The difficult case of healthcare cooperation across borders: German-Polish bilateral arrangements in the light of previous European borderland experiences

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Abstract: This chapter discusses the state of Polish–German bilateral relations on healthcare and health policy, focusing on the potentials and practices in the regions and municipalities situated close to the border. Reviewing actions taken, discussed or highlighted by Euroregions, twin towns, intergovernmental bodies and media, the chapter finds that the overall activity level in this field is low compared to other policy sectors, even though there are signs of increased cooperation. The analysis shows that the cross-border integration and bilateral relations in the health sector are impacted by the asymmetric resources on the respective sides of the borders. This has largely spurred an increase in private exchanges but hindered the effective development of integrated public services at the local level. This is related to the notions of interdependence, where actors and citizens do not perceive their health or health sectors to be affected by their neighbours' activities, despite larger global systemic interdependence that concern human health. The analysis also demonstrates that historical legacies have relatively little importance in the area of healthcare. At the subnational level, lack of social capital and difficulties of local cross-border actors to efficiently work the multilevel governance scales were found to be key obstacles.

Introduction

Healthcare has strong symbolic power as a policy sector that is close to the nation state's core responsibility to keep its citizens safe. As was vividly demonstrated during the spread of the Covid-19 virus in spring 2020, there is a tendency for national interests to take primacy. At least initially, European Union member states focused on themselves, at the expense of solidarity. However, the same crisis also showcased the need for cross-border cooperation. To effectively combat a fast-spreading airborne disease, knowledge must be shared, and complex international chains must work in order for goods and people with critical skills to be where they can be useful. The healthcare sector is often accused of inefficiencies or for not living up

to the demands on public service delivery. In the European Union, healthcare is also a sector with remarkable diversity in how it is territorially and administratively organised. For citizens living close to a national border more cross-border cooperation in this area would have a significant impact. Since many live in what counts as the peripheries of their respective countries, they are among the ones to gain most if resources in health services and public health are coordinated and if access to those resources were facilitated. This is regardless of whether it happens within the framework of European integration or through bilateral relations between actors of the countries that are involved.

Responding primarily to the second research question set out in this volume and focusing on the third level of analysis (subnational relations), this chapter examines the external and internal factors that support or hinder bilateral relations between Poland and Germany at the subnational level in the healthcare policy area. In other words, what drives or hinders effective cross-border provision of healthcare in borderlands? Following this volume's analytical framework, the analysis focuses on whether factors related to asymmetry, interdependence and historical legacy have an effect, but also investigates whether other factors that may be of importance. In addition, the chapter also aims at contributing to the volume's inquiry into whether subnational actors can jointly influence decision-making processes and overall dynamics at the European level. The analysis is based on reviewing publicly available accounts, reports and other material produced by actors relevant for cross-border cooperation, primarily from the following four categories: (1) Euroregions: associations comprising local and regional authorities in the borderland (Svensson 2013). (2) Twin towns: towns of close proximity, usually in this context divided by a river, the material in this case from official cooperation forums or city websites. (3) International or bilateral organisations: the European Union, the World Health Organization, cross-border cooperation working group of the Polish–German Intergovernmental Commission for Regional and Cross-Border Cooperation. (4) Media: regional and local newspapers (focus

on recent events not yet covered in official reports or scholarly articles). An important caveat concerns the source language: while sources in English and German could be read and analysed in full, Polish sources could only be reviewed superficially using computer translation tools.

The chapter starts with an overview of the state of knowledge on health policy in the light of European integration and local cross-border cooperation. It continues with an analysis of integration and cross-border cooperation in the health policy sector in the Polish–German borderland (the volume's dependent variable adapted to the aim of this chapter), followed by three separate sections analysing the influence of historical legacy, interdependence and asymmetry, i.e. each of the independent variables in focus in this volume. The research questions are returned to in the penultimate section, while the conclusion provides a summary of the findings.

