas han desarrollado algunas iniciativas en el sector sociosanitario sobre una base bilateral o trilateral, pero ***no se ha alcanzado una solución general aplicable en todos los Estados Miembros***. En cualquier caso, debe tenerse en cuenta la situación particular de cada región fronteriza y deben desarrollarse ***soluciones adecuadas y viables*** que garanticen el aprovechamiento eficaz de los recursos.

Debido a ***restricciones financieras de ámbito nacional***, los servicios sociales y las instalaciones sanitarias regionales han estado sometidos a presión en los últimos años, en especial en los entornos más golpeados por la crisis. Esto puede ser un estímulo para la creación de servicios sociales o instalaciones sanitarias regionales más coherentes. Estas son las medidas clave:

- ***Utilización transfronteriza de los hospitales***, con medidas tales como cooperación entre bancos de sangre y transferencia de pacientes. Para algunos residentes de zonas fronterizas el hospital más cercano y más idóneo se encuentra al otro lado.
- Cooperación entre ***servicios de emergencia y ambulancias***, incluyendo ejercicios de respuesta conjunta en situaciones de emergencia.
- Planificación de ***instalaciones sanitarias centrales conjuntas***, logrando así la máxima complementariedad.
- Creación de un ***fondo financiero transfronterizo entre compañías aseguradoras o administraciones públicas*** para equilibrar desembolsos en casos de utilización transfronteriza de servicios sanitarios y sociales.

Ya hace tiempo que la ARFE recomendaba la identificación de campos de estudio potenciales, proyectos piloto y opciones financieras en colaboración con las entidades y organismos financiadores y gestores de los servicios e instalaciones sociales, los usuarios, profesionales, ayuntamientos, etc.

Por lo que respecta a la ***planificación de instalaciones de atención sanitaria y servicios sociales***, debería considerarse a medio plazo la planificación y puesta en marcha de ***instalaciones conjuntas*** a ambos lados de la frontera, con áreas de influencia y opciones financieras transfronterizas, como ha sido el caso del Hospital TF de La Cerdanya y otras iniciativas. Por otra parte, debe posibilitarse legislativamente el uso de helicópteros de salvamento.

Deberían ponerse en práctica ***planes de contingencia transfronteriza*** en cuanto a servicios de emergencia y

rescate, de tal manera que se disponga de personal, vehículos, etc. Asimismo, deberían adoptarse planes nacionales para que la dotación de equipos y personal a través de la frontera pueda ponerse en marcha sin dificultad dentro de cada área de influencia nacional.

Sería preciso también ***examinar las instalaciones de gran envergadura*** en los sectores sanitario y de servicios sociales de las regiones fronterizas, con el fin de concretar si se pueden ***evitar duplicidades de financiación*** en el futuro y así planificar instalaciones transfronterizas más racionales. Además, las regiones fronterizas deben responsabilizarse de hacer propuestas sobre cualquier instalación de cierta envergadura que sea viable únicamente si va a ser utilizada por las poblaciones de ambos lados de la frontera.

La práctica diaria en las regiones fronterizas muestra repetidamente que la CTF en la atención sanitaria y en los servicios sociales es ***imprescindible*** para mejorar la calidad de vida de sus habitantes. Es comprensible que las instituciones financiadoras de la seguridad social acepten esta cooperación solo en casos individuales inicialmente, ya que no pueden evaluar las implicaciones financieras de soluciones más generales. A largo plazo, sin embargo, el sector sanitario, los servicios sociales, de emergencia y ambulancias, y las autoridades policiales y de lucha contra el narcotráfico exigen una cooperación generalizada, basándose en firmes normativas legales y financieras. Esta cooperación podría incluir la creación de fondos transfronterizos conjuntos, adaptados a las necesidades de cada región.

3.1 Instalaciones conjuntas

La *AECT Hospital TF de La Cerdanya* (ES-FR).

Algunas iniciativas son muy difíciles de llevar a cabo, como el viejo proyecto del *Macro-Hospital Universitario TF de Maastricht-Aquisgrán-Lieja* (NL-DE-BE).

Otras

3.2 Protocolos de Emergencia en Atención a Catástrofes

Numerosos. Hay una propuesta de proyecto sobre la gestión TF de crisis y emergencias que pretende realizar un inventario de protocolos activos.

3.3 eHealth y Telemedicina

Las oportunidades que han abierto las TIC han sido aprovechadas por muchas regiones. Desde la experiencia pionera de Telemedicina en Pomerania y algunas regiones nórdicas, hasta el contrato del Servicio Catalán de Salud con la sanidad sueca para el diagnóstico radiológico de los hospitales suecos, y muchos más.

3.4 Investigación y Salud Pública

- MRSA[1]
- EurSafety HealthNet

[1] Multiple-resistant *Staphylococcus aureus*

4. THE PROCESS TO APPROVE A EU DIRECTIVE ON CBC HEALTH AND PATIENTS' RIGHTS, AND THE ROLE OF THE AEBR

Everything begun with the case Decker vs the *Caisse de Maladie des Employés Privés* (C-120/95) and the case Kohll vs the *Union des Caisses des Maladies* (C-158/96).

The European Court of Justice (ECJ) ruled on 28 April 1998 (ECR I-01931) that EU citizens have a right to obtain planned medical and dental treatment in a Member State other than their home State. Just over ten years later, the European Commission published a proposal for a directive on cross-border healthcare, which aimed to clarify and facilitate these rights in relation to cross-border healthcare and to provide some legal certainty.

The Commission's proposal was not about the right to unplanned emergency treatment abroad, which is covered by the European Health Insurance Card. This allows all EU citizens to use the same state-provided healthcare as residents of the country that is being visited. Nor was the proposal about the mobility of healthcare professionals, which is covered by Directive 2005/36/EC on the recognition of professional qualifications.

The two 1998 cases both related to Luxembourg citizens who had been denied reimbursement for non-hospital medical services provided abroad. In the Kohll case, Mr Kohll's social security institution refused authorisation for his daughter to travel to Germany for dental treatment. The ECJ decided that rules under which reimbursement of the cost of dental treatment provided in another Member State is subject to authorisation constitute a restriction to the freedom to provide services. In the Decker case, Mr Decker was refused reimbursement for spectacles that he had bought across the border from an optician established in Arlon, Belgium using a prescription issued by an ophthalmologist established in Luxembourg. In that instance, the ECJ decided similarly that the rule constituted a restriction to the free movement of goods. It recognised that such a restriction could in principle be justified if it were necessary to ensure the financial balance of the social security scheme, maintaining a balanced medical and hospital service to all of its insured persons. But in these cases that justification was not established.

Since 1998, the ECJ has delivered further judgments clarifying its reasoning. One such judgment was the Watts case, delivered on 16 May 2006[2]. In 2002, a UK citizen, Mrs Watts, investigated the possibility of hip arthritis treatment abroad on the basis of an E112 form. The request was refused because the projected one-year wait for the operation was within Government targets and therefore could be considered to be "without undue delay" (one of the criteria for an E112 authorisation). Upon appeal, Mrs Watts' case was reviewed and considered to be more urgent, but it was felt that the revised period of three to four months was still "without undue delay". Having failed to secure prior authorisation, Mrs Watts proceeded with treatment in France and continued her case against the local Primary Care Trust.

(For a more complete background of the Commission Initiative for the Directive keep on reading the following report: *Healthcare across EU borders: a safe framework*, European Union Committee, Parliament of the UK, London, 2009 http://www.publications.parliament.uk/pa/ld200809/ldselect/ldeucom/30/3004.htm)

[2] Case C-372/04 Watts vs Bedford Primary Care Trust [2006] ECR I-4352

(AEBR Position paper from 21st May 2009, updated)

Since many years, the AEBR has made own opinions regarding important topics for the population living in border areas. One of these important issues is Cross-Border Health Care. In this sense, in September 2005, the AEBR together with the Regio Basiliensis organized in Basel the 1st AEBR Forum *Health without Borders: CBC in Health Care – Added Value for European People, Economy and Regions*. In February 2008, the 2nd AEBR –Regio Basiliensis Forum on CB Health Care was organized in Basel, paying special attention to the process to develop a proposal of directive regarding CB Health Care and Patients' Rights. In the meantime a specific Task Force had been implemented to deal with Cross-Border Health issues within the Association. The 2nd Basel Conference gave orientations to the Task Force on the main health issues for European border regions.

4.1. Follow up of the 2nd Basel Conference: Towards a real European Cross-Border Health Care

4.1.1. European Framework for Health Cooperation

- Internationalisation does not stop the shortage of health systems, in particular in border regions.
- A progressive reorganisation of national health systems as result of the common market and economy policy of the EU is obvious:
  - Current developments at the European level (…) have a great impact on patient insurance and service lists.
  - Cross-border utilisation of health services (patient mobility) entails also the aspect of free movement of services in the European common market.
- Hospital treatment abroad remains still quite complicated due to the strength of the nationally organised hospital structures and traditions.
- The quality of health cooperation depends quite often on the similarity of systems on both sides of the border.
- While using cross-border health services citizens need more clarity and legal certainty as regards their rights as patients. But: only up to five percent of patients go abroad for a treatment. This is one percent of total health expenses. (figures from 2008)
- Considering the effects of demographic change the efficiency of health systems has to be enhanced, also in a cross-border context.
- Health services have to take more into account the needs of patients.
- In the future patients will spend more on their health than today.

- With regard to cross-border provision of health services the patients' security is at risk due to growing antibiotic resistance (e.g. problems with MRSA).

4.1.2 Added value of CBC in Healthcare

- Cross-border regions have the function of laboratories for European integration, and provide pragmatic solutions.
- CBC clarifies the questions of access, quality, information, transparency and healthcare costs.
- CBC and mobility across borders provides the opportunity for:
  - more competitiveness and a better distribution of tasks between service providers that can result in lower costs and in the long-term in a qualitatively better service;
  - individual and targeted cooperation between health insurances, hospitals and other service providers;
  - cooperation projects that use health infrastructure and required resources from both sides of the borders and in this way ensure a better capacity utilisation.
- Cross-border healthcare develops into a significant economic sector:
  - live sciences, biotechnology and medical engineering are an important backbone of the regional economy;
  - producers of medical equipment as well as suppliers of medical services benefit from additional contracts in cross-border healthcare;
  - additional jobs are created in the growing health sector;
  - highly specialised medicine and division of services improve the attractiveness of the regional location.
- Thanks to cross-border catchment areas (critical mass for investments) it's possible for regions on both sides of the border:
  - to purchase even complex medical facilities enabling a medical specialisation;
  - to provide better services to citizens on both sides of the border as regards the spatial distance, waiting time and overcoming language barriers;
  - to ensure the availability of high-quality health services;
  - to improve the emergency care;
  - to improve the access to nursing services.
- A highly specialised medicine in a cross-border region comes along with education, research and investments in this region.
- A uniform certification system (including evaluation and adjustment to new requirements) is a helpful instrument while using the cooperation experiences gained in a border situation in the development of European health sectors.

4.1.3 Desirable contents of an EU Directive from the AEBR point of view[3]

- The directive should focus on the regulation of services, the harmonisation of vocational education and the mutual recognition of diplomas without, however, interfering with national healthcare systems.
- The patient has to be in the focus.

[3] This is a summary of AEBR's discussions by February 2008 (II Basel Conference), taking into account previous Commission's drafts of the proposal for a directive on safe, high-quality and efficient cross-border healthcare

- It should aim at supervising and strengthening patients' rights, in particular in the cross-border healthcare provision that requires the elaboration of individual solutions taking into account the regional situation.
- In the future patients treated abroad have to be legally entitled to the reimbursement of costs. As a principle, the refunding should be in accordance with the health care reimbursement rates at home, inclusively pharmaceutical specialities.
- For daily, routine consultations patients should be allowed to choose the closest hospital, and for complicated treatment the most competent hospital in the region. Permission by the health insurance might be necessary if a hospital in the neighbouring country has been chosen. The EU, however, should define transparent criteria in order to limit refusals.
- Ambulatory treatment in the neighbouring country has to be possible without a prior authorisation by health insurances of origin. A solution should be found if costs are higher as at home. The additional costs should be paid privately by the patient, or he should have a complementary private insurance, unless there are circumstances forcing the provision of care across the border.
- The risk of „uncontrolled medical tourism cannot jeopardise a reliable demand-planning in a given country (e.g. hospitals, specific medical equipment).
- Specific contact points in each Member State should be the first place to search information by the citizens. Border regions and patients' organisations should play a role in these contact points.

4.1.4 Developments at European level

- Health services are an important element of the European social model as well as the economic, social and territorial cohesion of the EU.
- Due to disadvantageous concerns of some Member States regarding the specificities of health care, they were finally not covered by the Services Directive. So, the EU Commission postponed the proposal for a directive on cross-border healthcare, while the European Parliament urged the Commission to present a draft paper regulating cross-border health services (April 2005: *European Parliament's Report on patient mobility and healthcare developments in the European Union*; March 2007: *European Parliament's resolution on Community action on the provision of cross-border healthcare*).
- Since February 2008, and following the orientations stablished at the II Basel Conference, the AEBR witnessed the extraordinary impetus given to cross-border health at European level.
- Finally, on 2nd July 2008, the new Commissioner Ms Androula Vassiliou presented her Proposal for a *Directive of the European Parliament and of the Council on the Application of Patients' Rights in Cross-Border Health Care*.
- Despite the efforts of Commissioner Vassiliou, as well as other actors, as the patients' associations or the border regions, most of the debates on this proposed Directive were concentrated on prior authorisation and other finance-driven aspects. The AEBR stressed the central role of patients and border regions at different fora.

