DIGIT2COAST – ITHR0701018

Interreg VI-A Italy–Croatia 2021–2027

DELIVERABLE D.1.1.1

JOINT COMPARATIVE ASSESSMENT

Phase 1 Desk Research – Cross-Border Synthesis

Croatian Pilot Areas (Primorsko-goranska County & Dubrovnik-Neretva County)

vs.

Italian Pilot Areas (Abruzzo Region & Marche Region)

Prepared by	RIT Croatia & ECIPA Abruzzo
Activity	A1.1 – Comparative Assessment of Legal, Administrative and Data-related Barriers
Deliverable	D.1.1.1 – Cross-border Comparative Assessment
Programme	Interreg VI-A Italy–Croatia 2021–2027
Status	Working Document – Phase 1 Joint Synthesis

Executive Summary

This Joint Comparative Assessment synthesises the Phase 1 Desk Research outputs produced separately by RIT Croatia (for Primorsko-goranska County and Dubrovnik-Neretva County) and by ECIPA Abruzzo (for Abruzzo Region and Marche Region). Both documents feed into Deliverable D.1.1.1 of the DIGIT2COAST project (ITHR0701018), funded under the Interreg VI-A Italy–Croatia Programme 2021–2027.

The purpose of this joint synthesis is to identify highlights, structural similarities and material differences between the two national contexts across the three analytical clusters of the project framework: (1) Regulatory Legislation, (2) Administrative Documents and Procedures, and (3) Digital Sources. Findings are presented chapter by chapter in a comparative format, using the same template as the country reports.

Overall Highlights

Both national systems share the same EU-level regulatory backbone (Regulation 883/2004, Directive 2011/24/EU, GDPR) and face structurally equivalent barriers for mobile and vulnerable users: absence of multilingual tourist-facing information at service entry points, digital booking systems closed to non-residents, and a gap between legally guaranteed rights and practical discoverability. The critical divergences lie in the architecture of health system governance — Italy's strong regional legislative autonomy vs. Croatia's centralised national framework with county-level implementation — and in the relative maturity of digital infrastructure, where Italy's regions expose more integrated portals but Croatia's counties, particularly Primorsko-goranska, show stronger open data practices.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
System type	National centralised health system (HZZO mandatory insurance); counties implement but cannot legislate	Regional health system (SSN); regions have strong planning and implementation autonomy; LEA define national floor
Pilot unit scale	County (NUTS3): Primorsko-goranska (HR031) ~265,000 pop.; Dubrovnik-Neretva (HR037) ~122,000 pop.	Region (NUTS2): Abruzzo and Marche — both larger planning units with multiple local health authorities (ASL)
EU frameworks	Fully applicable: Reg. 883/2004, Dir. 2011/24/EU, GDPR, INSPIRE, Open Data Dir., Web Accessibility Dir.	Fully applicable: same EU framework; national transpositions fully in place
Primary cross-border barrier	No bilateral IT–HR health agreement beyond EU Reg. 883/2004; no sub-national agreement at county level	Identical gap: no bilateral sub-national agreement; implementation of EU rights inconsistently explained to users
Tourist access language	Croatian only for most procedures; partial English on HZZO; no Italian-language health documents	Italian only for regional portals and procedures; Ministry of Health pages partially in English

Digital booking exclusion	National e-appointment (e-Naručivanje) requires Croatian OIB — excludes all EU tourists	CUP systems require Italian fiscal code (codice fiscale) — excludes non-residents
Open data maturity	PGŽ has dedicated county open data portal; DNŽ lacks one — significant intra-country gap	Both Abruzzo and Marche have regional open data portals; data mainly PDF/web reports; more uniform than Croatia

1. Introduction and Research Scope

1.1 Context and Purpose

We designed both reports as evidence-base inputs for Activity A1.1 to share the same rationale: the fragmentation of governance frameworks, digital asymmetries and legal mismatches along the Italy–Croatia Adriatic corridor limit access to health, social care and mobility services for mobile and vulnerable populations.

✔ **SIMILARITY** Both reports are targeting the 'practical invisibility' of rights and service pathways for mobile users — tourists, seasonal workers, persons with disabilities, and older persons — as the primary project problem.

1.2 Territorial Scope

A structural difference emerges immediately at the level of territorial unit, which is consequential for all downstream comparison.

⚡ **DIFFERENCE** Croatia uses counties (NUTS3) as the primary analysis unit — Primorsko-goranska and Dubrovnik-Neretva. Italy uses regions (NUTS2) — Abruzzo and Marche. Italian pilot territories are significantly larger planning units with multiple ASL operating underneath the regional level. This asymmetry means Croatian findings are more granular at the sub-regional level, while Italian findings are more uniform across a wider territory but less precise at the locality level. This has direct implications for the Care & Go data layer granularity.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
Sub-national unit	County (Županija) — NUTS3	Region (Regione) — NUTS2
Pilot 1	Primorsko-goranska County (HR031), ~265,000 pop.; Rijeka as regional hub	Abruzzo Region — Adriatic coast + inland; coastal tourism; multiple ASL
Pilot 2	Dubrovnik-Neretva County (HR037), ~122,000 pop.; extreme seasonal tourism; islands	Marche Region — articulated coastal strip; digital health strengths; tourism and labour mobility
Key geographic challenge	Island communities (DNŽ: Korčula, Lastovo, Mljet, Elafiti) with ferry-dependent access and severe health service fragmentation	Inland vs. coastal service concentration in Abruzzo; dispersed coastal settlements in Marche
Intra-country variation	Significant: PGŽ has stronger digital infrastructure than DNŽ; open data gap between the two counties	Moderate: both regions have mature digital portals; Abruzzo slightly more citizen-friendly; Marche strong on FSE/CUP

2. Regulatory Legislation (Cluster 1.1)

2.1 National Health Legislation

Both countries have a robust national legislative framework governing health service access. The core difference lies in the allocation of authority between the national and sub-national levels.