The potential and practice of cooperative health policy in European borderlands

Taking place within the same ideational and economic setting that led to the creation of the institutional predecessors of the European Union, institutionalised cross-border cooperation between regions and municipalities located close to a national border has increased over the past decades (Perkmann, 2002; Medve-Balint and Svensson, 2013). Once local subnational cross-border cooperation stopped being framed or regulated as 'illicit' diplomacy, or para-diplomacy, by subversive subnational actors (Aldecoa and Keating, 1999), it instead was seen as positive for regional development and European integration.

There is a vibrant scholarship on the causes, effects and manifestations of the particularities of borderland lives, exchanges and different types of cooperation, but the attention to health policy has been relatively scarce. This can be seen for instance on the pages of *Journal of Borderland Studies*, one of the specialised scholarly journals in this field, which has only published about

a dozen articles directly on health or healthcare since its foundation in 1986, although the topic seems to have become more popular recently (Quintana, Ganster et al., 2015; Heckert, 2019; Chinchilla and Payan, 2019; Jubas, Johnston and Chiang, 2020). However, none of these recently published articles has analysed cross-border cooperation around health policy in Europe. The sector generally also does not receive much attention in the field of European public policy and European integration and does not make it to standard textbooks on integration across public policy fields (e.g. Wallace et al., 2015; Cini and Borrogan, 2019) and rarely into major journals (an exception would be for instance Vollaard et al., 2016). The reason may be that the founding European treaties explicitly stated that health is a national competency (Hervey and Vanhercke, 2010), and therefore, in the European integration process, the historically close relation between health policy and nation states (Steffen et al., 2005:1) led to the situation where 'health policy actually appear[s] to be an enclave within the integration process, and consequently one of the last key realms – and one of the last retreats – of national policy competence' (Lamping, 2005, p. 18).

Yet, even in the face of this national primacy, the EU has made inroads into health policy, and has inch by inch taken on more tasks and responsibilities (Randall, 2001; Vollaard et al., 2013). Each treaty has extended the amount of text that in some way deals with health-related issues, leading to a situation where 'there is no European Union health system but there is EU health policy' (Greer et al., 2019:1). For instance, in 1995 the European Medicines Agency was founded and set up in London (it relocated to Amsterdam in 2020) and ten years later the European Centre for Disease Prevention and Control started its operations in Stockholm. Since 1999 there is a Commissioner in charge of health policy; in the 2019–2024 commission this is Stella Kyriakides, who is responsible for health policy and food safety, including supporting the union's member states in improving the quality and sustainability of their health systems.

Seen against the backdrop of the continuous development of the European Union's health policy, borderlands constitute special areas. Border regions often constitute centres of intense mobility, even when they are located at the periphery of member states. They have more potential for patient mobility that could reach relatively significant levels in some concentrated areas, since some borderlands have strong cross-border links in terms of, for instance, a common language or a shared culture (Palm and Glinos, 2010: 538). Historically, the special situation of borderlands made them fast-track integration areas, especially when and where workers started to commute across borders. So-called frontier workers received rights to healthcare for themselves and their families, in principle on the same condition as residents of the country where they worked, even if this has not always worked in practice (Palm and Glinos, 2010; Greer, 2013). Despite these developments, it is not common to see local and regional cross-border cooperation organisations give high priority to health as a cooperation activity (Svensson, 2017).

Health policy takes a back seat in comparison with infrastructure, transportation, culture or education, for instance. At the European level, health policy in borderlands was not highlighted at the start of the 2019–2024 commission, even if local actors hoped for more funding and support through the various funding programmes. Neither the priorities outlined in European Commission President Ursula von der Leyen's mission letter to Health Commissioner Stella Kyriakides in the autumn of 2019, nor her answers in the hearing preceding her appointment, indicated attention to the situation of citizens living in European borderlands (European Commission 2019). These documents also did not include references to the probably most important recent legislation in terms of bilateral and local cross-border relations, the 2011 directive on cross-border patient mobility rights, which clarified patients' rights to reimbursement and assistance with treatment abroad. This directive constituted a very important step towards interlinked health systems, even if there would still not be one health

system. The number of patients seeking treatment abroad is marginal and relatively stable, although there has been an increase in the number seeking treatment with prior authorisation. A recent European Commission report estimates that about '50% of patient mobility may be driven by issues of proximity, and possibly also *collaborations between clinicians in border regions*' (European Commission, 2018A, p. 9, my italics). Thus, it seems that the field of healthcare in borderlands is a relatively neglected subject of study by social science academics as well as by health policy specialists and practitioners. At the same time, the interest seems to be picking up, with somewhat more reports and publications in recent years. The situation at the Polish–German borderland, to be assessed in the next section, should be seen in the light of this.

