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Articles

Obstacles to patient mobility in Mercosur border areas: a typology proposal

Obstáculos a la movilidad de pacientes en zonas de frontera del Mercosur: una propuesta de tipología

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Abstract

The objective of this article is to identify the bottlenecks or restrictions that affect the mobility of patients in the border areas of the founding States of Mercosur: Argentina, Brazil, Paraguay and Uruguay. A qualitative analysis of the data collected and inputs prepared in the framework of the action "Cross-border cooperation in health with emphasis on facilitating patient mobility" proposed by the Mercosur Social Institute, before the COVID-19 pandemic to the Program for the strengthening the social cohesion in Latin America, known as EUROsociAL+ are key elements. As a result of this inter-institutional collaboration, a typology of obstacles to patient mobility in Mercosur is proposed.

Keywords: patient mobility, borders areas, Mercosur, COVID-19.

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Resumen

Este artículo tiene por objetivo identificar los cuellos de botella o restricciones que afectan a la movilidad de pacientes en las zonas de frontera de los Estados partes fundadores del Mercosur: Argentina, Brasil, Paraguay y Uruguay. Se realizó un análisis cualitativo de los datos recolectados e insumos elaborados en el marco de la acción "Cooperación transfronteriza en materia de salud con énfasis en la facilitación de la movilidad de los pacientes" propuesta por el Instituto Social del Mercosur, antes de la pandemia COVID-19, al Programa para el fortalecimiento de la cohesión social en América Latina, conocido como EUROsociAL+. Como resultado de esta colaboración interinstitucional se propone una tipología de obstáculos a la movilidad de pacientes en el Mercosur.

Palabras clave: Movilidad de pacientes, áreas de frontera, Mercosur, COVID-19.

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Introduction

Cooperation in border areas seeks to avoid duplication of objectives, functions, and services between institutions on both sides of the border. It also seeks to create competition between them through a harmonious, balanced, and rational combination of public policies that promote a specific governance system for the territory. This governance system needs to include several sectoral components, highlighting health cooperation in the current pandemic context.

In the months before the pandemic emergency, at the end of 2019, the signing of the Agreement on Linked Border Towns (*Acuerdo sobre Localidades Fronterizas Vinculadas*, ALFV) took place, an important step in terms of borders and health in the scope of the Common Market of the South (*Mercado Común del Sur*, Mercosur). This agreement, which includes a list of the towns covered by this status,[1] seeks differentiated treatment for border residents, including *access to public health services*, among others[2]. Specifically, Article VII establishes that

> public institutions responsible for the prevention and control of human diseases (...) shall collaborate with their counterparts in adjacent local governments, coordinated by the provincial/state health authorities and counterparts involved through the national health authorities, for joint public health work, epidemiological surveillance, and contingency plans to guide the response to public health events and other issues of common interest, including those of potential international importance. This work is carried out following the rules and procedures harmonized among the States Parties or, in their absence, under the respective national legislation. (Mercosur, 2019)

Likewise, Article III on "Granted Rights" provides that "the State Parties may grant other rights that they may agree, bilaterally or trilaterally, including medical care in the border public health systems under conditions of reciprocity and complementarity". This last article seeks to alleviate the asymmetries and disparities in health care on both sides of the border. It is still too early to assess the impact of ALFV on patient mobility in Mercosur border areas, especially since some of the main measures to prevent the spread of COVID-19 have been individual decisions to close the borders by Mercosur member states.

[1] The list of the linked border towns can be consulted at: https://www.mercosur.int/documento/acuerdo-localidades-fronterizas-vinculadas/

[2] Of particular relevance in terms of mobility is also the possibility of obtaining a Border Neighborhood Transit Document (*Documento de Tránsito Vecinal Fronterizo*, DTVF) accepted by the State Parties, with which the border citizen is guaranteed the following rights: *i*) Exercise of the work, trade or profession in accordance with the laws applicable to nationals of the State Parties in which the activity is carried out, including the requirements for training or professional practice under an employment contract under the conditions provided for in the international agreements in force between them, with equal labor and social security rights and compliance with the same labor, social security, and tax obligations of the State Parties; *ii*) Attendance at public educational establishments, free of charge and on a reciprocal basis; *iii*) Access to the border trade regime for subsistence goods or products; and, *iv*) Availability, as soon as possible and once the necessary infrastructure adjustments have been made, of an exclusive or priority lane for DTVF holders at the border checkpoints of the linked border localities covered by this agreement.

Mercosur border areas

The border areas of Mercosur are geographically, socioeconomically, and demographically very heterogeneous. For more than 6 000 km, rural areas with little trade alternate with economically more dynamic areas that contribute significantly to the economies of the member states. In part of the border area, it is possible to identify binational or tri-national cross-border territories with their own demographic and socioeconomic characteristics. In general terms, the internal borders of Mercosur are characterized by many elements that distinguish them from other geographic regions:

- Small and medium-sized twin cities, in some cases relatively isolated from the main socioeconomic centers of the respective countries;[3]
- Bi- or tri-national urban areas;
- The predominance of river borders;
- Cross-border connections over (few) international bridges;
- Long-distance transport corridors (such as the bioceanic corridor);
- Regional and local institutional asymmetries, due to the different degrees of administrative decentralization in the Member States;
- Presence of indigenous communities;
- Territorial asymmetries reflected in an unequal supply of health, education, labor, and commercial services between one side of the border and the other, generating exchange flows and territorial complementarity.

Over the last few years, strong relationships have developed between border communities, manifested through increased economic exchanges, social and family ties, and cooperation (formal and informal) between the different levels of authority on one side of the border and the other, among other factors. A cross-border identity and way of life have thus been defined and *a way of facing the daily challenges and obstacles that limit citizen integration* in this territory. Accordingly, healthcare and patient mobility represent a key sector for the welfare of border populations. The institutional cooperation developed within the framework of Mercosur has opened a path toward greater integration of the border areas of the member countries, but some challenges remain.

This research seeks to answer the guiding question, what are the main bottlenecks in patient mobility in the Mercosur member states? Based on this, the aim is to propose a typology that considers the challenges that persist in Mercosur to favor patient mobility and totality of care for the population of the bloc. Although there is currently a concern for resolving the problems caused by the SARS-CoV-2 pandemic, the intention was to make an analysis that covers the reality of health at the border beyond this pandemic period.

