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vers une normalisation des études européennes ?

EU patient mobility and the Austrian healthcare system:

Path-dependent conditions for the usages of Europe

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Abstract

During the last couple of years sociological approaches in Europeanization research have gained an increasing attention by scholars. This paper suggests a bottom-up approach in researching the EU's impact on Member States by using the "usages of Europe" concept (Jacquot&Woll 2008, 2010) in the field of healthcare. A series of European Court of Justice's landmark rulings on cross-border patient mobility made Member States fear that the boundaries of their healthcare systems could become dangerously porous. Looking at the Austrian *Bundesländer* positions regarding EU patient mobility law, the paper tries to evaluate if regional actors in the Austrian healthcare system could make a usage of Europe that would result in possible "destructuring of national welfare boundaries" (Ferrera 2005). Since the "usages of Europe" concept does not specify the conditions for actors using Europe, the paper argues that path-dependent logics of action defined by the set-up of the national healthcare system condition actors' strategies of using Europe. Therefore regional actors can make a use of Europe to their benefit, but do not "escape" from their national healthcare system and leave the national boundaries largely intact.

Résumé

La mobilité des patients et le système de santé autrichien : des conditions dépendant du sentier emprunté pour les usages de l'Europe

Pendants les dernières années, des approches sociologiques dans la recherche sur l'Européanisation ont attiré un intérêt croissant des chercheurs. Nous suggérons une approche *bottom-up* dans l'analyse de l'impacte de l'Union européenne sur les Etats-membres en utilisant le concept des « usages de l'Europe » (Jacquot&Woll 2008, 2010) dans le domaine des soins de santé. Une série des arrêts des la Cour de Justice sur la mobilité transfrontalière des patients ont entrainé une crainte des Etats-membres que les confins nationaux de leurs systèmes de santé pourraient devenir dangereusement poreux. En analysant les positions des positions des *Bundesländer* autrichiens vis-à-vis le droit européen en matière de la mobilité des patients, nous essayions d'évaluer si les acteurs régionaux pourraient faire un usage de l'Europe qui pourrait entrainer une « déstructuration des confins nationaux de l'Etat-providence » (Ferrera 2005). Comme le concept « des usages de l'Europe » ne spécifie pas les conditions dans lesquelles les acteurs feraient un usage de l'Europe, nous arguons que les logiques de dépendance du sentier crée par le système de santé national conditionnent les stratégies des acteurs dans leurs usages de l'Europe. Par conséquent, les acteurs régionaux peuvent faire un usage de l'Europe dans leur avantage, mais ils « n'échappent pas » de leurs systèmes de santé nationaux et laissent les confins nationaux largement intacts.

Introduction

A policy field of European Welfare States that has been considered for a long time a purely national competence has been put on the European Union's (EU) agenda by the European Court of Justice (ECJ). In a series of landmark rulings on patient mobility and cross-border healthcare the Court has made clear that Member States' healthcare systems have to comply with the rules of the EU's Internal Market when it comes to individual patient rights and the non-discrimination of healthcare providers. In 2011, a Directive has been passed on this issue following more than ten years of political debate. The Court rulings have been challenging the national boundaries of Welfare States (Ferrera 2005) by allowing individual patients to carry their once national rights to medical treatment also to other Member States. This issue has however an impact beyond individual rights as it also concerns providers. The ECJ's rulings are aimed at inhibiting the discrimination against healthcare providers from other EU countries by Member States' authorities (Greer, 2009, p. 42). These rulings do not only have political implications for the national level of government, but also for the subnational level.

In many Member States the subnational level is responsible for certain Welfare policies such as the provision of healthcare, and the decentralization process of competencies that has taken place in Europe after the economic crisis of the 1970s and 1980s has made the subnational level "much more sensitive and alert to their net financial balances vis-à-vis central governments, punctiliously comparing the revenues … appropriated by the central state with the transfers received from the central state" (Ferrera 2005, p. 174). The subnational level has furthermore gained institutional and financial options to engage directly with the EU level. Institutionally the subnational level is represented through the Committee of the Regions but also by possibilities of participating directly in the Council of Ministers. The EU has created furthermore economic incentives through its Regional Policy for the subnational level to engage directly with other subnational authorities across their national border (ibid., p.180-187).

The European involvement in Welfare policies such as healthcare on one hand and the strengthening of Europe-wide spatial interests of the subnational level on the other hand have the potential weaken the national control over the Welfare State slowly over time (ibid., p. 219). The research question of this study asks therefore how far EU Member States' healthcare systems have been Europeanized until now and if subnational actors could "use" Europe in a way that threatens the national boundaries of the Welfare State.

Austria has been chosen as a case-study for answering this question since Austria's federalism has only received limited attention by the Anglophone scientific literature. For example Kovziridze (2002) has analyzed how institutional relationship structures between the federal and the subnational level have been Europeanized. Otherwise Austrian federalism has been studied by Erk (2004) who considers Austria to be a "federation without federalism" because of its societal homogeneity and a lack of distinctiveness between subnational territories. Braun (2011) also finds Austria to be a centralized federal polity with its subnational governments (*Bundesländer*) usually implementing national legislation and with only limited exclusive competencies of the latter ones (ibid., p. 40). He also points out that centralized federal systems such as the Austrian one have been "neglected in comparative federal studies" (ibid., p. 5). Despite these analyses, literature on Austria's federal system is mainly limited to publications of Austrian scholars (e.g. Fallend 2002, 2003, 2006). The aim

of this study is therefore to analyze the interplay of Austrian federalism with the Europeanization of Member States' Welfare States in the field of healthcare.