Healthcare integration and bilateral relations on health policy in the Polish–German borderland

The concept of integration is often used as a shortcut for the European Union project, but it refers theoretically to a 'process of increasing and intensifying relations among entities that leads to the emergence and expansion of an inclusive integral whole' (Svensson and Nordlund, 2015, p. 3). In the borderland this implies a process of extended and intensified bilateral cooperation that leads to some level of joint cross-border output, such as the production and provision of healthcare services (e.g. cooperation around emergency services or treatments) or public health initiatives (e.g. screenings, guidelines, information). In order to understand the scope, need and potential for bilateral relations and actions in the field of healthcare at the German–Polish border, it is important to see that these would be set up to complement or clarify the reach of EU law. Citizens and actors in the Polish–German borderlands are subject to the same EU directives and regulations as all European citizens and actors. Poles and Germans have the right to seek treatment in the other country and to some extent get these treatments

covered due to the directive on cross-border patient mobility. However, Poland has deliberately implemented the directive in the strictest way possible in order to minimise usage, especially in high-quality but high-cost countries such as Germany (Kowalska-Bobko et al., 2016). Interestingly, this has led to a situation where few Poles travel to Germany for care (due to limitations on reimbursements) and vice versa (due to sufficient care capacity or quality at home), but where Poles getting authorisation to be treated in the Czech Republic represented one of the highest patient flows in Europe in the years 2015–2017 (European Commission, 2018a, p. 9).

The citizens in the borderlands are also subject to the same clauses as other European citizens when it comes to protection of the health and safety of workers (Treaty on the Functioning of the European Union, Article 153, paragraph 1(a)) and protection against threats to the environment that also damage public health (Treaty on the Functioning of the European Union, Article 191, paragraph 1) (Greer et al., 2019, pp. 94–101). Moreover, the European regulations regarding coordination of social security systems mean that Polish residents who work in Germany have the right to enrol in the German health security system, and vice versa (Triebel et al., 2018), which is important in the borderlands due to the large number of Polish residents who have their workplace, and thereby also social insurance, in Germany. A concept that even more clearly than integration captures the need to look at bilateral and multilateral relations in context is embedded bilateralism, which Krotz and Schild (2012) argue denotes both the 'intertwined nature of a robustly institutionalized and normatively grounded interstate relationship' and 'the interrelationship between this bilateral connection and multilateral European politics – of which this bilateral bond forms a constitutive part, and to the structuring of which it strongly contributes' (Krotz and Schild, 2012, p. 8). Instead of emphasising levels of government, embedded bilateralism is manifested in three categories: treaties and agreements on health cooperation (regularised intergovernmentalism), subnational and civil

society relations (parapublic underpinnings), and speeches and token cooperation (symbolic acts and practices).