[3] According to Machado, twin cities, which are pairs of urban centers facing each other face to face on an international boundary, represent the most evolved territorialization of border areas as they constitute a dynamic space "composed of the differences resulting from the international boundary, and of cross-border flows and interactions" (Machado do Oliveira, 2006) that have their own social processes, generally linked to regional or international networks or forums that, in general, expand their institutional capacity and their relationship with other actors (Oddone, 2016).

Methodology

This is a descriptive qualitative study. Its planning began in the pre-pandemic period of SARS-CoV-2. With the worsening of the health situation in all countries and the impossibility of mobility to the borders, it was decided to conduct semi-structured interviews with an online form in Spanish and Portuguese developed by the technical team of the EUROsociAL+ Program through GoogleForms®. The interview form was validated with the Council of Municipal Health Secretariats of Rio Grande do Sul (Cosems-RS), Brazil, as a pilot before being applied to the participants.

The questionnaire was divided into blocs, the first stage of which consisted of the ethical considerations of the study,[4] and only if the respondent agreed to participate could they continue to the questioning stage. The second bloc of the questionnaire included the socioeconomic characteristics of the participants. They were asked to indicate whether they could be categorized as local managers, regional or federal managers, border health workers, or researchers in border studies. From there, the participant proceeded to the other bloc with the specific questions according to their category.

The questionnaire was circulated by e-mail among health managers, representatives in health committees, health workers in border cities, and researchers involved in border studies. Data collection was individual and self-administered. The research was supported by the Council of Municipal Health Secretaries (Cosems) of the states of Rio Grande do Sul, Santa Catarina, Paraná, and Mato Grosso do Sul, in addition to the border nucleus of the State of Rio Grande do Sul and research group websites to broaden its dissemination. Data were collected from 65 participants in all survey categories from Argentina, Brazil, Paraguay, and Uruguay.

An Excel document was automatically generated in GoogleForms® with all the answers to the questions in the questionnaire. Once the collection was completed, the data were classified into thematic categories using the content analysis proposal of Bardin (2011).

Following the results of the survey, a classification of the main obstacles to mobility was drawn up. The obstacles to cross-border patient mobility in Mercosur border areas are the manifestations of dysfunctions of an administrative, legal, technological, infrastructure, or cooperation policy nature that affect the day-to-day management of health care. Nine types of obstacles have been identified, common to all the border territories analyzed, each of which may have a different weight or relevance depending on each specific case. Each obstacle, moreover, may be reflected in more than one typology; this is a fact that increases the complexity of the solutions in terms of social innovation and challenges for cross-border healthcare cooperation. These obstacles are presented below:

[4] The research project was, in turn, submitted to the Ethics Committee of the Universidad Federal de Pelotas (UFPel), Brazil, in accordance with the provisions of Resolution 466/12, and obtained approval under CAAE number 20364719.3.0000.5316. The ethical principles were guaranteed by acceptance in the Free Prior and Informed Consent (FPIC) form.

- **Political**: difficulty integrating national and local political agendas to develop an effective, long-term, multilevel cross-border health policy.
- **Legal**: the need for binational, tri-national, or regional agreements promoted by central states or regional and international organizations (Mercosur, Pan-American Health Organization, Amazon Basin Treaty Organization, among others).
- **Administrative**: bureaucratic impediments, often caused by the lack of (or lack of knowledge of) technical standards and protocols to implement the agreements signed by the parties. Furthermore, there are different interpretations of the latter by the State or regional authorities, without coordination with their counterparts on the other side of the border.
- **Governance**: lack of operational decision-making structures (on the part of local and regional authorities) to ensure the implementation and follow-up of agreements and cross-border patient flows.
- **Availability and accessibility of updated data**: lack of and difficult access to updated demographic-health data, patient mobility, and general cross-border health status data.
- **Physical accessibility**: the difficulty of connection by land or river due to lack of infrastructure or public transport services.
- **Sanitary supplies**: lack of equipment and specialized health care professionals.
- **Communication, information, and digitalization**: The authorities and citizens are unaware of how the health system of the neighboring country works and of the cross-border agreements in force. This situation also hinders the exchange of data and the establishment of automated work methodologies to make possible more expeditious attention to patients.
- **Cooperation**: lack of specific and stable programs to promote cross-border health cooperation on an ongoing basis. Cooperation contributes to the provision of the necessary technical and financial resources.

Main bottlenecks for patient mobility in Mercosur border areas

The efforts of Argentina, Brazil, Paraguay, and Uruguay, before the creation of Mercosur and especially since its creation in 1991, have been a key element in promoting a progressive harmonization of their regulatory frameworks toward the integration of key sectors such as health, transportation, and education, among others. The dialogue mechanisms used by national and local authorities are based on the agreements established over the past decades, promoted both by the integration process itself and based on bilateral agreements reached by the countries (see Table 1).

Table 1. Border conventions and agreements between Mercosur member states in the health field

Argentina-Uruguay	Year
Protocol of Intentions between the Ministry of Health of the Argentine Republic and the Ministry of Public Health of the Oriental Republic of Uruguay	2010
Specific agreement between the National Institute of Donation and Transplant of Cells, Tissues, and Organs (Instituto Nacional de Donación y Trasplante de Células, Tejidos y Órganos, INDT) of Uruguay and the National Central Institute for the Coordination of Ablation and Implantation (Instituto Nacional Central Único Coordinador de Ablación e Implante, INCUCAI) regarding transplants to natural or legal Uruguayan citizens residing in Uruguay	2010
Specific agreement between the National Institute of Donation and Transplant of Cells, Tissues, and Organs of Uruguay and the National Central Institute for the Coordination of Ablation and Implantation for the coordination of operations	2005
Reciprocity Agreement between the Ministry of Health of the Argentine Republic and the Ministry of Public Health of the Oriental Republic of Uruguay on organ and tissue donation and transplantation	2005
Protocol extending the cooperation agreement on health matters between the government of the Argentine Republic and the government of the Oriental Republic of Uruguay	1997
Health cooperation agreement between the government of the Argentine Republic and the government of the Oriental Republic of Uruguay	1991
Agreement on the exchange of frozen plasma and blood products between the government of the Argentine Republic and the government of the Oriental Republic of Uruguay, between the Universidad Nacional de Córdoba of the Argentine Republic and the Ministry of Public Health of the Oriental Republic of Uruguay	1985
Public health agreement between the government of the Oriental Republic of Uruguay and the government of the Argentine Republic	1979
Sanitary agreement between the government of the Oriental Republic of Uruguay and the government of the Republic of Argentina	1978
Cooperation and assistance agreement on public health between the Argentine Republic and the Oriental Republic of Uruguay	1971
Pan-American sanitary agreement between Uruguay, Argentina, Brazil, and Paraguay	1948
International Convention for the Control of Hydatid Disease	1945
International sanitary convention between the Republics of Argentina, United States of Brazil, Paraguay, and the Oriental Republic of Uruguay	1914
Sanitary Convention signed in Rio de Janeiro by the plenipotentiaries of the Republic of Argentina, Brazil, and the Oriental Republic of Uruguay	1887

