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Patient mobility within national borders. Drivers and politics of cross-border healthcare agreements in the Spanish decentralized system

Cross-border patient mobility has become a topic of increasing interest for policy-makers and academic scholars. However, the focus on international dynamics hinders the fact that healthcare mobility takes place within national boundaries as well, particularly in countries characterized by decentralized health systems. This paper shifts the focus from the drivers of international patient mobility to the ones of policy-making on patient mobility within national borders, analyzing more than fifty policy arrangements adopted between Spanish Regions in the period 2000-2020. As the findings indicate, geographical/historical, economic and political factors are key to understanding the development of cross-border healthcare agreements, as well as the conflicts that may arise therefrom. Accordingly, these arrangements may become a controversial issue and a key arena for partisan competition, affecting the articulation of effective responses to patient mobility in Spain and, ultimately, patients' rights.

Introduction

Cross-border patient mobility represents a topic of increasing interest for policy-makers and academic scholars. Within the European Union, the adoption of Directive 2011/24/EU on patients' rights in cross-border healthcare has received significant attention, delving into its content, how Member States have transposed it, its impact on national healthcare systems, and how it is assessed by stakeholders (among others, see: Azzopardi-Muscat et al., 2018; Diesenreiter & Österle, 2021; Glinos et al. 2012; Helena, 2016; Nys, 2014; Peeters, 2012). Likewise, different typologies of 'transnational medical mobility' have been proposed to explain why patients move to receive healthcare abroad (Glinos et al., 2010; Laugesen & Vargas-Bustamante, 2010; Mainil et al., 2012), highlighting how criteria of geographical/cultural distance, healthcare coverage, affordability, availability and quality shape healthcare-seeking decisions.

However, the focus on international dynamics hinders the fact that patient mobility often takes place within national borders, something which becomes particularly evident in decentralized systems (Cantarero, 2006; Fattore et al., 2014; Ricci et al., 2021). Among all public policy domains, healthcare exhibits the highest power reallocation to subnational governments (Costa-Font & Greer, 2012), which enjoy great autonomy in health regulation, financing and provision (Costa-Font, 2012).

Moreover, studies on patient mobility tend to de-politicize the phenomenon, often relegating political dynamics to 'contextual factors' (Legido-Quigley et al., 2012). Yet, health policy is characterized by conflict and uncertainty rather than consensus (Walt & Gilson, 1994), and healthcare systems represent a central arena for partisan competition (Greer, 2010; Fierlbeck, 2013).

This paper analyzes the drivers of policy-making on internal cross-border patient mobility, focusing on the factors that may explain policy-makers' decisions to engage and disengage in horizontal healthcare cooperation. To do so, we provide an extensive qualitative analysis of the policy arrangements adopted by the 17 Spanish Regions (Autonomous Communities, ACs) in the period 2000-2020. In Spain, internal cross-border patient mobility largely takes place under formal arrangements between regional governments. In this respect, the country represents a micro-cosmos for the analysis of cross-border healthcare policy-making.

Patient mobility and the drivers of horizontal healthcare cooperation

Cross-border patient mobility refers to a phenomenon that involves people moving to receive treatments outside the healthcare system to which they are affiliated. Although this concept evokes the idea of crossing national borders, healthcare systems are often characterized by significant political and fiscal decentralization (Costa-Font, 2012; Fierlbeck & Palley, 2015). As a linkage is created between the regional

healthcare system and the population residing in that region, healthcare systems structure territorial borders within countries, opening the door to internal cross-border dynamics.

Cross-border patient mobility may result from purely individual decisions, adopted outside any policy framework (which are not considered in this paper), or it can be facilitated by existing formal arrangements adopted by health actors in the territories across which patients move (Legido-Quigley et al., 2012, p. 28). The latter is usually referred to as 'institutionalized patient mobility' (Laugesen & Vargas-Bustamante, 2010). While various actors may participate in this process (including third-party payers, providers, patients, and brokers) (Legido-Quigley et al., 2012), policy-makers are the key actors responsible for the definition of the institutional framework in which that mobility is framed. In particular, politicians and health authorities are in charge of setting the criteria and conditions for patients to receive treatment in another healthcare system, as well as to coordinate the instruments and reimbursement mechanisms with policy-makers located in other systems, usually through the signing of bilateral or multi-lateral agreements (Holzmann, 2016; Konstantinidou, 2019).

Taking into account the centrality of policy-makers in institutionalized patient mobility, it is key to understand what factors may explain their decision to engage in horizontal cooperation dynamics by focusing on 'the politics of cross-border healthcare.'