While the impact of multilateral European policies is thus relatively powerful in theory (even if weaker in practice), intergovernmentalism in the form of national-level bilateral agreements between Germany and Poland on health and healthcare issues are scarce. There is only one with potential for significant upscaling of joint services, namely a 2011 framework agreement between Germany and Poland enabling cooperation between emergency ambulance services (Triebel et al., 2018, p. 24). However, the framework has been slow in being turned into action. It took two years before it went into force, and even after that uncertainties remained about for instance what kind of bilateral agreements at the regional level (German states and Polish regions) were needed for cooperation. This means that as late as 2019 it was an almost daily sight to see Polish and German ambulances meet up at borders for patient handovers, for instance close to the northern seaside resorts of German Seebad Heringsdorf and Polish Świnoujście. A German resident injured and initially treated in Poland would be brought to the border and there handed over to a German ambulance. German ambulances would sometimes cross the border, but Polish ones did not, citing the lack of a regional and more detailed agreement between the German county region Greifswald-Vorpommern and the Polish region Zachodniopomorskie about cooperation, which was expected to be signed by the end of the year (Horn, 2019). The situation further south at the border with the twin towns Guben-Gubin has been similar. Here the problem is less one of injured tourists, but of closeness to the nearest hospital. In emergencies, inhabitants in Polish Gubin are regularly taken to a hospital 60 kilometres away in Zielona Góra, instead of being taken to the hospital in Guben (Schauff, 2019). With funding from the European Union Interreg programme, a 2017–2020 project had brought actors together with the aim of having an agreement signed between Mecklenburg-Vorpommern, the region Zachodniopomorskie, Brandenburg, the region Lubuskie, Sachsen

and the region Dolnoslaskie (Euroregion Spree-Neisse-Bober representative, email 25 February 2020). The dissatisfactory speed of progress has been closely observed by the cross-border cooperation working group of the Polish–German Intergovernmental Commission for Regional and Cross-Border Cooperation (2020), which has used its annual meetings to express repeated calls to turn the framework agreement into real cooperation, as evident in its protocols from 2015–2019. On the other hand, the working group seems not to have prioritised other health-related actions, even though an initiative on cooperation on telemedicine in Pomerania was mentioned in the protocol of the 2014 meeting (Cross-border cooperation working group, 2020).

The scarcity of bilateral state-level treaties and agreements mean that so far activities in healthcare have mainly been pushed by local and regional actors. There are four Euroregions at the Polish–German borders, all of which are important actors for *parapublic underpinnings*, since most local and regional decision makers are represented in these organisations, and they also include or have bonds to civil society actors.[1] A review of documentation of health-sector-related material on the websites of the four Euroregions (Neisse, Spree-Neisse-Bober Pro Europa Viadrina and Pomerania) in January–February 2020 showed that there is a relatively limited set of activities in this area. There are working groups on health in for instance the Euroregion Viadrina and Euroregion Spree-Neisse-Bober, but few concrete outcomes. Examples of what is done include exchanges between healthcare institutions regarding research and ensuring staff resources, and the organisation of internships for Polish care-sector workers in German hospitals (Pro Europa Viadrina, 2014, p. 36) and a joint telemedicine network for certain specialist consultations in the Euroregion Pomerania. The latter was, as mentioned

[1]Scholars of international relations often lump cities and regions together with local civil society organisations. This may be analytically problematic since one belongs to the public sphere and one to civil society. Krotz and Schild (2012, pp. 104–107) confront this potential weakness by arguing that bilateralism is held up by *parapublic underpinnings*, which are often publicly funded but implemented by actors who do not act in the capacity of either elected officials (politicians) or public administrators. They include town, city and regional couplings in this category, as well as various types of joint institutions and associations.

above, singled out by the cross-border cooperation working group of the Polish–German Intergovernmental Commission for Regional and Cross-Border Cooperation and has been put forward as a best practice in the sector (European Commission, 2017, p. 51), even though there is little evidence that the project evolved beyond being funded beyond the 2007–2013 funding cycle.

An evaluation of the activities of the Euroregion Spree-Neisse-Bober showed that actors from the culture and sports sector constituted by far the most numerous type of partnership in the period 2007–2017. In the study, healthcare actors were categorised together with social partners and as such registered approximately the same number as partnerships from the educational sector (Sarmiento-Mirwaldt, 2018, p. 4). In written correspondence, a representative of the Euroregion Spree-Neisse-Bober confirms that this is a difficult field, but states that the activities in the area are increasing: 'There is a positive development, related to the engagement of more institutions, like the German–Polish health and social association and the Guben hospital. But it is still a cooperation that is at its beginning and cannot be compared with other regions in central and western Europe' (Euroregion Spree-Neisse-Bober representative, email 25 February 2020). The ambition is to strengthen the health theme in the upcoming funding period of 2021–2027.

