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When Europa meets Bismarck

How Europe is used in the Austrian Healthcare System

THOMAS KOSTERA

iee INSTITUT D'ETUDES EUROPEENNES

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ISBN 978-2-8004-1611-3
D/2016/0171/15
© 2016 by Editions de l'Université de Bruxelles
Avenue Paul Héger, 26 – 1000 Brussels (Belgium)

editions@ulb.ac.be
www.editions-universite-bruxelles.be

Printed in Belgium

Meinen Eltern und Großeltern

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Acknowledgements

This book is a revised and significantly shortened version of my doctoral thesis. Writing a doctoral thesis has been a fulfilling and challenging task at the same time and it would not have been possible without the help of many people. First of all I would like to express my heartfelt gratitude to my supervisor Prof. François Foret for his supportive and critical guidance throughout the years of research and writing. I also would like to express my gratitude to the members of my committee, Prof. Janine Goetschy and Dr. Fabrizio Cantelli who have been accompanying the development of my research with valuable constructive feedback, ideas and encouragements over the years. I would also like to express my deep appreciation to Prof. Ramona Coman for her advice and support. I would like to thank furthermore Prof. Sabine Saurugger for her valuable comments on my research and for her encouragements at various conferences in Strasbourg and Brussels. I would like to express my gratitude to Prof. Marianne Dony, President of the Institute for European Studies, for her support of my research and for the funding of various participations at conferences. I am much obliged to Prof. Sophie Jacquot for her comments on my research and for inviting me to publish in a special edition of *Politique européenne*. My sincere gratitude goes to Prof. Michele Chang for her invaluable advice.

I am much obliged to the team of the former library for State Science and Economic Science as well as to the team of the Research and Documentation service (RAD) of the University of Vienna for supporting my research. I would like to thank the various interviewees who have readily agreed to grant me interviews. For any inadequacies or errors that may remain in this work, of course, the responsibility is entirely my own.

1
Introduction

More than 30 years ago, the social security systems of OECD states were diagnosed to be in crisis. This crisis heralded in the end of the "Golden Age" of the national welfare state. The European OECD states, which were also part of the European Community, all witnessed rising unemployment in the wake of the oil crises, and as a result of economic openness to world markets and rising competition of labor costs, Keynesian economic policies of deficit spending became unavailable as an option to revive the economy. Not only did external processes of globalization demand adaptations of the welfare states, but also internal factors such as the rising age of populations and the change of family patterns questioned whether European welfare states were still capable of delivering for national populations, and how classical branches of the welfare state such as unemployment insurance, pension systems and healthcare systems should be adapted to meet these new challenges (Esping-Andersen, 1996). Along with this crisis diagnosis of the welfare state in general, healthcare systems have become the center of governments' attention since the 1980s, as spending on health policies has increased while the number people contributing to the social security schemes has decreased due to rising unemployment and slow economic growth. Insofar, healthcare mirrors the challenges that welfare states face in general. A "healthcare inflation" (Giaimo, 2002, p. 2) seems to be taking hold, caused by steadily ageing populations requiring technically more sophisticated and more expensive treatments, while the number of contributors is slowly declining. The fear of a race to the bottom has persisted among OECD states since the 1980s. As a consequence, most governments of OECD member states have been trying to reform their healthcare systems since the 1990s. After 20 years of reform efforts, the European welfare state has not vanished though, and a race to the bottom has not necessarily taken place. Nor is there a convergence to be found between different

types of welfare states (Starke, Obinger & Castles, 2008). However, with advancing European integration the welfare state faces additional challenges.

EU Member States are part of a political and economic system endowed with a single market, a common currency, and with a system of supra-national policy-making. While there is no sign of a convergence of Member States' welfare states towards a "unique European Welfare State" (Corrado *et al.*, 2003), especially labour market related issues such as parental leave are meanwhile negotiated in a corporatist pattern on the European level through collective agreements between labour unions and employer organizations (Falkner, 1998). This advancing European integration has potential impacts on the national level, especially for countries in Southern and Eastern Europe (Kvist & Saari, 2007). The introduction of the so-called new modes of governance such as the Open Method of Coordination (OMC), which stipulates peer-review and coordination of policy measures in the field of employment and labour policies between Member States, have triggered a "jump start to EU social policy" (*ibid.*, p. 2). These measures were introduced through the EU's Lisbon Agenda, which was aimed at reviving European economies in a globalized world. However, given the absence of a convergence of welfare states towards a single European model, we can witness a tension surrounding the issue of European integration in relation to the national welfare state. The accession of new Member States with lower household incomes, lower average salaries, and a different level of social protection have created new fears of a race to the bottom of social protection among possibly competing Member States (Guillén & Palier, 2004). Fears usually manifest themselves around politically salient pieces of European legislation like the famous Services Directive that aimed at facilitating the provision and consumption of services across the EU. These fears point "to a fundamental tension between the goals of creating a genuine single market among 27 plus countries with vast economic and social disparities" (Sapir, 2006, p. 388). This tension becomes more acute when the lacking competencies of the EU regarding redistributive policies are taken into account: the EU furthers economic integration while the welfare state remains mainly a national matter, thus potentially limiting national policy choices that impact on the economy and the welfare state alike. The problem "is the fact that the future viability of *national* welfare states is directly challenged by European *economic* integration which drastically reduces the effectiveness of democratic self-determination at the national level" (Scharpf, 1997, p. 23). Such a challenge is especially problematic when the fact is taken into account that the European nation state stays the main cognitive and normative reference for European citizens while the EU oftentimes lacks legitimacy (Foret, 2009). This challenge related to European Integration thus puts into question a purely national conception of social policies and points to a possible loss of institutional boundaries of the European welfare state. While the European welfare state has started to "leak", new spatial opportunities for actors are created and a restructuring of institutional rules at European level is the consequence (Ferrera, 2005).