Argentina-Paraguay	Year
Joint Operational Health Program in Border Areas	2013
Protocol of Intentions between the Ministry of Health of the Argentine Republic and the Ministry of Public Health and Social Welfare of the Republic of Paraguay	2006
Operational Plan for Joint Actions in Health in the Paraguay-Argentine Border Region (ARPA II)	2002
Operational Plan for Joint Health Actions in the Paraguay-Argentina Border Region (ARPA)	1997
Additional protocol	1995
Agreement between the Government of the Republic of Argentina and the Government of the Republic of Paraguay on border health matters	1992
Sanitary Agreement between the Government of the Argentine Republic and the Government of the Republic of Paraguay	1978
Brazil-Uruguay	**Year**
Brazil-Uruguay Agreement to Fight the Coronavirus Pandemic	2020
Memorandum of Understanding between the Oriental Republic of Uruguay and the Federative Republic of Brazil on Health Cooperation within the framework of the Uruguay-Brazil Binational Health Advisory Commission for the Creation of the Binational Center for Emergency Operations	2020
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation between the Government of the Federative Republic of Brazil and the Government of the Oriental Republic of Uruguay for the Implementation of the Project "Consolidation of the Institutional Capacity of the Ministry of Health of Uruguay and Expansion of the Regulatory Dialogue between the Health Authorities of Brazil and Uruguay"	2011
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation between the Government of the Federative Republic of Brazil and the Government of the Oriental Republic of Uruguay for the Implementation of the Project "Technical Support for the Expansion and Consolidation of the Uruguayan Network of Human Milk Banks"	2010
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation between the Government of the Federative Republic of Brazil and the Government of the Oriental Republic of Uruguay for the Implementation of the Project "Strengthening of Policies to Combat the STD/AIDS Epidemic in Uruguay	2009
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation between the Government of the Federative Republic of Brazil and the Government of the Oriental Republic of Uruguay for the Implementation of the Project "Support for the Strengthening of the National System of Blood and Blood-Derived Products of Uruguay"	2009
Complementary Adjustment to the Agreement for Brazilian and Uruguayan Border Nationals to Reside, Study, and Work Permits to Provide Health Services	2008
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation for the Implementation of the Project "Institutional Strengthening of the Public Health Secretariat of the Uruguayan Government in the Area of Health Surveillance"	2007
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation for the Implementation of the Project "Technical Support for the Implementation of Human Milk Banks in Uruguay"	2006
Complementary Adjustment to the Basic Agreement for Scientific and Technical Cooperation for the Implementation of the Project "Institutional Strengthening of the International Advisory Offices of the Ministries of Health of Brazil and Uruguay"	2006
Complementary Adjustment to the Agreement for Technical, Scientific, and Technological Cooperation for Border Health	2003
Memorandum of Understanding in the Framework of the Exchange of Experience in Organ and Tissue Transplantation	2003
Agreement for the Improvement of Sanitary Conditions in the Brazilian-Uruguayan Border Region	1969
Convention on the Fight Against Venereal-syphilitic Diseases in the Border Area Common to Both Countries	1928

Brazil-Argentina	Year
Complementary Adjustment to the Technical Cooperation Agreement for the Implementation of the "Project Technical Support for the Implementation of a Human Milk Bank in Argentina"	2008
Complementary Adjustment to the Technical Cooperation Agreement between the Government of the Federative Republic of Brazil and the Government of the Argentine Republic for Implementation of the Project "Strengthening of the Dengue Control Program"	2009
Memorandum of Understanding between the Ministry of Health of the Federative Republic of Brazil and the Ministry of Health of the Republic of Argentina on cooperation for social inclusion, access to health and human resources training in health	2013
Memorandum of Understanding Between the Ministry of Health of the Federative Republic of Brazil and the Ministry of Health of the Argentine Republic in Health Matters, Multivisceral Transplant	2015
Agreement between the Federative Republic of Brazil and the Argentine Republic on Linked Border Localities	2019
Brazil-Paraguay	**Year**
Sanitary Agreement- An agreement aimed at eliminating or diminishing the damages caused to the communities of said geographical region, as well as promoting measures capable of improving the respective health indices	1971
Supplementary Adjustment to the Sanitary Agreement of July 16, 1971, on Cooperation and Exchange of Health Technology	1992
Complementary Adjustment to the Technical Cooperation Agreement for the Implementation of the Project "Assistance and Treatment to People Living with HIV/AIDS in Paraguay"	2003
Complementary Adjustment to the Technical Cooperation Agreement for the Implementation of the Project "Support to the Implantation and Implementation of a Human Milk Bank in Paraguay"	2006
Complementary Adjustment to the Technical Cooperation Agreement for the Implementation of the Project "Institutional Strengthening of the International Advisory Offices of the Ministries of Health of Brazil and Paraguay"	2006
Complementary Adjustment to the Technical Cooperation Agreement between the Government of the Federative Republic of Brazil and the Government of the Republic of Paraguay for Implementation of the Project "Strengthening of Health Surveillance, with Emphasis on Combating Dengue and Implementation of International Health Regulations"	2007
Complementary Adjustment to the Basic Agreement for Technical Cooperation between the Government of the Federative Republic of Brazil and the Government of the Republic of Paraguay for Implementation of the Project "Institutional Strengthening of the National Health Surveillance Division of the Ministry of Public Health and Social Welfare of the Republic of Paraguay"	2012
Health Cooperation Agreement at the Border Carmelo Peralta-PY-Porto Murtinho-BR-Institutes the Paraguay-Brazil Health Commission	2013
Complementary Adjustment to the Agreement on the Permit for Residence, Study and Work for Brazilian and Uruguayan Border Nationals, for the Provision of Emergency Assistance Services and Civil Defense Cooperation (Montevideo Agreement)	2013
Memorandum of Understanding between the Ministry of Health of the Federative Republic of Brazil and the Ministry of Public Health and Social Welfare of the Republic of Paraguay	2015
Joint declaration between the Ministry of Health of the Federative Republic of Brazil and the Ministry of Public Health and Social Welfare of Paraguay	2017
Agreement for the formation of an Urgency and Emergency Health Network in the Triple Border area-Paraguay-Brazil-Argentina	2018