Previous research has pointed out that cross-border patient mobility can enter the political agenda when it is seen as a possible solution to capacity or size constraints of healthcare systems, and to foster economies of scale, especially in remote or border areas (Glinos & Baeten, 2006; Laugesen & Vargas-Bustamante, 2010). However, broader macro-economic considerations may shape policy-makers' decisions, as these arrangements usually imply medium-to-long term financial commitments. From this perspective, welfare research indicates that public social spending tends to grow in times of economic expansion (Lindert, 2004). Yet, in times of economic shocks, governments often adopt austerity measures and financial cuts targeting social spending (Matsaganis & Leventi, 2014; del Pino & Ramos, 2018). Hence, we can expect that policy-makers are more prone to engage in cross-border cooperation in periods of economic expansion, and to reduce it in times of economic downturn.

Once these agreements are signed, however, it may not be easy for policy-makers to retrench. As the literature on welfare policy reforms suggests (Pierson, 1996; Starke, 2006), welfare states have expanded to an extent where they are seen as part of the status quo, creating commitments, expectations, and interests among voters and stakeholders. Because of these emergence of these veto points, any significant retreat is unlikely. Hence, we can expect that, once cross-border healthcare arrangements have been signed, governments will not be able to retrench, except at the cost of losing political support.

For what concerns political dynamics, the literature is relatively ambiguous. On the one hand, research has frequently pointed out that governments' political orientation along the traditional right-left axis plays a role in welfare and health policy-making (Elmelund-Præstekær & Baggesen Klitgaard, 2012; Gallego et al., 2018; Greer, 2010; del Pino & Ramos, 2018; Starke, 2006). Left-wing parties tend to be more sensitive to social policy issues compared to right-wing ones, and their policy agendas often include expansionary measures. Hence, we can expect regions governed by left-wing parties to be more likely to engage in cross-border healthcare agreements than their right-wing counterparts. Moreover, as these arrangements involve policy-makers in two territories, we can expect that those belonging to similar political parties in the two concerned territories should be less prone to partisan competition - and thus more likely to sign cooperation agreements - than policy-makers belonging to competing political parties.

On the other hand, other studies have highlighted that, differently from other social policy domains, healthcare tends to enjoy a high level of public support regardless of political ideology, leading to lower issue competition between left and right-wing political actors (Green-Pedersen & Jensen, 2019; Jensen,

2012). From this alternative perspective, the political color of the governing party should be irrelevant to explaining the level of engagement of regional policy-makers in horizontal healthcare cooperation.

Materials and methods

To assess these expectations, we carried out an extensive qualitative analysis of the bilateral agreements signed among Spanish ACs in the period 2000-2020. Spain constitutes an appropriate representative case to analyze institutionalized cross-border healthcare mobility. The approval of the General Healthcare Law in 1986 marked the path toward developing the Spanish National Healthcare System (SNS, by its Spanish acronym) as a markedly decentralized system. Starting with seven ACs in charge of their own healthcare responsibilities, this decentralization process culminated in 2002, consolidating the SNS as a multilevel governance structure (Author). The Health Ministry is in charge of defining a common healthcare framework (entitlement criteria, minimum health services to be provided by ACs) and the annual healthcare budget, while regional governments are responsible for territorial healthcare planning, (a share of) financing, and service provision.

Concerning horizontal cooperation, article 48 of the 1986 Law states that ACs may sign agreements among themselves to achieve better efficiency of healthcare services. The central government only intervenes in terms of partial financing, setting an annual Healthcare Cohesion Fund (created in 2001), which should act as an instrument of financial compensation for those ACs that assume the cost of treating patients who reside in another AC. The scope, content and implementing procedures of these agreements lay on the willingness of regional governments to engage in healthcare cooperation.

To collect data for our analysis we relied on different sources. Firstly, we systematically analyzed the legislative texts and policy reports dealing with patient mobility and cross-border healthcare of the Ministry of Health (2016). Most importantly, we systematically screened the national Official Gazette of the General Courts for the period 1990-2020, which represents the official source to retrieve bilateral agreements signed among ACs. As no agreements were detected prior to the turn of the millennium, we limited our analysis to the period 2000-2020. However, the Official Gazette records those texts that require communication to or authorization from Parliament, meaning that informal agreements may have escaped our radar.

In addition to secondary sources, the study is based on primary evidence generated through semi-structured in-depth interviews with ten key informants of the Spanish healthcare system (Health Ministry, Health Departments of ACs, national patients' associations, health area of the Spanish Ombudsman). Moreover, we analyzed press articles on cross-border healthcare published between 2000 and 2021, performing the following searches (in Spanish) on Google engine search: (signature OR funding OR conflict) AND 'health cooperation agreement', followed by the name of each pair of ACs.

Results

- Engaging in cross-border healthcare: geographical proximity and economies of scale

Since the mid-2000s, the majority of 17 ACs have signed bilateral agreements in healthcare to allow their residents to benefit from services and treatments provided by the regional healthcare systems of other ACs. Currently, we can reconstruct the existence of more than 50 agreements and implementing protocols for horizontal healthcare cooperation (Annex 1). Aragon, Castile and León, Rioja, Navarre and the Basque Country are the most active regions in relative terms, since they have established collaboration agreements with all their respective neighboring communities.