The relatively limited amount of parapublic activity is also evident by the first comprehensive EU study and mapping exercise of health projects in all EU member state borderlands (European Commission, 2018a; European Commission, 2018b). The study was the first that covered all EU member states, including those accessioning in 2004, 2007 and 2013, and included projects from different funding schemes. Overall there were only four cross-border cooperation projects with health components which were led by Polish partners. This was low compared to other newer member states, such as Hungary (39), Romania (18), Slovenia (10) and Bulgaria (6). It was also low compared to most other countries in other parts of Europe.

The total number of projects teaming up Poland and Germany was ten (European Commission 2018b, pp. 43–44). At the same time, some efforts to cooperate in the health sector can be traced back to before the entry of Poland into the European Union. For instance, a Germany–Poland Health Academy with a seat in Forst was founded in 2002 (Regionomica, 2006, p. 48), at which time there were hopes to develop health and spa tourism (ibid, p. 84).

Some activities can also be seen in direct cooperation between twin towns at the border. However, it is also evident that healthcare cooperation is a difficult area. An action plan for the towns Frankfurt an der Oder and Slubice outlining visions for 2010–2020 listed concrete measures to be taken and divided into three categories. Joint service provisions, like homes for the elderly or hospices, were listed in the category for future action ideas, but with no immediate potential to be realised (Frankfurt (Oder) and Slubice, 2010, Annex B, pp. 3–4).

Different cooperation practices can have more or less significant real-life value, but they may take on meaning beyond this direct applicability in terms of demonstrating resilience or how past disagreements are overcome. Such *symbolic acts and practices* are perhaps more difficult to pin down in the healthcare and public health sector than in other policy sectors and appear insignificant as a driver for cooperation. That said, solving the difficulties surrounding cooperation on emergency services so that ambulances would frequently cross borders, and helicopters would be seen taking patients to hospitals in the other country, would have symbolic power precisely because of the national-state connotation of healthcare.

Structural explanations: asymmetry, interdependence and historical legacies

As was demonstrated in the preceding sections, healthcare has generally been a difficult area of cooperation for communities at European borders, although there are signs of increased levels of cooperation. Why is there relatively little cooperation in the area of healthcare, and what makes things develop in spite of bad odds? This volume assumes that different

combinations of factors that cluster around the broader concepts of asymmetry, interdependence and historical legacies can explain the development towards bilateralism (a bilateralism that is taking place in conjunction with the multilateral European integration project), but that these combinations may look different in different fields. Following Womack's definition of asymmetry as 'a clear and relatively stable disparity between the capabilities of the states involved' (Womack, 2016, p. 7), a borderland exhibits asymmetry if there are such differences in capacities of the state through its national, regional and local presence in the borderland. In the borderland, the border itself is a visible marker of asymmetry: one side is part of a system that has significantly greater political, economic or military power than the other. It can also mean that one side of the border has more natural or population resources, so that someone crossing the border experiences a simultaneous hierarchical transfer. Such asymmetry can lead to effects in bilateral relations on for instance bargaining power, the effectiveness of agenda-setting, crisis management and coalition-building which may be influenced by factors such as decision-making, distribution of competences or path dependencies.

Applying the concept of asymmetry to health and healthcare implies a situation in which inhabitants on one side of the border are a) healthier in terms of life expectancy or other health indicators and/or b) have closer or easier access to healthcare that also may be of higher quality. This, in turn, is expected to have consequences for the way and the extent to which cooperation is developed in this area. The Polish–German borderland is characterised by just such an asymmetry, with current significant differences in the quality of healthcare offered[2] and also differences in important health indicators. It is clear that so far asymmetry has been a hindering rather than a furthering factor for cross-border cooperation in this sector. Previous research and theorisation highlight that asymmetry can work in different ways for bilateral relations, which

[2] This has often been pointed out by local actors; see for instance a SWOT analysis of borderland cross-border cooperation carried out not long after Poland's accession to the EU (Regionomica, 2006, p. 107).

is very visible at borders. Differences in prices or wages may for instance lead to increased flows of people crossing the border in order to find cheaper goods or better wages, which in turn might spur cooperation. Thus, asymmetry may be a push factor for cooperation around rules and practices in these areas.