Healthcare is a prime example of these dynamics of advancing European integration. For a long time it was considered a purely national competence. Now, however, it has been put on the EU's agenda by the Court of Justice of the European Union (CJEU) and it shows all the emblematic symptoms of the tension between

European economic integration and national conceptions of the welfare state. While different domains of Member States' healthcare systems had been an object of European integration and European legal regulation well before these rulings – such as areas of public health, the fight against communicable diseases, but also concerning rules of public procurement, mobility of the health work force and the mutual recognition of diplomas (Mossialos, McKee & Palm, 2004; McKee, 2003; Hatzopoulos, 2008, Hatzopoulos, 2003; Hervey & McHale, 2004) – the rulings of the CJEU have touched the core area of healthcare systems, namely the access to and delivery of healthcare for Member States' citizens. 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 [1] (Greer, 2006). The rulings increased the possibilities for EU Member State citizens to get medical treatment in another Member State ("cross-border healthcare"), yet providing that under certain conditions the home Member State has to pay for these treatments in the other country. After a decade of negotiations, these rulings have been codified in a European Directive (Directive 2011/24 on the application of patients' rights in cross-border healthcare).

Following the landmark rulings of the CJEU, other studies have thus looked at institutional adjustments of healthcare policies or the legal impact on Member States from a top-down perspective, in order to determine whether healthcare systems have been Europeanized (Sindbjerg Martinsen, 2005; Sindbjerg Martinsen & Vrangbaek, 2008; Obermaier, 2009). While policy adjustments have been taking place, these studies usually do not focus on actors' responses to European integration in healthcare, even if it could be shown that the way governmental actors use Europe has largely contributed to Member States' stance towards European integration in healthcare (Davesne, 2011). The aim here however is to look beyond what has been called a "Europeanisation of Social Protection" (Kvist & Saari, 2007) in terms of policy-changes or to ask whether Europe has started to matter in national welfare policy-making. More recent research shows that Europe does indeed have a differential impact on national welfare states and that there is a Europeanization of welfare (Graziano, Jacquot & Palier, 2011b). However, not only institutional changes in the form of policy adaptations are important, as actor relations such as corporatist bargaining structures can also affect European integration (Falkner & Leiber, 2004). The more recent literature therefore calls for a closer look at how national actors adapt to, mediate or resist a Europeanization of welfare, and how this relates to institutional change at national level (Graziano, 2009).

Assuming that European integration has an impact on national welfare states and taking the example of European rules on access to cross-border healthcare, this book suggests a change of perspective by analyzing the domestic impact of European integration in terms of Europeanization within the context of the interplay between actors' interests and practices on the one hand, and institutional effects on the other.

[1] Starting in 1998 with the *Kohll-Decker* ruling of the CJEU (cases C-158/96 and C-120/95).

European cross-border healthcare in forms of regional projects and privately or publicly organized healthcare arrangements has already become a reality in many European countries, especially in border regions. While available literature has addressed these projects mainly from the perspective of public health studies, and economic or legal perspectives (Rosenmöller, Baeten & McKee, 2006; Wismar, 2011; Odendahl, Tschudi & Faller, 2010; Zimmermann, 2008), oftentimes the political implications are only marginally addressed. The topic will be addressed by two theoretical assumptions, which will serve as an analytical framework, to be developed in the following sections of this chapter.

The first assumption concerns the national institutional environment of actors, and is based on Historical Institutionalism: national institutions that define what is possible and impossible for an actor are liable to path-dependence, and are hence difficult to change, a fact which in the field of welfare state reforms can be witnessed by incremental policy change and slow – if at all existing – adaptations to new policy challenges (Pierson, 1993, Pierson, 1996). While Historical Institutionalism has been criticized for putting too much weight on policy inertia (Pollack, 2009), more recent accounts of historical institutionalist policy analyses have been theorizing the role that actors play in institutional change. Actors have different strategies available that they can use to circumvent institutional rules and which may change these very institutions over time (Streeck & Thelen, 2005a; Mahoney & Thelen, 2010). Thus, while actors might be constrained by national institutions, they are also able to deviate from institutional rules. In the case of European integration in healthcare, Europe offers new avenues for actors to do so.

The second assumption is thus derived from Comparative Federalism, and concerns the opportunity structure that Europe offers to national actors that could chose to "break out" of their national institutional set-up. The development of a patchy, yet existent health policy at European level (Greer, 2008) provides in fact a new layer of supranational governance beyond the regional and national level to which healthcare actors can have access. The European rules on cross-border healthcare can in fact provide a sort of "bypass" to Europe reminiscent of the development of welfare states in federal polities (Obinger, Leibfried & Castles, 2005a; Obinger, Leibfried & Castles, 2005b). In order to provide a theoretical approach to analyse how actors might seize (or not) the opportunities that Europe offers them, two notions stemming from Political Sociology will be borrowed in order to supplement the chosen historical institutionalist approach: the concepts of *practices* and *usages*. Here, mainly the usages of Europe by national actors will be considered and how they are incorporated into their routines. The concept of 'usages of Europe' developed by Jacquot and Woll is 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). In this bottom-up perspective, national actors are considered as mediators of European rules since they have the capability of filtering them and using them as a resource to pursue their own agenda on the domestic level (Jacquot & Woll, 2008, p. 21). Following the above developed theoretical assumptions, and given that European integration in healthcare delivery is a rather "recent" phenomenon, and based on the assumption that actors' strategies change more easily than national institutions, the following

hypotheses can be formulated: (1) *Even if national healthcare actors use Europe, their interests remain largely determined by the national institutional set-up of the healthcare system. (2) The institutional boundaries of the national healthcare system may have become porous, but they remain intact.* The hypotheses are tested in a single-case study on Austria. The book will then be analyzing the responses to European integration of the different kinds of actors that are responsible for the delivery of healthcare in the Austrian healthcare system. As key groups of national healthcare governance tend to follow different goals in health politics (Blank & Burau, 2010), it is assumed that their usages of Europe should differ accordingly.