The term interplay refers here to the cyclical dimension of Europeanization processes. As Saurugger (2010, p. 259) has noted, Europeanization is not necessarily a uniform nor a linear process of adapting to European rules. Actors and institutions on various governance levels might adapt to Europe in different ways. Member States and subnational governments also have the opportunity to upload their interests which have an impact on European integration where finally the Europeanization cycle starts again. Among the different definitions of Europeanization that have been suggested, Radaelli's (2000) definition accounts best for this complex relationship: "Europeanization refers to: Processes of (a) construction (b) diffusion and (c) institutionalization of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and shared beliefs and norms which are first defined and consolidated in the making of EU decisions and then incorporated in the logic of domestic discourse, identities, political structures and public policies" (ibid., p.1). This definition leaves the choice of analytical tools to be used to the researcher but highlights at the same time that 'ways of doing things' requires a subtle analysis (Ladrech 2010, p. 15). In order to account for the complex Europeanization process, a bottom-up approach will be used in this study: it "starts from actors, problems, resources… at the domestic level. … A bottom-up approach checks if, when, and how the EU provides a change in any of the main components of the system of interaction" (Radaelli 2004, p. 4).

The theoretical approach applied here stems from sociology and scrutinizes actors' "usages of Europe" (Jacquot&Woll 2008, 2010). In order not to neglect institutional factors that may determine actors' interests, the approach is combined with historical institutionalism and path dependence. The main argument that is put forward here is that subnational actors in the Austrian healthcare system will make use of Europe in order to pursue their own goals. Yet a path-dependent logic of action will define their usage of Europe and thus lead to a strategy where subnational actors will not "escape" from the paths determining their national healthcare system and leave the national boundaries largely intact.

This contribution is structured in five parts. The first section develops the theoretical framework. The following second section briefly describes the process that has led to the EU's involvement in healthcare. The third section defines the federalist imprint of Austrian policy-making in healthcare and the subnational influence on formulation of EU policies. The following empirical section is mainly based on semi-structured interviews carried out with relevant bureaucratic actors of the Austrian healthcare system at the *Länder* level (the *Bundesländer* of Lower Austria, Vorarlberg, and Vienna have been chosen) and the federal level. The interviews have been conducted and transcribed in German. The parts of interviews that are presented in the paper have been translated by the author. The last section of the paper provides the conclusion and aims at answering the research question.

Path-dependent conditions for the Usages of Europe

During the last couple of years, sociological approaches in European Studies have gained an increasing attention by scholars, yet a research agenda that is common to these approaches is still lacking and the approaches show a high degree of heterogeneity. There is however a common research standard marked by two elements. The first one is the focus on

interactions of individual actors or groups and the dynamics of European integration. The second element implies a bottom-up approach of analysis by looking at "the complex processes which can be found in the heart of integration" (Saurugger 2009, pp. 936f).

One of these sociological bottom-up approaches concerns the 'usages of Europe' developed by Jacquot and Woll (2003, 2004, 2008, 2010). They argue that policy change on the national level can occur even without any adaptive pressures from the EU level since the EU can provide actors with different resources that these can use in strategically (Woll & Jacquot, 2010, p. 113). They understand actors as the mediators of European integration since they have the capability of analyzing, interpreting and using European rules as a resource to follow their own agenda on the domestic level (Jacquot, 2008, p. 21). Hence strategic interactions of individuals and on the resulting dynamics of Europeanization are in the focus of this approach.

Nonetheless actors do not necessarily formulate an automatic response to a given input from the EU level. Actors can learn to use the acquired knowledge: they can engage with European integration, but they also can choose to ignore it. Consequently the 'usage of Europe' concept can be defined as "social practices that seize the European Union as a set of opportunities, be they institutional, ideological, political or organizational" (Woll & Jacquot, 2010, p. 116). Such a definition implies that any opportunity provided by the EU is not sufficient in itself for a strategic action. An actor will intentionally have to make use of this opportunity offered by the EU. Yet such a use does not mean that an actor might reach his intended goal automatically as the effects of actions are hard to predict. Actors will have to adapt to their environment that can influence their behavior as well (ibidem.).

Jacquot and Woll distinguish three types of usages: a cognitive usage referring to the interpretation of a political topic and mechanisms of persuasion; the legitimating usage which refers to the public justification of political decisions; a strategic usage which refers to an actor's strategy in pursuing defined goals trying to influence either the political process, building coalitions with other actors or just to increase the own room of maneuver. The last type is the most common and occurs mostly when most of the actors' stakes have become clear. Mostly bureaucratic actors and decision-makers will use institutions, and legal, budgetary and political resources for a strategic usage of European integration (ibid., p. 117). As this paper focuses on bureaucratic actors from the Austrian *Bundesländer* and the federal level, we can expect a strategic usage of Europe.

Looking only at actors' usage of Europe would however underestimate the institutional set-up that represents actors' environment, especially since healthcare systems are "built on strong historical and institutional legacies" (Sindbjerg Martinsen, 2005, p. 1031). Based on the assumption that "institutional approaches to the EU would greatly benefit from a dose of sociological thinking" (Jenson & Mérand 2010, p. 74), I want to suggest an analytical framework that combines both the usages of Europe approach with historical institutionalism. The theoretical assumption is that the historical legacy of a healthcare system will also influence actors' strategies. This assumption is hence analog to Pierson's (1993) line of argumentation. A federal polity as well as its healthcare system will create incentives for a certain way of action for all actors requiring an investment in the structure of interest mediation of the Welfare State they operate in (ibid., pp. 608/609). Insofar the paths that determine policy-making in the healthcare system set also the rules of the game for actors and determine the costs of alternative strategies that actors could pursue (ibid., p. 596):

"… Welfare institutions structure debates, political preferences and policy choices. They affect the positions of various actors and groups involved in reform processes. They frame the kind of interests and resources that actors can mobilize …" (Palier, 2010, p. 27).