⚡ **DIFFERENCE** Italy's national framework (Law 833/1978 establishing SSN; D.Lgs. 502/1992 reforming ASL; DPCM LEA 2017 defining essential care levels) creates a decentralised system where regions hold significant planning and operational power. Croatia's framework (Act on Healthcare NN 100/2018; Act on Mandatory Health Insurance NN 80/2013 as amended) is centralised through HZZO, with counties implementing but unable to legislate independently. This means Italian cross-border barriers are partly regional in origin, while Croatian barriers are primarily national with county-level execution gaps.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
System foundation law	Act on Healthcare (NN 100/2018, with 2022–23 NPOO amendments)	Law 833/1978 (SSN institution); D.Lgs. 502/1992 (reform); 229/1999 (further reform)
Insurance mechanism	Mandatory national insurance through HZZO; compulsory benefits package nationally defined	Universal coverage through SSN; LEA (DPCM 2017) define minimum guaranteed services nationally
Regional/county autonomy	Counties cannot legislate on health; implement national law through county health plans and public health institutes	Regions hold strong planning autonomy; each region has its own health plan (e.g. Piano Prevenzione Regionale Abruzzo 2021–2025; Marche PSSR 2023–2025)
Disability legislation	Act on Persons with Disabilities (NN 33/2015, 157/2023); Act on Accessible Design	Law 104/1992 (comprehensive disability rights and accessibility); D.Lgs. 285/1992 (transport accessibility and parking)
Emergency medical services	Governed by specific Ordinance (NN 52/2013); county Emergency Centres; National EMS Plan 2023; island-specific protocols in DNŽ	Integrated within SSN; 112/118 emergency chain; clinical access universal; post-access administrative layer varies by user status
Maritime/transport legislation	Act on Maritime Domain (NN 83/2023); EU Reg. 1177/2010; County Transport Plans — critical for island access in DNŽ	Law 118/1971 (public transport accessibility); EU Reg. 1177/2010; Directive 2016/2102 (web accessibility)

📌 **Key Finding:** Both systems satisfy the EU minimum standards. The critical risk for DIGIT2COAST is not legal absence of rights but practical inaccessibility of service pathways. Both Croatia and Italy have primary care, emergency, and disability legislative frameworks in place — yet neither provides a coherent tourist-facing navigation pathway.

2.2 Regional / County Health Legislation and Policies

✔ **SIMILARITY** Both countries have adopted sub-national health plans for the 2021–2027 period, aligning with EU programming cycles. All four pilot territories have adopted county/regional health plans that are publicly available and relevant to DIGIT2COAST data needs.

⚡ **DIFFERENCE** Italian regional health plans (Abruzzo Piano Prevenzione 2021–2025; Marche PSSR 2023–2025) carry regulatory weight because regions hold legislative competence. Croatian county health plans are administrative instruments operationalising national law — they cannot override or expand national legislation. The Marche PSSR integrates social and health planning in a single document; Croatian counties maintain separate health and social plans.

2.3 Eligibility Rules

2.3.1 Citizens and Residents

✔ **SIMILARITY** Both systems use a registration/insurance model for residents. Both require a chosen/registered primary care doctor for standard care access, with tourists directed to on-call or emergency services. Eligibility for social services is means-tested in both countries and administered at the local/county level, creating variation in practice despite national legislative uniformity.

⚡ **DIFFERENCE** Croatia's residence-based HZZO insurance is national and portable across counties. Italy's SSN registration ties users to their ASL territory, with separate procedures for Italians seeking care in a different region. This is relevant because non-resident Italian patients in Marche (Scenario D.2) face intra-national barriers analogous to, though less severe than, cross-border barriers.

2.3.2 EU Citizens (Tourists and Seasonal Workers)

This is the most critical category for DIGIT2COAST's cross-border focus.

✔ **SIMILARITY** Both countries are fully bound by EU Regulation 883/2004 and Directive 2011/24/EU. The EHIC/TEAM card is the primary entitlement document for temporary visitors. In both Croatia and Italy, EHIC holders are entitled to medically necessary care on the same conditions as insured nationals, including co-payments where applicable. Both countries have a National Contact Point under Directive 2011/24/EU, though county/local level implementation is uneven.

⚡ **DIFFERENCE** Italy provides clearer national-level explanatory content for EU tourists through the Ministry of Health portal (TEAM/EHIC guidance in English). Croatia's HZZO portal provides partial English information but no Italian-language content. In Italy, Emergency Room access is immediate but

outpatient specialist services require CUP navigation — creating a second-tier barrier after the initial clinical access. In Croatia, the tourist-facing information gap is more severe: no single portal directs EU visitors to eligible services, and seasonal spikes in DNŽ (2–3M tourists/year) exacerbate this gap acutely.

2.3.3 Third-Country Nationals

✔ **SIMILARITY** Both countries guarantee emergency care to all persons regardless of legal status. Non-EU tourists rely on private insurance or out-of-pocket payment in both systems. Both countries identify this as the category with the most significant access gap, and both note that national legal clarity does not translate into consistent local operational practice.