1.1 Case Selection and Structure of the Book

Case Selection

Austria has been chosen, as it is a *crucial case* to test the hypotheses, with a crucial case being "one in which a theory that passes empirical testing is strongly supported and one that fails is strongly impugned" (George & Bennett, 2005, p. 9). Austria being a crucial case for hypothesis testing is due to two puzzles, one of a theoretical nature, the other being empirical: from a theoretical point of view, the Austrian welfare state and its healthcare system belong to the Bismarckian type of welfare states (Esping-Andersen, 1998), and Austria has been classified as a typical consociational democracy (Lijphart, 1999). It has been argued from the perspective of Europeanization studies that Bismarckian healthcare states show a relatively high compatibility with European rules on cross-border healthcare (Sindbjerg Martinsen, 2005). We could therefore expect that actors would not find significant obstacles in adapting their interests and strategies to European integration in healthcare, even in a shorter time period. Potential effects of changing the dynamics between agency and institutions should hence be clearly visible. At the same time, this theoretical argument is in contradiction with the existing literature on public policy analysis which claims that institutional *and* policy changes in Bismarckian welfare states tend to be extremely slow, and in many aspects Bismarckian types of welfare states have been showing institutional inertia when it comes to analysing potential institutional change (Esping-Andersen, 1996; Palier, 2008 ; Palier, 2010a). These findings have also been found in the Bismarckian type of healthcare systems (Hassenteufel & Palier, 2008). This theoretical puzzle is corroborated by an empirical puzzle: on the one hand, Austria has been the only Member State where national legislation did not need to be changed due to the CJEU's rulings on cross-border healthcare, as Austria already permitted the reimbursement of elective cross-border healthcare before the rulings were issued, and even before Austria's accession to the European Union (Obermaier, 2009, p. 79). Yet, Austria was one of the few Member States that have been voting against the European Directive which codified the CJEU's rulings, thus opposing European integration at least symbolically, i.e. while policy change was not necessary, institutionally shaped interests might lead to resistance. Both puzzles point at inner-Austrian dynamics which have to be thoroughly scrutinized. Austria should therefore be a fertile research ground to determine whether public policy assumptions about institutional change in Bismarckian welfare states can be corroborated or whether Europe can effectively overcome national institutional inertia. Austria is furthermore

an interesting case study from the perspective of Comparative Federalism. Even if Austria has been considered to be a "federation without federalism" because of its societal homogeneity and a lack of distinctiveness between subnational territories (Erk, 2004), its polity clearly is a federal state with important competencies for the subnational level with regard to the regulation, financing and provision of healthcare. As European integration in healthcare can be conceived as offering national actors an additional quasi-federal layer of governance beyond the national boundaries (see chapter 3), this book can contribute to more recent research concerning the effects of federalism on healthcare (Costa-Font & Greer, 2013).

Structure of the Book

The aim of the following sections of chapter 1 is to provide an analytical framework. Following the chosen bottom-up approach, the next sections first theorizes the national institutional *regime* that welfare states and healthcare systems represent for shaping actors' competencies and interests. It discusses the notion of institutions and their relationship to agency from a historical-institutionalist perspective, then it presents the typical characteristics of a Bismarckian welfare state and the most common goal orientations on the part of actors in Bismarckian type healthcare systems. The chapter is concluded by presenting the 'usages of Europe' approach that will be used for the analysis in chapter 4.

Mirroring the theoretical bottom-up approach, chapter 2 starts at national level and briefly retraces the historical development of the Austrian welfare state as well as the development of the Austrian healthcare system starting with the final decades of the Austrian-Hungarian Empire. It describes how certain institutional characteristics of the Austrian welfare state, namely a strong role of corporate actors, political parties and regional governments in welfare – and even to a larger extent in healthcare – have been built up, developed further, and have been carried over from the Empire to today's Second Austrian Republic, despite several political regime changes over the past 170 years. After having developed the historical background of the case study, the chapter addresses the dynamics between institutions and actors inside the Austrian healthcare system by looking at the more recent developments of governance, financing and provision of healthcare. While consociational politics, a strong implication of political parties and federalism mark the healthcare system from the outside, the Austrian healthcare system shows further institutional features that make it one of the most complex healthcare systems of the OECD. The chapter also develops the role that each group of actors (the state – i.e. executives and the legislative, corporate actors such as social insurance institutions and providers) plays in healthcare governance and then addresses how these actors through more recent reforms have been positioning themselves vis-à-vis the institutional split between inpatient care and outpatient care in the healthcare system. The chapter looks furthermore at the practices of healthcare governance which include consensual and informal negotiations as well as political bargaining between corporate actors and the state as well as between the federal level and the regional level.

Chapter 3 then describes the rulings of the Court of Justice of the European Union concerning cross-border healthcare and their potential to remove national institutional

boundaries, and how European integration in healthcare provides for a quasi-federal opportunity structure for national actors to potentially "escape" their national system or to make use of European resources for their own benefit. The chapter furthermore provides data on the rules governing the provision of cross-border healthcare services in Austria.

Chapter 4 then analyses the usages of Europe due to European integration in cross-border healthcare by the four most important actor groups responsible for the delivery of healthcare in Austria, i.e. the Austrian *Länder*, payers (social insurance institutions/sickness funds), and providers (physicians and dentists). The chapter starts with the lower level of governance, namely local and regional providers of healthcare that operate cross-border hospital projects and analyses how the *Länder* in their role as providers, regulators and payers of inpatient care use Europe. The following sections analyse how corporate actors on the one hand deal with European rules on cross-border healthcare in their roles as payers and providers at national level and whether they make use of Europe at national level. Furthermore, it is analysed how these actors have used Europe at European level to influence decision-making on the Directive codifying the European rulings on cross-border healthcare. The subsequent section then looks at the possibilities for patient representatives to use Europe. Chapter 5 forms the conclusion verifying the hypotheses. It also discusses the empirical findings as well as the theoretical implications of these findings for further research on European integration in healthcare.