While path dependence is a useful explanatory variable for the inert shaping of interests it lacks however analytical strength at explaining why change can occur nonetheless (Hassenteufel, 2008, p. 244). This is where actors' usage of Europe comes in. European rules, resources and opportunities come from the 'outside', and actors will be able to interpret them, to learn and to make use of Europe as has been described above. An actor will have to weigh his or her strategic options that the EU provides against the position and resources his national system has allocated him, but also against the interests of other actors in the respective environment. This study argues therefore that path-dependent logics of action defined by the set-up of the federal and the healthcare system will define actors' strategies of using Europe. Therefore subnational actors can make a use of Europe pursuing their own benefit, but they do not "escape" from their national healthcare system and will leave the national boundaries largely intact.

Cross-border healthcare and patient mobility on the European agenda

Before cross-border healthcare and patient mobility became politically salient on the European level, the access to medical treatment for European citizens in other Member States has been solely regulated by Regulation 1408/71, now amended by Regulation 883/2004. These legislative acts provide for the possibility of urgent medical treatment in another EU Member State. The Regulation applies to workers, tourists, pensioners and students. The Regulation also allows a second possibility of receiving medical treatment in a Member State other than the home country in case a certain type of medical treatment would not be available at home. In these cases prior authorization to receive a treatment in another Member State by the sickness funds in the home country would be needed (Hervey & McHale, 2004, p. 115).

What the Regulation does not provide for is an elective medical treatment in another state, i.e. a patient travelling abroad to receive medical treatment at his or her own discretion. In such cases reimbursement would be usually refused by the home sickness funds. Yet several patients challenged this consideration of medical treatment that would fall outside of the scope of the Regulation. In a series of landmark rulings the ECJ has subsequently challenged exclusive national control over the respective healthcare systems. Starting with the Kohll-Decker ruling in 1998 (cases C-158/96 and C-120/95) the Court ruled that if a national healthcare system allows patients to choose freely a physician for extramural care, this permission must be extended to any physician in the EU. Adjusting its position, the ECJ held in subsequent rulings that a procedure for prior authorization would still be necessary for hospital or intramural care, but that patients should get permission to leave for another country if an 'undue delay' occurred during waiting times for a necessary surgery (Obermaier 2009, p. 191; Harvey & McHale, 2004, p. 132). In the last case of 2006 concerning Yvonne Watts (case C-372/04) the ECJ ruled that the previous rulings would have to be applied in all Member States. In other words Member States would not be able to discriminate against foreign healthcare providers in favor of providers in their home countries (Greer & Rauscher, 2011, p.4).

Given the potential of the rulings to jeopardize the conception of healthcare services that are essentially linked to national territory, a political discussion started between the Council, the Commission and the Parliament about determining clear rules on patients receiving elective medical treatment in other EU countries. Due to the conflicting views of Member States on the issue a Directive could only be passed in 2011 (Directive 2011/24) that clarifies the rulings. Given the complexity of national healthcare systems, this long time span of negotiation is due to the fact that not only individual patients but also healthcare providers such as physicians and hospital operators could try to gain legitimacy for national policy demands from the European rules on cross-border provision of healthcare and strive for an individual benefit that could damage the system as whole (cf. country case studies of Baeten, Coucheir & Vanhercke, 2009). This means that the EU provides different actors of healthcare systems with opportunities that could lead them to change their political strategies or even their loyalties towards the national system which could destabilize a national healthcare system on the long run (Ferrera 2005, pp. 219ff).

Two of the main issues that arose in the negotiation of Directive 2011/24 concerned the control of patient migration and the financing. The first issue concerns the remaining national control of patient influxes from other Member States and patient exits of national patients to other countries, the second issue concerned the financing of medical treatment. The Directive addresses these issues in various articles. Article 4 (3) allows a Member State to control the access to its national healthcare facilities in order to assure the systems' financial balance and planning capacities. According to article 7 (1) a patient must get reimbursed for the costs that occurred in another Member State at the level of prices that would have been paid in the home country without however exceeding the actual costs of medical treatment. This article clearly aims at inhibiting any possible financial gains for an individual patient by getting less expensive treatment in another Member State. For intramural care the Directive has also codified that Member States can impose a procedure of prior authorization to patients (article 8), but that this procedure must evaluate the patients individual medical condition in an objective and non-discriminatory way (article 9). Looking at these provisions it seems at first sight that Member States have reasserted their national control over patient fluxes and reimbursement of costs albeit limited by the EU's fundamental rights of non-discrimination and the free movement of persons and services.

The Austrian legislation on health insurance was already in line with EU requirements before the Court's rulings on cross-border healthcare. The Austrian General Social Security Act states that a patient, who receives ambulatory care or inpatient treatment with providers that are not affiliated to sickness funds, will receive reimbursement for the medical treatment: the reimbursement is fixed at 80 percent of the amount the sickness fund would have paid for the treatment to a contracted provider. The reduction of 20 percent is justified by additional administrative costs for the sickness funds. The Austrian healthcare system therefore offers already the possibilities in the ambulatory sector granted by the ECJ besides the possibilities of Regulation 1408/71 (Obermaier 2009, p. 79/80). Austria has nonetheless voted against the Directive which points at severe concerns with regard to the hospital sector that will be considered in the empirical section. In addition the Austrian *Bundesländer* play an important role in the provision of intramural healthcare and also have a say in formulating Austria's policy responses to European integration. The next section will thus be looking at how healthcare is organized between the federal and the subnational level and how the *Bundesländer* are involved in European policy-making.