- The AEBR's Task Force on Cross-Border Health developed some initiatives to influence discussions on the draft Directive at the European Parliament. MEPs Ria Oomen and Lambert van Nistelrooij approached the input given to the debate by MEP John Bowis and tried amendments at the ENVI Committee of the Parliament to involve patients organisations and border regions, especially regarding the implementation of the national contact points foreseen in the Directive.
- Finally, on 23rd April, the Parliament approved a set of amendments to the Draft Directive, including a new article 15a, with the following text: "The Commission, in cooperation with the Member States, may designate border regions as trial areas in which innovative cross-border healthcare initiatives can be tested, analysed and evaluated."
- EPECS[4] also met Commissioner Vassiliou, with very good perspectives for the future work of both the AEBR and EPECS.
- The following Employment, Social Policy, Health and Consumer Affairs Council (EPSCO), held on 8-9th June 2009 in Luxembourg, did the first reading of the draft Directive.

4.2 AEBR Statement on the Commission's Directive Proposal

As it can be deducted from previous statements, this proposal was generally welcomed by AEBR member regions. Due to the fact that one third of the European population live in EU Member States' border areas, these are dealing with border and cross-border issues (that is to say, European issues) in a daily basis, becoming the best laboratories for the European integration process. Furthermore, the greater mobility in Europe is even much more evident at the border areas.

The AEBR considered this proposal as crucial, tackling the issue of a better coordination of Member States' Health systems towards a real European one. These first efforts to synchronize European health systems should have increased the level of protection of European citizens' rights. The cooperation of health care institutions is essential in border regions in order to get optimal infrastructure by complementing each other and/or creating the critical mass needed to fulfil outstanding needs. This aspect was not fully developed at that moment, and regulations at European level should have taken this more into account.

Patients need to receive in everyday life suitable, clear and evident information on the functioning mechanisms of health systems in European countries (including services portfolio, prices, reimbursement conditions, and quality), especially at the other side of their border. The Commission's proposal demanded not only national rules and information on the quality of care, but also transparent rules on the reimbursement of costs. So, patients can be sovereign when taking decisions on their own health.

But citizens should also take more active part in the decision-making processes,

[4] European Patients Empowerment for Customized Solucions, www.epecs.eu

particularly regarding very important public services, as it is this case. As the patients' network EPECS already stated, and especially due to the demographic change, Europe need a vision and a long term strategy on the organisation of cross-border health care. The Commission's proposal could have brought very positive values to have European high-quality cross-border heath care, but the citizens should have taken part as relevant stakeholders on its implementation, in order to exercise their liberties and opportunities. European health care should be oriented to the citizen's basic rights. Citizens want to freely choose their health care across the border, demanding a higher quality.

The AEBR found EPECS as a competent partner to design an active role of European patients within this field.

In the same sense, European border and cross-border regions can play a perfect role checking and following up the process to implement the Directive in all border areas. The greater cross-border coordination of health care is, the better services will be provided for the citizens living in border areas, and it is even possible to make a more efficient utilisation of resources across the borders.

European border and cross-border regions (and their Association, the AEBR) can monitor the developments at the European border areas in close cooperation with the national contact points foreseen in the draft directive. This can be done within a framework with the format of an "observatory"·for the implementation of a real European cross-border Health (or using existing health observation structures, but including border regions and patient organisations as relevant partners).

The success of the process initiated by this Directive can also be the cornerstone of a real European Health System, as main frictions, problems and opportunities happen at the borders. If there is a real progress in this field at European level, certain regions can be considered as pilot ones in order to guide next proposals to better implement the Directive. Moreover, these pilot border regions can be a perfect source to obtain a new generation of cross-border data in order to be taken into account by researchers and policy-makers when defining real European and Europe-wide health measures.

In any case, these national contact points should be developed in cross-border settings, in close cooperation with the neighbouring country and with regional and local authorities affected by the border.

Thus, from the point of view of European border and cross-border regions:

- Cooperation between healthcare institutions is essential in border regions to get the most optimal and efficient infrastructure. Facilitating of this aspect should get more attention as the Directive focusses on patient rights and mobility.
- Citizens in border regions need understandable and precise information about services, prices, reimbursement, and quality. National contact points should be ready to answer specific cross border questions.
- Citizens in cross border regions should be guaranteed minimal standards of quality, while respecting that every member state will define its own quality standards.
- National contact points should be implemented in cross-border settings, if possible in cooperation with the neighbouring country.
- Border regions should be considered as pilot regions to get relevant data for future health policy.
- Patients or their representatives should get a more explicit role in the implementation of the Directive.

Anyway, first of all a Directive was needed, and this took quite a long time. There were some Member States with a great reluctance, probably because they did not understand properly what it was meant with "cross-border health care". National parliaments should be informed about the needs of the citizens living in border areas, and of course about the opportunities opened by an effective cross-border cooperation in health care services (as well as with any other effective type of cross-border cooperation, which creates added value in many fields).

4.3 Specific actions in border and cross-border regions

- Joint cross-border supply and demand planning in healthcare, joint healthcare funding models and joint management of a cross-border health region.
- In-kind distribution of health services with mutual disclaimer planning (specialisation and focus on particular medical fields).
- Coordination of cross-border healthcare planning inclusively hospital demand planning, rescue, etc., with strategies in the countries' interior.
- Cooperation between hospitals with multilingual staff that are in the position to ensure a full service nursing care.
- Network of hospitals specialised on particular disease research that facilitates the cross-border admission of patients.
- Creation of a cross-border rescue service (with ambulances, emergency physicians, staff and guidelines for treatment, operating time of ambulances, working time of physicians, medical care in the ambulance as well as uniform audible and visible signals).
- Cross-border training in theory and practice (professional language courses, information on the different systems, mutual recognition of diploma, training in comparable treatment and care methods).
- Staff with linguistic competence in healthcare facilities on both sides of the border.
- Cross-border health insurance card as well as quick and reliable electronic payment processes.
- Suspension of the territoriality principle in the health insurance systems.
- Joint actions against antibiotic resistance.
- Border and cross-border regions could be appointed as pilot regions to monitor the implementation of the directive.

4.4 Role of the AEBR

- Mouthpiece and lobby of border and cross-border regions.
- Active participation in the development of cross-border healthcare in Europe.
- Partnership with the European Hospital and Healthcare Federation (HOPE), as well as with patients' associations like EPECS (European Patients Empowerment for Customized Solutions).
- Organisation of European seminars on cross-border healthcare.
- Partner in European networks, projects and pilot actions, etc.
- Platform for the exchange of best practices.
- Task Force for the analysis of best available practise, project drafting, programme implementation and production of reliable arguments.

5. THE FINAL STAGES TO THE DIRECTIVE

After a long process to come out with a final proposal, it was the time for this Directive to be implemented. This was the maximum that could be accepted by all member states at this stage and not every recommendation made by border regions were taken into account. However, there was a stronger focus on the case of citizens living in border areas where the better healthcare can only be provided across the border.

Unlike the first drafts of this Directive, the text approved by the Parliament included references to border regions.

(text from AEBR news: http://www.aebr.eu/en/news/news_detail.php?news_id=60) This Draft Directive entered quite a fast second reading process after its approval in first reading at the end of the Spanish Presidency of the Council (June 2010). The Belgian Presidency promoted a three-way meeting on 15 December 2010, together with the European Parliament's rapporteur and the Commission. They achieved a compromise and waited for the Committee of Permanent Representatives (Coreper) to clear the Directive on 21 December.

Within this agreement, the main issue still was "prior authorization" for the following services: hospital care, specialised care, patients at particular risk and treatment that could raise serious concerns. This agreement also tried to clarify the cases justifying the refusal of that authorization.

Member States' competences are a main issue when dealing with healthcare, but it was the time for the EU to go one step forward in order to strengthen the integration of all European territories. Still, national logic prevailed and the focus on national competences hindered the opportunity to discuss a real European task: cross-border healthcare for citizens living in border regions.

Then, on 19th January 2011, the European Parliament debated and voted (Plenary Session, Strasbourg) the ***Recommendations for a second reading of the Directive on Patients' rights in Cross-border Healthcare***, proposed by the Committee on the Environment, Public Health and Food Safety. MEP Françoise Grossetête (EPP, FR) was the rapporteur on cross-border health care. As it was widely supported by various political groups, the voting developed very positively. Then, this Directive was to be approved by the Council in February or March, and Member States had thirty months to adapt their legislation accordingly.

The following elements within these "Recommendations" were particularly relevant for border and cross-border regions (bold means new text included during the Parliamentarian debate:

Introduction, new paragraph 39:

Patient flows between Member States are limited and expected to remain so as the vast majority of patients in the Union receive healthcare in their own country and prefer to do so. However, in certain circumstances patients may seek for some forms of healthcare to be provided abroad. Examples include highly specialised care or healthcare provided in frontier areas where the nearest appropriate facility is on the other side of the border. Furthermore, some patients wish to be treated abroad in order to be close to their family members who are residing in another Member State, in order to have access to a different method of treatment than that provided at home or because they believe that they will receive better quality healthcare in another Member State.

Introduction, new paragraph 49; it was already included that:

The existence of national contact points should not preclude Member States from establishing other linked contact points at regional or local level, reflecting the specific organisation of their healthcare system.

Introduction, new paragraph 50; it was already included that:

Member States should facilitate cooperation between providers, purchasers and regulators of different Member States at

national, regional or local level in order to ensure safe, high-quality and efficient cross-border healthcare. This could be of particular importance in border regions, where cross-border provision of services may be the most efficient way of organising health services for the local population, but where achieving such cross-border provision on a sustained basis requires cooperation between the health systems of different Member States. Such cooperation may concern joint planning, mutual recognition or adaptation of procedures or standards, interoperability of respective national information and communication technology (hereinafter 'ICT') systems, practical mechanisms to ensure continuity of care or practical facilitating of cross-border provision of healthcare by health professionals on a temporary or occasional basis. Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications(9) stipulates that free provision of services of a temporary or occasional nature, including services provided by health professionals, in another Member State is not, subject to specific provisions of Union law, to be restricted for any reason relating to professional qualifications. This Directive should be without prejudice to Directive 2005/36/EC.

Introduction, new paragraph 51, was amended as follows:

The Commission should encourage cooperation between Member States in the areas set out in Chapter IV of this Directive and may, in accordance with Article 168(2) of the Treaty, take, in close contact with the Member States, any useful initiative to facilitate and promote such cooperation. In that context, the Commission should encourage cooperation in cross-border healthcare provision at regional and local level, particularly by identifying major obstacles to collaboration between healthcare providers in border regions, and by making recommendations and disseminating information and best practices on how to overcome such obstacles.

Article 10, paragraph 2, was amended as follows:

Member States shall facilitate cooperation in cross-border healthcare provision at regional and local level as well as through information and communication technologies and other forms of cross-border cooperation.

...adding a new paragraph:

The Commission shall encourage Member States, particularly neighbouring countries, to conclude agreements among themselves and to develop joint action programmes. The Commission shall also encourage the Member States to cooperate to create areas in which patients will have improved access to health care, particularly in cross-border areas.

Article 12, paragraph 1, was proposed to be amended as follows:

The Commission shall support Member States in the development of European reference networks between healthcare providers and centres of expertise in the Member States, in particular in the area of rare diseases, which shall draw on the health cooperation experience acquired within the European groupings of territorial cooperation (EGTCs). Those networks shall at all times be open to new healthcare providers which might wish to join them, provided that such healthcare providers fulfil all the required conditions and criteria.

Article 1 2, paragraph 2, a new bullet point on European reference networks:

(fa) to implement instruments which enable the best possible use to be made of existing healthcare resources in the event of serious accidents, particularly in cross-border areas.

There were also many references to the consultation of patients and patients' organizations. The amendments reinforced this and gave some more dynamism to the proposed Directive.

This Resolution and Consolidated Text can be found here.

(text Newsflash 16 March 2011)

On 28th February, the Council of Ministers validated the European Parliament's amendments of the draft directive on cross-border healthcare, with the exception of the Austrian, Polish, Portuguese, Romanian and Slovak delegations. Therefore, the directive to facilitate access to safe and high quality cross-border health care, would be applicable as of August 2013.

In this moment, a new book on cross-border health care was published by the WHO. Cross-border health care has become a much more prominent phenomenon in the European Union. When in need of medical treatment, patients increasingly act as informed consumers who claim the right to choose their own providers, including those beyond borders. This book explores such trends and also looks at the legal framework for cross-border care as well as examining some of the uncertainties surrounding it. The information and analysis presented in the study can be of considerable use to policy-makers and those with an interest in key aspects of cross-border health care to accompany or follow this process. Full text available for download

(text NF September 2011)

On 5th September 2011, the EU Commission (DG SANCO) provided updated information on cross-border care policy and legislative framework - available in 22 languages:

On 4th October 2011 a video on Patients' Rights in Cross-Border Healthcare was also produced, in order to give an overview of the EU law on Patients' Rights in Cross-border Healthcare. This law clarifies the right for patients to be treated in another EU country and the right to be reimbursed for it.

(…)

El 16 de marzo de 2015 se inició en Madrid el X aniversario del Foro Español de Pacientes, contando con la participación de especialistas europeos que constataron que España va lenta en la transposición (RDL 81/2014) de la Directiva sobre Asistencia Sanitaria Transfronteriza Europea (2011/24/UE).

http://www.actasanitaria.com/espana-aplica-con-lentitud-la-legislacion-sanitaria-transfronteriza/

On 19th March 2015, a Cross-Border Healthcare Mini-Workshop took place in Warsaw (Poland) organized by the European Patients Forum (EPF).

EPF will continue to monitor the implementation of the Cross-Border Healthcare Directive with mini-workshops organised in eight countries not covered by the four regional conferences held in 2013-2014.

This mini-workshop helps to raise awareness about the Cross Border Healthcare (CBHC) Directive and patients' rights enshrined within this legislation. They ensure to 'unpack' various aspects of the Directive which have wider policy and systems implications of interest to patients (eHealth provision, HTA provision, general provisions on Quality of Care and Patient Safety, specific provisions linked to Rare Diseases, etc.).

Attendees acquired greater understanding regarding the role on National Contact Points in their country and how patient groups could support their effectiveness. They were supposed to create an informal network of patient leaders interested in CBHC to monitor developments over the coming years.