1.2 Institutional Regimes and Agency in a Bismarckian Healthcare System

1.2.1 Building Welfare Institutions and Healthcare Systems

One of the main assumptions of this study is that European integration, very much like globalisation, does not operate in an "institutional void", given that national welfare states have a strong historical institutional legacy. According to Ferrera (Ferrera, 2005), nation building in Europe is intimately linked to the development of welfare states as the European nation state has become "socially structured" by stabilizing patterns of interaction and organizational forms through coalition building among different actors along national cleavages. As chapter 2 will show, the strongest cleavages during the Austro-Hungarian Empire were for example between the right and left political spectrum, between various nationalities, and between the center and the periphery. The Austro-Hungarian Empire tried therefore to create welfare institutions that would hold the Empire together in a politically instable environment. For such a process of structuring to take place, boundaries were necessary. They denote "any kind of marker of a distinctive condition relevant to the life chances of a territorial collectivity and perceived as such by the collectivity itself" (*ibid.*, p. 19), i.e. in geographic terms it means the demarcation of a territory through borders that separate national communities from one another. But these boundaries do not only have a physical function. In their symbolic significance they represent the constitutive power for group or more precisely national identities (*ibid.*, p. 19f): "It was through boundary-setting that European states and nations were built. Boundaries 'caged' [preexisting structures and] actors into the national terrain and prompted their

politicization" (*ibid.*, p. 20). At the same time, institutions were shaped that stabilized the system of the state creating domestic loyalty. This finally initiated a process of 'system building' in the given territorial space (*ibid*., p. 21). The European welfare state that had been created along the borders of nation states has led to systems in which national "territories carried social rights […] that could not be severed from them" (*ibid*., p. 59). These social rights are based on national solidarity as welfare states pool citizens' resources in order to protect them from old-age poverty, the consequences of sickness and unemployment. Welfare states are therefore a highly institutionalized form of solidarity trying to be efficient and serving social justice at the same time. As described in chapter 2, this process of institutionalizing solidarity to stabilize the state did not succeed in the Austro-Hungarian Empire, rather the welfare state was built along national and ethnic lines *inside* the Empire. However, the welfare state institutions that had been built during the times of the Empire continued to exist after the Empire's demise and were carried over to the First Austrian Republic.

Austria has developed a Bismarckian type of welfare state which is a specialized form of compulsory social insurance against old-age poverty, sickness and unemployment, amongst other social risks, which were chosen to make social rights 'function' by nationalizing redistribution amongst the citizens of these states (*ibid.*, pp. 44-49). This development also concerns Bismarckian type healthcare systems that constitute one of the core parts of the welfare state. Hence, Freeman points out "the health system is coterminous with public (state) intervention: health policy problems are problems of and for the state" (Freeman, 2000, p. 8). Health systems do not only regulate the access to healthcare and its financing, but they also regulate the interests of the pharmaceutical industry, the development of medical technologies, and at the same time they regulate struggles between different interest groups such as physicians' associations, patients' associations, and the pharmaceutical industry's associations (*ibid*., p. 8).

During the 'Golden Age' of the welfare state, i.e. the three decades after the Second World War, the national welfare state had reached a climax in its institutional and political development. In all European countries the coverage of the population had reached (nearly) a hundred percent. Healthcare systems had shifted in this time from the provision of cash benefits to systems of benefits in kind, i.e. the free-of-charge delivery of hospital and physician's treatments as well as pharmaceuticals. This shift made the welfare state's provision of healthcare even more complex since more regulation among service providers, patients and the pharmaceutical industry was needed (Ferrera, 2005, p. 75). By 1970, every European state disposed of distinct insurance space with much reduced exit options for its insured members. This meant that obtaining an exemption from the compulsory insurance scheme was very restricted and entry options for foreigners were very limited (*ibid.*, pp. 49, 75). This process of consolidation and expansion can be exemplified by the codification of legal regulations of the Austrian welfare state in the General Social Security Act during the 1950s. Social insurance coverage in healthcare for example was then extended to cover most parts of the Austrian population during this period (see chapter 2).

From the 1970s onwards, after the first two oil price shocks, many European economies slid into a phase of recession, and welfare state reforms were enacted.

Many feared a race to the bottom in social policies. However, the historically grown welfare states have proven to be quite resilient in their institutional structures vis-à-vis the forces of globalization. From a theoretical point of view, historical institutionalist scholars have therefore been pointing out the inertia of these institutional arrangements and their role in shaping actors' interests.

1.2.2 Welfare States as Institutional Regimes

As has been noticed by historical institutional scholars working on the effects globalization has on welfare states, welfare state institutions have proven to be much more resilient to bow to external pressures than one might expect, and national institutions once created show some important 'stickiness': "Both the popularity of the welfare state and the prevalence of 'stickiness' must be at the centre of an investigation of restructuring. The essential point is that welfare states face severe strains and they retain deep reservoirs of political support" (Pierson, 2001, p. 416). Historical Institutionalists are interested in how institutional choices exert long-term effects on the political decisions of their creators. Once an institution is created for a certain policy, actors will adapt to these institutions. In their view, organizational or policy designs are reinforced over time once they have been created and initiate the development of political, economic and social networks. These networks will then show resilience to alternatives to the existing organizational set-up in place as actors have invested energy, time and money in the creation and running of these networks. Hence, national welfare states with their historically grown form have more than a simple tendency to discourage exit from the national system. The organizational form of welfare states and the networks that actors engage in, set more generally 'the rules of the game' and they determine the costs of alternative strategies that actors can pursue (Pierson, 1993, p. 596).