Federalist policy-making in healthcare and EU level influence

The federalist financing of the hospital sector

Austria's healthcare system is marked by the organizational principles of a typical Bismarckian type of Welfare States implying a financing based on citizens' payroll contributions to sickness funds and marked by corporatist structure of governance (Obinger & Tálos 2010: 101f). An important part of the general expenditure on healthcare is however also funded through Austria's general tax income which is mainly used to finance the hospital infrastructure (Heitzmann & Österle 2008, p. 53ff). Besides the corporatist organizational principle the federalist structure of Austria marks the provision of healthcare. According to article 12 of the Austrian constitution the federal level has the right to legislate on the general principles of hospital care, but the *Bundesländer* have the competence to issue laws that implement the organization of intramural care. This means also that the nine Bundesländer own most publicly (co-) financed hospitals while the outpatient sector is regulated by corporatist negotiations between the Medical Association and the sickness funds (Hofmarcher & Rack 2006, p. xviii). We can therefore find an organizational separation between the outpatient sector and the inpatient sector (Theurl 1999, p. 334). Given that the subnational level operates and co-finances the hospital sector, a closer look at Austria's federalist organization of finances is needed.

Austria's polity can be formally characterized as a centralized (Braun 2011) or a unitarian federal system, albeit this constitutionally centralist structure finds a more decentralized counterbalance in form of informal conferences of the *Bundesländer* that aim at policy coordination and common positions vis-à-vis the federal level (Fallend 2006, p. 1025). The centralized character becomes nonetheless apparent looking at Austria's fiscal system. While 83% of the tax income can be attributed to the federal level, only 28,5% of the expenditure are spent by the subnational level. On the basis of the Finance Constitutional Law (*Finanzverfassungsgesetz*) the tax income is distributed vertically through a fiscal equalization scheme through a bill presented to parliament by the federal minister of finance. He or she is only obliged by to negotiate the financial allocation with the *Bundesländer* taking into account their economic performance. This very vague obligation leaves a broad room of maneuver for the federal minister in drafting the bill. The bill that determines the allocations per quotas for a limited time period of usually five years is then voted by the lower house of the federal parliament with a simple majority and without needing any formal assent by the upper house representing the *Bundesländer* (ibid., p. 1030). The financial equalization laws limit the fiscal autonomy to the latter ones' capacity of negotiation with the federal level. As far as expenditures are concerned, the subnational level spends theses allocations on public administration – mostly carrying out federal laws – and on the other hand on a more autonomous economic policy comprising subsidies for infrastructure. The negotiations between the federal level and the *Bundesländer* tend to have a quite intense character and sometimes are used by subnational politicians as a public stage to manifest a firm federalist stance with a view to their electorate (Dirninger 2003, pp. 232/233).

Besides this official scheme a system of "grey financial equalization" has been developed since the 1970s. As the federal and the subnational level have a common interest in advancing their economic and social structural policy, different funds have been created that are co-financed by the federal budget and the concerned *Bundesland*. This development has been coined as "cooperative federalism" (ibid., p. 241). Part of this structural policy has been

the building and improvement of public infrastructure such as kindergartens or hospitals by the *Bundesländer*. This area of structural policy is of special interest for them since there is no clear constitutional allocation of competencies between the federal and the subnational level regarding structural subsidies which enhances the *Bundesländers'* political and economic scope of action (Fallend 2006, p. 1029). As a consequence the co-financing of hospital infrastructure has become an important part of this grey financial equalization. This co-operation is usually regulated by an agreement between the *Bundesländer* and the federal level according to article 15a of the constitution which determines that the subnational entities can close agreements among each other and that the federal level can close agreements with the *Bundesländer*. The first 15a-agreement concerning hospitals was closed in 1978. An addendum to the agreement also involved the sickness funds and communes. A hospital co-operation fund was created that is fueled by contributions from the federal level, the *Bundesländer*, communes and the sickness funds. The fund had several tasks: it was meant to help the *Bundesländer* to reduce deficits of hospital operators and to finance structural reforms. Furthermore it was aimed at strategically developing further the Austrian Hospital Plan to improve efficiency in capacity planning. The financial means of the fund were allocated according to determined quotas to each *Bundesland* and thus streamlined with the general financial equalization scheme (Dirninger 2003, pp. 291-294). During the 1980s it became visible that especially the *Bundesländer* were profiting from the hospital co-operation fund as the share of the financial participation was growing for the federal level leading to a supplementary vertical financial equalization in hospital financing. At the same time however the financial responsibilities of the *Bundesländer* for infrastructure projects such as public housing, street works and healthcare were constantly growing while their possibility to generate tax income stayed mainly limited to the financial equalization schemes. This development has led to an increase of public debts on the subnational level (ibid., p. 300/301).

Health reforms and side effects of subnational structural policies

Healthcare reforms of the 1990s aimed at reducing the costs of the healthcare system as Austria's accession to the EU had an effect on public finances: to fulfill the Maastricht criteria for the Euro currency, Austria aimed at reducing its public deficit to nearly 0% in 2001. In 1997, the hospital co-operation fund was dissolved by a new 15a-agreement valid for three years. The agreement created a structural fund at the federal level and nine health funds in each *Bundesland*. This measure aimed at a better co-operation between the ambulatory sector and the hospital sector. For an improvement in structural planning an obligatory hospital plan was created. As a result nearly all *Länder* with the exception of Vienna have re-organized their hospital sector during the last years. Hospitals have been privatized in forms of *organizational* privatization: usually an operating company runs the hospitals while the *Länder* as owners of these companies act as guarantors through their health funds (*Gesundheitsfonds*) (Hofmarcher & Rack 2006, p. 18).