As Figure 1 suggests, proximity represents a relevant factor to explain the 'direction' of horizontal cooperation between ACs. Yet, it is not merely the fact of sharing borders (de Biase & Dougherty, 2021), but rather the pre-existence of historical ties (Jamison et al., 2001; Konstantinidou, 2019), and informal cross-border patient mobility patterns that constitute a fundamental driver for the signing of these arrangements

(Interview 4; Interview 6). For instance, the introductory text of the 2008 agreement between Castile and León and Galicia mentions that:

> With the full assumption of competencies in healthcare and the possibility of establishing inter-autonomic collaboration agreements between ACs, which, due to their proximity, have traditionally maintained relations in the field of healthcare, it is necessary to develop a Framework Agreement to normalize bilateral cooperation.

Likewise, the 2014 agreement between the Basque Country and Rioja indicates that:

> Traditionally, healthcare between these two neighboring communities has been managed by means of a tacit agreement whereby the AC of Rioja attended to residents of the Rioja Alavesa area [in the Basque Country) and the Basque Country attended to patients from Rioja for certain treatments. With the aim of expressly stating in an agreement what had been operating tacitly, […] an agreement was signed.

Only three arrangements constitute an exception in this regard (Aragon-Basque Country, on healthcare research; Canary Islands-Community of Madrid, on pediatric patients with congenital heart disease; and Canary Islands-Valencian Community, on healthcare innovation). Accordingly, bilateral agreements signed between geographically-distant territories usually cover extremely specialized treatments/programs to be provided by specific centers, rather than the provision of primary or secondary care.

Figure 1. Bilateral agreements on cross-border healthcare in Spain

Source: Official Gazette of the General Courts (2000-2020). Own elaboration.

While geographical proximity explains 'with whom' a bilateral agreement is signed, the decision to engage in such arrangements is mainly justified on the basis of considerations of economies of scale, particularly for those living in border areas. For instance, the introductory text of the 2009 agreement between Aragon and Navarre states that:

> The purpose of this General Protocol is to lay the foundations for inter-autonomic collaboration and to define formal channels for relations between Navarre and the AC of Aragon, which contribute to achieving common interests in their areas of competence in terms of rationality, simplicity, transparency and economies of scale.

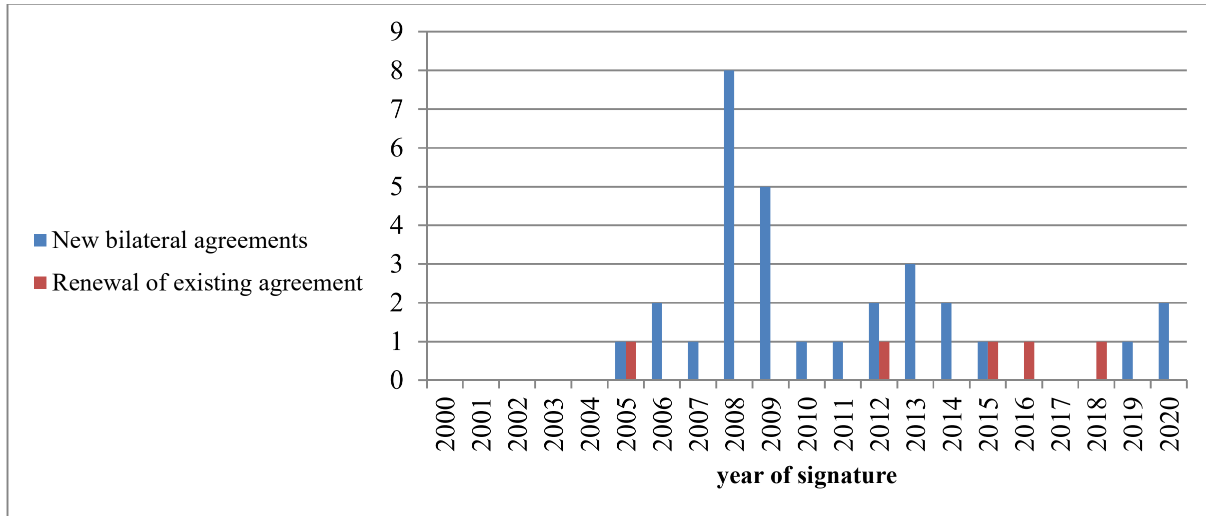
Similarly, the introduction of the 2005 agreement between Aragon and Catalonia identifies efficiency as the main motivation for horizontal healthcare cooperation, stating that the agreement shall contribute to 'greater social cohesion between the two communities so that health resources are used in the most efficient way.'

- Financial in-security: austerity measures and reforms affecting cross-border healthcare cooperation

The peak of inter-autonomic cooperation in healthcare dates back to the mid-2000s, after the creation of the Healthcare Cohesion Fund (2001), the finalization of healthcare decentralization (2002), and the approval of the new Statutes of Autonomy in different ACs (2004-2007). These processes resulted in further decentralization of competencies towards ACs, extending their powers in healthcare planning, financing and provision, and their capacity for inter-autonomic cooperation.