⚡ **DIFFERENCE** Italy's Ministry of Health maintains a dedicated information architecture for non-EU citizens covering both mandatory SSN enrolment procedures and voluntary options, with reference to Legislative Decree 286/1998. Croatia's framework for this category is less systematically documented at the county level; the desk research identifies it as a high-priority validation gap.

2.4 Cross-Border Agreements

✔ **SIMILARITY** The EU-level regulatory framework is identical for both countries: Regulation 883/2004 (social security coordination), Regulation 987/2009 (implementation procedures), Directive 2011/24/EU (cross-border healthcare rights), GDPR, Open Data Directive, INSPIRE, and EU Regulation 1177/2010 (maritime passenger rights). Both countries have transposed EU directives into national law. The same bilateral instruments apply to both sides: Convention on Social Security with former Yugoslavia (1957), Treaty of Osimo (1975), Treaty of Friendship (1994), maritime boundary agreements.

⚡ **DIFFERENCE** Italy has additionally ratified the Agreement on the Delimitation of Exclusive Economic Zones (Law 62/2023), which is more recent and operationally relevant for Adriatic maritime coordination. Croatia references the Interreg CYROS and Tourism4All projects as evidence-base predecessors; Italy does not reference equivalent predecessor projects in the same analytical detail. Both desk research reports confirm the same critical gap: no bilateral Italy–Croatia agreement specifically addresses cross-border health service access for tourists or persons with disabilities beyond the EU regulatory floor.

📌 **Key Finding:** The absence of a bilateral sub-national agreement is identified as a High severity barrier (CR-L1 / IT-L1) in both countries. This is the most structurally significant shared gap for DIGIT2COAST, and the MoU and Service Charter outputs of the project are the direct response to this finding.

3. Administrative Documents (Cluster 1.2)

3.1 Health Service Access Procedures

3.1.1 Primary Healthcare Access

✔ **SIMILARITY** Both countries operate a 'chosen doctor' model for residents (izabrani doktor in Croatia; medico di famiglia / MMG in Italy). Both direct tourists to on-call or emergency services. Both systems rely on a one-time national registration procedure for residents, and both present a partial barrier for EU tourists at the point of seeking non-emergency outpatient care.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
Step 1: Registration	HZZO registration (one-time for residents); EHIC replaces this for EU tourists — no advance registration possible	ASL registration with National Sanitary Card (tessera sanitaria) for residents; EHIC for EU tourists
Step 2: GP choice	Declaration of chosen doctor (Izjava o odabiru doktora); residents only; tourists to dežurni doktor	Choice declaration for preferred doctor, online or in-person; residents only; tourists to on-call/emergency
Step 3: Portal access	CEZIH national e-health system; requires Croatian OIB — inaccessible to tourists	Portale Sanitario Regionale; requires SPID/CIE identity — inaccessible to tourists
Step 4: Prescriptions	Croatian prescriptions not valid in Italian pharmacies; cross-border prescription under Dir. 2011/24 rarely applied in practice	Non-Italian prescriptions must include patient data and INN medication name; Italian doctor may re-prescribe
Step 5: Specialist referral	Uputnica (referral) from primary doctor; not transferable cross-border without S2 form; key barrier for non-residents	CUP booking required for specialist care; significant navigation barrier for non-residents without fiscal code

⚡ **DIFFERENCE** Croatia's tourist access flow reveals a more severe information gap at the point of service discovery: tourists in both Croatian counties have no single portal or information source to locate eligible services. In Italy, the barrier is more pronounced at the booking stage (CUP requires fiscal code), but the service location information is relatively better — hospitals are listed on regional portals and accessible via Google Maps. Both country reports note that Google Maps is the de facto navigation tool for tourists — a clear signal of the information architecture failure in both systems.

3.1.2 Social Service Access Procedures

✔ **SIMILARITY** Social service access in both countries is administered at sub-national level (county CZSS in Croatia; municipal social services / Ambiti Territoriali Sociali in Italy) and is more fragmented and less visible than health service access. In both systems, the first access point is not clearly identifiable to non-residents, and online intake is limited to registered users.

⚡ **DIFFERENCE** Croatia's social service structure is institutionally clearer: the County Social Welfare Centre (CZSS) is the single statutory access point at county level, and the national register of social service providers is searchable online. Italy's system involves municipalities, social districts, ASL socio-health units and specialised services simultaneously — creating a multi-door architecture with no obvious single first point for a temporary or cross-border user. The Italian report identifies 'discoverability barrier' as the primary social services challenge; the Croatian report identifies 'paper-based, in-person-only' procedures as the primary barrier.