Patient leaders from Poland with the capacity to transfer learning from the conference to peers within their organisation and networks (board representatives, directors and communication specialists within the organisations) took part in this event.

EPF Event Manager, Véronique Tarasovici, +32 (0)2 280 23 34, veronique.tarasovici@eu-patient.eu

http://www.eu-patient.eu/Events/upcoming-events/cross-border-healthcare-mini-workhop-poland/

6. PERSPECTIVAS EN 2015-2016

- UE
- Europa no-UE (Mediterráneo, Balcanes, Ucrania, Rusia)
- Otros continentes

7. 2017

- Commission's Cross-Border Review, social-health aspects and cases
- Different studies on CB Health care: ***cross-border care*** and more.
- Listado de proyectos de *cross-border care*.

8. 2018

Follow up CB Review and b-Solutions.
Commission's joint Conference DG Santé – DG Regio

9. 2019

EUREGHA Conference in St. Pölten

EJEMPLOS DE PROYECTOS

Las regiones fronterizas de la UE y de Europa Central aportan una rica experiencia acerca de cómo se pueden desarrollar en la práctica las actividades transfronterizas en materia de salud y servicios sociales. Seguidamente presentamos una selección de ejemplos de buenas prácticas.

1. Investigación, estudios y estrategias de desarrollo

Caso C.7.1: ***Prevención de Accidentes en la Infancia (IE/UK)***

Este proyecto se centra en la prevención de accidentes entre niños pertenecientes a familias de los grupos socio-económicos más bajos; más de doscientas familias hasta la fecha se han beneficiado de este proyecto, que incluye apoyo especializado, formación en primeros auxilios y dotación de equipamientos de material de seguridad. Entre los resultados previstos podemos citar los siguientes:

- Prevención de accidentes entre niños de grupos específicos y por extensión a comunidades mayores.
- La creación de una estrategia de prevención de accidentes consensuada a lo largo de la frontera entre los cuatro grupos de servicios sanitarios y sociales.
- Mejora de las relaciones laborales entre las comunidades locales

Contacto: Ms Cathy Mullan, Project Manager, WHSSB, Gransha Park, Derry, Irlanda del Norte, Tel: +44 1504 860086

Caso C.7.2: ***Sistema de atención primaria entre comunidades y fronteras (IE/UK)***

Este proyecto tiene por objetivo la mejora en la atención primaria de índole transfronteriza mediante:

- La creación de centros piloto (apoyados por una infraestructura adecuada para mejorar los servicios de atención primaria)
- La aportación de un amplio equipo completamente integrado de atención primaria.
- La utilización de las nuevas tecnologías para establecer nexos de conexión y prácticas (especialmente en comunidades aisladas) con una red más amplia de servicios sanitarios y sociales, garantizando de esta forma que las comunidades afectadas dispongan de los servicios que necesitan.

Entre los primeros resultados destacan: mejoras en los servicios prestados a la población; agrupación de profesionales de atención primaria, médicos de familia, farmacéuticos, etc.; mejora del aprendizaje en cuestiones relacionadas con la prestación de atención primaria en el ámbito transfronterizo.

Contacto: Mr. Eugene Gallagher, W.H.S.S.B., Gransha Park, Derry, Irlanda del Norte
Tel: +44 1504 860086

Mr Tom Kelly, N.W.H.B., Markieviez House, Sligo, Irlanda
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Caso C.7.3: ***Investigación sobre la complementariedad de los Sistemas de Atención Sanitaria (FR/BE)***

Además de identificar posibles áreas de cooperación en la Eurorregión Nord-Pas de Calais-Flandes Occidental que supondrían una reducción de costes y un aprovechamiento más eficaz de los recursos de la Eurorregión, los resultados de este estudio son muy útiles para la Asociación Internacional de Mutualidades, encargada de observar el flujo de los servicios de atención sanitaria dentro de la UE.

El estudio se llevó a cabo durante tres años, por encargo de la Comisión Europea (DG V) y fue desarrollado por 3 mutualidades de seguros sociales: dos miembros de la *Féderation des Mutualités Chrétiennes* (BE) y uno de la *Mutalité du Nord* (FR). La investigación se realizó conforme a la siguiente organización: Un comité ejecutivo, que se reunía dos veces al año, formado por representantes de las principales mutuas aseguradoras, se encargaba de controlar los progresos de la investigación, divulgando información entre los interesados y coordinando la coherencia global de la investigación. Este comité también era responsable del presupuesto del proyecto. Un comité de apoyo coordinaba la investigación TF siguiendo las directrices trazadas por el comité ejecutivo. Dos grupos de trabajo, uno francés y otro belga, llevaron a cabo el trabajo de campo que permitiría la realización de los objetivos del estudio. Cada grupo estaba formado por un investigador, un coordinador y numerosos asesores especializados, que variaban en función del ámbito del estudio.

Resultados:

- Estudio demográfico de las dos regiones, investigación de los estudios epidemiológicos llevados a cabo en los dos estados con referencia a las dos regiones, inventario de las infraestructuras (hospitales, clínicas, etc.) y de los trabajadores y del material (personal; legislación europea y nacional en relación con la instalación de equipamientos de servicios; requisitos oficiales exigidos al personal, etc.);
- Creación de una base de datos que muestra las deficiencias de las dos regiones en materia de sanidad y la distribución de los puntos de atención sanitaria, la demanda por parte de la población local de servicios fuera de la zona y la demanda por parte de la población exterior de servicios de la región, así como las dificultades para acceder a los servicios de atención sanitaria en la región transfronteriza y en los alrededores;
- Identificación de las áreas subdesarrolladas dentro de la infraestructura de servicios sanitarios de la Eurorregión Nord-Hainaut, así como la identificación de las áreas complementarias con potencial sinérgico; identificación de proyectos complementarios y estudio de su viabilidad, e implicación de agentes socio-económicos para que se involucren en la puesta en práctica de los proyectos.

Presupuesto: Coste total: 184.305 euros; 50% de los socios regionales, 50% del FEDER

Contacto: Union Générale Mutualité du Nord
Boulevard Denis Pain 18/20/22, F- 59015 Lille,
Tel: + 33 20 58 10 00, Fax: + 33 20 58 10 39

Caso C.7.4: ***Estudio Comparativo sobre la accesibilidad a los Servicios Sociales y Sanitarios (ES/PT)***

Este proyecto, llevado a cabo en 1996, consistía en un estudio sobre las condiciones de acceso de los trabajadores transfronterizos de Galicia y Zona Norte a los servicios sanitarios y sociales.

El objetivo general ha sido ofrecer un incentivo para armonizar la legislación de forma que las dos poblaciones puedan conseguir un trato idéntico en el ámbito de la salud, seguridad social, empleo y formación profesional. Los resultados de este estudio han sido publicados y distribuidos entre las organizaciones interesadas. Se espera que al destacar los obstáculos reales que conlleva la movilidad transfronteriza, el entorno legislativo termine por cambiar y adaptarse para mejorar la situación de los trabajadores transfronterizos.

Presupuesto: 140.725 euros, de los cuales el 75% procedía de Interreg

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P-4100 Porto, Tel +351 2 6001312, Fax +351 2 6009621;
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Tel +34 981 546040, Fax +34 981 546336

2. Cooperación entre servicios de emergencia

SAFETY
(Ensuring safer living conditions)

25 years of Interreg has also improved the well-being of European citizens by helping to create a safer and more secure environment. Among the initiatives taken have been numerous joint actions in risk prevention and management, tackling drug trafficking and illegal immigration. This cooperation has seen public services working together on some 1.900 Interreg projects striving towards safer living conditions for the benefit of European citizens.

(Folleto de proyectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

Caso C.7.5: ***Programa Transfronterizo de Formación Conjunta – Servicio de Ambulancias (IE/UK)***

Este proyecto pretende conseguir una respuesta a las urgencias sanitarias que se produzcan en las zonas fronterizas adyacentes. Se trata de poner en marcha una serie de programas de formación para personal de ambulancias y para el personal operativo, con el fin de desarrollar procedimientos comunes para optimizar el aprovechamiento de los recursos disponibles sin tener en cuenta su ubicación; el apoyo financiero está siendo prestado por la C.A.W.T

Entre los resultados previstos se espera una mejora de la respuesta TF a los principales incidentes que se produzcan en las regiones fronterizas mediante la coordinación de planes, programas de formación y necesidades organizativas que permitan dar respuesta a las necesidades identificadas. Esto será muy beneficioso para ambas poblaciones y facilitará la aplicación de este enfoque en otras áreas fronterizas.

Contacto: Mr Jim Christie, Northern Ireland Ambulance Trust
12 – 22 Linen Hall Street, Belfast, Tel +44 1232 246 113

Caso C.7.6: ***Rescate de Montaña (FR/IT)***

En la montaña los peligros, accidentes y rescates no se detienen en la frontera. El incremento del turismo alpino hace más frecuentes los accidentes de montaña, siendo la organización de rescates cada vez más compleja y costosa. Las autoridades de Alta Saboya (FR), Valais Suizo (CH) y Valle de Aosta (IT) han organizado un servicio conjunto de rescate aéreo con base en la estación de Chamonix. Cada año salen 850 helicópteros de rescate desde la estación de Saboya.

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Tel +33 1 40 65 11 58, Fax +33 1 40 65 12 39

Dipartamento per il Coordinamento delle Politiche Comunitarie
Via del Tritone 142, I00187 Roma, Tel +39 6 482 67 66

Caso C.7.7: ***Die grenzüberschreitende Nutzung des Rettungswagens und einer Kinderstation: Zwei Beispielprojekte aus der DE-NL Euregio (Gronau)***

http://www.euroinstitut.org/pdf/Download-Unterlagen/2015-Berlin/MAES_ZIEMANN.pdf

Marieke MAES, Directora adjunta de EUREGIO, y **Alexandra ZIEMANN**, Responsable del Bureau Acute Zorg Euregio

Presentación en el Taller sobre Grenzüberschreitende Gesundheitsversorgung - *(Atención Sanitaria Transfronteriza),* organizado durante la Conferencia Internacional "Los Servicios Públicos Locales en el Contexto Transfronterizo en las Fronteras Alemanas – Potenciales y Obstáculos Jurídicos y Culturales", organizado por el EuroInstitut y el Ministerio del Interior Federal de Alemania en la Representación del Land Baden-Württenberg, Berlín, 30 de junio y 1° de julio de 2015.

Caso C.7.8: ***RAT (ES-PT)***

RAT project cutting disaster response times. A real-time information system jointly developed by Spanish and Portuguese public authorities improves emergency services' efficiency.

(Folleto de projectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

Caso C.7.8bis: ***EMRIC (BE-DE-NL)***

EMRIC steht für den Niederländischen Namen Euregio Maas-Rhijn *Incidentenbestijding en Crisisbeheersing* (Euregio Maas-Rhein Einsatz- und Krisenbewältigung). EMRIC ist ein einzigartiger Zusammenarbeitsverband von Behörden, die für die Sicherheit in den Bereichen Brandschutz, technische Hilfeleistung und Rettungsdienst in ihrem Bereich zuständig sind.

In einer grenzreichen Region wie der Euregio Maas-Rhein können die ausländischen Hilfsdienste häufig schneller zur Stelle sein, als die eigenen Dienste. Wenn jede Sekunde zählt, ist schnelle Hilfe lebenswichtig.

Deshalb gilt, dass GRENZÜBERSCHREITENDE ZUSAMMENARBEIT EIN MUSS ist.

Die folgenden Dienste sind Teil der Zusammenarbeit: die Feuerwehr der Stadt Aachen, die Ordnungsämter des Kreises Heinsberg und der Städteregion Aachen in Deutschland; die Provinz Limburg in Belgien und die Veiligheidsregio Zuid-Limburg in den Niederlanden. Diese Organisationen finanzieren die Zusammenarbeit und das sogenannte EMRIC-Büro.

Neben diesen sechs Partnern arbeiten noch gut 30 Dienste und Behörden mit dem EMRIC-Verband zusammen.

EMRIC sorgt dafür, dass grenzüberschreitende Zusammenarbeit möglich ist, denn selbstverständlich ist das keineswegs. Die Systeme und Gesetze sind in den drei Ländern derart unterschiedlich, dass viel geregelt werden muss, um mit einem Rettungs- oder Feuerwehrwagen die Grenze überqueren zu dürfen. In einer grenzreichen Region wie der Euregio Maas-Rhein ist es selbstverständlich, über die Grenze hinweg zu arbeiten, zu studieren oder die Freizeit zu verbringen; sich gegenseitig in Notsituationen zu helfen war es aber in der Vergangenheit nicht.

Zum Glück ist inzwischen viel geregelt, häufig in Zusammenarbeit mit anderen Behörden (nationalen, föderalen, provinzialen und kommunal). Zurzeit fahren jährlich etwa 900 Rettungswagen über die Grenze, um so schnell wie möglich adäquate Hilfe zu leisten, und helfen sich in rund 300 Fällen Feuerwehren gegenseitig, wenn Not am Mann ist.

Weitere Informationen über die EMRIC-Zusammenarbeit finden Sie in den verschiedenen Abschnitten dieser Website. Werfen Sie auch ruhig einen Blick in den Bereich für Professionals, wo Sie detailliertere Informationen finden.

https://www.emric.info/de/buerger/was-ist-emric (incluido también en C5 *Medio Ambiente*)

3. Cooperación entre otros servicios (p.e.: hospitales)

Caso C.7.9: ***Higiene y Tratamiento Dental (GR/AL)***

El proyecto consistió en la creación y equipamiento de una unidad dental móvil que visita colegios de las zonas fronterizas específicas, especialmente en Albania. La creación de la unidad móvil estuvo acompañada de un programa de formación para dentistas y técnicos dentales de Albania. La unidad, formada por un dentista griego (el instructor) y un dentista de Albania (el aprendiz), realizó visitas a colegios para proporcionar a los alumnos material informativo sobre hábitos de higiene y tratamiento dental.