However, this trend did not continue (Figure 2). The outbreak of the financial crisis and the adoption of strict austerity measures in the years 2009-2014 seem to have greatly reduced the engagement of regional decision-makers in new agreements involving financial commitments, and horizontal cooperation was mainly focused on the renewal of previous arrangements.

Figure 2. Bilateral agreements by year of signature

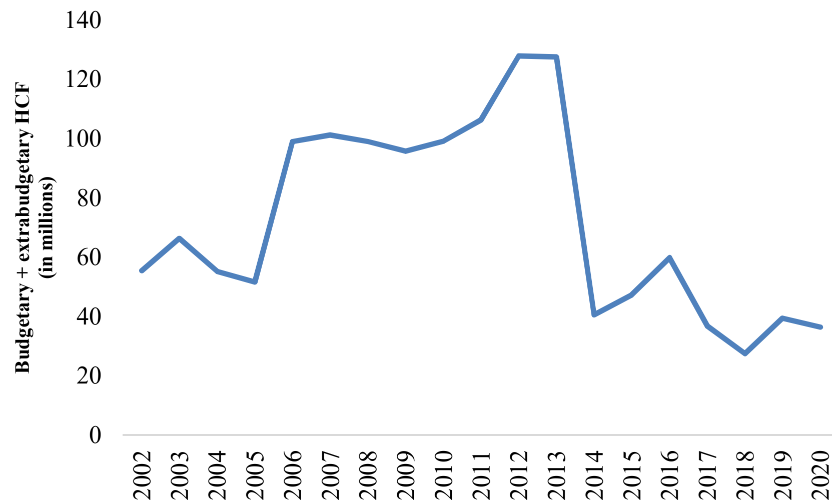


Source: Official Gazette of the General Courts (2000-2020). Note: in the case of implementing protocols of agreements signed between the same ACs in the same year, these protocols and agreements are counted as one. The count includes both new agreements and renewals of previous ones.

Beyond macro-economic trends, further financial insecurity has been induced by a reform in the financial mechanisms compensating ACs for the treatments provided to patients residing in other territories. Accordingly, with the adoption of Royal Decree-Law 16/2012 by the conservative government of Mariano Rajoy, the Healthcare Cohesion Fund came to be considered extra-budgetary in nature, making its amount dependent on the political will of the government in office. Due to this reform, the annual budget allocated to cross-border healthcare suffered drastic reductions (Figure 3). This, in turn, affected its capacity to function as an instrument facilitating cross-border patient mobility (Interview 5), reducing the willingness of regional policy-makers to engage in formal arrangements implying financial commitments. As expressed by one of our interviewees:

> The Fund functioned quite well when it had a budget. It even had a budget of 100 million euros during Zapatero's government [2004-2011, socialist party PSOE]. When it became extra-budgetary, and its use left at the will of the ACs, everything became very complex. (Interview 3).

Figure 3. Evolution of the Healthcare Cohesion Fund – years 2002-2020



Source: own elaboration on data provided by the Ministry of Health; available data: 2002-2020. From 2015 there is no budget allocated to cross-border healthcare (Healthcare Cohesion Fund); therefore data refers to extra-budgetary expenses.

Most importantly, these financial shortcomings represented the central motivation for the conflicts between ACs (interviews 4, 5, and 7), two examples detailed in the following section. As summarized by a key informant, 'The whole problem of patient mobility is mainly associated with the issue of funding and with how to manage the accounts between ACs' (Interview 10).

- Parties do not (initially) matter, politics do: the politicization of cross-border healthcare

Of the agreements signed in the period 2000-2020 (see Annex 1), 23 involved left and center-left governments (PSOE, as unique governing party, or in coalition with other left-wing parties), while 26 resulted from the implication of right-wing governments (PP, as unique governing party, or in coalition with other right-wing parties). Looking at the governing parties of each pair of ACs involved, the majority of agreements (22) were signed between ACs governed by competing parties at the national and regional levels, while 14 agreements were signed between ACs governed by the same political parties (8 between ACs both governed by PP; 5 between ACs both governed by PSOE).

These findings contradict the assumption that partisanship matter to explain governments' level of engagement in horizontal healthcare cooperation. Rather, they seem to indicate that cross-border healthcare cooperation is characterized by lower issue competition between opposing parties compared to other social policy areas (Green-Pedersen & Jensen, 2019; Jensen, 2012).

However, this does not mean that cross-border healthcare cooperation is completely neutral to partisan dynamics. In the words of our key informants, 'In the area of healthcare, politics has a terrible influence. It's a very sensitive issue' (Interview 5), with the consequence that 'there is always an attempt to obtain political returns out of health decisions. […] The relationship among ACs in relation to healthcare is not bad. However, when political interests appear, it may become quite tense. Because they are no longer technical relations, but political issues.' (Interview 6). Similarly, another participant claimed that:

> Tensions arise due to purely political circumstances because if they are economic or management issues, they can be resolved by renewing or modifying the agreement […]. Tensions arise for political reasons. (Interview 2).