3.2 Available Forms and User Guides

✔ **SIMILARITY** Both countries make EU-standardised cross-border forms available (S1, S2, A1 portable documents; EHIC/TEAM application). Both countries have the same structural gap: key patient-facing administrative documents are available only in the national language (Croatian or Italian). No Italian-language health service documentation exists in Croatia; no Croatian-language documentation in Italy.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
EHIC/TEAM guidance	HZZO portal: partial English, no Italian; Croatian only for most forms	Ministry of Health portal: EU standard TEAM guidance; partial English; regional portals Italian-only
Portable documents (S1/S2/A1)	Available in EU-standardised format via HZZO; Croatian language only on portal	Available in EU-standardised format; referenced via Ministry and national portals
Disability card application	County-issued Iskaznica osobe s invaliditetom — paper form, Croatian only, county-level variation	County-issued card (Italy also in implementation of EU Disability Card pilot); forms Italian-only
Health record access	CEZIH national system for Croatian insured persons; no cross-border access	Fascicolo Sanitario Elettronico (FSE) for registered Italian patients; SPID/CIE required; no cross-border access
County/regional user guides	PGŽ has Accessible City Guide (HR+EN) and CZSS social rights guide; DNŽ has very limited public documentation; Dubrovnik TB has multilingual accessibility info (includes IT) for tourism sites only	Abruzzo health portal has citizen channel; Marche has MyCUPMarche guidance; both Italian-only; no tourist-oriented health navigation guide

⚡ **DIFFERENCE** Croatia's Dubrovnik Tourist Board provides multilingual accessibility information including Italian for tourism sites — a notable but partial good practice, since it covers tourist attractions but not health and social services. No equivalent tourist-board health information bridge was identified in Italy. Conversely, Italy's Ministry of Health provides a more structured national information architecture for EU and international care than Croatia's HZZO portal.

4. Digital Sources (Cluster 1.3)

4.1 Regional and County Health Portals

✔ **SIMILARITY** Both countries operate dedicated regional/county health portals that serve as the primary digital front door for healthcare information. Both portals provide facility directories, service information and patient rights content. Both require national identity credentials (OIB in Croatia; SPID/CIE in Italy) for personalised services — excluding all non-resident users from the full portal functionality. Both portals are available only in the national language for the substantive service content.

⚡ **DIFFERENCE** Italian regional portals (Abruzzo: sanita.regione.abruzzo.it; Marche: fse-classic.sanita.marche.it) are more mature and integrated, combining facility directories, FSE access, online services and CUP booking in a single regional environment. Croatian county portals (zzjzpgz.hr; zzjzdnz.hr) are primarily information publishing platforms — they do not offer interactive service access, and data is mainly in PDF report format. KBC Rijeka (PGŽ) is the most digitally advanced public health facility in the Croatian pilot area, with partial e-appointment functionality.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
Portal maturity	County-level portals: information-publishing; PDF reports; limited interactivity. KBC Rijeka is outlier with partial e-appointment.	Regional portals: integrated digital environments combining FSE, CUP, facility search, online services. More mature and functional.
National patient record system	CEZIH/e-Zdravlje: national EHR; accessible to Croatian OIB holders only; relevant for interoperability capability assessment	FSE (Fascicolo Sanitario Elettronico): national standard; both regions provide activation and access via regional portal; SPID/CIE required
Language accessibility	Croatian only; HZZO: partial English; no Italian-language health portal content identified	Italian only across regional portals; Ministry of Health portal: partial English for EU/international content
Tourist-facing content	Absent from county health portals; Dubrovnik TB provides some multilingual tourism accessibility info; private clinics in Dubrovnik have multilingual online booking (good practice)	Absent from regional health portals; Ministry of Health EHIC page is primary reference; CUP guidance presupposes Italian resident user

4.2 Open Data Platforms and Portals

✔ **SIMILARITY** Both countries have national open data portals (data.gov.hr; dati.gov.it / regional portals) and INSPIRE-compliant geoportals. Both countries have open data relevant to health facility locations and social service providers, though often in non-machine-readable formats (PDF, web pages). Both are members of the EU open data ecosystem and have transposed the Open Data Directive 2019/1024.

⚡ **DIFFERENCE** Croatia shows greater intra-country variation in open data maturity: Primorsko-goranska County has a dedicated county open data portal (podaci.pgz.hr) publishing GeoJSON and CSV datasets — a relatively rare achievement at Croatian county level and a direct asset for the DIGIT2COAST data layer. Dubrovnik-Neretva County lacks a dedicated open data portal entirely. Italy's open data is distributed at regional level: both Abruzzo (opendata.regione.abruzzo.it) and Marche (dati.regione.marche.it) operate regional portals, but datasets are primarily web pages and PDFs rather than machine-readable structured exports. The Croatian state geoportal (geoportal.dgu.hr) and Italian regional geoportals are both INSPIRE-compliant and directly usable for GeoJSON base data in the Care & Go data layer.

Dimension	🇭🇷 Croatia (PGŽ & DNŽ)	🇮🇹 Italy (Abruzzo & Marche)
National open data portal	data.gov.hr — health facility register (partial, irregular updates); social service register; basic CSV/JSON	dati.gov.it + regional portals — general health statistics; facility data; mainly web/PDF
Sub-national open data	PGŽ: podaci.pgz.hr (GeoJSON, CSV — active, good practice). DNŽ: no dedicated portal — critical gap	Abruzzo: opendata.regione.abruzzo.it + geoportale.regione.abruzzo.it. Marche: dati.regione.marche.it. Both active.
Geoportal/INSPIRE compliance	geoportal.dgu.hr — INSPIRE-compliant; address and building data downloadable; critical reference for Care & Go GeoJSON layer	Regional geoportals in both Abruzzo and Marche — INSPIRE-compliant; territorial datasets available
OSM coverage quality	Good in Rijeka urban area; partial in coastal municipalities; very limited in island communities (DNŽ) — significant gap for Care & Go	Good at regional level; quality better in urban/coastal centres; less systematic data on accessibility tagging
Key open data gap	No national or county register of accessible parking spaces; island municipality data virtually absent from any digital platform	Health and social service datasets primarily in PDF/web format; machine-readable structured exports not consistently available

4.3 Service Registers

✔ **SIMILARITY** Both countries maintain national registers of healthcare providers and social service providers. Both are accessible online and searchable by territory. Both lack accessibility information (step-free access, language availability) and do not include tourist-facing information fields. Neither national register includes operating hours for non-residents or EHIC-eligibility flags.