Resultados: a través de este programa se equipó y se puso en funcionamiento la unidad dental móvil que permitió tratar los problemas dentales de un gran sector de la población fronteriza. Asimismo, un número significativo de dentistas y técnicos dentales de Albania recibieron formación teórica y práctica sobre nuevas técnicas dentales, materiales e investigación.

Elementos de buena práctica: apoyo social de las ONGs y departamentos científicos sanitarios que cooperaron con el fin de mejorar las condiciones sanitarias en las regiones fronterizas. La Escuela de Odontología de la Universidad de Atenas apoyó este proyecto de colaboración entre el Sagrado Monasterio de Simonos Prtras en Agio Oros y la Iglesia Ortodoxa de Albania

Presupuesto: 600.566 euros

Contacto: Prof Nikos Kafousias, Escuela de Odontología de la Universidad de Atenas Drakontos 7, GR- 161 21 Atenas, Tel +30 1 723 0153

Caso C.7.10: ***Plan Transfronterizo de trabajo flexible (IE/UK)***

Este proyecto aplica diferentes enfoques en relación la asistencia a personas con discapacidades para el aprendizaje, en sus hogares. Las zonas piloto difieren en cuanto a los modelos de formación para los cuidadores y los modelos de intervención de los cuidadores. Este proyecto mejorará la calidad de vida de las personas con dificultades de aprendizaje y proporcionará empleo a los cuidadores. Asimismo, el proyecto mejorará la preparación de los cuidadores, así como el aprendizaje de los Comités directivos en cuanto a las necesidades de los cuidadores que trabajan con personas con discapacidades de aprendizaje. Está previsto que los Comités se ocupen de la fase piloto y de la línea principal de la buena práctica.

Contacto: Mr. Martin Sweeney, S.H.S.S.B, Tower Hill Hospital, Armagh
Tel +01861 522381
Mr Leo Kinsella, NEHB, Gilligan House, Dublin Road, Dundalk
Tel 042 29 230

Caso C.7.11: ***STRENGTHENING FORENSIC CAPACITIES IN CRIME PREVENTION (BG/RS)***

A key project within the Bulgaria-Serbia cross-border programme involved in fighting drugs trafficking and organised cross-border crime, setting up workshops with police officers and 6 forensic laboratories.

(Folleto de projectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

Caso C.7.12: ***Radio Asistencia Domiciliaria (ES/PT)***

Este proyecto, iniciado en 1995, tenía por objetivo reunir las dos organizaciones de "Cruz Roja" de España y Portugal. El proyecto "Radio Asistencia Domiciliaria" ya existía en España pero no en Portugal. El aspecto transnacional del proyecto consistía en la creación de una red radiofónica que permitiera la coordinación de acciones desde una emisora central en Badajoz (E).

En 1996 el proyecto se amplió aún más. Se hizo un intento de incluir dentro de la organización portuguesa de la Cruz Roja un proyecto propio de "Radio Asistencia" en la región de Alentejo, en la misma línea del proyecto español

Este nuevo proyecto pretendía ampliar el proyecto de Radio Asistencia a Extremadura y Alentejo e incluir usuarios con dificultades físicas. Se apoya en una red de telecomunicaciones que permite la coordinación entre los recursos portugueses existentes y la emisora Central de Alerta de la Cruz Roja de Badajoz. En un principio, el proyecto está enfocado a las poblaciones de Évora, Beja, Portalegre, Estremoz y en la parte española, a las localidades donde la Cruz Roja opera en la actualidad.

El proyecto ha conseguido hacer algo nuevo al aproximar la Cruz Roja española y su homólogo portugués. Se espera en el futuro que los usuarios de los servicios puedan tener acceso tanto a los servicios españoles como a los portugueses.

Presupuesto: Coste total: 2.704.000 Ptas ; 2.000.000 Ptas de Interreg II

Contacto: Gabinete de Iniciativas Transfronterizas Mérida-Évora (GIT)
Paseo de Roma s/n Modulo B – 2a planta, E-06800 Mérida
Tel +34 924 006137, Fax +34 924 006145, Cortiz@prejuntaex.org

Oficina Provincial de Cruz Roja Española
C/Padre Tomás 2, E-06011 Badajoz, Tel +34 924 240433

Caso C.7.13: ***Grenzüberschreitende Gesundheitsversorgung (DE-CH)***

http://www.euroinstitut.org/pdf/Download-Unterlagen/2015-Berlin/INDRA.pdf
Dr. med. Peter Indra, MPH, Leiter Gesundheitsversorgung Kanton Basel-Stadt, Suiza

Vorsitzender der AG Gesundheitspolitik der Oberrheinkonferenz ORK
Presentación en el Taller sobre Grenzüberschreitende Gesundheitsversorgung - *(Atención Sanitaria Transfronteriza),* organizado durante la Conferencia Internacional "Los Servicios Públicos Locales en el Contexto Transfronterizo en las Fronteras Alemanas – Potenciales y Obstáculos Jurídicos y Culturales", organizado por el EuroInstitut y el Ministerio del Interior Federal de Alemania en la Representación del Land Baden-Württenberg, Berlín, 30 de junio y 1° de julio de 2015

Caso C.7.14: ***Cooperación entre los hospitales de Selestat y Offenburg (DE/FR)***

Este proyecto tiene por finalidad reforzar los contactos profesionales a nivel personal entre funcionarios de hospitales de Offenburg (DE) y Sélestat (FR) en el ámbito de la educación y formación continua. Asimismo, el proyecto pretende fomentar el intercambio de información con respecto al trabajo del hospital e incrementar los conocimientos de lenguaje técnico.

Se organizarán las siguientes actividades:

- Organización conjunta de cursos de idiomas durante el intercambio
- Convocatoria de prácticas para estudiantes de enfermería
- Recopilación conjunta de documentación sobre la terminología médica común
- Intercambios entre profesionales de los dos hospitales
- Organización de conferencias sobre temas médicos definidos por los dos hospitales
- Documentación general

Resultados previstos: Numerosos intercambios y encuentros entre profesionales hospitalarios, así como entre estudiantes de enfermería; Formación lingüística específica sobre el sector médico y de enfermería y publicación de un diccionario sobre terminología médica francés/alemán. Asimismo, está prevista la organización de puestos centrados en especialidades concretas, tales como el SIDA o la Diabetes.

Presupuesto: coste total: 150.000 euros, el 50% del FSE

Contacto: Dr Franz Hahn, St Josefskrankenhaus, Weingartenstr. 70, D-77654 Offenburg
Tel +49 781 471, Fax +49 781 435 40

4. Desarrollo y CTF de instalaciones y servicios (p.e.: Centros de especialistas en materia sanitaria e investigación)

Caso C.7.15: ***Institutos de Investigación TF sobre NN.TT. de Rehabilitación (DE/NL)***

El objetivo general de proyecto es prestar apoyo TF a la tecnología de rehabilitación y lograr una mayor eficacia de la medicina de rehabilitación dentro de la Euroregio. Los objetivos específicos incluyen el establecimiento de un instituto de doble nacionalidad para la tecnología de rehabilitación. Los socios participantes son: el Centro de Rehabilitación de la Fundación Het Roessingh, en Enschede (NL), el Instituto Bio-Médico de Tecnología de la Universidad de Twente (NL), y el Departamento de Fisiología Ortopédica de la Universidad de Münster (D).

En la fase actual se realizará una investigación conjunta de la tecnología de rehabilitación y se presentará un programa transfronterizo de formación. En la próxima fase se someterá a prueba la tecnología y los programas y se adaptarán cuando sea necesario.

El instituto de investigación transfronteriza trabajará en las siguientes áreas:

- Dirección de un programa de investigación sobre tecnología de rehabilitación, realizado a partir de las investigaciones existentes. Debe llevarse a la práctica en un período de 5 años;
- creación de instituciones TF para la medicina de rehabilitación, en cooperación con la Fundación Het Roessingh y el clínico y policlínico de tecnologías de la ortopedia y rehabilitación de la Universidad de Münster;
- constitución de un organismo conjunto de formación para médicos y personal sanitario que refleje la creciente demanda en tecnología de la rehabilitación y el cambio derivado del fenómeno de envejecimiento de la población en Europa.

El desarrollo de una estructura de atención sanitaria en el marco del proyecto prevé hacer posible que los pacientes reciban tratamiento en las instituciones que más se ajusten a sus necesidades. Se espera obtener resultados económicos positivos de la creación de este instituto ya que favorecerá la creación de PYMEs especializadas en la Euroregio. Además, una institución TF conjunta de medicina de rehabilitación supone una considerable reducción de costes.

Presupuesto: coste total:1.725.000 euros, 862.000 contribución de Interreg

Contacto: EUREGIO, Enschederstraße 362, D-48599 Gronau
Tel: +49 2562 70 232, Fax: +49 2562 70259, info@euregionet.de

Caso C.7.16: ***Centro para la Determinación de Características Superficiales y Celulares mediante Análisis Microscópicos y Espectroscópicos (DE/NL)***

La tecnología fotomicroscópica y espectrostócopica hace posible el análisis de las características superficiales y celulares de las estructuras moleculares y ofrece una mayor capacidad gracias al uso de métodos de rastreo microscópico de electrones. El Instituto de Tecnología Biomédica de la Universidad de Twente (NL) y el Instituto de Física y Biofísica Médica de la Universidad de Münster (D) han creado un centro conjunto para la determinación de las características superficiales y celulares mediante el empleo de análisis microscópicos y espectroscópicos. Esta tecnología es especialmente valiosa en la investigación de la eficacia de (nuevos) medicamentos, análisis de sangre y plasma sanguíneo, control de calidad de productos alimenticios, y para el análisis del material empleado en productos médicos tales como prótesis e implantes.

El Centro proporcionará un servicio muy valioso a las PYMEs que no cuentan con la experiencia, ni con los medios necesarios para poder permitirse el equipo necesario. Además de hospitales y laboratorios de análisis sanguíneos, este centro es utilizado por las empresas relacionadas con la física biomédica y empresas alimentarias y agrícolas. La incorporación de la tecnología desarrollada por el Centro incrementará la capacidad de las PYMEs localizadas en la euroregión para competir con empresas internacionales.

Presupuesto: coste total: 800.000 euros; contribución de Interreg: 400.000 euros

Contacto: EUREGIO, Enschederstraße 362, D-48599 Gronau
Tel: +49 2562 70 232, Fax: +49 2562 70259, e-mail: info@euregionet.de

Caso C.7.17: ***Creación de Centros Sanitarios TF (GR/FYROM)***

El proyecto tiene por objetivo apoyar a las regiones fronterizas para afrontar sus problemas en el sector sanitario, ocasionados tanto por su alejada ubicación geográfica como por los considerables flujos de transporte legal o ilegal de personas, animales o mercancías. El proyecto también favorecerá la cooperación con los países vecinos en el ámbito de la investigación y educación, así como el apoyo al intercambio de experiencias en el campo de la sanidad pública, con el fin de desarrollar una red de comunicación y coordinación Greco/ Balcánica, organizada alrededor de los Centros TF de Salud Pública, creados para tratar las graves enfermedades transmisibles y otros problemas de salud pública de la región fronteriza.

Entre los resultados esperados podemos destacar el desarrollo de una infraestructura regional de servicios sanitarios, la definición de enfoques estratégicos para tratar los problemas sanitarios de la región, y la mejora del nivel de vida de los residentes de la región fronteriza.

Presupuesto: coste total: 1.800.000 euros

Contacto: Ms F. Tsaousi, Ministro de Sanidad y Bienestar
Departamento de Infraestructuras Técnicas, Tel +30 1 8254608

Caso C.7.18: ***Intercambio mutuo entre Servicios Sanitarios Públicos (SE/NO)***

En los habitantes de la zona fronteriza se ha detectado un cuadro patológico idéntico con un alto índice de dolencias cardiacas y vasculares. Mediante la cooperación de Strömstad (Suecia) y Fredrikstad (Noruega), este proyecto quiere ampliar el conocimiento sobre el tratamiento de pacientes con enfermedades crónicas. En Strömstad el proyecto se dirige a individuos con alto riesgo de dolencias coronarias y vasculares. Incluye el desarrollo de métodos pedagógicos y la presentación de esta información a personas con alto riesgo. En Frederikstad el proyecto va a desarrollar una cooperación con intercambio mutuo de información entre asmáticos y el personal sanitario y del hospital. Con ello se pretende aumentar la cooperación de los pacientes en relación con su tratamiento y dotar al paciente individual de un mayor control sobre su enfermedad. Una parte de este proyecto está preparando un tratamiento común, un centro de formación y una fórmula para cooperar con instituciones más avanzadas y con los servicios sanitarios de Dalsland. Se pretende crear organismos de formación e investigación tomando los proyectos de Strömstad y Fredrikstad como modelos para una mayor cooperación regional.

Presupuesto: 600.000 SEK (FEDER)

Contacto: Public Health Services of the Local Authorities/Municipalities
Bohuslandstinget (Suecia), http://server.liku.no/interreg/prodkat.html

Caso C.7.19: ***Creación de un Centro Médico transfronterizo (DE/CZ)***

El centro médico de Dippoldiswalde (DE) está situado justo en la frontera de la República Checa. Se trata de una importante zona turística, especialmente para deportes de invierno. Las obligaciones del puesto médico debidas al turismo y al tráfico internacional se multiplican por su proximidad a la E55, incluyendo el cruce fronterizo de Zinnwald/Cinovec. El equipamiento del actual puesto médico es muy pobre y los pacientes de nacionalidad checa a menudo son llevados al distrito vecino de Teplice. La atención conjunta de servicios de emergencia de ambos lados de la frontera se hace necesaria con mucha frecuencia en el complicado tramo de la E55 a su paso por la zona fronteriza.

El nuevo centro médico de Dippoldiswalde prestará su apoyo a los servicios médicos locales y también a la Cruz Roja Alemana. Esta última organización está trabajando más allá de lo convencional, con un compromiso de CTF con la Cruz Roja Checa del distrito de Teplice, que incluye colaboraciones en un proyecto específico de prevención del Sida puesto en marcha por el Ministerio de Sanidad y Asuntos Sociales de Sajonia (Ministerio de Asuntos Sociales, Salud y Familia del Estado Libre de Sajonia), con fondos de la UE.