Especially the latest healthcare reforms tackled the organization of the financing of the hospital sector and an increase in state control over the fragmented healthcare system (Obinger & Tálos 2010, p. 111). The reform efforts and the introduction of the binding hospital plan gave rise to a discussion on the number of hospitals operated by the *Bundesländer*. It can be said that the increased role of the subnational level in structural policy has had significant side effects on the number of Austrian hospitals. It seems likely that building hospitals was sometimes seen by subnational governments as a measure to rather

improve the economic situation of a certain region than merely offering an equitable access to healthcare for citizens. In a study of 2010, the Austrian Court of Auditors has criticized the large number of hospitals. The study found that hospitals with less than 300 beds show a lack of cost-efficiency. However, 60% of Austrian hospitals have less than 300 beds for medical treatment. The side effects of subnational structural policy seem to be even more significant when it comes to the number of hospital beds for acute treatment: the number of hospital beds per 1000 inhabitants is 70% higher than the EU-15 average (Rechnungshof 31.05.2010, p. 12). Furthermore guarantees by several *Bundesländer* governments that local hospitals will not have to close are said to prevent saving effects. The tabloid press even used this allegation to call small and less efficient hospitals "political hospitals" (Kronenzeitung 08.06.2010). A suggestion by a federal secretary of state to think about the closure of smaller hospitals was immediately refuted by several *Bundesland* prime-ministers (Tiroler Tageszeitung, 10.05.2010).

Since 2010 the discussion about a more efficient planning of hospitals has gained momentum, just in time before the current 15a-agreement on hospital financing will come to an end in 2013. The *Bundesländer* have been reticent to a more centralized financing of healthcare as their role as employers for several thousands of hospital employees and their competencies in structural policies represent significant political power. In a recently published paper the *Bundesländer* have nonetheless signaled a possible agreement to draft a single federal law for hospital planning and to set up a single fund that would allocate means for hospital financing according to quotas. There would be hence one single financial source for financing the hospital infrastructure (Der Standard, 24 May 2011).

The subnational influence in EU policy-making

The competencies of the *Bundesländer* concerning structural policies do not only have an impact on hospital planning, but also led to an early support of Austria's accession to the EU in 1995. Already in 1987 the conference of *Bundesland* prime-ministers (*Landeshauptleutekonferenz*) invited the federal government to initiate accession negotiations with the European Community (EC) at the time. The main motives were that firstly subnational executives hoped for a general positive economic effect of the accession, but secondly the EC's structural funds for its Regional Policy were an incentive for aiming at a smooth accession to the EC (Fallend 2003, pp. 38). The subnational level was nonetheless worried about a possible loss of competencies and thus a procedure was created that should assure the *Bundesländer's* influence in European policy-making.

Following the German constitutional model, article 23d of the Austrian constitution stipulates that the federal government has to inform the *Bundesländer* about all processes that concern their legislative competencies or which are of interest to them. The *Bundesländer* can formulate a "uniform comment" if EU policy-making concerns a subject where legislation is a competence of a *Bundesland*. The federal government is bound by this uniform comment as regards negotiations and voting in the Council of Ministers. The federal government can only deviate from the *Bundesländer* position if "compelling foreign and integration policy reasons" arise. The institution of an "integration conference" had the task to issue these uniform comments. It was created by a 15a-agreement among the *Bundesländer* and included *Land* prime-ministers and presidents of the *Land* parliaments. Yet, in political practice this conference never played an important role. Instead the already existing conference of *Land*

prime-ministers that assures already the common positions of the *Bundesländer* in national policy-making would issue these uniform comments. As an informal institution issues these uniform comments concerns arose if this practice would be conform to the constitution. Until now however the federal government has always recognized uniform comments issued by the conference of *Land* prime-minsters as valid and binding. From 1995 to 2001 the *Bundesländer* issued however only 41 uniform comments. This is firstly due to the fact that they only use this instrument for politically salient issues and it is secondly a sign that subnational administrations are sometimes overwhelmed with information and that co-ordination among the *Bundesländer* can takes up too much time in order to respond in a timely manner (Fallend 2002, p.213). Representatives of the *Bundesländer* can also participate directly in the Austrian delegation in the Council of Ministers, for which they have to nominate a representative who is usually coming from one of the *Land* administrations. While this does not happen often, state officials participate regularly in the ministerial internal discussions before Council meetings (Fallend 2003, p. 41).

On the EU level the *Bundesländer* are also directly represented in the Committee of the Regions. The sessions of the Committee are usually prepared by *Bundesland* administrations. While the Committee of the Regions is only *consulted* for European legislation, the Austrian *Bundesländer* have been active in influencing positions of the Committee. Nearly all of the *Bundesländer* have also opened liaison offices in Brussels. Their significance is however more of a symbolic character; more important are two desk officers that represent their common interest in the Austrian Permanent Representation to the EU (Fallend 2002, p. 210).

Even though Austria's federal system allots a predominant role in legislation and public finances to the federal level of government, the Bundesländer play a significant role in the financing of hospitals and other structural policies. They also participate in European policy-making. Which then is the interplay between Austrian federalism and European rules on patient mobility and cross-border healthcare? What usage do the *Bundesländer* make of Europe and to what effect?