Source: created by the author

Since the beginning of the 21st century, cooperation in border areas has accelerated relatively quickly at different territorial scales. However, despite the cross-border institutional capital generated, numerous obstacles persist that hinder patients' mobility from one side of the border to the other. The 20 bottlenecks detected are below. A representative case or example is shown for each of them, although it is

more common for a cross-border area to present more than one obstacle and for the bottlenecks to be combined (see Table 2).

Table 2. Summary of bottlenecks identified for cross-border health mobility in Mercosur grouped by thematic areas

Subject Area	Type of obstacle to patient mobility (bottleneck)
Citizenship and the right of access to health care	1) Recognition of citizenship for those born on the other side of the border 2) Loss of entitlement to social assistance from the country of origin if residing on the other side of the border 3) Reimbursement of health care expenses 4) Medications not available on one side of the border when being treated in the neighboring country
Patient transfer	5) Excessive bureaucracy for patient transfers 6) Patient transfers are limited to emergency cases and do not include more complex situations
Health professionals	7) Invalidity of prescriptions issued by a physician or hospital on one side of the border because pharmacies or physicians do not recognize them on the other side of the border 8) Partial right to practice of physicians practicing on the other side of the border. The recognition of degrees and the legal practice of medicine on the other side of the border is still a pending issue
Accessibility and healthcare facilities	9) Lack of healthcare equipment, especially of high complexity and quality 10) Lack of road infrastructures and regular public transport services 11) Repatriation of corpses does not have a streamlined system for border nationals
Information exchange, monitoring, and communication	12) Discontinuity in the surveillance and control of communicable diseases 13) Lack of a shared cross-border sanitary monitoring system among Mercosur countries 14) Lack of disaggregated, updated and shared statistical data among the competent authorities 15) Lack of technological integration in the provision of services 16) Need for a joint and integrated approach to healthcare in the cross-border territory that shares procurement / contracting systems and financing procedures 17) Communication and information to the public on the agreements and procedures in force
Support for cross-border cooperation	18) Lack of support to local administrations to undertake and maintain cross-border cooperation measures in the health field 19) Cooperation programs with topics specifically aimed at cross-border health promoted by Mercosur or other international organizations
Gender focus	20) Little attention to the gender approach in healthcare cooperation

Source: created by the author

The following are the bottlenecks detected in the follow-up to the recently proposed categories.

Citizenship and the right of access to health care

1) Recognition of citizenship for those born on the other side of the border.

   According to Brazilian legislation, if a pregnant woman goes to the other side of the border to be attended to in the last stages of labor, either due to the lack of services in the twin city or other needs, those born a few kilometers from the border will not obtain the certificate of live birth in Brazil.[5] Therefore, citizenship is not guaranteed from birth. This situation negatively impacts demographic statistics (birth rate and population growth). It is necessary to explore a legal solution and introduce technical standards to avoid unnecessary displacements of the mother to seek a quality service in her own country, putting her health and that of the fetus at high risk. For example, mothers from Barra do Quaraí (Brazil) who travel to Uruguaiana (70 km further north) to have their babies delivered within the national territory could instead go to Bella Unión (Uruguay), only 7 km away. Alternatively, if there was a bridge, they could go to Monte Caseros (Argentina), which has a more complex public health care system.[6]

2) Loss of entitlement to social assistance from one's own country if residing on the other side of the border.

   This problem has arisen, especially in the Brazilian border areas, due to the payment of the Continuous Cash Benefit (*Beneficio de Pago Continuo*, BPC). This is an additional social inclusion payment made by the Brazilian government to low-income people over 60 years of age. In many cases, it represents fundamental financial support for households, especially for the purchase of medicines. When residing on the other side of the border, particularly in the twin cities, the right to this benefit is lost since residency in Brazil is a requirement. For this reason, some beneficiaries do not communicate the effective transfer of their domicile to the other side of the border. This entails a situation of illegality (false declaration of residence). However, it is obvious that these people's daily lives revolve around the border, and they continue to carry out social, economic, political (and electoral) activities in Brazilian territory. According to the documentation consulted, this is more of an administrative bottleneck; it is the responsibility of the National Social Security Institute (*Instituto Nacional de Seguridad Social*, INSS), which is decentralized in each federated State.

3) Reimbursement of health care expenses.

   The health authorities of a border region do not always recognize access to their national health system in neighboring border countries. Although there are agreements in this respect, a serious problem is registration in the social security

[5] Instance remarked by the local authorities of Barra do Quaraí. See Pêgo, 2020, pp. 187-188.

[6] On this point, see "Without crossing the border there is no integration: Monte Caseros, Bella União and Barra do Quaraí in regional dialogue" (Oddone & Pauluk, 2020, pp. 49-67).

system and the consequent reimbursement of health expenses. Not all Mercosur countries guarantee universal access to medical care. Argentina, Uruguay, and Brazil do, while Paraguay is still moving in this direction.