Several Central European countries, including Poland, have been successful in tempting foreigners to come for various types of private medical treatment, with dental surgery and cosmetic surgery being common. In Poland, these are provided by private dentists. Often these are in borderlands – Silesia in the south, bordering Germany and the Czech Republic, has the second highest number of dental practices in Poland (the highest number are located in the Masovian region, where Warsaw is located). In general, medical tourism either goes to cities with excellent incoming airport connections or to the border areas, and the patient tourists in border areas need not be rich (Lubowiecki-Vikuk, 2018; Lubowiecki-Vikuk and Dryglas, 2019). However, exchange between the national healthcare systems for citizens is an entirely different undertaking, especially since in the Polish–German borderland there is also asymmetry in the distribution of competences. The German side provides healthcare at the regional (state) level, whereas healthcare in Poland is primarily a national-level competence, with the National Health Fund, under the supervision of the Ministry of Health, as the key actor. Regional branches of the National Health Fund, as well as regional and local level authorities, have specific roles with regards to public health promotion and are mostly the owners of hospitals (Sowada, 2019, p. 102; Triebel et al., 2018, pp. 13–14). Thus, the asymmetry of provision, combined with the asymmetry of decision-making and distribution of competences, make the area more complex and obfuscates the existence of win-win situations. While there might be overall efficiency gains to make from cooperation (less need for each side to have certain provisions next to the border for instance), it might be less clear to the German side why they should offer access to their hospitals or clinics, since they are already relatively satisfied

with their healthcare. Spillovers in terms of Polish residents working in Germany being insured in Germany or cooperation projects around emergency services or education therefore remain marginal. Actors in the Euroregions on the German side may be more reluctant to address issues where their citizens do not support the pooling of resources.

In recent years, efforts have been made to systematically map obstacles to cross-border cooperation and integration in various sectors, and the European Commission supported the creation of an inventory of legal and administrative obstacles in EU border regions (European Commission, 2016). Of interest to this chapter is a submission by the twin towns Frankfurt (Oder) and Slubice, through its cooperation centre for municipal public administration, which stated that 'differences between national health systems and insurance legislation hinder cooperation in the field of health care services' (European Commission, 2016, record 121), such as in the case of diagnosis, surgery and therapy. They stated that the obstacle was due to 'differences in the administrative cultures of neighbouring countries (i.e. diverging ways of understanding, conceiving, organising, managing and implementing public policies), from the administrative use of different languages on both sides of a border or from absent/inadequate information provision by administrations on issues of cross-border relevance'. While it is not self-evident that simple differences in administrative and legal rules equal the capabilities at the centre of asymmetric relations, the listing's specific mentioning of different tariffs for healthcare services and levels of reimbursement means that differences also reflect economic disparities (European Commission, 2016, record 121).

Moving on to the next cluster of explanatory factors, the Covid-19 crisis in the spring of 2020 demonstrates *systemic interdependence* between actors located on different sides of man-made borders. The risk of spread in the population will to some degree depend on measures taken on the other side of the border, and elsewhere in the world. At the same time, the Covid-19 crisis also demonstrates the primacy of national-level action over that of subnational and EU actors,

even in the knowledge of such interdependence. Through the sheer scale of this event, it also puts into perspective the mundanity of regular health-sector activities in which the systematic interdependence of health and health-sector activities is relatively limited (be it check-ups or cancer treatments). We see even less of integrative interdependence (intertwinement of actor activities) or functional interdependence, apart from relevant EU regulations. Normally, the healthcare systems display little *sensitivity*, i.e. a low degree of responsiveness in terms of costly changes in one country following decisions in the other, and there is a relatively low level of *vulnerability*, i.e. an actor is not likely to suffer costs due to external disruptions.