Subnational usages of Europe in cross-border healthcare and policy-making

Cross-border healthcare and patient mobility in practice

Austria borders on seven different countries and is a tourism destination for example for ski tourists. Therefore all *Bundesländer* have to admit foreign patients and some of the *Bundesländer* have projects that are co-financed by the European structural funds with regard to cross-border healthcare in the hospital sector. Given the scope of this contribution two examples from Vorarlberg and Upper Austria will be briefly presented.

The *Land* of Vorarlberg has to treat every year foreign tourists especially in the winter season when mainly fractures or other emergency cases arise in hospitals. These cases are usually covered by Regulation 883/2004 and are reimbursed between the sickness funds from the patients' home countries and the Austrian sickness funds. For patients from Vorarlberg going to other countries the Regulation is applied, too. If a patient wants an elective treatment

that is available at home a prior authorization must be granted by the regional sickness fund. For treatments that are not available or because of geographic reasons, agreements exist with neighbouring countries such as Germany. The Kleinwalser Valley for example is cut off from the rest of *Land* by mountains and German hospitals are the closest medical facilities for specialized treatment. Therefore an agreement exists with German hospital operators and Austrian sickness funds that regularly pay for hospital treatment of patients from the Austrian valley in Germany. Furthermore Vorarlberg does not have the facilities for heart surgery and patients are usually transported via helicopter to Innsbruck in Tyrol. If the weather does not permit the flight to Innsbruck, patients are regularly transported to Germany or Switzerland and treatment costs are settled between sickness funds. The hospital operator of Vorarlberg is also part of a cardiologic network in which German, Austrian and Swiss hospitals in bordering regions co-operate. The project is co-financed at 40% by the EU's European Regional Development Fund for social and structural cross-border co-operation[1].

A project that is an example for a much more structured initiative can be found at the border between Lower Austria and the Czech Republic. It is based on an initiative of the Lower Austrian health fund and the Lower Austrian hospital operator with the support of the *Land's* government. In Gmünd, some kilometers away from the Czech border, the holding operates one hospital of 180 beds, i.e. one of the rather small hospitals (cf. Landeskliniken-Holding, 09.07.2010). The main goal of the project was to build a new hospital that caters for the medical needs of the Austrian and Czech side of the border where a "twin" city to Gmünd is located. The project is supported and partly financed by the European Regional development fund (Healthacross Report I, 2010, p. 10-13). Developments on cross-border healthcare have however played a role from the outset of the project, and the judgments of the Court have been used strategically to use them as argumentation to win the political support to set up the project by pointing out that healthcare has become a European issue[2]. While the European dimension is used to raise political awareness, a strong regional identity is put forward when the question of a possible coordination with the federal level arises – it is seen as a Lower Austrian lead project in regional co-operation and the *Land* should be responsible, co-operation with the federal level would neither be necessary nor really wanted. The responsible manager of the Hospital Holding also hopes that with a view to other Austrian *Länder*, Lower Austria would be cutting-edge in cross-border cooperation in healthcare. The EU is also seen as a means to revive an economically separated region, starting with cross-border healthcare. Due to the times of the iron curtain economic and cultural ties have been cut and re-establishing these ties would be desirable[3]. The project aims at saving the small border hospital from closure since it offers 300 to 400 jobs in the city on the Austrian side. It should also provide quick medical access for Czech citizens who have to travel around 60km to the next hospital on the other side of the border. Since a renovation for the old hospital would be too expensive a new building could be used to treat Austrian and Czech patients[4]. The project's future is however uncertain given the price differences between both countries: "It is unthinkable, that treatments are provided in Austria at Czech rates because of the higher price levels [in Austria] and the higher material costs"[5].

[1] Interview Dr. Till Hornung, Director, Krankenhausbetriebsgesellschaft Vorarlberg, 18 January 2011, Feldkirch.
[2] Interview Martin Wieland, project manager, Healthacross Project, 05 August 2009, Vienna
[3] Interview Elke Ledl, Head of Unit, EU Affairs, Lower Austrian health fund, 13 January 2010, St. Pölten
[4] Interview Renate Burger, project manager, Healthacross Project, 10 August 2009, Vienna
[5] Interview Dr. Robert Griessner, Director, Lower Austrian health fund, 13 January 2010, St. Pölten

Both examples illustrate hypothetical *extrema* on a range of cross-border co-operation and patient mobility in healthcare. While the first example shows that Europe is used to facilitate medically necessary cross-border treatment for geographical or capacity reasons, the second example shows a much more targeted use of Europe for structural policy. The Vorarlberg example shows that Europe is actually used to improve the performance of the home healthcare system where it reaches its (geographical) limits or special treatment is not available. This happens however without a challenge to national boundaries as national control is assured through bi- or trilateral formal agreements and patients are subject to Regulation 883/2004 covering their emergency treatment. The second example illustrates a usage of Europe to gain regional political support and which is in line with the *Bundesländer's* role in structural policy. The cross-border hospital project is even trying to save an existing path in Austria's healthcare system – the existence of small hospitals – by co-operating with a Czech region across the border. Nonetheless the usage of Europe stops once the hard fact of financing arises and the national system of financing healthcare is not put into question, leaving the future of the project uncertain. A European challenge to national sovereignty over the healthcare system is therefore not (yet) detectable.