The analysis of press articles suggests the existence of at least four cases of tensions between ACs in cross-border healthcare (Aragon/Catalonia, in 2009; Rioja/Navarre, in 2011; Rioja/Basque Country, in 2011; Community of Madrid/Castile-La Mancha, in 2014). All of them broke out in the years of austerity following the 2008 crisis. Two of them ended up in open conflicts that reached a national audience: the one between Rioja and the Basque Country, in 2011; and the one between the Community of Madrid and Castile-La Mancha, in 2014.

In relation to the first case, cross-border healthcare between Rioja and the Basque Country had been historically managed through an implicit collaboration agreement according to which patients from one community were treated in hospitals of the other one and vice versa. However, in September 2011, the Community of Rioja, governed by the right-wing party PP, refused to continue treating patients from the Basque Country (Redacción Médica, 2013), alleging the existence of a 'welfare magnet' effect against Rioja (Interview 5). For its part, the Basque socialist government contradicted such argument, claiming that the balance between the two ACs was not as unequal as the President of Rioja claimed. However, what was basically a problem of management of flows and compensations turned into an openly political conflict (Europa Press, 2011). As reconstructed by one of our key informants, 'we started a negotiation, but it became politicized. It became politicized because they wanted to politicize it.' (Interview 4).

In the run-up to the national general elections of November 2011, various Basque politicians mobilized identity-based arguments to criticize the decision of Rioja to interrupt the provision of healthcare to Basque patients. In the words of a candidate of the Basque Nationalist Party (PNV), 'it is enough to use Euskadi [name of the Basque Country in Basque language] and to talk against Euskadi to obtain electoral gains in neighboring communities' (La Rioja, 2011a). Similarly, the President of the Basque Country defined the actions of his Riojan counterpart in terms of electoral strategy, declaring that 'he has made his particular war against the Basque Country, his anti-Basque sentiment, as his electoral base' (La Rioja, 2011b). On the other hand, the President of Rioja and Riojan politicians emphasized the 'closed' nature of healthcare systems, arguing that the services provided by a regional system are for the exclusive use of its citizens (Redacción Médica, 2011). In the words of a key informant, 'You always have to take care of those at home before those [coming from] abroad. It is human.' (Interview 5).

This partisan confrontation concluded only after several interventions by the Ministry of Health, who required Rioja to withdraw the instructions proscribing its healthcare centers to provide treatments to Basque patients (Health and Social Services Commission, 2012; Público.es, 2011). As a result of this intervention, the two ACs engaged in a long negotiation process aimed at drafting a bilateral agreement, which was finalized in 2014. As this case reveals, cross-border healthcare can not only turn into a key issue of partisan competition, but it may be used to signal and strengthen feelings of sub-national territorial identity, distinguishing between those who are deemed as legitimate healthcare beneficiaries, and those who are not.

The conflict between the Communities of Madrid and Castile-La Mancha is even more revelatory of the politicization of cross-border healthcare. The signing of the agreement in 2015 resulted from a complex negotiation process. Prior to this formal arrangement, the budgetary insufficiency of the Healthcare Cohesion Fund had created tensions between the two communities, due to the lack of compensation for the treatments already provided by Madrid to Castilian-La Mancha citizens (Interview 2). For this reason, the definition of an alternative compensation mechanism - whereby the Community of Castile-La Mancha commits to periodically pay Madrid certain compensation fees for the treatments provided to its patients - represented a crucial element for the signing of the agreement in 2015 between the two ACs, both governed by the right-wing party PP (El Global, 2014).

However, the compensation conditions defined in that agreement raised criticisms in Castile-La Mancha. The Official College of Physicians of Toledo (capital city of the region) expressed its concern about the impact

that the agreement could have on Toledo's citizens. The agreement allowed almost 30% of the population of Toledo to be attended by hospitals in Madrid, for which almost 65 million euros would have been paid for a period of four years. From the perspective of local health professionals, the agreement affected municipal areas well communicated with hospitals in Toledo: 'it seems the perfect excuse to make a smaller hospital with fewer resources [...], leaving the rest of the citizens of Toledo in a situation of inequality.' (ABC, 2014a; ABC, 2015a)

Together with health professionals, firm opposition to the agreement came from left-wing opposition parties PSOE and Podemos, which declared their rejection of the agreement before its adoption, and promised to revise it in case of victory in the following regional elections of Castile-La Mancha (May 2015). Indeed, one of the first measures proposed by the new PSOE-Podemos coalition government who took office was the revision of the healthcare agreement with Madrid (ABC, 2015b). The incoming regional government asked the Community of Madrid to delink the municipalities of northern Toledo from the scope of the agreement, emphasizing its high cost versus the reduced advantages for Toledo patients (ABC, 2015c).