Institutions as "building blocks of social order" have an *obligatory* character. This means that actors are usually expected to comply with institutionally prescribed behaviour and can "call upon a third party" (Streeck & Thelen, 2005b, pp. 10-11) to impose compliance on an actor that might not want to comply with the behavioural regime imposed by institutions. Welfare policies, for example, are institutions to the extent that they provide actors with certain responsibilities and create expectations in the society about the way in which these policies are implemented: "[…] they constitute rules that can and need to be implemented and that are legitimate in that they will if necessary be enforced by agents acting on behalf of the society as a whole" (*ibid.*, p. 12). *Legitimacy* of national welfare institutions results therefore from an enactment of these behavioural rules by actors. Complex systems of institutions such as welfare states and their related healthcare systems are hence *regimes* which can be defined as "a set of rules stipulating expected behaviour and 'ruling out' behaviour deemed to be undesirable" (*ibid.*). Seeing institutions as behavioural regimes according to Streeck and Thelen means therefore to be able to analyse "relations between identifiable social actors" (*ibid.*, p.13). Actors in a welfare state and their healthcare systems are thus part of a complex regime of interactions. So even if the EU offers opportunities beyond this regime, it seems questionable that actors can exit from it that easily as their core functions and competencies have been defined by

the national institutional *regime*. In Austria, for example, the welfare state forms an institutional *regime* that has grown since its inception during the Austro-Hungarian Empire and which has been carried over to the First and then to the Second Austrian Republic. While the Austrian state's executive functions as the main regulator of the welfare state and the healthcare system, various corporate and regional actors to whom tasks of delivering healthcare have been delegated, have legally and sometimes even constitutionally defined competencies relating to the governance, financing and provision of healthcare. Already inside the national system, changes that could lead to reconfigurations of competency arrangements are difficult to bring about. Such a phenomenon is called path-dependence. National healthcare reforms in different states have been analyzed from this angle, aiming at explaining why healthcare systems are difficult to reform 'in a big way' (Wilsford, 1994). As chapter 2 will show, the Austrian healthcare system shows many signs of a path-dependent policy development. However, careful analysis must take into account that national welfare institutions are not completely unchangeable objects.

Streeck and Thelen (2005a) have tackled this issue by reconsidering the role of incremental change (Streeck & Thelen, 2005b, p. 1). Accounting thus for resistance to change by various actors on the one hand, as well as accounting for gradual changes over time that could lead nevertheless to a transformation of existing institutional set-ups on the other, means that the enactment of institutions needs to be considered. There needs to be a distinction between the rule itself and the *implementation* by actors. If an actor does not fully comply with the role he is expected to fulfil, the opportunities that the actor has for strategic action can become an object of analysis, and we can thus focus on processes that allow for gradual change. Opportunities for action (and hence for change) manifest themselves through different factors. To illustrate this aspect, Streeck and Thelen provide as an example tax lawyers who try to find loopholes in the tax law for their clients (*ibid.*, p. 15). Finally, social control is not omnipotent. This leads to the conclusion that the interactions between those who create the rules and those who execute them specify what an institution is in practice. Institutions can thus gradually change despite their disposition for inertia. An example for such gradual change can be found in the governance reforms of the Austrian healthcare system described in section 2.2. Several consecutive federal governments have been striving for increased coordination amongst the various actors responsible for healthcare delivery. To this purpose, new institutions – a Federal Health Agency and a Federal Health Commission – have been created inside the existing healthcare system to serve as platforms for coordination between actors. Over time, such new institution's competencies are then usually increased while the other institutional competencies of actors are kept at their status quo. This strategy is called institutional layering: it works by *differential growth* of institutions, i.e. the new ones are expanded at the edge of old ones. The long-term aim of the creation of those new institutions is then to slowly overcome older institutional arrangements (*ibid.*). This reform strategy and the necessity of coordination amongst actors responsible for healthcare governance in the Austrian healthcare system illustrate an important feature of the Bismarckian type of welfare state, namely the high dispersion of power among different actors that will be addressed by the next section.

1.2.3 Bismarckian Welfare Regimes and Healthcare Systems

Bismarckian welfare states and their healthcare systems show a high dispersion of power between the state and corporatist actors concerning the regulation and delivery of healthcare. This dispersion of power means on the one hand that actors have to fulfil different roles in regulation and will pursue a variety of goals in a healthcare system; it means on the other hand, that their relationship and attitudes towards European integration in healthcare should not be uniform. Different bigger and smaller current EU Member States can be classified as having a Bismarckian type of welfare state. These states include Austria, Germany, France, Italy, Belgium, the Netherlands, Spain, and also Hungary, Poland and Slovakia (Palier, 2010b). The classification of these welfare states as a Bismarckian type go back to Gøsta Esping-Andersen's (1998) work "The Three Worlds of Welfare Capitalism" which has become the central point of reference for welfare state research and still inspires today's research (Schubert, Hegelich & Bazant, 2008, p. 15).

Esping-Andersen (1998) distinguishes three types of institutional *welfare regimes* that have developed in Europe – the liberal, the social-democratic and the conservative-corporatist (or Bismarckian) welfare *regimes*: "To talk of a regime is to denote the fact that in the relation between state and economy a complex of legal and organizational features are systematically interwoven" (Esping-Andersen, 1998, p. 2). The general aim of the Bismarckian type of welfare state in comparison to other types of welfare states is to safeguard the social status of the citizens. The state thus only intervenes if a family is not capable of guaranteeing a socially acceptable life-standard. These states tend to perpetuate the traditional family model, meaning that the wife and children of the insured worker are not usually insured autonomously but depend on the 'bread-winner's' affiliation to the system (Esping-Andersen, 1998, pp. 21ff). Bismarckian welfare states usually share several institutional key variables: The financing mechanism of the welfare state is mainly based on social contributions ('payroll taxes'). These contributions are used to fund para-public administrations or social insurance funds. These funds can be pension funds, sickness funds etc. As a rule the corporatist Social Partners are involved in the management of these funds, which means that the state's bureaucracy plays a more limited role. When it comes to entitlements for social benefits, citizens will generally be entitled to benefits if they have paid their contributions, thus linking the benefit structure to their employment status. The benefits that the insured receive are most often also related to their earnings, and thus to their monetary degree of contributions into the system (Palier, 2010a, p. 24). These principles are valid in many aspects of the welfare state of the Second Austrian Republic, even though some Austrian reforms – especially from the 1970s onwards – have introduced tax-financed benefits which are usually not to be found in Bismarckian welfare states (see chapter 2).