Negotiating Austria's position at the European level

The formulation of Austria's position in negotiating the Directive on patient mobility and cross-border healthcare was led by the EU affairs unit in the Federal Ministry of Health. A consultation group of 15 participants was set up that consisted of officials from the Ministry, the Main Association of the Social Insurance, the social partners and *Bundesländer* representatives. The goal of the Ministry among others was to reach a clarification of the patients' rights regarding the reimbursement of costs when treated in hospitals and concerning which requirements would be needed for a prior authorization procedure. Another point was the inclusion of private practitioners of ambulatory care in the scope of the Directive. This is due to the fact that Austria already was in line with Court's rulings beforehand and allowed reimbursement of patients at rates that would apply if an Austrian patient was choosing a provider that is not contracted by sickness funds in the national system[6]. The *Bundesländer* had however a much more critical stance on the Directive in general.

When the first proposal of a Directive was presented by the European Commission, the *Bundesländer* nominated a common representative from Vorarlberg that would co-ordinate their position. In August 2008 the conference of *Bundesland* prime-ministers issued a first uniform comment which was also sent to the Committee of the Regions' for its consultation in its subsidiarity monitoring network (Committee of the Regions, August 2008). In their uniform comment the *Bundesländer* criticized the lack of clarity regarding the reimbursement of costs for hospital treatment. According to their comment the Directive proposal would not make clear if the total amount of costs of a hospital treatment in Austria would have to be paid by the patient or would be reimbursed by other Member States' sickness funds. Put differently the question was if a foreign patient could be charged with the costs that would usually be covered by Austrian sickness funds *plus* the part that is usually covered by taxes or if only the part of the sickness funds could be charged. If only the part of the sickness funds could be charged this would mean for the *Bundesländer* that they could face substantial losses over time with each patient using the rights that the Court has created

[6] Interviews Mag. Claudia Sedlmeier, Deputy Head of Unit, EU Affairs, Federal Ministry of Health, 12 January 2010 and 09 March 2011, Vienna

in its rulings. They also found that a prior authorization procedure might not be feasible in Austria because of the mixed financing of hospital care. They argued that a prior authorization procedure would create substantial additional costs that would go beyond the lump sum that the sickness funds pay for hospital treatment according to the 15a-agreement. And more importantly the *Bundesländer* found that a Directive would not be needed beyond the existing Regulation 883/2004 and the rulings of the Court. They judged that a further Directive that would establish a second system of reimbursement in hospital care is disproportionate and is limiting too much the room of maneuver of the national authorities (ibid, p. 71-74).

The *Bundesländer* all backed in principle this appreciation of the Directive proposal. The overall agreement was reached by informal contacts before the prime-ministers conference and through a co-ordination by the *Bundesländer* liaison office to the federation. Vienna seemed to be more concerned about some details of the Directive[7]. It has also elaborated a detailed position paper on the Directive as Vienna has a large number of specialized and major hospitals that also treat patients from the *Bundesländer* surrounding it. The position paper insists on the fact that the total costs of hospital treatment representing the sickness funds and the tax part should be charged to foreign patients who seek elective treatment. It furthermore points at existing problems with the reimbursement between Member States under Regulation 883/2004, i.e. that some Member States have delayed reimbursements to Austria significantly and hence the usefulness the creation of a new system through the Directive under negotiation was doubted (Magistratsabteilung 24, August 2010). In a more pro-active sense the new rules on patient mobility and cross-border healthcare also do not seem to be useful from an Austrian subnational perspective. When asked about the possibility of offering actively empty beds or specialized treatment to foreign patients, an official from Upper Austria said that the current system of mixed financing of hospital treatment in Austria would not set any incentives to do this. Hence offering foreign patients specialized hospital treatment has never been considered. [8]

At the beginning of the negotiations the *Bundesländer* had the impression that the federal level would not be especially open to listen to their concerns. This situation changed however when the subnational ministers' of health conference asked for a greater involvement of the *Bundesländer*[9]. While Europe was used to publish the first uniform comment through the Committee of the Regions, the *Bundesländer* concentrated on national strategies for negotiation. Even though the co-operation between the federal level and the *Bundesländer* has improved over time from their perspective, the Federal Ministry of Health had doubts about the binding effect of a uniform comment by the *Bundesländer* in matter of shared competencies according to art. 12 of the Austrian constitution and asked the legal service of the Federal Chancellery for an expertise. As the *Bundesländer's* representative notes in a footnote in a forthcoming article, this left the impression that the federal level would have preferred to negotiate Directive without any influence of the *Bundesländer* (Büchel-Germann, Kraft 2011, p. 31). The opinion of the legal service was indeed that the uniform comment would not be binding the federal level in its negotiations. It doubted that uniform comments

[7] Interview Dr. Robert Gmeiner, Senior desk officer, Länder liasion office to the federation, 25 January 2010, Vienna

[8] Interview Stefan Potyka, Head of Unit, Unit for inpatient care, Upper Austrian health fund, 29 October 2010, Linz.

[9] Interview Dr. Harald Kraft, Senior desk officer, coordinator for the patients' rights directive, Health Fund Vorarlberg, 19 January 2011, Bregenz

by the conference of prime-ministers would be constitutional and that secondly uniform comments could be only binding if exclusive competencies of the *Bundesländer* would be concerned by European legal acts (Kröll 2009). This was however refuted by the *Bundesländer* representative by pointing at the *Bundesländer*'s competence to define exactly the prices of hospital treatments and that basic legislation of the federal level does not touch upon these competencies (Büchel-Germann, Kraft 2011, p. 20).