La eficaz organización y salvaguarda de los servicios de emergencia médica es un deber importante de la comunidad. Como resultado de la puesta en marcha de este proyecto se espera que el proceso de cooperación en este ámbito continúe involucrando a un mayor número de entidades implicadas y que sirva de ejemplo para posteriores colaboraciones entre organizaciones de voluntariado que trabajen en el campo de la medicina y primeros auxilios.

Presupuesto 1 000 000 €, contribución de Interreg II

Contacto: Eurorregión Elbe Labe, Zehistaer Straße 9, D-1796 Pirna
Tel: +49 3501 520013, Fax: +49 3501 527457

Caso C.7.20: ***Cooperation and Working Together (CAWT) (IE-UK)***

Cooperation and Working Together (CAWT) in UK and Ireland meant the setting up of a cross-border Ear, Nose and Throat (ENT) service between health services of North East Dublin and Northern Ireland – and much shorter waiting times for patients.

(Folleto de projectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

Caso C.7.21: ***Refbio – Red Biomédica de los Pirineos (ES/FR)***

El conocimiento traspasa fronteras. Refbio es una red de cooperación transpirenáica en investigación biomédica en la que participan ocho entidades de cinco regiones situadas a ambos lados de los Pirineos. Su principal objetivo es la promoción de investigaciones competitivas a nivel europeo en estas materias: oncología, hematología, terapia celular, neurociencias, epidemiología y salud pública, cardiovascular, enfermedades infecciosas y ensayos clínicos.
Cofinanciado por el Programa Operativo de CTF España-Francia-Andorra (POCTEFA)
Contacto: www.refbio.eu

Between February 2009 and December 2011 the Centre for Cross Border Studies undertook five major new research, development, training and information projects funded by the EU cross-border programme Interreg IV-A. These were packaged under the collective title: ***the Ireland-Northern Ireland Cross-Border Cooperation Observatory (INICCO)***. One of the five constituent projects was:

Caso C.7.22: ***Exploring the Potential for Cross-Border Hospital Services in the Border Region (IE/UK)***

This project - in which Centre will be partnered by the Institute of Public Health in Ireland - will consist of two linked research studies on modelling hospital service planning on a border region basis, and on the democratisation of health care. The first study, which will build on a piece of initial desk research completed in late 2007, will examine the number, size, composition and possible locations of the hospitals that would be required in the future if the planning of acute services in the border region was on the basis of population needs rather than jurisdictional frontiers. It will work towards developing a prototype model of cross-border health service accessibility driven by geographical considerations around the distribution of patients (potential need and demand); the configuration of hospitals North and South (potential supply based on bed numbers and specialisms); and the transport network (modelling of accessibility based on travel time). While population modelling is important for health service planning, it is less than useful if the needs and rights of the people who use those services are ignored. The second study will examine the role of community involvement in decision making in the planning of hospital services in the border regions of both jurisdictions.

Caso C.7.23: ***Hospital Transfronterizo de la Cerdanya (ES/FR)***

El primer hospital transfronterizo de Europa proporciona a los ciudadanos de la frontera entre España y Francia acceso a servicios sanitarios de alta calidad en una región montañosa donde cada minuto cuenta para salvar vidas (folleto de proyectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015).

Proyecto iniciado en 2003. Este hospital dará servicios sanitarios a unos 30.000 habitantes del valle de la Cerdanya, a ambos lados de la frontera hispano-francesa. Ha pasado por diversas fases, desde la creación de una Fundación Privada. El 19 de marzo de 2007 se firmó una carta de intenciones para la creación de una Agrupación Europea de Cooperación Territorial (AECT). El 26 de abril de 2010, José Montilla, Presidente de la Generalitat de Catalunya, y Roselyne Bachelot, Ministra de Sanidad y Deportes de la República Francesa firmaron las convenciones y el acuerdo para constituir esta AECT. El 30 de abril, el Consejo de Ministros español aprobó dicha constitución y ordenó su publicación en el Diario Oficial del Estado.
https://portal.cor.europa.eu/egtc/en-US/Register/already/Documents/Dossier%20de%20Presse%20avril%202010.pdf

La obra fue entregada a principios de 2013. Según informa desde Puigcerdà Marina López (Acn) para *La Vanguardia* de Barcelona el 19 de septiembre de 2014 **el hospital transfronterizo de la Cerdanya ya funciona a pleno rendimiento**. El traslado del servicio de urgencias y de los pacientes ingresados ha puesto punto final a un proceso que comenzó hace diez años y que culmina con la entrada en servicio del primer equipamiento sanitario de Europa destinado a atender pacientes de dos países diferentes. Aún quedan, sin embargo, algunos "problemas por solucionar" como crear un protocolo para agilizar la repatriación de difuntos a Francia, establecer pautas para que la policía francesa pueda interrogar o tomar muestras a sospechosos atendidos en el hospital o unificar la prescripción de medicamentos porque algunos fármacos que se utilizan en Catalunya no están permitidos en Francia.

A las siete de la mañana del viernes entró en servicio el área de urgencias. A lo largo de la mañana, para evitar situaciones de caos o confusiones de los pacientes, han funcionado también al mismo tiempo las urgencias del antiguo hospital. Hasta media mañana no ha llegado la primera urgencia. Noemí, una niña de siete años y catalana, ha sido quien ha estrenado el equipamiento. A la una del mediodía ha llegado el primer paciente francés a urgencias, procedente de Porté Puymorens.

El director del hospital transfronterizo ha asegurado que estos asuntos pendientes no afectan al funcionamiento normal y diario del hospital. Jordi Gassió ha afirmado que este viernes es un "día histórico" que culmina un proyecto que comenzó hace diez años. A principios de mes, el traslado comenzó con algunos servicios de consultas externas pero la prueba ha sido el viernes, con el traslado del servicio de urgencias que puede atender desde 30 hasta 150 pacientes en un solo día, dependiendo de si es fin de semana o época turística. También han trasladado los cuatro pacientes que estaban ingresados en el antiguo hospital y ha entrado en servicio la unidad de hemodiálisis.

El coste de construcción del hospital transfronterizo ha sido de 31 millones de euros, financiados entre el Fondo Europeo de Desarrollo Regional (FEDER) y las administraciones catalana y francesa. El coste total de su equipamiento ha sido de 10 millones de euros, mientras que el presupuesto de funcionamiento del Hospital de La Cerdanya para 2015 es de 20 millones de euros. La presidencia de la AECT-HT será alternativa entre Catalunya y Francia cada dos años. El 60% de la plantilla es catalana y el 40% francesa. El centro cuenta con 67 camas (el doble de las anteriores) y ofrece los siguientes servicios: consultas externas, diagnóstico por imagen, urgencias, hemodiálisis, hospital de día, admisión, quirófanos, recuperación post-quirúrgica, obstetricia, neonatología, laboratorio y farmacia. Además pretende convertirse en centro de referencia mundial de medicina deportiva de montaña, ante la proximidad de las pistas de esquí.

http://www.lavanguardia.com/local/girona/20140919/54415224976/girona-cerdanya-hospital-transfronterizo.html#ixzz3FseoHeyI

http://www.diaridegirona.cat/comarques/2014/09/20/nou-hospital-cerdanya-ple-rendiment/688417.html

Contacto: AECT Hospital de Cerdanyahttp://www.hcerdanya.eu/ca
Cami d'Ur nº 31; E-17520 Puigcerdà (Cataluña/España); Tel. (+34) 972 65 77 77

5. Redes

Caso C.7.24: ***EurSafety HealthNet (DE/NL)***

Red de instituciones, profesionales y expertos en salud iniciada en EUREGIO (DE/NL) durante Interreg III, desarrollada más ampliamente durante Interreg IV y aspirando a extenderse en otras fronteras europeas en Interreg V.
(completar)
Contacto: Prof. Alexander Friedrich, Facultad de Medicina, Universidad de Groningen

Caso C.7.24bis: ***EUREGHA***

…
(completar)
Contacto: …

Caso C.7.24ter: ***HOPE***

…
(completar)
Contacto: …

6. e-Health

Caso C.7.25: ***Telemedicina en la Eurorregión POMERANIA (DE-PL): La Red Pomerania***

http://www.euroinstitut.org/pdf/Download-Unterlagen/2015-Berlin/HOSTEN_Telemedizin_Pomerania.pdf

Prof. Dr. Norbert Hosten

Presentación en el Taller sobre Grenzüberschreitende Gesundheitsversorgung - *(Atención Sanitaria Transfronteriza),* organizado durante la Conferencia Internacional "Los Servicios Públicos Locales en el Contexto Transfronterizo en las Fronteras Alemanas – Potenciales y Obstáculos Jurídicos y Culturales", organizado por el EuroInstitut y el Ministerio del Interior Federal de Alemania en la Representación del Land Baden-Württenberg, Berlín, 30 de junio y 1° de julio de 2015

Caso C.7.26: ***TELEDIAG (RO-RS)***

Un modelo de Salud-e ha desarrollado una red de telediagnóstico y teleconsulta transfronteriza. Los médicos rumanos y serbios comparten información y diagnóstico especializado.

(Folleto de proyectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

7. Medio ambiente y Salud

(Un ambiente saludable para mejorar el bienestar de los ciudadanos)

Siguiendo la creciente preocupación de los ciudadanos sobre la salud y la conservación de un ambiente saludable, los proyectos de Interreg han mejorado el acceso a los servicios públicos de salud y el bienestar de los pacientes en Europa. Durante los últimos 25 años, la protección del medio ambiente ha mejorado con aproximadamente unos 2.000 proyectos respetuosos con el medio ambiente.

(Folleto de proyectos "25 years Interreg Cooperation across and beyond borders", Interact, DG Regio, 2015)

Véanse varios proyectos en el capítulo C5 *Medio Ambiente*.

Caso C.7.27: ***...***

8. Otros Proyectos de Carácter Social

8.1 Handicapped

Caso C.7.28.a: ***BESPRACHANDIC (Best practise at the beginning of life - the first steps in developing handicapped children) (HU-RO)***

Description: The main aim of the project is to enlarge the professional knowledge of kindergarten teachers and developers with new and efficient methods within the frame of an in-service training. Through these trainings disadvantaged children under their care will reach a higher quality development, their life quality will improve and their chances of integration will be increase. Through the project two methods aiming early child development are devised and adapted to the Romanian local needs. One is the Montessori pedagogy applied for the disadvantaged children; the other method aims to integrate and to develop the abilities of the autistic children in a majority community. General objective: Special education teachers, expansion of knowledge of professionals working with children with disabilities, to develop new therapeutic methods. Specific objectives: 1. Transfer of best practise. 2. Training for special education teachers, kindergarten teachers, social professionals. The direct beneficiaries of the project are those teachers (45), kindergarten teachers and their helpers who take part in trainings, teachers of children with special needs. Among the project results: 1 course prepared, 1 webpage developed, 30 h of training for kindergarten teachers and special education teachers.

Web: http://www.huro-cbc.eu/

Project start date: 2012-02-29; ***project end date***: 2013-10-29; ***project status***: Closed

Total budget/expenditure: EUR 54.496,00; ***European Union funding***: EUR 45.070,40

Lead Partner: ÚJ ÉFOÉSZ Tarnai Ottó Egyesület, Nyíregyháza (HU)

Other partners: Municipality of Carei (RO)

Caso C.7.28.b: ***Cross-border cooperation - form to help to employ handicapped applicants (SK-CZ)***

Description: By support of educating activities, which leads to change of qualification structure of applicant´s help to solve the problem of disadvataged applicants

Achievements: Support of educational activities that contribute to the change of qualification structure of jobseekers with regard to labor market requirements

Web: http://www.erves.sk

Project start date: 2008-12-31; ***Project end date***: 2010-04-29; ***Project status***: closed

Total budget/expenditure: € 256.173,00; ***European Union funding***: € 201.584,97

Lead Partner: ERVES, n. o. , Dubnica nad Váhom (SK)

Other partners: EURO EDUCA, Hodonín (CZ)

Caso C.7.28.c: ***Fruitful cooperation on the labour market (HU-RO)***

Description: The general objective is the education of disadvantaged unemployed people for self-care, and self-employed on long-term. The main activities of the project are: Training, consultancy, Executing orchard planting, Elaborating a study based on survey. The target group is formed by: 30 people from Culciu Mare, and 5 farmers in Csengersima who provide a sample for garden planting of culture and 4 people employed in the social cooperative - disadvantaged (low-skilled, romani, handicapped, women), unemployed or people living from occasional, farmers providing example, who are involved in the project, enterprises, who are commissioned with the external services. Among the project results: 39 people trained, 12,5 ha of new

Web: http://www.huro-cbc.eu/

Project start date: 2012-06-30; ***Project end date***: 2013-06-29; ***Project status***: closed

Total budget/expenditure: € 196.054,99; ***European Union funding***: € 166.646,74

Lead Partner: Csengersima Község Önkormányzat, Csengersima (HU)

Other partners: Municipality of Culciu (RO)

Caso C.7.28.d: ***FITS – Strategy for Fostering Social Inclusion and Mutual Cohesion of Visually Impaired People through Sports (LT-BY)***

Description: Social inclusion is a notable problem all around the world, demanding huge financial and human resources. The social exclusion of the visually impaired people is the common problem in Belarus and Lithuania. The tight collaboration between the two countries in fighting social exclusion through sports is the core solution to this problem. Cooperation between Belarusian and Lithuanian NGOs through creation of joint sports events and exchange of good practice will combat the social exclusion of people with special needs and will foster mutual cohesion and collaboration of people. Project aims to contribute to combating social exclusion of the visually impaired people, by fostering their mutual cooperation through sports in Programme regions of Lithuania and Belarus and raising the consciousness of society upon this issue.