The main issue is the rejection by a national health system of health care costs generated by a patient coming from the other side of the border. Often, cross-border healthcare flows are generated by the failure to find an adequate service in the municipality itself. This situation hinders the right to cross-border healthcare for both basic and more advanced and complex treatment. In some cases, there is a lack of an appropriate legal framework to recognize reimbursement; but in many other cases, the bilateral agreement exists, however, the competent administrations do not apply it due to a lack of technical standards for action, ignorance of the agreement, or lack of resources for its implementation. It is a case of an administrative/bureaucratic nature. There are many examples of this, but a complicated situation often arises along the Argentine-Paraguayan border. According to the bilateral agreement between the government of the province of Misiones, Argentina, and the government of the department of Itapúa, Paraguay, citizens of the department of Itapúa can go to specific hospitals in Posadas after a series of authorizations from Paraguayan authorities, the relevant health professional, the director of the Regional Hospital of Encarnación, the Secretary of Health of the Government and, finally, the confirmation of the availability of the Posadas hospitals, and only through the Misiones mobile unit service. However, many patients present themselves in the Posada facilities without following this procedure (the so-called *self-referred*) who should be charged for health expenses according to the current regulations. In many cases, they are treated in the same way as self-referred patients due to the urgency of the treatment and ethical reasons.

4) Medications are not available on one side of the border when being treated in the neighboring country.

This problem has arisen due to the closure of the Argentine-Paraguayan border in response to the spread of the COVID-19 pandemic. Due to the health agreement between the government of Misiones and the government of Itapúa, residents of the Paraguayan department—especially in the city of Encarnación and surrounding areas—received health care in the hospitals of Posadas. They were provided with oncological drugs not available in Paraguay, and the national government reimbursed the benefits. With the closure of the international bridge, patient mobility was interrupted, as were treatment cycles. Many had to be treated by a foundation in Encarnación, which does not have the medicines supplied by the Argentine hospitals, since the Paraguayan ministry does not include it in its health care system. Patients have to buy these drugs at market prices, and the health operators supply them to them. This case received significant attention in the local press. At that time, the Paraguayan consul in Posadas called on the families of cancer patients in Encarnación to deliver the drugs to the consulate to take care of the shipment across the border. The health structures in Encarnación were then concerned with providing the cure to the patients after consular management. In this case, the problem is twofold. On the one hand, the closure of the border generates unforeseen health situations in the border country, and there is no protocol to propose an alternative to the patients. On the other hand, there is no

shared record of the drugs supplied to the patients and their introduction into the national health system of each country.

Patient transfer

5) Excessive bureaucracy for patient transfer.

Excessive bureaucracy is a very common situation in the study area, especially between the twin cities of Carmelo Peralta (Alto Paraguay, Paraguay) and Porto Murtinho (Mato Grosso do Sul, Brazil). Local authorities admit that bureaucracy and legal issues slow down the transfer of patients. In case of emergencies, transfers are carried out more often through personal relationships and the willingness of the health authorities than through legal channels. The bureaucratic and legal time required for medical transfers is often incompatible with emergencies. It is, therefore, a problem of administrative flexibility.

Some local authorities also point out that the free circulation of emergency vehicles in the linked border localities of Brazil is not fully operational. Despite the existence of bilateral agreements (Montevideo Agreement of 2013) and Mercosur (Agreement on Linked Border Localities of 2019), it seems that the technical implementation of the agreement is at a standstill in the Brazilian capital. The above is, therefore, both an administrative and, hypothetically, a political problem. According to these agreements, vehicles used for emergencies (accidents, natural disasters, among others) such as ambulances and fire trucks can provide assistance services in urban, suburban, and rural areas of the border localities linked to the country's border areas. These will be coordinated by the focal points and must comply with the technical regulations of both parties.

6) Patient transfers are limited to emergency cases and do not include situations of greater complexity.

The above bottleneck shows how informal cross-border relationships can be used to operate in emergencies, despite regional, State, or federal legal and administrative difficulties. An even more difficult issue is the transfer of patients for more complex situations, such as surgery and specific treatments (oncology, contagious and transmissible respiratory diseases, among others). Bilateral agreements and technical protocols shared by both countries, such as the agreement between the provincial government of Misiones and the departmental government of Itapúa, are often used for this purpose. Even so, the closure of the international bridge between Posadas and Encarnación as a COVID-19 containment measure has shown the fragility of these agreements. Highly complex health transfers lack a common legislative and operational framework based on multilevel governance to integrate border needs with national policies.

Health professionals

7) Invalidity of prescriptions issued by a physician or hospital on one side of the border because pharmacies or physicians do not recognize them on the other side of the border.

   The lack of collaboration between border health authorities leads to difficulties in obtaining some medicines. It is a bottleneck that mainly affects twin cities. In particular, a medicine prescribed by a doctor in a neighboring country is not always valid on the other side of the border. For the above reason, pharmacies do not recognize the validity of the document issued, especially if it concerns specific and expensive drugs not subsidized by the national health system. In addition to this problem, it is important to mention that the high cost of drugs in a country limits access to cures. The difficulty in cross-border territories is twofold: expensive drugs in the country and prescriptions that pharmacies do not recognize in twin cities where the cost could be more affordable. The situation is even more complicated in Paraguay, where universal health care has not been implemented for all its citizens, although there have been many advances in recent years.

8) Partial right to practice of physicians practicing on the other side of the border. The recognition of degrees and the legal practice of medicine on the other side of the border is still a pending issue.

   Health professionals (doctors and nurses, among others) who have studied in their country of origin cannot perform their functions in the neighboring country due to a lack of validation of their degrees. Between Uruguaiana and Paso de los Libres and between Bella Unión and Barra do Quaraí, professionals working in hospitals in the neighboring country are not authorized to issue medical prescriptions because they are not registered in the national professional registries. For example, in the case of Brazil, this situation generates great inefficiency since Brazilian physicians must reissue the certificate issued by their counterparts in Argentina or Uruguay. Although there is an agreement with Argentina that attempts to solve this problem, the mutual validation of qualifications is still pending. Similarly, when studying at a university in another country, nationals who return to their country of origin without a validation process do not have their studies recognized. The above is the case for future Argentine and Uruguayan doctors studying at the Universidade Federal do Pampa (Unipampa) in Uruguaiana or those Brazilians studying medicine at universities in Paraguay and Argentina. This issue continues to be a long and costly process managed by the central authorities of the border countries, which hinders the labor mobility of health professionals in the border areas and negatively affects patient mobility and the organization of the health services network.