⚡ **DIFFERENCE** Croatia's national Register of Healthcare Institutions and Register of Social Service Providers (MRMS) are available in downloadable formats (PDF and partial CSV) — providing a structured starting point for the Care & Go data layer. Italy's equivalent national datasets are distributed across regional portals and the Ministry of Health website, with no consolidated downloadable national register identified at the level of granularity needed for facility-by-facility Care & Go mapping. Croatia

has a notable gap: no national register of accessible parking spaces exists. Italy does not report an equivalent specific gap in parking register data.

⚡ **DIFFERENCE** County-level service registers show the sharpest intra-country contrast in Croatia: CZSS PGŽ maintains an annually updated social services directory (PDF) that is reasonably comprehensive; CZSS DNŽ publishes an incomplete, irregularly updated list, with island services entirely absent. Italy's regional health portals publish hospital lists for both Abruzzo and Marche that are consistently structured and up to date, representing a stronger baseline for facility mapping than the Croatian county directories.

4.4 Online Booking and Appointment Systems

✔ **SIMILARITY** Both countries operate national/regional online appointment systems (Croatia: e-Naručivanje via CEZIH; Italy: CUP — CUP Online Abruzzo, MyCUPMarche). Both systems cover the full territory of their respective pilot areas. Both systems are exclusively accessible to registered residents with national identity credentials, creating identical structural exclusion of EU tourists and non-residents.

⚡ **DIFFERENCE** Italy's CUP systems are more developed and consistent across the pilot regions — MyCUPMarche and the Abruzzo CUP both provide full online booking for all province-level services. Croatia's e-Naručivanje system has patchy coverage: large hospitals (KBC Rijeka) have partial integration, while General Hospital Dubrovnik primarily uses phone-based outpatient booking. Private clinics in Dubrovnik (e.g., Poliklinika Dubrovnik Med) have developed tourist-accessible multilingual online booking — a good practice not replicated in the Italian pilot areas' private sector at comparable scale.

📌 **Key Finding:** Both countries confirm the same 'manual fallback' challenge: EU tourists who cannot access automated booking systems must rely on phone, email or in-person contact — options that are not multilingual or clearly signposted. The Care & Go Toolkit must provide this fallback pathway as a minimum service standard.

5. Barrier Typology and Good Practices – Joint Analysis

5.1 Cross-Border Barrier Comparison Matrix

The following matrix aligns the barrier typologies developed independently in each country report, maps equivalent barriers, identifies where barriers are shared (structural cross-border barriers) and where they are country-specific, and assesses their combined severity for the DIGIT2COAST Care & Go Toolkit design.

HR ID	Barrier Type	IT ID	Joint Assessment	Combined Severity
CR-L1	Legal / No bilateral agreement	IT-L1	SHARED — Both countries confirm the absence of any bilateral IT–HR health service agreement beyond EU Reg. 883/2004. This is the most structurally significant cross-border gap and the primary rationale for DIGIT2COAST's MoU deliverable.	HIGH — Both
CR-L2	Legal / GDPR data sharing	IT-L2	SHARED — Both countries face GDPR constraints on cross-border health data sharing without explicit consent frameworks. No joint data processing agreement template exists at the county/regional level on either side.	HIGH — Both
CR-L3	Legal / Prescription recognition	(IT-A2 partial)	PARTIALLY SHARED — Croatian report identifies this as a distinct barrier (M severity); Italian report treats it within the broader administrative form barrier. Both confirm that cross-border prescription dispensing is legally possible under Dir. 2011/24 but operationally inconsistent.	MEDIUM — Both
CR-A1	Admin / Eligibility info gap	IT-A1	SHARED — Both countries confirm the absence of a single information point for EU citizens to understand their rights and locate available services. Identified as High severity in both reports. The only difference is degree: Croatia's gap is more severe due to lower portal maturity and island geography.	HIGH — Both (worse in Croatia)
CR-A2	Admin / Language	IT-A2	SHARED — All administrative procedures and forms are available only in the national language (Croatian or Italian). No cross-language documents identified except EU-standardised portable forms. Partial English on HZZO and Ministry of Health portals; no Italian↔Croatian bridging content.	HIGH — Both
CR-A3	Admin / Disability card	IT-A3	SHARED — Personal Disability Card is county/locally issued, paper-based and	MEDIUM — Both