Achievements:

1) 2 sports halls (1 in Lith uania, 1 in Belarus) renewed and fully adapted to the special needs of visually impaired people;

2) web-site of the project developed to further inform society and the primary target group about the ongoing activities and opportunities;

3) promotional materials prepared (posters, brochures, T-shirts) to raise the visibility of the activities of the project;

4) audio books (CDs) with the information on results of the project prepared and distributed among the participating organisations (also available for free on the web-site of the project);

5) society better acquainted with the sports of visually impaired people.

Web: http://www.enpi-cbc.eu/

Project start date: 2012-11-30; ***Project end date***: 2014-06-29; ***Project status***: closed

Total budget/expenditure: € 215.260,90; ***European Union funding***: € 193.730,90

Lead Partner: Sports Club of the Blind and Visually Handicapped in Vilnius "Šaltinis" (LT)

Other partners: Belarus Association of the Visually Handicapped, Misnsk (BY)

Caso C.7.28.e: ***HU-SLO-IRON-WILL - With iron will for a life can be lived better in the Hungarian-Slovene frontier zone Z (HU-SI)***

Description: Cross-border network-building, coaching physically handicapped people for healthy lifestyle. The strengthening of the social contacts of the physically handicapped people living in the Hungarian and Slovene frontier zone, the reduction of their information “chance inequality”, the conservation of the traditional folk trades.

Expected Results: Networks between civil organizations of physically handicapped and hygienic services - The number of those, who lead healthy lifestyle from the target group's members with the help of the project (20 heads) - The number of those, who get qualification on Hungarian-Slovene basic training connected to lingual informatics basic training (18 heads) - The number of preserved traditional trades (2 pieces)

Web: http://84.39.218.249/

Project start date: 2009-06-30; ***Project end date***: 2010-06-29; ***Project status***: closed

Total budget/expenditure: € 114.067,00; ***European Union funding***: € 96.956,96

Lead Partner: Handicapped Sports Club's iron will, Szombathely (HU)

Other partners: Inter-municipal association of disabled persons, Murska Sobota (SI)

Caso C.7.28.f: ***HUSKROUA/1001/225 - Handing over methods for visually impaired persons' rehabilitation, materialized already in the region of Northern Hungary, to the partners from abroad (HU-RO-UA)***

Description: The overall objective of the joint action is to transfer, hand over the Ukrainian and Romanian partners, methods for visually impaired persons' rehabilitation, materialized already in the region where the Applicant organization is activating. Specific objectives: Training the experts methods and techniques of working with, supporting visually impaired persons, methods that have already been applied by the Applicant with positive outcomes, Training directly visually impaired participants in camps, Training and handing over guide dogs to blind persons in the action areas. Main activities: Project management; Training experts working with visually impaired persons; Organizing camps for visually impaired persons assisted by trainers and experts; Training and handing over guide dogs; Project publicity.

Achievements: 20 trained experts; at least 21 visually impaired persons participating to the camps; 4 camps organized for experts and visually impaired persons; 3 street forums organized for the public; 6 guide dogs trained and handed over to 6 blind persons; 1 web page; 1 publication published in 700 copies, in 3 languages, a total of 2100 copies.

Web: http://www.huskroua-cbc.net/

Project start date: 2012-04-14; ***Project end date***: 2013-08-13; ***Project status***: closed

Total budget/expenditure: € 110.981,00; ***European Union funding***: € 99.882,00

Lead Partner: Búzavirág Foundation, Vámosújfalu (HU)

Other partners:

- "Angel Dog" Association, Satu Mare (RO)
- Uzhgorod municipal non-governmental organization of visually handicapped people «Dyvosvit» (UA)

Caso C.7.28.g: ***INTERFACE - Intermodal cross-border passenger transport solutions supporting regional integration of interface regions in South Baltic Area (DE-DK-SE-PL)***

Description: Crossing SBA as foot passenger by ferry has lost its importance during the last decades. This trend has triggered a circuit of negative effects, becoming evident esp. in interface areas. Services of infrastructure providers & transport operators are adjusted to cargo & car passenger traffic only, whereas raising service requirements of foot passengers were neglected completely. Ferry ports do not even offer a minimum of service quality, but present themselves as unattractive waiting areas. Transport operators linking ports with cities strongly lack interoperability. Access for people with reduced mobility is limited. Infrastructure gaps additionally hinder smooth transport chains. As a consequence attractiveness of cross-border foot passenger transport is poor & suffers a low demand. Thus Interface main objective is to develop foot passenger traffic to a comfortable & environmental friendly alternative for SBA cross-border travel. In detail the project wants to upgrade the service environment in ferry ports, facilitate access for handicapped, improve interoperability between ferry & transport means linking ports with city centres, implement intermodal passenger information, prepare investments to close gaps in transport infrastructure & promote improved connections. Major target groups are foot passengers, traffic operators, ports & port cities. Partnership reflects practicability, sustainability & interoperability. Project activities are focused on the transport axes Karlskrona-Gdynia, Gdansk-Kaliningrad & Trelleborg/Gedser-Rostock but consider ports in the whole SBA as well. Interface improves the service quality for foot passengers in ferry ports by analysing their service infrastructure in the light of customers needs & setting minimum standards for service environment based on a SBA-wide benchmark study. The results will be compiled in port related action plans. First implementations will be started. Interface closes gaps betw. ports & cities & improves interoperability by harmonizing timetables, implementing intermodal (passenger) info systems/communication tools, testing new shuttle services & preparing feasibility studies for infrastructure investments. Finally improved connections will be spread to the public by developing & testing intermodal combi-tickets, connected with target

group-oriented offers & accomplishing advertisement campaigns & awareness conferences. Expected results are: Enhanced number & satisfaction of foot passengers in SBA, accelerated interoperability of passenger transport means, easier access to intermodal traffic information, better consideration of (handicapped) passenger rights, increased role of cross-border public passenger transport, enhanced economic efficiency of public transport systems, better prerequisites for infrastructure investments diminishing gaps & upgrading service environments, speeded up regional integration, enhanced benefit of SBA interface cities from passenger transport, increased political awareness.

Achievements: INTERFACE corporate design implemented. Project Website www.interfaceproject.eu developed. Three international workshops carried out. Four public and political awareness events accomplished in Gedser, Rostock and Gdynia. More than 800 involved participants at project meetings and events so far. Four Image films about the project and its outputs produced. TV spot in German and Polish TV broadcasted. Several press conferences performed. Different kind of promo material for INTERFACE produced and distributed, Communication strategy and dissemination plan elaborated and maintained. More than 60 newspaper articles about the project published. Awarded 2nd place in South Baltic project competition. 3 posters, displaying the project achievements produced and presented. Four passenger requirement analyses elaborated, covering more than 3.000 interviews in the ports and on board ferries between Gdynia, Karlskrona, Gedser & Rostock. A plan for reconstruction of Gedser port developed. One comprehensive foot passenger services related benchmark study elaborated, covering comparative investigations of foot passenger services in 9 South Baltic ferry ports and resulting in over 320 recommendations for hard and soft infrastructure & service improvements. First service improvements implemented in selected ports –passenger signs in Karlskrona, Rostock, Trelleborg, Gedser & Gdynia, automatic doors for handicapped passenger in Gdynia ,etc.. New ferry terminal in Rostock with improved service for foot passengers. Started with test operations in 2010, two new direct bus shuttle services between Gdynia/Rostock main station and port established in 2011. As a consequence of this and simultaneously harmonization of schedules, more than 200 cross-border ferry crossings per week synchronized with public transport services in Gedser/ Nykøbing, Rostock and Gdynia/Karslkrona. New bus stop in Gedser established directly at the ferry gate. An agreement (contract) between Scandlines, VVW & Movia on long-term operation of Intercombi-ticket was signed. Almost 20 different pieces of materials containing intermodal and cross-border info produced for Karlskrona, Gdynia, Rostock & Gedser (Signs at bus stations, inside terminals, busses and ferries, new or updated internet pages, different multilingual flyers & brochures.). New internal communication systems established between involved transport operators to provide mutual up-to-date info on foot passenger numbers, combi-ticket bookings, delays, etc. Feasibility study for new bus shuttle service in Rostock as well as enlarged rail connection between Karlskrona Port and Inner City elaborated. Nine action plans with recommendations for improved interoperability of cross border passenger connections for 9 SBA interfaces developed. First South-Baltic intermodal foot passenger information system launched: www.portlink.eu C 5: Cross-borderCombi-tickets developed for Rostock-Gedser (InterCombi- Ticket) and Gdynia-Karlskrona. InterCombi-Ticket is bookable online at new website www.intercombi-ticket.de. Huge cross-border marketing campaigns for the new offers developed. More than 100.000 flyers, brochures and posters as well as image films and websites produced. Different bookable cross-border tourism packages (focused on foot passengers) developed & tested for Karlskrona-Gdynia and Rostock- Gedser. Three cross-border events carried out in Gedser & Rostock. A comprehensive marketing study for the connection Gdynia-Baltijsk was elaborated. Cross-border workshops carried out with tourism experts and representatives from the retail industry to give developed cross-border tickets a push in sales. 8 interactive information boards were installed on board of ferries, ferry terminals and in tourism offices of Guldborgsund, Rostock, Karlskrona and Gdynia. Passengers can a.o. find travel information and tourism information from both side of the relevant transport connection. A special feature is that some of the boards are connected with the new online information system for foot passengers www.portlink.eu

Web: http://www.interfaceproject.eu

Project start date: 2009-04-26; ***Project end date***: 2012-12-30; ***Project status***: closed

Total budget/expenditure: € 1.608.100,00; ***European Union funding***: € 1.251.450,00

Lead Partner: Hanseatic City of Rostock (DE)

Other partners: Guldborgsund Municipality (DK), Karlskrona Municipality (SE), Municipality of Trelleborg (SE), Public Transport Association Warnow (DE), Port Authority Rostock (DE), Public Transport Association Blekinge (SE), Polish-Swedish Chamber of Commerce in Gdansk (PL), Port of Karlskrona/ Kruthusen (SE), Ministry for Transport, Building and Regional Development Mecklenburg-Vorpommern (DE), Regional Planning Association Mittleres Mecklenburg Rostock (DE), Gdynia Municipality (PL)

Caso C.7.28.h: ***IPBU.03.01.00-06-715/11 - Cross-border cooperation for education, rehabilitation and tourism of people with disabilities - reconstruction, development and adaptation of buildings and rehabilitation in Alojzów Lviv (PL-UA)***

Description: Overall objective is to improve the quality and availability of rehabilitation and educational services targeted to people with mental disabilities in the border area. The achievement of the overall objective of the Project will have a significant impact on the development of centres such as Polish Association for Mentally Handicapped Werbkowice Circle and Dzherelo Educations and Rehabilitation Centre as it will enable them to use owned but not yet utilized premises. Thanks to this, these centres will be able to support more people who need it. Project is also about establishing cross-border cooperation to help and support for people with mental disabilities, improving of the rehabilitation and educational infrastructure through the development and adaptation of centres in Alojzów and Lviv and exchanging of knowledge and experiences in the area of care of people with disabilities and integrated training of personnel in the field of rehabilitation and integration.

Web: http://www.pl-by-ua.eu

Project start date: 2013-05-06; ***Project end date***: 2015-05-05; ***Project status***: closed

Total budget/expenditure: € 2.273.083,91; ***European Union funding***: € 2.045.775,52

Lead Partner: Polskie Stowarzyszenie Na Rzecz Osób z Upośledzeniem Umysłowym Koło w Werbkowicach (PL)

Other partners: Dzherelo Educations and Rehabilitation Centre, Lviv (UA)

Caso C.7.28.i: ***RECReate - Re-vitalisation of the European Culture Route in the South Baltic Area – Pomeranian Way of St. James (DE-PL-LT)***

Description: The project aims at reinforcing the existing cultural heritage to use it for regional development as a new tourist product in the SB Region - Tourist Route of St. James and at mobilisation of local societies (in particular young people) around join initiative. The Routs of St James have recently gained importance (added to the UNESCO list of cultural heritage in 1987) due to the desire of the European citizens to come back to the European cultural roots. The evidence can be a book "Ich bin dann mal weg. Meine Reise auf dem Jakob" by famous TV presenter Hape Kerkeling. Such routes established in Germany, Southern Poland and in many other countries enjoy a high level of popularity. The main idea behind is encouraging people to a slow move through different countries and regions tasting their diversity and understanding their specificity. This corresponds to ancient habits when people spent hundreds of days moving to Santiago de Compostella being exposed to cultural diversity, new ideas and development trends. St. James Route also used to exist in the SB Region stretched from Konigsberg through Gdańsk and Szczecin to Rostock and further on westward. The project aims at restoration of this particular Route and joining the existing heritage with broader European network. This is not a simple tourist project. It aims at "social inclusion" of social groups rarely engaged in such form of tourism e.g. families with young children who rarely visit Mecklenburg-Vorpommern (M-V) or old in many cases less educated people from Lithuania or Poland who normally spent their holidays home. It will create for them opportunities to visit neighbouring countries in inexpensive way. It will also enable handicapped people to take part in the tourist undertakings. Last but not least it will mobilise local social groups around the Route idea by e.g. training volunteers to serve and assist Route users. The important added value of the project is economic and social activation of the areas lagging behind both in Poland and in Lithuania and better use during off peak season of the existing tourist facilities. The project also offers the SB better positioning at European level. The region will become a part of a wider pan-European undertaking i.e. European tourist network rapidly gaining importance. The project will be composed of four components: C1 management, C2 dissemination, C3 creation of the route, C4 building a social part of the Route. The logic of the project is based on two features: need to capitalize on existing cultural heritage and on existing experience: transferring know how from Germany to Poland, Lithuania and Russia and testing its application in those countries. The main results are following: establishment of a new SB tourist product, social activation of the regions lagging behind, increased tourist mobility among social groups rarely engaged in high quality tourism.