Applied to the German–Polish border we see how it is possible to have separate systems working on the two sides of the border, one of which supplies substantially higher-quality care than the other. Policy decisions that improve or worsen the healthcare on one side of the border do not immediately translate into effects on the other side. Likewise, the lifestyle choices people make only marginally affects the other. Some effects might hypothetically be seen. For instance, interdependence is a key theoretical component of the neo-functionalist theory on European integration, which states that the European project is driven by spillovers from one functional area of cooperation to another. In the Polish–German border area one can to some extent see how integration of the labour markets has led to more Poles having access to German health insurance, which might put pressure on Poland to provide similar levels of care. Also, decisions in the educational sector that have enabled youngsters from Poland to study for medical professions in Germany may have had an effect of worsening shortfalls in Poland, creating a policy problem that might spur cooperation (no such examples could be seen in the activities of the Euroregions, however).

The effects of interdependence created by the integration of the labour market and cooperation in education is more unsure. In the care area, the Covid-19 crisis in 2020 showed the extent to which Germany is dependent on commuting workers from abroad for providing care to the

elderly in their homes. The exact number of Poles who work with the elderly in their homes is not known, but they constitute the bulk of the foreign workers in this area and estimates are in the range of several hundred thousand. When borders closed, many Polish care workers discontinued their care contracts in Germany due to difficulties with regulations and transport, or for fear of becoming infected (Zajonz, 2020; Pallokat, 2020; Deutsche Welle, 2020). Many of them do long-distance commuting and are therefore not the subject of Euroregional or twin-town involvement, but there are also care workers and employees in hospitals who commute daily in the borderland.

Judged by the type of activities in healthcare that are popular among Euroregions such as mapping exercises, getting to know each other, etc., generally the Euroregions in the early days of their operations *do not react and respond to pre-existing interdependence*, as measured by sensitivity and vulnerability. Instead, early and continued cooperation efforts aim to *create* interdependence, which then may create sensitivity to ruptures (e.g., once there is an integrated interdependent labour market, the Euroregions are more likely to respond to threats or ruptures to it; see Svensson, 2013). The same can to some extent be stated for twin towns, although the interdependence there may be more at the centre. Thus, overall interdependence is not found to be a major driver of bilateral relations at the subnational borderland level until there is already a significant level of integration, something which is not found in healthcare. Rather, a lack of or slowly progressing interdependence is an explanation for the relative lack of bilateral relations.

The same can be said for factors clustering around historical legacies. Low levels of cooperation in healthcare can be seen as a 'continuation of the past' type of legacy (see introduction to this volume, based on Wittenberg, 2011, pp. 16–17) in the sense that healthcare is provided through complicated patterns involving institutional actors at several levels that have all been shaped by the strong forces of historical nation-building. The historical forces that have made

cooperation around health difficult at the European level are also present to a larger or smaller extent at the Polish–German border. However, while the situation at the Polish–German border is therefore not unlike that of many other European border areas, the level and intensity of cooperation is below that of the most integrated border areas in northern and western Europe. The historical legacy at play here is perhaps first and foremost the timing of cross-border cooperation. The European Union started supporting cooperation with the East through its PHARE programmes in the 1990s, and for partners in the 'East' it made most sense to start with areas that were closer to EU competences (regional development). Moreover, while symbolic cooperation in different areas is important to demonstrate the return of history, or in the case of Poland and Germany overcoming some difficult past, such willingness to engage in symbolic acts of overcoming history is generally transposed into areas of least resistance, and actors in the borderland such as the Euroregion may understandably therefore first focus on projects and areas with more chances of success.

Actor perspectives at the subnational and cross-border level: Institutions, social capital and multilevel governance

From the perspective of the institutional actors that work to promote increased cross-border cooperation overall, including healthcare, other factors are also highlighted as obstacles to cooperation, i.e. factors that explain the relatively slow development in this field. For instance, the Euroregion Spree-Neisse-Bober highlighted in a 2017 report (Triebel et al., 2018, p. 33) and in a follow-up email conversation with the author (Euroregion Spree-Neisse-Bober representative, email 25 February 2020) a range of barriers to cooperation in healthcare. These barriers, or hindering factors, were identified through multiple discussions and workshops

arranged by the Euroregion for local actors and also reflects the accumulated experience of the Euroregion in working in this area.