Accessibility and healthcare facilities

9) Lack of health care equipment, especially highly complex equipment.

There is a lack of healthcare facilities at different border points, particularly highly complex ones such as oncology, radiology, and hemodialysis centers. Among the areas that stand out is the lack of neonatal care centers between Nueva Palmira-Carmelo-Colonia de Sacramento-Juan Lacaze-Rosario and Pedro Juan Caballero and Ponta Porã, or of mobile units in more rural areas. To avoid legal and administrative obstacles, many patients turn to the closest healthcare facilities in their own country, even if they are far away. Therefore, a comprehensive approach is needed, one that corresponds to the geographical, demographic, and socioeconomic reality of the border areas, where health facilities consider the population of their own country and the population living on the other side of the border, i.e., a functional cross-border health area. There are no mobile river units in a border territory dominated by rivers, whether owned by one country or bi- or tri-national. These structures would increase healthcare access in the most rural and underpopulated border areas according to river conditions. Likewise, the use of border telemedicine seems to be not very widespread. However, digital access to health is one of the main challenges of the post-covid era that will have to be considered for future cross-border health policies in Mercosur.

10) Lack of road infrastructure and regular public transport services.

Despite the presence of important border crossings (bridges, fords, or urban crossings) and attempts to continuously improve accessibility, especially between Argentina and Paraguay (inauguration of the Ituzaingó-Ayolas International Crossing in 2019 and the future bridge between Puerto Iguazú and Presidente Franco), connectivity between many linked border towns remains precarious. However, patient mobility depends not only on the presence of physical infrastructure but also on transportation services. Excluding specific agreements for patient transfer, there is a lack of regular river crossings and cross-border buses in terms of the number of routes and timetables. Moreover, the supply of integrated cross-border transportation, whether public or private, is conditioned by the different sector regulations in each country. For these reasons, flows go through social and family relationships that can offer an emergency transfer to the jetty in the neighboring city or a car ride to the necessary health structure, free of charge or at an affordable price. Likewise, displacement impacts health care, since in many cases, low-income people have greater mobility difficulties.

11) The repatriation of corpses does not have a streamlined system for border citizens.

Bureaucratic problems hinder the quick and easy repatriation of the deceased across the border, respecting the family's wishes. The cases in which this situation occurs are very diverse: an accident, a death following hospital treatment, whether due to an emergency or of high complexity, elderly people admitted to nursing homes on the other side of the border, or simply residents in the neighboring country who have not communicated their change of residence to their State (see point 2). For bureaucratic reasons, the repatriation of corpses in cross-border areas is considered international repatriation. It entails a too slow and costly process

because it is only a few kilometers from the border, requiring protocols from consular bodies or embassies. In addition, the coffin must arrive in the country already sealed. For these reasons, in cases of the imminent death of a border resident, and thanks to the good informal relations between local authorities, the person is transferred to the competent structures on the other side of the border. This is a situation at the limit of legality that needs a response through a bilateral agreement and for all Mercosur countries.

Information exchange, monitoring, and communication

12) Discontinuity in the surveillance and control of communicable diseases.

Over the past decades, Mercosur countries have reached important agreements on epidemiological surveillance and control of communicable diseases. Bilateral agreements have been signed, especially with the Brazilian authorities. These agreements generally include implementing specific actions such as joint vaccination campaigns, coordination, exchanging information, and joint sanitary controls. Some examples are the cooperation for the control of influenza between Chuy (Rocha, Uruguay) and Chui (Rio Grande do Sul, Brazil), of dengue, yellow fever, and HIV-AIDS between Paraguay and Argentina, or for the creation of a Binational Emergency Operations Center (*Centro Binacional de Operaciones de Emergencia*, COE) to face the current COVID-19 pandemic between Santana do Livramento (Rio Grande do Sul, Brazil) and Rivera (Rivera, Uruguay). However, many initiatives lack appropriate resources and an integrated vision between territories and the different communicable diseases. In the Bella União-Barra do Quaraí-Monte Caseros triple border, local authorities have called for joint action against leishmaniasis for years, and a cooperation agreement is still lacking. The agreement between Brazil and Uruguay on joint control of COVID-19 in the transboundary strip seems to be moving in this direction. However, the major difficulty is to transfer the results of the pilot projects within regional policies to truly address surveillance and sanitary control. The above is a crucial point for the internal borders of Mercosur exposed to multiple communicable diseases that can combine with each other. In the north of the province of Salta in Argentina, cases of corona-dengue and corona-salmonella have recently been detected, i.e., patients affected by COVID-19 and dengue or salmonella (Programación Canal 9 Televida, 2021). Coordinated initiatives are therefore needed to provide diagnostic tools and adequate treatment.

13) Lack of a shared cross-border sanitary monitoring system among Mercosur countries.

The monitoring of cross-border health flows is a fundamental element to understand the communities' needs and plan joint actions between the competent authorities. Although pilot projects for the integration and exchange of health data have been carried out at some local or regional levels, a permanent network for monitoring health mobility is still lacking. Accordingly, big data studies would be very useful to detect the concentration and evolution of cross-border flows. To this end, it is essential to establish stable collaboration between public and private institutions. Through this collaboration, it will be possible to establish shared

definitions, methodologies, and indicators supported by the Mercosur Observatory of Health Systems (*Observatorio Mercosur de Sistemas de Salud*, OMSS) or the Pan American Health Organization (PAHO).

14) Lack of disaggregated, updated and shared statistical data among the competent authorities.

The lack of updated socioeconomic, demographic, and health statistics remains a challenge. Methodological differences in data collection remain between statistical institutes in each country and at the provincial/departmental/state level. It is therefore difficult to gather evidence to identify the needs of border communities for proper planning.

15) Lack of integration of technology in the provision of services.

Health cooperation in the technological field between Mercosur countries includes some experiences. The current pandemic has marked a turning point in applying information and communication technologies (ICT), especially in the health sector. The use of technologies between the healthcare structures of the linked border localities does not seem to be widespread. Sharing and exchanging the clinical history of patients treated between healthcare structures in the cross-border area, activating telemedicine to provide quality service and proximity to patients (*virtual accessibility*), and harmonizing customer care methods are some of the challenges that should be prioritized to ensure quality healthcare along the internal borders of Mercosur.