Despite some methodological criticism about the difficulties of creating ideal types of welfare state or lacking consideration for the role women in the welfare state (Schubert, Hegelich & Bazant, 2008, p. 16), Esping-Andersen's typology remains the most prominent and useful one to analyze the welfare state. The criticism reminds us however that careful bottom-up analysis must take into account a high degree of institutional complexity: "it should be emphasized and acknowledged that no real

welfare system is ever pure and always represents a complex mix of policy goals and institutions" (Palier, 2010a, p. 25). One can argue that this holds even truer for healthcare systems. The institutional regimes of healthcare systems of EU Member States depend in their set-up on the type of welfare state they are part of. Social-democratic welfare states such as Sweden, Denmark and Norway as well as liberal welfare states such as the United Kingdom have created *National Health Systems* that are funded by taxes with strong state control over expenses and governance. Conservative-corporatist welfare states like Germany, Austria and the Benelux countries as well as France operate *social insurance systems* that are funded by payroll contributions. These features have several structural implications for the delivery of healthcare and actors' interests:

> "Tax-based finance tends to imply universal coverage, the public ownership of healthcare facilities and a salaried medical profession. Insurance contributions, meanwhile, are paid into funds organized by occupation or region. Funds contract with what is usually a greater mixture of public and private providers of inpatient care, and with independent physicians paid according to the service they provide" (Freeman, 2000, p. 5).

This citation points at different important institutional features of Bismarckian healthcare systems that influence not only the delivery of healthcare, but also how politics are made in healthcare systems, how the system is regulated, and which actors can be expected to follow which goals. Four institutional key variables can be identified that influence actors' power and interests in healthcare systems: (1) Policy-making and the political system, (2) funding, (3) provision, and (4) governance.

The Political system of a country that operates a social insurance based healthcare system sets the larger institutional context of healthcare politics. Political systems which concentrate the authority for policy-making at the central level, i.e. unitary systems, show a higher capability of making policy changes. In contrast, federal systems like Austria which divide political authority between the central government and sub-national governments often show a lower capacity for making comprehensive policy changes, and have a higher tendency to show incremental healthcare policy change. This is the case in federal systems where most often powers regarding healthcare are attributed at least partly to the sub-national level. However, the distribution of power between concentration and fragmentation does not only concern different levels of government (federal, regional, local), but also the number of actors involved. Bismarckian healthcare systems disperse decision-making powers between different non-state actors such as corporatist provider organizations, sickness funds, and the state itself. In such systems the influence of the government on healthcare policy change can be limited (Blank & Burau, 2010, pp. 35-41). The Austrian healthcare system is a prime example of such dispersion of power among different actors (see chapter 2).

The second institutional feature is the funding of healthcare which is "concerned with raising resources and allocating monies to the provider" (*ibid.*, p. 69). Funding through social insurance institutions such as sickness funds is a hybrid form of financing between state funding and private insurance: while the funding as such is paid for by an independent insurance fund it has nonetheless a public mandate. Usually

the insured citizens will pay their contributions according to their salaries instead of their individual health risks, which means that the funding mechanism represents a form of social solidarity. In most social insurance systems the contributions are shared between employees and employers (*ibid.*, p. 75). This type of funding has however also implications for different actors in a healthcare system: "funding is about more than raising and allocating financial resources. How funds are raised and allocated is also a pointer to power. Different types of funding result in different types of control, and different types of control lead to different types of pressures for reform" (*ibid.*, p. 79). In Bismarckian type healthcare systems the degree of state control is therefore more limited than in healthcare systems that are financed directly through taxes. Oftentimes the state has problems to control the health care expenditure of social insurance bodies as they raise their contributions themselves. This argument can be illustrated by the complex system of healthcare financing in Austria: not only is outpatient care financed by payroll contributions and hence controlled to a large part by corporate actors. Inpatient care is mainly funded through taxes and the federal government has only limited competencies concerning how these tax subsidies are spent at regional level.

The third institutional feature concerns the provision of healthcare: "Healthcare services are first and foremost medical services, reflecting the prominence of doctors in the delivery of services and the allocation of healthcare resources" (*ibid.*, p. 83). Most often primary medical care is delivered in ambulatory setting by individual general practitioners (GPs), whereas acute medical care is most often delivered in hospitals. In most countries, hospital care represents the single largest share of healthcare expenditure. Furthermore, healthcare systems also determine how freely patients can choose medical treatment, such as the free choice of doctors and in which kind of hospital they want to be treated in. Healthcare systems also determine the exact rules of contracting between sickness funds and medical providers. Depending on the form that these rules take, actors will form their interests (*ibid.*, pp. 83-91). Healthcare delivery in Austria is for example based on patients' free choice of physicians. At the same time, the system shows an organizational split between inpatient and outpatient care, and hospital infrastructure is an important element of electoral competition at regional level.

The last institutional feature is the governance of healthcare. The form of funding through sickness funds and the way contracting between these funds and medical providers is organized influences also the governance of a Bismarckian healthcare system. Governance means here the coordination of the healthcare system and the actors in that system (*ibid*., p. 91). Bismarckian healthcare systems usually show a high institutional complexity of governance given the corporatist administration of sickness funds. Furthermore, corporatism can operate at different levels. In Bismarckian welfare states the central level sets the framework for contracting between funds and providers while the sickness funds, physicians and hospitals negotiate precise contracts at the sub-state or even local level (*ibid*.). Corporatist actors such as medical associations, sickness funds, and other provider organizations can raise their own financial resources and have also the right to determine the content of their contracts. If such a form of corporatism is combined with a federal political system, government

control is reduced and decision-making power is quite dispersed, which is the case for Austria. Moreover, different types of actors operate in the Austrian healthcare system. These actors generally show different interests and goal orientations.