In the following process of negotiation the conference of prime-ministers issued two more uniform comments which show the political salience of the issue for the *Bundesländer*. The European Parliament suggested after the first reading that reimbursement of hospital costs should be directly carried out between Member States. As a consequence the third uniform comment insisted on the *Bundesländer's* concerns and invited the federal level to represent their previous position. The initial proposal of the Directive failed however to get a final agreement in the Council of Ministers in December 2009. In April 2010, the Spanish Presidency had tabled a new proposal for compromise to which Austria agreed by issuing a unilateral declaration that the recitals of the future Directive should make clear that the full cost of hospital treatment could be charged to foreign patients wanting elective medical treatment. Such a recital was however not included and after a compromise on the Directive was found between the majority of Member States and the European Parliament, the Directive was voted by the Council and later by the European Parliament coming into effect in 2011. Austria (along with Poland, Romania and Portugal) had voted against the Directive. According to the Austrian position the agreed Directive is too imprecise on the issue of reimbursement and the procedure of prior authorization by leaving too much leeway for legal interpretation and thus contradicting the Austrian wish for more legal clarity. The Directive was passed however with a qualified majority (Büchel-Germann, Kraft 2011, p. 25-28).

While the responsible official from the Federal Ministry generally agrees on Austria's negative vote on the lack of clarification, she does not fully share the *Bundesländer* representative's perception of the negotiation process and the problematic parts of the Directive:

"Without wanting to be judgmental … they [the *Bundesländer*] had a very national view. … The calculation of costs of hospital treatment was a huge issue and the *Bundesländer* did not find the Directive detailed enough … while we have believed that it [the Direcetive] would be conform the ECJ's rulings and that Austria would survive [the regulations of the Directive]. … A lot of what has happened in these discussions does not really relate to the EU but is limited to the financial equalization scheme and 15a-agreements inside of Austria. And that is a bit of position taking for the upcoming 15a-agreements. But by God, the *Länder* have not been unhappy not to have to agree to this piece of legislation."[10]

The official also denies that the federal level would have preferred to negotiate the Directive without any subnational influence, but that she wanted to be sure if the uniform comment of the *Bundesländer* would be binding on the matter under discussion and that the aim was to have a coherent Austrian position. According to her the *Bundesländer* have been informed in a detailed way which is rarely the case. Even if on the short run an exclusion of the subnational level would have facilitated the European negotiations the discussion would have arisen at the stage of national transposition of the Directive. Therefore she wanted a co-operation during the negotiations and was satisfied that an agreement could be found among

[10] Interview Mag. Claudia Sedlmeier, ibid.

state officials from the federal and the *Land* level[11]. It therefore seems that expertise from the Federal Chancellery's legal service was commanded in case of an internal conflict that however did not arise. Austria has voted against the Directive to underline its initial stance of needing clarification of the ECJ's ruling but knowing that it would not prevent the coming into effect of the Directive.

Conclusion

Austria's *Bundesländer* actively use Europe in the field of patient mobility and cross-border healthcare. Besides the regular treatment of foreign patients, the Regulation 883/2004 is applied. Beyond this 'regular' procedure they also use Europe as a financial resource to improve access to medical treatment in areas where geographical conditions make treatments of patients in a neighboring more reasonable. Also in cases where local treatment in border regions is not possible agreements exist with foreign providers to treat Austrian patients. Furthermore some *Bundesländer* are actively involved in advancing cross-border healthcare through projects that aim at cross-border co-operation of hospital providers. In the presented case the Court's judgments were strategically used to get political support and as a financial resource. This usage of Europe does not put the national boundaries of the healthcare system into question. State control over the patient fluxes is guaranteed through bi- and trilateral agreements and when it comes to the financing of healthcare a clearly national stance has been put forward by the regional actors. Quite contrary to potential destructuring effects of cross-border healthcare, the project on the Austrian-Czech border has shown that it even aims at using Europe to save the national path of running small hospitals as infrastructure projects. This usage is also in line and thus defined by the *Bundesländer's* important general role in structural policy. The room of maneuver that the subnational level has gained in this field makes any intrusion from the federal level undesirable and Europe offers resources to continue on that path.

Given the existing usage of Europe, the Bundesländer's firm criticism of the Directive on cross-border healthcare seems is at first sight somewhat contradictory to their involvement in structural policies. It becomes however clear when the *Bundesländer*'s position is interpreted in the light of the national system of financial equalization: the allocation of financial means to finance the regional infrastructure depends largely on the negotiation with the federal level and the renewal of 15-agreements every five years. As they only have very limited possibilities to generate own tax income, any possible financial burden through European regulations has to be avoided. Consequently the *Bundesländer* insist of being able to charge foreign patients not only for what Austrian sickness funds would have paid, but also to charge the portion of taxes being used for hospital infrastructure. Therefore they are also skeptical about a procedure of prior authorization that could create an additional financial burden.

Tracing back the process of negotiation on the Directive, it becomes clear that Europe only offers a very limited opportunity to convey the subnational level's political position by participating in the Committee of the Regions legally non-binding consultations. The possible conflict on the internal influence on European policy-making through uniform comments

[11] Ibidem.

seems to have been rather a reflection of internal reform discussions about the influence of the federal level in healthcare and to be the attempt of the *Bundesländer* and the federal level to assert a respective maximum of influence. Nonetheless a conflict was avoided by following a pattern of 'co-operative federalism' (even though it seems to be useful to have a legal 'defence' in the drawer of the office desk if the need for it arises).

Europe has become a vector of change in healthcare, but the resources and opportunities that it offers seem to be too limited compared to the incentive structures by the national healthcare system and the usage of Europe stays defined by these incentive structures. A destructuring effect has not appeared yet, even though the transposition of the Directive might generate new impetus for patients traveling abroad or providers offering services to foreign patients which in turn could lead to a challenge of national structures.

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