16) Need for a joint and integrated approach to healthcare in the cross-border territory, sharing procurement and contracting systems and financing procedures.

Many of the bottlenecks identified, such as the lack of health equipment, health professionals, or the partial right to practice of doctors in the neighboring country, have a common origin. It is, therefore, appropriate to move toward a more "holistic" approach to cross-border cooperation in health matters, promoting virtuous and efficient investments. Concrete aspects could be, for example, a single system for the purchase of health material and the recruitment of health professionals for the border localities linked to each other.

17) Communication and information to the population on the agreements and procedures.

It is very common for patients to go to the other side of the border searching for health care without knowing the cooperation agreements and conventions in force. This is due, in part, to the lack of an effective communication plan by the institutions and health structures on the procedures to be followed. The phenomenon of Paraguayan *self-referrals* in the hospitals of Posadas (see point 2) at times generates some difficulties (refusal of free care, complaints, tension between health personnel and patients, among others), which in some circumstances have required the intervention of diplomatic bodies to resolve the situation.

Support for cross-border cooperation

18) Lack of support to local administrations to undertake and maintain cross-border cooperation measures in the health field.

Along the Mercosur borders, there are highly innovative cross-border cooperation structures that have emerged from the local level, such as the border integration consortium (*Consorcios de Integración Fronteriza*, CIF), binational working groups, and the Permanent Municipal Interparliamentary Forum between the cities of Posadas and Encarnación, among others. The local administrations involved in health cooperation experiences share the same concern of not having sufficient financial and human resources to maintain the measures undertaken in health matters. For a cooperation structure to work effectively and efficiently, it is necessary to have adequate human (technical and administrative personnel), technological, and financial resources.

19) Cooperation programs with topics specifically aimed at cross-border health promoted by Mercosur or other international organizations.

Local institutions have shown their willingness, proactivity, and creativity to face the daily challenges of healthcare in cross-border areas. They have developed relevant *cross-border institutional capital*[7] and territorial know-how embodied in agreements, partnerships, projects, and informal relationships. In this context, the studies carried out by the Mercosur Social Institute (*Instituto Social del Mercosur*, ISM) represent a fundamental contribution to the design of new cross-border health cooperation projects and policies. Among the most relevant studies, the following stand out:

a) *Políticas Sociais no Mercosul-Estrutura dos organismos públicos de oferta dos serviços sociais*: characterization of the supply of social services in the Mercosur countries, the form of organization and governance, as well as their deployment in the territory, which describes in detail the ministerial programs of the education, health, labor, security, and social assistance sectors in each State party (Instituto Social do Mercosul, 2018c).

b) *Cidadania Social no Mercosul. Acesso a serviços sociais em regiões de fronteira*: presents a systematization of regional and national legal and administrative mechanisms that directly impact border dynamics. The study describes binational and tri-national cooperation experiences, such as the Integration Committees and specific programs. It also analyzes the social situation in thirteen border cities (Instituto Social do Mercosul, 2018a).

c) *Integração Social de Fronteira no Mercosul:* bibliographic review of research groups and observatories that are linked to the analysis of the social integration of the border (Instituto Social do Mercosul, 2018b).

[7] As has been demonstrated in other cross-border contexts, cross-border institutional capital is a fundamental requirement for generating cross-border local economic development processes (Berzi, 2017; Berzi & Castañer, 2018).

Beyond these studies, a financial cooperation mechanism to support direct actions in border territories with a regional approach at the Mercosur level still needs to be defined.

Gender approach

20) Little attention to the gender approach in health cooperation.

While every administration develops some kind of initiative focused on improving access to healthcare for women, in general, many cross-border cooperation projects and initiatives lack a gender perspective. Health is perhaps the sector where this approach should be adopted in all aspects. The approach to cross-border health cooperation based on gender covers several dimensions, from representing women in cross-border organizations (mostly led by and composed of men) to promoting cross-border policies and actions aimed at specific issues. Some of these issues are the right to assistance in childbirth and abortion, protection and shelter for victims of domestic violence, abuse, prostitution, and human trafficking. It is also important to promote and guarantee access to health care for women belonging to ethnic-linguistic minorities and socially vulnerable groups.

Covid-19 and bottlenecks at borders

During the SARS-CoV-2 pandemic, the border populations of the countries under study experienced the closure of national borders. Initially, only exceptional goods traffic was allowed between countries, but the restrictions have been gradually eased for some borders thanks to the evolution of diplomatic relations and the health situation. The free movement of people in the cross-border area represents a vital factor for commercial and family relations and guaranteeing access to health care. However, there has not been a univocal and mutually collaborative response among the Mercosur States, which have retreated into searching for national responses to the problem. As a result, Mercosur has witnessed, in some cases, the signing of a few bilateral agreements in the health sector, which are very innovative in terms of the type of instruments and approaches used in those cases where a previous culture of cross-border collaboration already existed, such as in the cities of Santana do Livramento (Brazil) and Rivera (Uruguay). In most cases, however, drastic measures limiting cross-border mobility have led to protests from local communities (institutions, companies, associations) that could no longer access medical care on the other side of the border. In addition, pre-existing problems have been exacerbated, which shows the fragility of these territories and the strong interdependence between border territories. Accordingly, it is possible to affirm that the current pandemic has had a threefold effect on border territories:

1) *Demonstrable effect of the structural weaknesses* of border territories due to the closure of borders and cross-border flows. Many territories have increased their geographic and socioeconomic isolation within their own country, suffering from a shortage of resources, equipment, and health personnel.

2) *Re-definition of borders effect*, conceived as "the reinforcement of state principles of sovereignty or through temporary or permanent closures of borders through control, protection or differentiation practices" (Giband & Rufí, 2018), which usually affects at least three dimensions:

   a) recentralization of decision-making regarding border and *hinterland* management;

   b) perception of borders as a security perimeter and the adjacent area as a space of risk that weakens the vision of socio-cultural integration promoted in the last decades; and,

   c) devaluation of the border area in economic, socio-cultural, political, environmental, and public health terms.

3) *Accelerating effect on cross-border cooperation*: there have been cases of increased cross-border cooperation activity, both formal and informal, especially in those contexts where cross-border relations were more stable and developed, such as the Uruguayan-Brazilian border.