Against this proposal, the Community of Madrid, governed by the right-wing party PP, refused to modify the agreement, and threatened to terminate it as a whole in the event of non-compliance of its financial commitments by Castile-La Mancha (La Vanguardia, 2016; Cadena SER, 2016). This threat also led to the mobilization of part of the citizens of Castile-La Mancha (particularly in the areas of Guadalajara, the area that would have suffered the most from the eventual termination of the agreement), with the creation of a platform of neighbors to defend the agreement (ABC, 2015d). Likewise, several PP mayors of Castile-La Mancha's municipalities in the concerned areas launched a signature campaign to defend the agreement and against the PSOE-Podemos regional government (ABC, 2015e). Confronted with increasing partisan competition and citizens' discontent, the attempt of the coalition government of Castile-La Mancha to modify the conditions of their horizontal cooperation with the Community of Madrid failed. The institutionalization of cross-border healthcare via the signature of the agreement had already unfolded interests among patients/voters, making the regional government unable to retrench, except at the cost of losing significant political support.

Discussion

Healthcare exhibits the highest level of power decentralization to subnational governments among all public policy domains, turning these actors into key players in developing cross-border healthcare arrangements. From this perspective, the analysis of cross-border healthcare within national borders may deepen our understanding of the processes, dynamics and challenges that characterize horizontal cooperation in healthcare more broadly. This study systematically analyzed the cross-border healthcare agreements signed between the Spanish ACs from 2000-2020. Beyond a description of these tools, our study pointed out the importance of geographical/historical, economic and political factors in interpreting both the dynamics of articulation of bilateral agreements between ACs, as well as the conflicts that may arise between them.

In line with previous findings on international cross-border healthcare, regional policy-makers' decision to engage in such arrangements is mainly justified on the basis of considerations of economies of scale, particularly for those populations living in border areas. Accordingly, establishing these horizontal coordination mechanisms has constituted a bottom-up response to the challenges arising from patient mobility between regional healthcare systems. Although with differences in their scope and degree of institutionalization, these agreements aim to guarantee the right of Spanish citizens to healthcare throughout the national territory and to foster efficiency.

Economic considerations also explain decision-makers' level of engagement in bilateral agreements over time. Accordingly, macro-economic dynamics, and the capacity of each AC to respect financial commitments, seem to constitute determining factors in interpreting the general trend of involvement in

cross-border healthcare, operating as potential triggering factors for conflicts between ACs. As our analysis points out, the peak of horizontal inter-regional cooperation in healthcare dates back to the end of the 2000s, during a period of economic growth in the country. Yet, after the 2008 economic crisis the signing of new agreements involving financial commitments was greatly reduced. Since 2012, the practical disappearance of the national fund specifically intended to finance patient mobility between ACs, as well as its change in nature - from budgetary to extra-budgetary, and therefore subject to the political will of the central government in office -, introduced structural uncertainties for the ACs. The lack of guarantees concerning the possibility of being compensated for the treatments provided to patients from other ACs caused attitudes of mistrust between sub-national governments. Importantly, it represented the key cause of tensions – and even open conflicts – in cross-border healthcare.

Finally, as far as the political factor is concerned, the orientation of the regional governments along the traditional right-left axis does not seem significant in explaining the decision of two ACs to cooperate in cross-border healthcare. However, our analysis shows that cross-border healthcare may turn into a key arena for partisan competition and political capitalization, particularly at times of elections (national elections, in the case of the conflict between the Basque Country and Rioja; regional elections, in the one between Castile-La Mancha and Madrid). Likewise, they may be used as a key instrument for consolidating regional belonging and identity sentiments. Cross-border healthcare can bring to the surface not only administrative, but also political and identitarian tensions, where the borders between sub-national territories resemble external frontiers across States.

Conclusions

Cross-border healthcare arrangements may represent a key tool to foster efficiency in health provision. As our study points out, they may also become a controversial issue and a key arena for partisan competition, potentially affecting patient mobility.

Despite the diffusion of cross-border healthcare arrangements, the existence of institutional, political and financial tensions translates into concrete obstacles to articulating an effective response to patient mobility in Spain, challenging the General Health Law's goal of guaranteeing access to healthcare for all citizens regardless of their place of residence. Bringing politics back into the study of cross-border healthcare enhances our understanding of decision-makers' motivations to engage and disengage in these arrangements within and across national borders.