			non-digitally verifiable in both countries. Both reports note the EU Disability Card pilot as a potential improvement pathway. Croatia also notes the card is not cross-border verifiable.	
CR-A4	Admin / Social services	**IT-A4**	SHARED — Social service access is paper-based / in-person only for non-residents in both countries. Online procedures require national eID (OIB / SPID). Italy's system is more fragmented (multi-door architecture); Croatia's is more centralised but less digitised.	**MEDIUM — Both**
CR-A5	Admin / Island access (DNŽ)	**N/A**	CROATIA-SPECIFIC — Island communities in Dubrovnik-Neretva County (Korčula, Lastovo, Mljet, Elafiti) face additional ferry-dependent access barriers with no equivalent in the Italian pilot areas.	**HIGH — Croatia only**
CR-T1	Technical / Data format	**IT-T1**	SHARED — County/regional health and social service data exists primarily in PDF and unstructured formats in both countries. Croatia shows greater internal variation: PGŽ has structured open data; DNŽ does not. Italy's data is more uniformly available but equally non-machine-readable.	**HIGH — Croatia (M — Italy)**
CR-T2	Technical / Interoperability	**IT-T2**	SHARED — No data exchange protocol or common data standard between Croatian county health systems and Italian ASL/regional health systems. CEZIH (Croatia) and FSE (Italy) are both nationally siloed and incompatible cross-border.	**HIGH — Both**
CR-T3	Technical / Digital exclusion	**IT-T3**	SHARED — National e-appointment systems (e-Naručivanje / CUP) require national identity credentials, excluding EU tourists. Italy's CUP coverage is more comprehensive; Croatia's system has patchy sub-national coverage. Effect is identical: tourists excluded from digital booking.	**MEDIUM — Both**
CR-T4	Technical / OSM accessibility tagging	**(not coded separately)**	CROATIA-SPECIFIC (explicit) — Croatian report explicitly codes this as a barrier; Italian report notes OSM coverage is 'good at regional level' but does not code it as a specific barrier. Both pilot areas will need OSM accessibility tagging improvement for the Care & Go data layer.	**MEDIUM — Croatia (implicit — Italy)**
CR-U1	User-facing / Multilingual info	**IT-U1**	SHARED — No multilingual health and social service access information for tourists at key entry points (ports, ferry terminals, tourist information offices) in	**HIGH — Both**

			either country. Critical in peak season in both territories.	
CR-U2	User-facing / Navigation	**IT-U2**	SHARED — No integrated accessible route information combining health/social services with mobility infrastructure. Italy additionally notes that hospital locations are not properly mapped for tourists beyond generic map services. Both countries rely on Google Maps as de facto navigation.	**MEDIUM — Both**

5.2 Good Practices – Joint Review

The following table consolidates and compares the good practices identified in both country reports. Transferability is assessed in terms of DIGIT2COAST Care & Go Toolkit design.

Country	Good Practice	Actor	Description	Transferability
HR	**Accessible City Guide – Rijeka**	City of Rijeka	Digital and printed guide to accessible Rijeka (transport, health facilities, parking, cultural venues) in Croatian and English. Produced with disability organisations.	HIGH — methodology directly adaptable for Care & Go user guide; extendable with Italian version
HR	**County Open Data Portal – PGŽ**	Primorsko-goranska County	Dedicated county open data portal (podaci.pgz.hr) publishing GeoJSON and CSV spatial and administrative data including some infrastructure data relevant to accessibility.	HIGH — model for DNŽ data infrastructure; data structure can be used in Care & Go data layer
HR	**Tourist-Oriented Private Health Clinics – Dubrovnik**	Poliklinika Dubrovnik Med; Sv. Nikola	Multilingual websites (EN, DE, IT), online appointment booking open to non-Croatian patients, clear pricing/insurance information. Response to high tourist demand.	MEDIUM — model for public sector tourist-accessible health info layer
HR	**Jadrolinija Accessibility Booking**	Jadrolinija (national ferry)	Online form for requesting assistance for passengers with reduced mobility; English-language; covers boarding, wheelchair space, on island routes.	HIGH — directly relevant to Care & Go mobility data layer; model for transport operator accessibility integration

IT	**Stable National Rights Framework & Mature Digital Health Portals**	Abruzzo & Marche regions	Both regions operate within a stable national legal framework (SSN/LEA) and expose integrated digital health portals (FSE + CUP + facility search) accessible to registered citizens.	HIGH — demonstrates what a mature regional digital health environment looks like; benchmark for portal design standards
IT	**Abruzzo Citizen Channel (Canale Cittadini)**	Regione Abruzzo	Health portal features a dedicated citizen channel with clear service pages, supporting first-step navigation better than a dispersed provider architecture.	HIGH — model for organising tourist-facing information in a recognisable single channel
IT	**MyCUPMarche / FSE Ecosystem**	Regione Marche	Integrated CUP booking + FSE environment with explicit digital-service orientation across all Marche provinces.	HIGH — benchmark for pathway visibility and booking system design
IT	**Ministry of Health EU/International Care Architecture**	Italian Ministry of Health	Relatively solid institutional information architecture for EU/international care including EHIC/TEAM and non-EU access guidance on official portal.	MEDIUM — can be translated into simpler corridor-oriented user content in later project stages
Both	**Open Data & Territorial Information Infrastructures**	Both countries	Both countries have open data portals and INSPIRE-compliant geoportals that can serve as source data for Care & Go GeoJSON mapping layer.	HIGH — combined cross-border dataset integration is technically feasible via INSPIRE interoperability standards

6. Research Gaps and Joint Validation Priorities

The following table consolidates the research gaps from both country reports and identifies joint validation priorities for the bilateral online sessions in Activity A1.1.