1.2.4 Actors' Interests in a Bismarckian Healthcare Systems

A Bismarckian institutional regime sets the 'rules of the game' for regulation of a healthcare system that actors have to comply with. The actors develop their interests and goals according to their assigned institutional roles: broadly speaking, actors define their interests towards three main goals of health policy. The first two goals of health policy marked all types of healthcare systems in the Golden Age of the welfare state following World War II, namely the equity and *access* to healthcare as well as the *quality* of healthcare. Most healthcare systems follow the goal of equal access of citizens to medical treatment. And they try secondly to ensure the best possible quality of medical treatment for their citizens. Since the end of the Golden Age of the welfare state in the 1970s, however, healthcare systems have faced steadily rising costs and an increase of more complex technological but also more expensive medical treatments. Therefore a third goal of health policy developed: that of cost *containment or efficiency*. These goals are not necessarily complementary, but rather compete with each other (Blank & Burau, 2010, pp. 97-102), i.e. efforts to control costs can mean a decline in access or quality, or improving quality or access to healthcare can be detrimental for healthcare spending.

Four types of actors can be identified in a healthcare system: the state (national or regional government and agencies), providers (physicians, hospitals), payers (sickness funds) and users (patients or patient organizations). For example, sickness funds will be more concerned about cost control since they literally have to pay, whereas providers will emphasize the quality of healthcare services. Actors might however be pursuing several goals at a time, and hold different ideas about one and the same goal (*ibid.*, p. 246).

Diverse goal orientation of actors in a healthcare system implies also that these actors will not necessarily share the same views about European rules on access to cross-border healthcare services (see chapter 4). For example, during recent decades the federal government in Austria has put an emphasis on increasing the efficiency of the healthcare system by aiming at reforms of outpatient and inpatient care. Many of these reforms have met resistance because corporate actors such as physicians or sickness funds and regional governments feared a limitation of access to healthcare. At the same time, other reforms aiming at improving financial efficiency, such as the reduction of costs for medication and reforms of calculating reimbursement for inpatient care, have been enacted (see section 2.2). It is therefore necessary to see not only how each and every important actor positions himself towards national reforms, but also how these actors will perceive European rules on cross-border healthcare. And these actors do not necessarily hold the same ideas about taking up the opportunities offered by the European Union for going beyond the national borders or interacting with the European level. The following section will therefore present the resources that Europe can provide to these actors in order to follow their own interests.

1.3 National Actors' Usages of Europe

In order to theorize the strategies which are available for individual national healthcare actors facing European Integration in healthcare a more recent approach concerning "the usages of Europe" (Jacquot & Woll, 2003) will be used. It has been developed in the field of studies on Europeanization. While the suggested research could certainly have been constructed without even mentioning the concept of Europeanization, this would not do justice to the importance of the concept in the field of European Studies in Political Science. As the aim of this section is to provide an analytical concept to scrutinize the interaction between national healthcare regimes and actors' agency facing European integration, only the very basic features of Europeanization will be presented instead of providing an academic recount and discussion of the vast Europeanization literature[2], which has already been done several times and in a more detailed and complex manner than this present study would require.

The concept of Europeanization has become popular among political scientists since the middle of the 1990s. Europeanization moves the focus away from the integration process outcomes for the EU towards domestic changes that occur due to European integration (Börzel & Risse, 2007, pp. 483f). This analytical focus on the EU's impacts on Member States therefore means that scholars try to explain domestic processes and outcomes due to European integration rather than trying to categorize the EU itself (Featherstone & Radaelli, 2003, p. 4). The variety in approaches and study objects available has caused criticism, given the lack of a single definition of Europeanization. Therefore Radaelli (Radaelli, 2000, p. 1) has argued that the concept of Europeanization "runs the risk of conceptual stretching", i.e. that the term Europeanization needs external boundaries towards other analytical concepts and suggested the following definition that is used here: "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*.)

The advantage of this rather broad definition is that it leaves the choice of the analytical tools to be used to the researcher but alerts us also to the fact that 'ways of doing things' is a concept of great subtlety (Ladrech, 2010, p. 15). The definition allows us furthermore to take account of the complex relationship between the EU and the Member States. Instead of having a unidirectional conception of the EU's impact on Member States (top-down perspective), it allows to consider Member State reactions and what they try to upload to the European level (bottom-up perspective). We can thus think of different institutions, actors and levels of action that might change at the same time. Insofar, Europeanization is not a simple linear process of adaptation, but rather a circular process in which Europeanized Member States upload

[2] To cite just some of the most acclaimed works: Cowles, Caporaso & Risse-Kappen, 2001; Featherstone & Radaelli, 2003; Graziano & Vink, 2007; Börzel & Risse, 2007; Ladrech, 2010; Saurugger, 2009b; Sanchez-Salgado, 2007; Palier & Surel, 2007 (in French).

their interests, which in turn has an impact on European integration, which in turn will again lead to an impact on the national level, influencing once more the European level (Saurugger, 2009b, p. 259).