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Annex 1. Bilateral agreements on cross-border healthcare by AC

CA	Other CA involved in the agreement	Text	Parties at government at the time of signature
Andalusia	Ceuta y Melilla (INGESA)	**2013**. Cooperation agreement between the Andalusian Health Service and INGESA.	Andalusia: PSOE (left) INGESA (national government): PP (right)
Aragon	Castile-La Mancha	**2014**. Cooperation agreement between the Autonomous Communities of Aragon and Castilla-La Mancha on health care.	Aragon: PP (right) Castilla-La Mancha: PP (right)
	Catalonia	**2005**. Framework cooperation agreement between the health department of the Government of Aragon and the health department of the Government of Catalonia. **2005**. Specific cooperation agreement for emergency care in the bordering areas between Catalonia and Aragon. **2005**. Specific cooperation agreement for health care in the Pyrenees area between Catalonia and Aragon.	Aragon: PSOE (left) Catalonia: PSOE (left)
		2018. Specific cooperation agreement between the Government of Aragón and the Government of Catalonia, for the development of the framework cooperation agreement signed on April 29, 2005, for health care in the border area between the two Communities (renewal).	Aragon: PSOE (left) Catalonia: Coalition of nationalist parties (JxCAT, ERC and PDECAT)
	Castile and León	**2008**. Framework cooperation agreement between the Community of Aragon and the Community of Castile and León for coordination in health care. **2008**. Specific cooperation agreement between the Community of Aragon and the Community of Castile and León for emergency care in the border area. **2008**. Specific cooperation agreement between the Community of Aragon and the Community of Castile and León for primary and specialized health care.	Aragon: PSOE (left) Castile and León: PP (right)
	Navarre	**2009**. General protocol of cooperation between the Federal Community of Navarre and the Autonomous Community of Aragon to promote inter-autonomic cooperation (includes health care).	Aragon: PSOE (left) Navarre: UPN (right)
	Valencian Community	**2006**. Framework cooperation agreement between the health department of Generalitat Valenciana and the health department of the Government of Aragón on health care between neighbouring towns.	Aragon: PSOE (left) Valencian Community: PP (right)
		2016. Collaboration agreement between the health department of the Government of Aragón and the health department of the Generalitat Valenciana, for the provision of health care in neighboring areas (renewal of the 2006 agreement).	Aragón: PSOE (left) Valencian Community: PSOE (left)
	La Rioja	**2009**. General cooperation protocol between the Autonomous Community of La Rioja and the Autonomous Community of Aragón (includes collaboration in health care).	Aragón: PSOE (left) La Rioja: PP (right)
Asturias	Castile and León	**2008**. General cooperation protocol between the government of Asturias and the Government of Castile and León (includes collaboration in health care).	Asturias: PSOE (left) Castile and León: PP (right)

	Cantabria	**2006**. Cooperation agreement between the Cantabrian Health Service and the Asturias Health Service for the coordination of emergency care in neighboring areas. **2006**. Cooperation agreement between the Cantabrian Health Service and the Asturias Health Service for the use of the Hyperbaric Center of the Marqués de Valdecilla University Hospital.	Asturias: PSOE (left) Cantabria: PSOE (left)
		2019. Cooperation agreement between the Autonomous Community of Cantabria and Asturias regarding the provision of health care and the improvement of accessibility to the National Health System for patients residing in neighbouring municipalities.	Asturias: PSOE (left) Cantabria: coalition nationalist and left-wing parties (PRC and PSOE)
	Galicia	**2008**. Cooperation agreement on health training. **2008**. Cooperation agreement on acute myocardial infarction.	Asturias: PSOE (left) Galicia: PP (right)
Balearic Islands	Catalonia	**2008**. Cooperation protocol between the health department of the Balearic Islands and the health department of the Government of Catalonia.	Balearic Islands: PSOE (left) Catalonia: PSOE and ERC (left)
Basque Country	Cantabria	**2008**. Cooperation agreement for the provision of health care in the bordering areas of the Autonomous Community of Cantabria and the Basque Country. **2008**. Protocol for the coordination of emergency care between the Autonomous Community of Cantabria and the Basque Country (Annex I of the Cooperation agreement). **2008**. Cooperation agreement between the Basque Country and the Autonomous Community of Cantabria on cardiac and pulmonary transplants (Annex II of the Cooperation agreement).	Basque Country: PNV (nationalist, right) Cantabria: PSOE (socialist)
	Castile and León	**2012**. General cooperation protocol between the Basque Country and the Government of Castile and León (includes cooperation in health care).	Basque Country: PNV (nationalist, right) Castile and León: PP (right)
	La Rioja	**2011**. Cooperation agreement between the Autonomous Community of the Basque Country and the Autonomous Community of La Rioja on renal transplantation.	Basque Country: PSOE (left) La Rioja: PP (right)
		2014. Cooperation agreement between the Autonomous Community of the Basque Country and the Autonomous Community of La Rioja on health care.	Basque Country: PNV (nationalist, right) La Rioja: PP (right)
	Navarre	**1988**. Cooperation agreement on health care between the Basque Country and the Foral Community of Navarre.	Basque Country: PNV (nationalist, right) Navarre: PSOE (left)
		2015. Cooperation agreement between the Basque Country and the Foral Community of Navarre on health care (renewal).	Basque Country: PNV (nationalist, right) Navarre: coalition of nationalist and left-wing parties (GBai, EH Bildu, Podemos, IU Navarra)
Canary Islands	Community of Madrid	**2013**. Specific agreement between the Community of Madrid and the Canary Islands whereby doctors from La Paz Hospital will provide health care to paediatric patients with congenital heart disease in the Community of the Canary Islands.	Canary Islands: CC (regionalist, right) Community of Madrid: PP (right)
	Valencian Community	**2020**. Cooperation agreement between the Autonomous Community of the Canary Islands and the Generalitat Valenciana for the management and provision of services in	Canary Islands: PSOE (left) Valencian Community: PSOE (left)