HR Gap	IT Gap	Joint Gap Description	Priority	Possible Action
G3	G1	Implementation of EU Directive 2011/24 National Contact Point function at county/regional level has not been confirmed in either country. It is unclear whether designated contact points are operational and providing accurate guidance to mobile users.	HIGH	Both partners to contact regional or sub-regional CPs and verify whether county/regional dissemination is operational.
G1	G2	No consolidated machine-readable register of accessible health facilities exists at the sub-national level in either country pilot area. DNŽ is most critical (Croatia); Italy has better facility data but no accessibility fields in existing registers.	HIGH	Joint data collection protocol: direct contact with CZSS DNŽ, Zavod za javno zdravstvo DNŽ (Croatia) and regional ASL/health authorities (Italy); develop a minimum common data field specification for facility accessibility.
G1/G2	G2	No shared cross-border toolkit vision or set of local service entry points has been agreed. Both reports call for defining which actor can maintain future information layers and which digital assets are reusable components.	HIGH	Bilateral coordination call to define actor mapping and data governance model for Care & Go Toolkit. Establish minimum interoperable data fields (see Italian report Annex D as starting point).
—	G3	No multilingual information package exists for tourists navigating health services in the Italian pilot areas. Croatia has a partial equivalent in the Dubrovnik TB multilingual tourism guide but without health content.	MEDIUM	Joint development of multilingual information module as Care & Go Toolkit component; validate language needs (IT, HR, EN minimum) in bilateral sessions; test with tourist-facing organisations on both sides.
G5	—	Status of EU Disability Card implementation in Croatia has not been confirmed; Italy's status is similarly not confirmed as operational. This is a cross-border issue: Croatian and Italian disability documentation does not yet exist in a mutually verifiable digital format.	MEDIUM	Contact national disability authorities (Croatian MRMS; Italian INPS/MLPS) for EU Disability Card implementation timeline.
G6	(implied)	OSM accessibility tagging quality in both countries' pilot areas has not been systematically assessed. Both need improvement to support the Care & Go GeoJSON layer, with Croatia's island communities being the most critical gap.	MEDIUM	Joint OSM methodology and common accessibility tagging protocol to be agreed by both partners. PGŽ open data and Italian geoportal INSPIRE data to be used as reference layers.

G7	(implied)	Data on multilingual staff competency (Italian-language in Croatian facilities; Croatian-language in Italian facilities) has not been systematically collected in either country. Relevant for Care & Go language availability data field.	LOW–MEDIUM	Relevant primarily for the health facility data layer; validate whether this field is practically maintainable.

The followings are the activities that the project will implement:

HR Gap	IT Gap	Joint Gap Description	Priority	Possible Action
G3	G1	Implementation of EU Directive 2011/24 National Contact Point function at county/regional level has not been confirmed in either country. It is unclear whether designated contact points are operational and providing accurate guidance to mobile users.	HIGH	Both partners to contact regional or sub-regional CPs and verify whether county/regional dissemination is operational.
G1	G2	No consolidated machine-readable register of accessible health facilities exists at the sub-national level in either country pilot area. DNŽ is most critical (Croatia); Italy has better facility data but no accessibility fields in existing registers.	HIGH	Joint data collection protocol: direct contact with CZSS DNŽ, Zavod za javno zdravstvo DNŽ (Croatia) and regional ASL/health authorities (Italy); develop a minimum common data field specification for facility accessibility.
G1/G2	G2	No shared cross-border toolkit vision or set of local service entry points has been agreed. Both reports call for defining which actor can maintain future information layers and which digital assets are reusable components.	HIGH	Bilateral coordination call to define actor mapping and data governance model for Care & Go Toolkit. Establish minimum interoperable data fields (see Italian report Annex D as starting point).
G5	—	Status of EU Disability Card implementation in Croatia has not been confirmed; Italy's status is similarly not confirmed as operational. This is a cross-border issue: Croatian and Italian disability documentation does not yet exist in a mutually verifiable digital format.	MEDIUM	Contact national disability authorities (Croatian MRMS; Italian INPS/MLPS) for EU Disability Card implementation timeline.
G6	(implied)	OSM accessibility tagging quality in both countries' pilot areas has not been systematically assessed. Both need improvement to support the Care & Go GeoJSON layer, with Croatia's island communities being the most critical gap.	MEDIUM	Joint OSM methodology and common accessibility tagging protocol to be agreed by both partners. PGŽ open data and Italian geoportal INSPIRE data to be used as reference layers.

7. Summary Analytical Grid – Cross-Border Comparison

This consolidated grid presents the joint analytical overview, integrating both national pilot areas into a single cross-border comparison matrix. It is designed for direct use in the D.1.1.1 deliverable comparative synthesis.