The following are significant examples of how the pandemic has positively or negatively affected patient mobility in Mercosur border regions.

Positive impacts

1) Memorandum of understanding on sanitary cooperation between Uruguay and Brazil:
   - Creation of the Binational Emergency Operations Center (COE).[8]
   - Santa Ana do Livramento-Rivera cooperation area up to a radius of 20 kilometers from the border, understood as an "indivisible epidemiological unit".[9]
   - Vaccination of border residents who have dual citizenship in Uruguay; Uruguay has already made more progress than Brazil in vaccination age groups.
2) Barra do Quaraí-Bella Unión and Quaraí-Artigas coordination committees to create a single epidemiological unit.
   - Joint meetings to coordinate health measures and the performance of PCR testing.
   - Case Tracking.

[8] The COE has expanded the capacity for action and response of the border municipalities of the two countries by jointly developing surveillance and testing protocols for suspected cases, among other activities. The measures agreed in the COE include the joint supply of PCR kits in the event of a shortage in any of the localities, as well as the processing of samples from the counterpart in the event of being required in both public and private laboratories.

[9] For example, the epidemiological surveillance and swabbing activities planned by the Uruguayan government are being carried out by the local authorities of the Brazilian city as a way to quickly identify COVID-19 infected cases and thus generate greater epidemiological security for both countries.

3) CIF of Barracão-Bom Jesus do Sul-Dionísio Cerqueira-Bernardo de Irigoyen:
   - Coordination on epidemiological surveillance and control.
   - The participation of the Argentine municipality has been advisory only on epidemiological data.
4) Promotion of the project for a new international bridge between Puerto Iguazú and Presidente Franco.
5) Implementation of facial recognition technology at the Friendship Bridge border crossing between Ciudad del Este (Paraguay) and Foz do Iguaçú (Brazil), to increase controls and streamline cross-border flows.
6) Inauguration of a new pediatric hospital in Eldorado, which increases the availability of healthcare facilities at this border crossing point.
7) Reopening of the border between Brazil and Paraguay in October 2020 through a protocol for the coordination of sanitary controls (*Paraguay y Brasil reabrieron sus tres fronteras terrestres tras siete meses de cierre por el coronavirus*, 2021).
8) Increase in health infrastructure in the border department of Ñeembucú (Paraguay), supported by the Yacyretá Binational Entity, including the new hemodialysis service in Pilar (*Ñeembucú ya cuenta con su propio servicio de hemodiálisis, mediante inversión del Gobierno nacional y departamental*, 2021).

Negative impacts

1) Divergence between Brazil and Argentina for customs controls on truck drivers crossing the border (Dioniso Cerqueira-Bernardo de Irigoyen).
2) There is a general lack of joint information systems open to the public for consulting the epidemiological evolution, main statistics, and measures adopted by each country, health region, and municipality.
3) Lack of cooperation in the triple border of Iguazú to distribute hospitalized patients, ICU, and drug supplies. The situation in Ciudad del Este is still quite critical (*En IPS hay escasez de dos fármacos para tratar a pacientes en terapia*, 2021).
4) The municipal initiative of Foz do Iguaçú to require a negative swab test (PCR) for Paraguayan citizens wishing to enter the Brazilian city (*En Foz exigirán test negativo de Covid-19 a paraguayos*, 2021).
5) Protests against the closing of the triple border Puerto Iguazú-Foz Iguaçú-Ciudad del Este.
6) The impossibility for cancer patients from Encarnación to continue treatment in Posada hospitals and consequent difficulties in continuing treatment in Paraguay (lack of facilities and medicines not subsidized by the Paraguayan health system).

7) Impossibility of transferring serious patients by COVID-19 in Posadas and consequent displacements in Paraguayan hospitals farther away, which exposes them to high risk (and sometimes death (*Ambulancia trasladaba a karai con covid, chocaron y paciente ñanderejaite*, 2021).

8) Little bi-national cooperation with Argentina, due to the decision to tighten restrictions.

Conclusions

Cross-border patient mobility is a matter of primary importance for the Mercosur member states. Despite the numerous bilateral and multilateral agreements between Argentina, Brazil, Paraguay, and Uruguay over the past decades, several legal, administrative, technological, health equipment, and infrastructure obstacles prevent border communities from having full access to health care. To overcome these obstacles, local and regional authorities often develop innovative border cooperation programs with their counterparts on the other side of the border. This article has identified twenty obstacles common to all Mercosur border territories, although each of them may have a different weight or relevance depending on the particular territorial context. To reflect the complexity of cross-border healthcare cooperation and have a more detailed view of the causes that limit cross-border patient mobility, the obstacles have been cataloged according to a typology that includes administrative, legal, technological, infrastructural, or cooperation policy nature.

The identified bottlenecks are common to the Mercosur border region. Therefore, regional responses are needed. However, the Agreement of Linked Border Localities, having been approved in 2019, shortly before the emergence of the COVID-19 pandemic, has not yet made it possible to evaluate the functionality of what is proposed in its articles to streamline patient mobility in border areas. Border populations have deeply felt this agreement. Once the pandemic has passed, they will likely demand its prompt implementation, which entails effective work for parliamentarians and national ministries to expedite the movement of people living on the border.

The proposed typology has also proved valid, conceptually and methodologically, to partially study the consequences of the COVID-19 pandemic in the border territories under analysis. In general, the pandemic wave has had a *demonstrable effect* that highlights the fragilities and structural asymmetries of the border territories, both globally and regionally. The limitation of mobility and border crossings—as a first measure to prevent the spread of the virus—has been a measure common to the Mercosur member states, which as a result, has limited interactions in border areas. Although it is not yet possible to determine whether the effect of *rebordering* will be permanent or only circumstantial until the entire population has access to vaccines, social life at the borders has certainly been greatly affected, and local communities have expressed their concerns about possible difficulties in medical care.

The reestablishment of border relations and the normalization of crossings cannot prevent the need to respond to the bottlenecks identified in terms of patient mobility in Mercosur. Accordingly, rethinking regional integration based on the fight against COVID-19 and projecting the post-pandemic scenario is a key opportunity to reduce asymmetries and strengthen the ownership of rights within the Mercosur bloc.

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