Achievements: There were few significant project events during the 1st reporting period: opening concerence, conferences in Gdańsk and Elbląg, study visit in Santiago de Compostela and many smaller but important project meetings. All partners gathered during 2 steering group meetings and workshop in Greifswald. There was also decided that there will be 3 working groups of the project and partners have divided the most importatnt tasks and responsibilities. There were undertaken numerous promotional iniciatives, for example, first newsletter, project news on websites of partner institutions and project websites with internal forum. The stock-taking process was also iniciated during this reporting period. In second half of 2011 partners met during meetings in Lębork, there were established action plans, LB created 2nd newsletter, Partners 3, 5 and 7 organized seminars for local stakeholders. During 3rd reporting period partners met one more time during project workshop in Greifswald and participated in steering group meeting. There were also organized conferences in Szczecin, partners participated in few events as guests and informed about the project. Started process aiming at pilgrim accomodation in the neighbourhood of St James Church in Lębork. There were collected the ideas concerning the ways of signing and promoting St James Way during consultations with many institutions and organizations (incl NGO) which already have an experience in signing its area. There was selected a contractor for preparing a technical project of the route in Westpomeranian, which contains detailed specification of the course, applying for all necessary administrational permissions and preparing a complete specification of signs used on the route. Some of the partners have already planned participation on trade fairs in 2012 and 2013. Another achievement is the model of how to establish a route as a touristic product, which was presented during the conference in Szczecin. All partners paid attention to promotion and dissemination of the project and its first results - project leaflets, articles in press, news in radio, updating project website, displaying logo in new places. There took place first of the series of trainings on the route - first in Duninowo and during next reporting period there will take place next meetings in other towns. LB published two new newsletters. Project website has been systematicly updated. Representatives of P1 and P2 visited Kaliningrad and fixed the issue of Russian part of the route. There also started works on preparing materials to the book guide. The most important achievements of last few months was to provide accommodation for pilgrims in two important town where the way of St. James goes. In addition, a very important indicator was to prepare and deliver to the Museum in Lębork 30 audioguides. There were created new promotional materials, the project has been introduced during fair trades and started the process of organizing seminars on the route. In addition, there took place 3rd and last know-how seminnar in Greifswald. Project partners trained number of volunteers, hosts and young people willing to create the route, many people were met and encouraged during international tourist trades and local meetings. All partners work on promotion and dissemination - project website is still being updated, LB publishes project newsletters of the website, the SB logo was displayed in new places and promotion also took place in the media. There were marked 1045 km of the route in Pomorskie and Zachodniopomorskie. 1st international pilgrimage of St James went from Gdańsk to Lebork in July 2013. PP2 orgabized oficial opening of the route and LB organized closing conference. The project was promoted during fair trades in Dusseldorf, Augsburg and Warsaw. There was also printed guide book and there was broadcasted promotional movie "Pomeranian Way of St James". In Zachodniopomorskie there were bought 5 multimedia kiosks. Few partners ordered additional tourist guide print and map's print.

Web: http://2007-2013.southbaltic.eu/index/

Project start date: 2011-01-01; ***Project end date***: 2014-12-31; ***Project status***: closed

Total budget/expenditure: € 1.372.741,93; ***European Union funding***: € 1.163.430,64

Lead Partner: Lebork Municipality (PL)

Other partners: County of Lebork (PL); Westpomeranian Region, Szczecin (PL); Self-Government of the Pomorskie Voivodeship, Gdansk (PL); "Szczecińska" Foundation, Szczecin (PL); Pomorskie Tourist Board, Gdansk (PL); Kretinga district municipality administration, Lretinga (LT); Ernst Moritz Arndt University of Greifswald (DE); European College Of Hotel Management, Tourism And Entrepreneurship (PL)

Caso C.7.28.j: ***STEP - Sustainable Tourism in Estuary Parks (NL-BE-UK)***

Description: Partners in STEP aim to tackle the environmental concerns faced by estuaries, such as industry, climate change, rising sea levels and decreased agricultural usage, by developing sustainable tourism in those areas. The partnership brings together a great deal of knowledge and experience in the field of the development and management of nature, tourism and education in water-rich nature reserves. Because environmental issues affect countless

European estuaries, partners have chosen crossborder cooperation to find adequate solutions and to implement the European Charter for sustainable tourism. Over the course of the project, the sustainable concept will become tangible as the project produces a handbook for sustainable facilities, an action-plan for branding sustainable tourism, an action-plan for visitors management in estuarine nature, new visitors management tools and publishes study reports.

Expected Results: What are the key results of the project? Studies and plans -action plans for promoting sustainable tourism; website and a green destination guide -reports on the visitor surveys, workshops, peer reviews, designs/technical specifications for sustainable amenities - development of visitor management plan in Polders of Kruibeke - report on the feasibility study carried out into public-private cooperation in the Polders of Kruibeke - concepts for involving inhabitants, visitors and companies: visitor pay back systems -(re)submitting applications of The Biesbosch and The Broads to obtain the EU Charter - participation plans for involving new target groups - proposals for the usage of new ICT technologies at visitors' centres, for routes and on location - economic valuation of tourism and improvement plans for the visitors' centres in The Broads and de Biesbosch Education and Training resources - information and education programs concerning themes as climate, biodiversity and safety - monitoring programs and report on the initial measurement (baseline measurement) - new nature experience and package programs for De Biesbosch Sustainable tourism resources for companies - company checks for Green Key and Green Tourism Business Scheme - concept for new Quality Charters in The Broads - manual and checklists for carrying out company checks and supporting tourist companies to become more sustainable Pilots -small scale investments; (cycle) paths, camp sites, hiking shelters, observation decks, signposting, fishing infrastructure, electric charging stations and ferry links - GPS-routes - new public-private cooperation in de Biesbosch - development and promotion of new sustainable products and services - new cooperations with companies in The Broads Are all partners and territories benefitting from the results? Target groups which will and already have experience a direct, positive effect from the executed actions are; nature organisations: Staatsbosbeheer and Agentschap voor Bos en Natuur; nature and recreation authorities: Parkschap NP De Biesbosch and The Broads Authority; water managers: Waterwegen en Zeekanaal; municipalities: Dordrecht, Drimmelen, Norwich, Kruibeke, Rupelmonde, Basel; provinces: Zuid-Holland and Noord-Brabant, Antwerpen, Norfolk and Suffolk as well as the tourist industry in and around De Biesbosch, The Broads and the Polders of Kruibeke. End beneficiaries of this project are; the inhabitants and neighbours of the three areas; visitors: ramblers, cyclists, water-based sports enthusiasts, fishermen, etc.; companies: bars, restaurants, hotels, camp sites, bicycle and boat rental companies, suppliers; visitor centres and museums in the areas as well as the particularly hard to reach target groups such as young people, minorities and the handicapped. All of the above mentioned target groups, end beneficiaries and of course also all involved territories benefit from the activities carried out and the investments made aimed at making the three areas more accessible, the tourist infrastructure is expanded, improved digital information provision is created, explanations of nature and landscape are improved, it becomes possible to enter the area on board electrically driven vessels and simple accommodation is created. Companies and museums will benefit from more visitors, sustainable amenities, the improved branding and marketing of the areas and better public-private cooperation. What are the effects / outcomes for the territories involved? In the Biesbosch more companies will work sustainably. The area will be more accessible for visitors using electric boats, bicycle or hiking. An important effect is the intensified cooperation between companies. The area will be used more sustainably by visitors and inhabitants, so impacts on nature and landscape will decrease. In the Polder of Kruibeke the access-plan and the design of the northern reception site will give local people more possibilities to meet, recreate in different ways and enjoy the nearby nature area in a safe and modern manner without jeopardizing the nature and safety goals of the area. Through access-plans, locals will be able to enjoy their ‘backyard’ again without jeopardizing nature. Economic opportunities for the local area will be created, as the Polders of Kruibeke becomes more known to tourists. In the Broad more companies will work sustainably and become Green Tourism Business Scheme companies. The area will be more accessible for visitors using electric boats. More information will be available for special interest groups (climate and biodiversity) and for difficult to reach target groups. The area will be used by visitors and inhabitants in a more sustainable way and negative impacts on nature and landscape will decrease. In all areas of the project, the information about the area, nature, landscape and facilities will be improved by digital information in visitor centres, on locations, on websites, smart phones, brochures etc.

Web: http://www.step.eu

Project start date: 2008-06-30; ***Project end date***: 2013-06-29; ***Project status***: closed

Total budget/expenditure: € 6.061.348,00; ***European Union funding***: € 2.528.795,00

Lead Partner: Natuur- en Recreatieschap De Hollandse Biesbosch, Dordrecht (NL)

Other partners: Stichting Beheer Nationaal Park De Biesbosch, Drimmelen (NL); Waterwegen en Zeekanaal, Antwerpen (BE); Agentschap Natuur en Bos, Gent (BE); Broads Authority, Norwich (UK)

Caso C.7.28.k: ***SUFACARE – Supporting Family Caregivers and Receivers (FI-EE)***

Description: Aims of this project are to improve the work conditions, living conditions and improve social inclusion of caregivers/receivers in Finland and Estonia.There are differences in home care systems and practices between countries, also variations within each country and differences between urban and rural regions. However, the problems and aims are similar for all, and it is important to develop the home care system, for the caregivers/receivers sake and for decreasing the costs for eldercare and care for handicapped for the society. Project regions are Tallinn,Rakvere,Helsinki,Raasepori, Salo. The program consists of evaluation, education/information courses for caregivers, supportive functions, better physical/mental functional capacity, improving environmental indoor/outdoor accessibility,increase social participation by info/practical assistance and finally to form a model of home care system which includes all before mentioned ingrediences. Proposal for home care system is presented WP1:Adm. of the project and publishing the project results at the end, WP2:evaluation of the situation by survey (totally all regions n=2000) and interviews (n=200) of caregivers/receivers(Estonian language in Est./Finnish/Swedish in Finland): needs for support, accessibility, resources, networks WP3: a) Info/education course for caregivers (n=300)(soc & health care system, health promotion, self-care, how to solve practical problems, about mental health/disorders, help with job control), with follow-ups in every 3 mo, b) practical supportive system for help (24h),ICT-support (pilot study) c) improve accessibility in environment, ergonomics, improve physical/mental functional capacity, WP4: increase social participation by assisting in networking, creating hobbies, clubs, leisure and citizen activities (choir, art etc). Project group creates and offers different models for social participation and cultural involvement and hobbies and helps in information and in practical arrangements WP5: to create a model which includes all the sub-items mentioned before. To create a model for good and cost efficient home care, which promotes the well-being and social inclusion of family caregivers/receivers. The model shall be tested during the program in several pilot studies and the cost/benefit relationship shall be evaluated and compared with the home care systems which are usually in use in Estonia and Finland. The model is based on previous knowledge, our evaluation survey, interviews and our experiences of educational courses, professional consultations, accessibility outcome, assisted social participation activities and pilot studies. The model aims to: 1) improve the knowledge of caregivers by education/info,2) improve accessibility, 3) give supportive tools and aid systems (job breaks, immediate help etc), 4) increase social participation by practical assisted leisure and citizen activities. We shall make proposals for improving living conditions in city and rural área.

Achievements: The SUFACARE project created a practical model for informal and formal elderly care in Estonia and Finland, providing solutions for family caregivers and caretakers as well as professionals working with home care in both urban and rural areas of both countries. The model comprises a set of tools to improve the situation. These include education for caregivers to help them in their daily work, practical solutions for better security in home care, better networking and more cost-effective solutions. The project also created tools for social participation in neighbourhood help and social networking as well as leisure, community and cultural activities.

Web: http://www.centralbaltic.eu/

Project start date: 2009-09-01; ***Project end date***: 2011-12-31; ***Project status***: closed

Total budget/expenditure: € 529.999,00; ***European Union funding***: € 416.999,00

Lead Partner: Arcada University of Applied Sciences, Helsinki (FI)

Other partners: Universitz of Tallinn (EE)

Caso C.7.28.l: ***Wind up the barriers (continuation) - Analysis and advice for the best solutions for the disabled people and their environment (DE-PL)***

Description: Current situation of SB regions is diverse and so is the situation concerning the disabled people and their environment which is the target group of the project. Partners' organisations have come up with common needs and goals which is finding new methodology for

activation of the disabled in accordance with which the representatives of the disabled would be able to prevent development of problem as soon as it is identified and as soon as it comes into existence, and hereby to avoid severe future outcomes. Invoking integrated social work is necessary to cover all socially weak groups of the society.It is project's aim to determine to what extent the providers of social services are able to meet the needs of support recipients.Governmental and non-governmental organisations having faced problems of the disabled search for new methods to solve them. People with mental or physical or social disabilities often show willingness to be engaged in daily useful as well as occupational activities and to participate actively in the life of the society is still in existence.Close collaboration of specialists of all spheres (health, education, social assistance, occupational rehabilitation, consultancy) is of high importance.Such project research includes knowledge, experience exchange and acquisition. To find the right way, first of all it is necessary to evaluate the present situation properly.Joint analysis of Partners' regions will bring the wider view on problems.The results will be obtained due to joint activities. The activities will be prepared to test methods of supporting the disabled, and what means should be applied to activate the disabled into the social life and labour market. The activities within pilot components are called Open World, Occupational Rehabilitation Centre, Psycho-social Therapy Center. For most precise study and egagement of target group there will be workshops and study visits.They will be coordinated by appointed Partners and evaluated during meetings of Partners. The results of the research and study activities will be best methods for activation of the disabled, the level of self-reliance and obstacles for the disabled in their environment tested in Partners' regions which will be described in Good Practice Handbook.Formal agreements on cooperation between governmental and non-governmental organisations will be concluded concerning implementation of resulting methods and supporting the organisations that will follow the good-practice activities.Administrations of Stralsund and Kleszczewo Kościerskie/Zblewo commune will gain base materials for modernized strategies on development of services concerning the disabled. Research will help governmental and non-governmental organisations to ascertain the problems that are the most severe, the true needs of the clients and the changes that have to be implemented while organizing social work with the disabled people.