		the field of health innovation.	
Cantabria	Asturias Basque Country	See corresponding line of Asturias and Basque Country	
	Castile and León	**2020**. Cooperation agreement between the Government of Cantabria and the Regional Government of Castile and León (includes collaboration in health care).	Cantabria: PSOE (left) Castile and León: PP (right)
	La Rioja	**2009**. Convenio de colaboración entre la Comunidad Autónoma de La Rioja y la Comunidad Autónoma de Cantabria sobre trasplante hepático, cardiaco y pulmonar.	Cantabria: PSOE (left) La Rioja: PP (right)
Castile and León	Aragón Asturias Basque Country Cantabria	See corresponding lines for Aragón, Asturias, Basque Country and Cantabria	
	Castile-La Mancha	**2009**. General cooperation protocol between the Governments of the Communities of Castilla-La Manch and Castile and León. **2009**. Addendum on health care.	Castile and León: PP (right) Castilla-La Mancha: PSOE (left)
	Galicia	**2008**. Framework cooperation agreement between the health department of Health of the Xunta de Galicia, the Galician Health Service and the health department of the Junta de Castile and León to regulate the scope of cooperation in health care. **2008**. Specific cooperation agreement between the health department of the Xunta de Galicia, the Galician Health Service and the Regional health department of Castile and León for specialized primary care and emergency care in certain bordering areas of both Communities.	Castile and León: PP (right) Galicia: PP (right)
	Extremadura	**2009**. General cooperation protocol between the Government of Extremadura and the Government of Castile and León. **2009**. Addendum on health care. **2010**. Second addendum on health care.	Castile and León: PP (right) Extremadura: PSOE (left)
	La Rioja	**2008**. General cooperation protocol between the Community of La Rioja and the Government of Castile and León. **2009**. General addendum on health care. **2010**. Second addendum. **2010**. Second annex to the addendum on health care. **2013**. Third addendum.	Castile and León: PP (right) La Rioja: PP (right)
	Community of Madrid	**2008**. General cooperation protocol between the Community of Madrid and the Government of Castile and León (includes cooperation in health care).	Castile and León: PP (right) Community of Madrid: PP (right)
Castile–La Mancha	Aragón Castile and León	See corresponding lines of Aragón and Castile and León	
	Community of Madrid	**2015**. Cooperation agreement between the Autonomous Communities of Castilla-La Mancha and Madrid for the provision of specialized health care in certain bordering areas of both Autonomous Communities.	Castilla-La Mancha: PP (right) Community of Madrid: PP (right)

	Valencian Community	**2007**. Framework cooperation agreement between the health department of the Generalitat Valenciana and the health department of the Junta de Comunidades de Castilla-La Mancha. **2007**. Specific cooperation agreement for the bordering areas of the communities of Castilla-La Mancha and the Valencian Community.	Castilla-La Mancha: PSOE (left) Valencian Community: PP (right)
		2012. Cooperation agreement on health care for the bordering areas of the communities of Castilla-La Mancha and the Valencian Community (renewal).	Castilla-La Mancha: PP (right) Valencian Community: PP (right)
Catalonia	Aragón Balearic Islands	See corresponding line of Aragón and Balearic Islands	
	Valencian Community	**2008**. Cooperation protocol between the health department of the Generalitat Valenciana and the health department of the Generalitat de Cataluña	Catalonia: PSOE and ERC (left) Valencian Community: PP (right)
Extremadura	Castile and León	See corresponding line of Castile and León	
Galicia	Asturias Castile and León	See corresponding lines of Asturias and Castile and León	
La Rioja	Aragón Basque Country Cantabria Castile and León	See corresponding lines of Aragón, Basque Country, Cantabria and Castile and León	
	Navarre	**2012**. Agreement between the Foral Community of Navarre and the Autonomous Community of La Rioja on mutual cooperation of their healthcare systems.	La Rioja: PP (right) Navarre: UPN (nationalist, right)
Comunity of Madrid	Canary Islands Castile and León Castilla-La Mancha	See corresponding lines of Canary Islands, Castile and León, and Castile-La Mancha	
Murcia	No agreements signed		
Navarre	Aragón Basque Country La Rioja	See corresponding lines for Aragón, Basque Country and La Rioja	
Valencian Community	Aragón Castilla-La Mancha Canarias Cataluña	See corresponding lines of Aragón, Castilla-La Mancha, Canary Islands and Catalonia	