Dimension	🇭🇷 Primorsko-goranska (PGŽ)	🇭🇷 Dubrovnik-Neretva (DNŽ)	🇮🇹 Abruzzo & Marche
Key legislation – health	Act on Healthcare (NN 100/2018 as amended); HZZO mandatory insurance; County Health Plan 2021–2027	Act on Healthcare (NN 100/2018 as amended); County Health Plan 2022–2027 (with island provisions)	Law 833/1978 (SSN); D.Lgs. 502/1992; DPCM LEA 2017; Piano Prevenzione 2021–25 (AB); PSSR 2023–25 (MC)
Key legislation – social services	Act on Social Services (NN 16/2019); Act on Social Welfare (NN 18/2022); County Social Plan 2021–2024	Act on Social Services; Act on Social Welfare; County Social Development Strategy 2021–2027	Law 328/2000; Piano Sociale Regionale 2022–24 (AB); PSSR 2023–25 integrates social + health (MC)
Key legislation – mobility/accessibility	Act on Roads; EU Reg. 1177/2010 (maritime)	Act on Roads; Act on Maritime Domain (NN 83/2023); EU Reg. 1177/2010 — critical for islands	Law 118/1971; D.Lgs. 285/1992; EU Reg. 1177/2010; Directive 2016/2102 (web accessibility)
Cross-border agreements	EU Reg. 883/2004; Dir. 2011/24; no bilateral IT–HR sub-national agreement	Same as PGŽ	EU Reg. 883/2004; Dir. 2011/24; no bilateral IT–HR sub-national agreement; EEZ Agreement (Law 62/2023)
EU citizen eligibility (tourists)	EHIC coverage for medically necessary care; practical information severely limited on portals	EHIC coverage; practical info absent; multilingual tourist info (DNŽ TB) does not cover health services	EHIC/TEAM coverage for medically necessary care; limited portal information; Ministry site partial English
Service access procedures (tourist)	Dežurni doktor (on-call); emergency services; no digital booking without OIB	Same + island-specific visiting doctor schedules; ferry dependency	On-call services; Emergency Room access; CUP booking not accessible without fiscal code
Available forms (EN/IT)	EHIC info on HZZO partial EN; disability card HR only; most forms HR only	Same + Dubrovnik TB multilingual accessibility info (includes IT) for tourism sites only	Ministry of Health EU care pages in partial EN; regional portals Italian only; no Croatian-language content
County/regional health portal	zzjzpgz.hr — active; HR only; PDF reports; limited downloads	zzjzdnz.hr — active; HR only; annual reports; no open data	sanita.regione.abruzzo.it (Abruzzo); fse-classic.sanita.marche.it (Marche) — integrated FSE + CUP + services

Open data portal	podaci.pgz.hr — active; GeoJSON, CSV — strong model for Care & Go	No dedicated county portal — critical gap	opendata.regione.abruzzo.it ; dati.regione.marche.it — active; mainly web/PDF data
Service register (county/regional)	CZSS PGŽ directory PDF; reasonably comprehensive; MRMS national register (CSV)	CZSS DNŽ list PDF; incomplete; island services absent — most critical gap in the pilot	Regional health portals list hospitals and services; structured; up to date; no accessibility fields
OSM coverage quality	Good in Rijeka urban area; partial coastal; accessibility tagging incomplete	Good in Dubrovnik Old City tourist zone; very limited in outer areas and island communities	Good at regional level; better in urban/coastal centres; systematic accessibility tagging not confirmed
e-Appointment systems	KBC Rijeka partial; national e-Naručivanje (OIB required — excludes tourists)	Opća bolnica Dubrovnik phone-based; private clinics multilingual online booking (good practice)	Full CUP coverage (Abruzzo CUP Online; MyCUPMarche); fiscal code required — excludes tourists
Primary barriers	CR-T1, CR-A1, CR-A2, CR-T3, CR-U1	CR-A5, CR-T1, CR-U1, CR-A1, CR-A2, CR-T4 (severe on islands)	IT-A1, IT-A2, IT-T2, IT-T3, IT-U1 (both regions); IT-T1 moderate (Marche > Abruzzo)
Good practices	Accessible City Guide Rijeka; Open Data PGŽ portal; County Health Plan with digital priorities	Tourist private clinic multilingual booking; Jadrolinija accessibility booking; Dubrovnik TB multilingual info (tourism only)	Stable national rights framework; mature FSE/CUP digital environments; Abruzzo citizen channel; Ministry EU care guidance

8. Next Steps and Joint Recommendations

8.1 Outputs to Activity A1.1

This Joint Comparative Assessment synthesises the two country-level desk research outputs into a cross-border comparative baseline. Its primary outputs feeding into Activity A1.1 are:

- Input to D.1.1.1 Cross-border Comparative Assessment — the findings in Chapters 2–7 constitute the full comparative analysis of regulatory, administrative and digital barriers across all four pilot areas.
- Preparation of bilateral online validation sessions — the joint gap table (Chapter 6) and barrier comparison matrix (Section 5.1) form the agenda input. Priority validation topics: NCP implementation, shared data fields, multilingual information strategy, OSM accessibility tagging protocol.
- Input to Care & Go Data Scheme design (Activity A1.2) — the comparative digital infrastructure assessment (Chapter 4) directly informs the technical design of the cross-border data model: INSPIRE-compliant base layers are available on both sides; the minimum interoperable data fields from Italian report Annex D provide a validated starting point.
- Input to cross-border MoU and Service Charter — the shared absence of sub-national bilateral agreements (CR-L1/IT-L1) is confirmed as the primary structural gap. The MoU should address a minimum set of common service access standards for pilot area territories.

8.2 Priority Joint Actions

Action	Responsible	Timeline	Priority
Joint bilateral coordination call to review analytical grid outputs from both partners and align barrier typologies for D.1.1.1 synthesis	RIT Croatia + ECIPA Abruzzo	Sept. 2026	HIGH
Contact with Zavod za javno zdravstvo to request accessible health and social service data (Gap G1)	RIT Croatia	Aug. 2026	HIGH
Contact Italian regional health authorities (Abruzzo, Marche) to map reusable data assets and potential open data collaboration for Care & Go layer	ECIPA Abruzzo	Jul. 2026	HIGH
Agree minimum common data field specification for Care & Go facility accessibility data layer, using Italian report Annex D as starting point	Both partners jointly	Sept. 2026	HIGH

Develop joint OSM accessibility tagging protocol and organise activities in both pilot areas (Gap G6)	RIT Croatia (lead) + ECIPA Abruzzo	Oct. 2026	**MEDIUM**
Review outputs and methodology for Care & Go Toolkit design adaptation	RIT Croatia	Oct. 2026	**MEDIUM**