Achievements: The main achievements in the project-continuation are so far: - periodical management-meetings (January, February and June 2012) and regular telephone conferences - Adaptation of the study design to the new project application - Analysis of the initial situation in the Stralsunder Werkstätten through guidline-based interviews - Development of survey instuments for a situation analysis of disabled people: questionnaire for handicapped people, questionnaire for companies, questionnaire for handicapped people, questionnaire for staff, and questionnaire for relatives and support persons - Implementation of a written questionnaire in companies in the region of Stralsund - Implementation of a survey of disabled people in the Stralsunder Werkstätten - Analysis of the situation concerning help for disabled people in Poland on the basis of secondary literature - Adaption of the survey instruments to the polish situation - implementation of a written questionaire of disabled people, staff and relatives and support person of pogoda - realization of a study visit in Stralsund and a workshop for expert staff - realization of two study visits in Poland with two workshop - one for relatives and support person and one for disabled people - realization of three workshops with staff of the LB for the development of testinstruments for pilot components on the bases of the survey results in the different target groups - development of structuring of good practice handbook - writing the theoretical part - capital 1-5 - and writing the practical part - capital 6-with appendix - beginning of translation of parts of the good practice handbook in polish language Partner no. 2: The program of the Open world Club was pursued with Pogoda participants of the project. There have taken place tours with disabilities to swimming pool, "My Fair Lady" show in theater and trip to castle in Malbork. Furthermore there were other activities concerning learning social competences and getting to know some possible jobs. during the last period the following activties were held in Pogoda: - Carnival party in restaurant Twardy Dol - Joint meal in restaurant Starogrod - easter breakfast in Twardy Dol - football tournament in Chojnice - trip to museum in Gdansk - trip to Malbork Castle - Joint meal in restaurant Grodzisko - meal in restaurant Twardy Dol Furthermore there were other activities concerning social competence and getting to know some possible jobs. People with disabilities participating in the project were taught self-reliance, care of their own garden, play musical instruments and enjoy an actice sports. Two partner management meetings were held in Kleszczewo Koscierskie - Poland (27 February 2013 and 24 June 2013); Two sudy visits were held in Kleszczewo Koscierskie - Poland (28 February 2013 and 25 June 2013); Two workshops were held in Kleszczewo Koscierskie - Poland (01 March 2013 and 25 June 2013)

Web: http://2007-2013.southbaltic.eu/index/

Project start date: 2010-05-31; ***Project end date***: 2013-09-29; ***Project status***: closed

Total budget/expenditure: € 720.744,00; ***European Union funding***: € 612.632,40

Lead Partner: Rehabilitation Center of Stralsund (DE)
Other partners: "Pogoda" - Association of People with Disabilities, Kleszczewo Kościerskie (PL); Institute of Social Research and Further Training, Neustrelitz (DE)

9. PROYECTOS NO EUROPEOS

Caso C.7.29: ***Comitê binacional de Integraçao em Saúde Santana do Livramento-Rivera (BR-UY)***

…

Caso C.7.30: ***Hospital Transfronterizo entre Burkina Faso y Malí***

…

(video AUBP)

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(seguir completando la bibliografía)

Cross-border Health in the European Union

Guillermo Ramírez, M.
Association of European Border Regions
Gronau, Westphalia, Germany
(*et alii*)

Arbeitsgemeinschaft Europäischer Grenzregionen (AGEG)
Asociación de Regiones Fronterizas Europeas (ARFE)
Association des régions frontalières européennes (ARFE)
Association of European Border Regions (AEBR)
Comunità di lavoro delle regioni europee di confine (AGEG)
Europæiske grænseregioners Arbejdsfællesskab (AGEG)
Werkgemeenschap van Europese grensgebieden (WVEG)
Associação das Regiões Fronteiriças Europeias (ARFE)
Σύνδεσμος Ευρωπαϊκών Συνοριακών Περιφερειών (ΣΕΣΠ)
Stowarzyszenie Europejskich Regionów Granicznych (SERG)
Ассоциация Европейских Приграничных Регионов (АЕПР)

12th Conference
International Society of Travel Medicine
8th-12th May 2011
John B. Hynes Veterans Memorial Center
Boston, Mass., USA

There is a need of building an authentic European Healthcare System. Cross-Border Cooperation in healthcare can be very cost-efficient, while increasing the health status of the citizens and adding value to the European integration process.
From "Europe and Health" to a "Europe of Health".

50 years of Cross-Border Cooperation (CBC) in the European Union (EU)

CBC across the EU's internal and external borders has been a fact during the last 50 years. The EU has promoted this territorial cooperation between regions and municipalities in all 27 Member States and neighbouring countries in order to overcome difficulties faced by citizens living in border areas (more than 30% of the EU population) regarding their location, infrastructures or services.

CB Health issues

Patient and personnel mobility
New skills and jobs
R&D and Innovation
Mutual learning
Involvement of Local and Regional Authorities
Healthcare
Recognition of qualifications across borders
e-Health
Benchmarking
Emergencies
Sharing equipments
Social inclusion

National Logics vs. EU Integration

Many fields are covered by CBC, but the provision of cross-border services, particularly healthcare, is still difficult because of imperative national logics. Despite of the freedom of movement of citizens, goods, services and knowledge enshrined in the European Treaties, Europeans are still far from sharing some basic services, adding real value to the European integration process.

It is not only about travellers, businessmen and tourists, but also about a special population that counts for more than one third of Europeans: citizens living at border areas. These areas are in many cases rural and peripheral, sometimes with considerable handicaps when compared with European or national standards. Bilateral agreements, European funding, political will, and many de facto solutions have solved many daily problems, but a European-wide regulation is still missing.

"Bottom-up" Efforts for CB Healthcare

In a growing "open borders" process, hesitations to make real steps create more misunderstanding amongst EU citizens and stress in patients, health professionals and authorities. CBC in healthcare can be considered a tradition in many European border areas, in particular in the structures known as "**euroregions**", as it was evidenced by the **EUREGIO Project** (Evaluation of cross-border activities in the EU, Good Practices for Better Health) developed by the Institute of Public Health of North-Rhine-Westphalia (Germany) and other European organizations, like the Association of European Border Regions (**AEBR**), which has created a specific Task Force to deal with Cross-Border Healthcare.
EUREGIO II deals with "Solutions for improving health care cooperation in border regions" (http://inthealth.eu/research/euregio-ii/); and
EUREGIO III with "Learning Lessons from Health investments in EU Structural Funds 2000-2006" (http://inthealth.eu/research/euregio-iii/), under the leadership of the **University of Maastricht**.
Other relevant actors are **HOPE** (European Hospital and Health Care Federation); **EPECS** (European Patients Empowerment for Customized Solutions); **EMPIRICA**; **euroregions**, **regions**, **EGTCs**, and many others.

"Top-down" Efforts

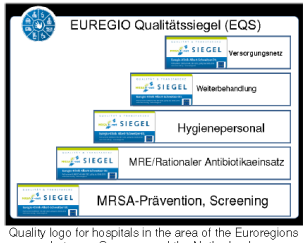
Increased **patient mobility** in the EU and some rulings by the European Court of Justice, as well as Member States' needs of clarification has lead to an **EU Directive on Cross-Border Healthcare and Patients' Rights**, adopted on 28th February 2011. Concentrated on cost refund and prior authorization for certain services provided in a different country than the one of residence, it does not address the reality of border citizens. Member States still have their own saying in how far they want to go, though European institutions want to implement a real European e-health system, as defined in the Portorož Declaration (Slovenia, 2008) and regulate quality and safety standards, but these will hardly be addressed at EU level, kept limited to cooperation between States. Their sovereignties play a key role when dealing with healthcare, but it is the time for the EU to go one step forward to strengthen the integration of all European territories.
Actors: **Committee of the Regions**' Interregional Group and Technical Platform for Cooperation on Health; **European Parliament**, **European Commission** (DG SANCO) and the **EU Members States**.

Map of European CBC areas

There are many examples of CBC in health related issues. From University Hospital cooperation to genuine CB Hospitals (Cerdanya), high-tech cooperation between urban areas, CB prevention programmes, nursing home, home care, CB training, CB cards, telemedicine, etc.

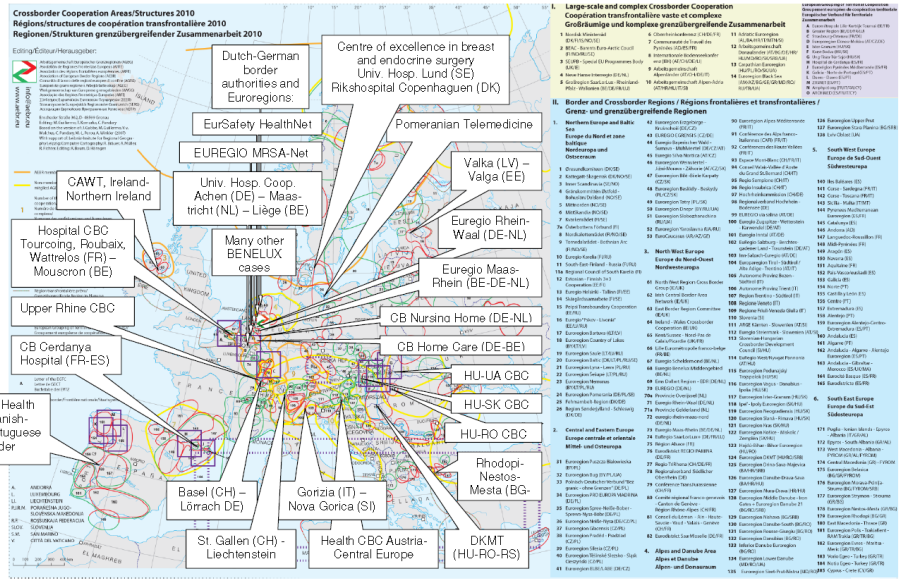
Hundreds of projects have been implemented only in the last decade, and most European border areas have developed any type of cooperation.

What's next? The experience of local and regional authorities in cooperating for the benefit of their populations is triggering an authentic process of integration simultaneously at many European border areas.



Quality logo for hospitals in the area of the Euroregions between Germany and the Netherlands

Courtesy of Prof. Alexander Friedrich
University of Groningen (NL), EurSafety HealthNet



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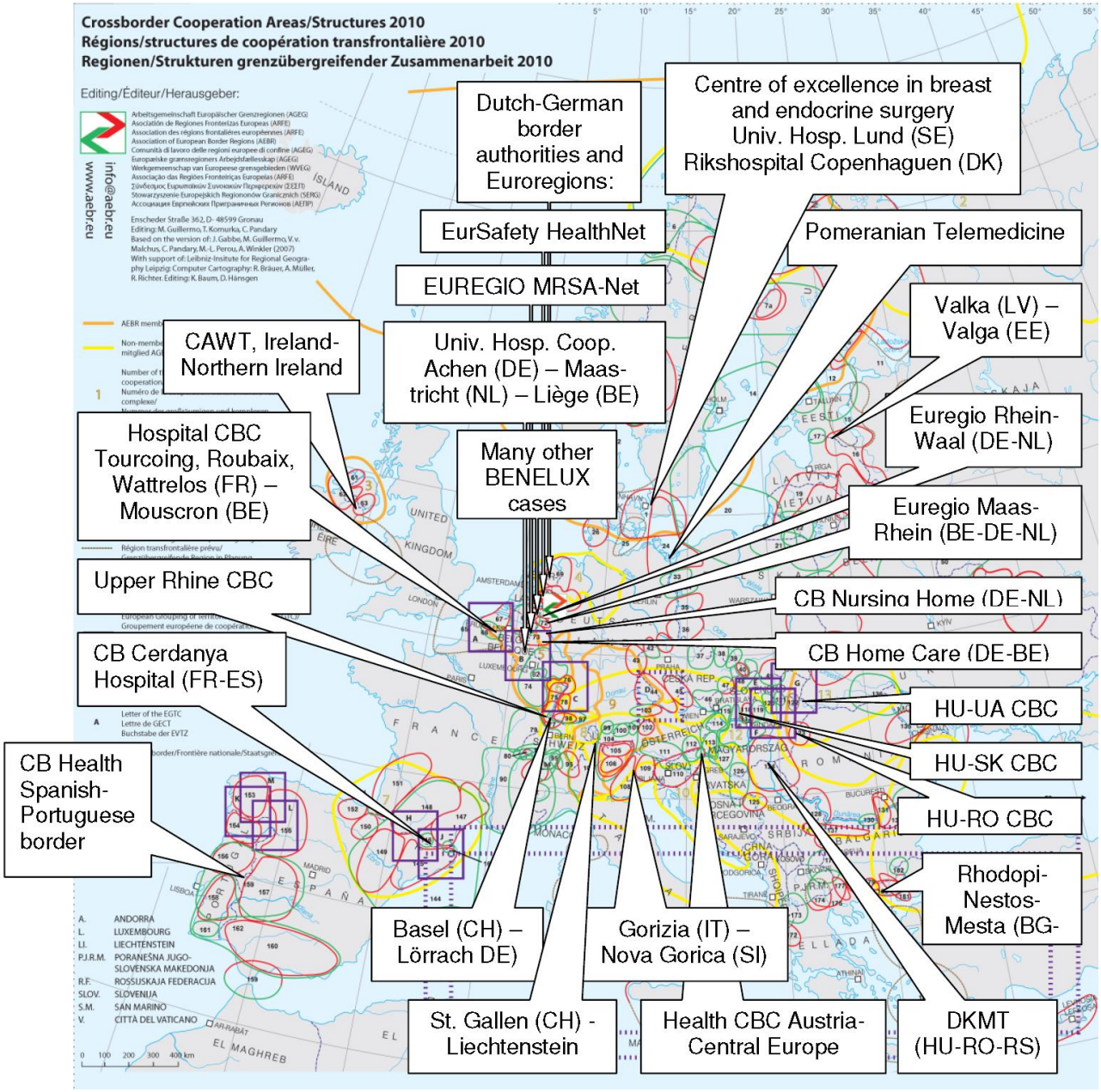
Casos de CTF en asuntos sociosanitarios



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