These obstacles can be aggregated into two theoretical clusters. The first relates broadly to deficits in the civic component of parapublic underpinnings of Polish–German relations in the borderlands, which could also be said to be a lack of social capital. High levels of social capital are generally identified as a driver for policy development in borderlands, and low levels as a hindering factor (Svensson, 2015). For the actors in the Spree-Neisse-Bober Euroregion this comprised issues such as language barriers (especially few Germans understanding Polish), with a specific lack of knowledge of health-sector-related vocabulary. It further comprised a 'lack of personal contacts', for instance between professionals in the health sector, and a lack of knowledge of how the system works on the other side, which reflects the lack of both personal networks and formal training on how the different systems work. The second cluster broadly concerns the positioning of local actors in the multilevel governance system (Hooghe and Marks 2001; Hooghe and Marks 2003) of healthcare and public health, in that local actors lack sustainable long-term political and financial support for the kind of changes that would be needed to enhance integration and intensified bilateral relations in the health sector. Political support could mean both enhanced regularised intergovernmentalism and a rhetorical emphasis on these issues.

This links in with what I would argue is a limited potential of subnational actors to influence decision-making processes and overall dynamics of health policy at the European level. The capacity of subnational actors from the borderland to effectively bring issues to the fore of the agenda is in general also limited. They can do so through local and regional representatives in the Committee of the Regions, but the influence of this advisory body is limited (Hönnige and Panke, 2016). The number and weight of regional representation offices in Brussels has increased (Tatham, 2015), but whereas all of Germany's regions are represented, that is not the

case with Poland. Some border regions lack representation (Association of Accredited Public Policy Advocates to the European Union, 2016), again demonstrating asymmetric relations. Furthermore, synchronised action between Polish and German representation is rare. Other channels, such as direct contact with the Commission or the Parliament, has not been utilised in this field, according to the information collected for this chapter. There is therefore little evidence of direct influence by the Poland–German borderland that has shaped European policy in the field. Germany has for a long time been the engine of Europe's economy, and politically is one of the Union's most important members. Its relations with its neighbours should therefore be of interest to everyone in the European capital. However, this does not translate equally across policy sectors, and health policy is a sector that has developed in the shadow of other policy fields.

Nonetheless, it is not unlikely that indirectly the images and practices at the borderlands will play a role in the future development of European legislation around for instance the situation of cross-border commuters when it comes to healthcare and health rights, and practices around the sharing of medical equipment. Images of hospital workers unable to get to their workplaces and essential equipment being held up by member states during the Covid-19 crisis is likely to be remembered for a long time, and these images may constitute powerful arguments for change.

Conclusion

Health policy was slow to develop at the European level, which has been reflected in a relative lack of attention to this field among cross-border cooperation actors in Europe. The review of bilateral agreements and local activities proved this to be the case at the Polish–German border as well, which is still working on solving issues that other countries have managed to progress

on, such as how and when ambulances should be allowed or mandated to operate across borders. On a structural level, the analysis showed that the cross-border integration and bilateral relations in the health sector are impacted by the asymmetric resources on the respective sides of the borders. This has largely spurred an increase in private exchanges but hindered the effective development of integrated public services at the local level. This is related to the notions of interdependence, where actors and citizens do not perceive their health or health sectors to be affected by their neighbours' activities, despite larger global systemic interdependence that concerns human health. The analysis also showed that historical legacies have relatively little importance in the area of healthcare. At the subnational level and from the perspective of local and cross-border actors, a lack of social capital and difficulties of local cross-border actors to efficiently work the multilevel governance scales were found to be key obstacles. Finally, it is possible that the broad societal changes that are expected in the wake of the Covid-19 crisis (ongoing at the time of writing this in April 2020) may provide the proverbial window of opportunity that will increase the speed of policy change.

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