Several studies have been carried out on the impact of the CJEU's rulings on cross-border patient mobility on Member States' healthcare systems using the misfit concept and/or looking at mediating factors that determine the change that occurs on Member State level: With regard to Denmark and Germany, Sindbjerg Martinsen (2005) has analyzed the role of the misfit of national institutions as well as the role of legal activism of national courts when it comes to the implementation of the CJEU's rulings. Furthermore, Sindbjerg Martinsen and Vrangbæk (2008) have analyzed how much institutional change occurs due to rulings in the Danish healthcare system, considering veto points and the institutional legacy of the Danish system as mediating factors. A major study by Obermaier (2009) has analyzed the implementation and compliance of the CJEU rulings on cross-border patient mobility in France, the United Kingdom and Germany. He finds that even a substantial legal and financial misfit can only partly explain the way these countries have chosen to implement the rulings, but that domestic policy preferences in healthcare, the activism of national courts acting as a 'sword of the CJEU', pressure of the European Commission as well as the CJEU's 'fine-tuning' of its own jurisprudence account for national patterns of implementation (*ibid.*, pp. 157-183). Yet, what these previous studies all have in common is that they take a top-down approach of Europeanization as their analytical point of departure and mostly focus on administrative or legal and institutional factors, even if they consider certain political preferences of actors. These previously used approaches seem to underestimate the opportunities that the European Union offers even single actors in a healthcare system to pursue their own interests. Taking into account only institutional factors from a top-down perspective tends to reduce actors' role to those of simple 'rule takers', and in terms of outcomes only (visible) institutional changes could be taken into account. With regard to the complexity of Europeanization processes there thus seems to be a 'blind spot' in these studies, given that not only institutional factors are important, but that actors in the national healthcare system also play a crucial role (Radaelli, 2004, p. 4).

I therefore suggest using an analytical framework that combines both a sociological approach focusing on actors with a historical institutionalist approach in respect of the institutional legacy of welfare states and healthcare systems. This is based on the assumption that "institutional approaches to the EU would greatly benefit from a dose of sociological thinking" (Jenson & Mérand, 2010, p. 74). Sociological approaches to study the EU increased throughout the mid-1990s, but are very heterogeneous. Even though a common research-agenda is lacking, these approaches are based upon a common research standard. According to Saurugger (Saurugger, 2009a, p. 936), sociological approaches can be distinguished from other approaches in political science by two factors: first, they focus on the interaction of individuals or smaller groups, concentrating on the dynamics of European integration, be they institutional, cognitive, political or sociohistoric. Second, when it comes to European integration, the focus of research is thus not on the development of further EU competencies but on "the complex processes which can be found in the heart of integration" (*ibid.*, p. 937).

By taking sociological approaches and analyzing actors, a bottom-up research design is used. "Such a bottom-up research design "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).

One of these sociological bottom-up approaches concerns the 'usages of Europe' developed by Jacquot and Woll (Jacquot & Woll, 2003; Jacquot & Woll, 2004; Jacquot & Woll, 2008; Jacquot, 2008). Their approach tries to go beyond the goodness of fit approach and the pure study of institutional constraints in Europeanization research. They argue that policy change on the national level can occur without any adaptive pressures from the EU level since "the European Union can become a vector of change by providing new resources […] which policy actors use strategically" (Woll & Jacquot, 2010, p. 113). Whereas negative European integration might be putting constraints on actors in Member States with regard to their usual national resources of action, the EU offers different kinds of resources for actors. The latest research on usages of Europe and national welfare state reforms distinguishes five types of opportunities for resources:

Table 1. Resources for Usages of Europe [3]

Type	Possible resources
Legal	EU-legislation (primary & secondary) CJEU case law, etc.
Financial	Budgetary constraints Funding (e.g. funding from the structural funds, etc.)
Cognitive and Normative	Ideas, communications, references, etc.
Political	Multilevel games, blame avoidance mechanisms, argumentation
Institutional	Participation in agencies, committees, etc.

This large variety of resources does not lead to an automatic usage. Actors need to take these opportunities and transform them into resources that can be used at the national level (*ibid.*). In this perspective, national actors are not considered as intermediary variable, but as the mediators of European requirements since they have the capability of filtering these requirements and use them as a resource to follow their own agenda on the domestic level (Jacquot & Woll, 2008, p. 21). Their micro-sociological approach focuses hence on the strategic interactions of individuals, and resulting from these interactions the strategic and cognitive dynamics of Europeanization. Actors will not have an automatic response to a given EU input into the national system. They are able to learn and to use this learning process for their advantage. The behavior of actors is thus important for the manner in which a Member State is Europeanized, since actors can choose to interpret, engage with, or even ignore European integration. The concept of the 'usage of Europe' is therefore defined as "social practices that seize the European Union as a set of opportunities,

[3] Content of table taken from Graziano, Jacquot & Palier, 2011a, p. 10.

be they institutional, ideological, political or organizational" (Woll & Jacquot, 2010, p. 116). This definition implies that the resources and constraints that are supplied by the EU for individual action are not sufficient for strategic action. An actor will intentionally have to make use of these resources. This voluntary action might not however lead automatically to the strategic goal set by the actor since the effects of an individual action are difficult to predict. An actor will thus in turn have to adapt to his environment which influences his behaviour on the long run (*ibid.*). Therefore an actor will have the ability to use European resources on different levels of governance, i.e. actors can play "multi-level" or "two-level games" (Graziano, Jacquot & Palier, 2011a, p. 13). Jacquot and Woll distinguish three types of usages: a *cognitive usage* referring to the interpretation of a political topic and mechanisms of persuasion; 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 manoeuvre. This type of usage is the most common and occurs mostly when most of the actors' stakes have become clear. The last type of usage is the *legitimating usage* which refers to the public justification of political decisions (Woll & Jacquot, 2010, p. 117).

Each of these types of usages is usually associated with typical elements that actors engage with in order to follow their goals. Furthermore, different actors will use Europe differently. As far as cognitive usage is concerned, ideas and expertise will serve actors such as public policy networks or political entrepreneurs in order to build and to frame a political problem. Also public policy networks are associated with a cognitive usage of Europe. With regard to the strategic usage of Europe, mostly bureaucratic or institutional actors will use European institutions, legal, budgetary and political resources for their political work. Legitimating usage is linked mostly to politicians who will use Europe for deliberation or to justify political decisions (Graziano, Jacquot & Palier, 2011a, p. 15).

If we take the example of welfare states and more precisely that of healthcare systems, the number of actors that have to be considered for potential usages of Europe should be enlarged. Previous works have mainly looked at national debates of employment-friendly welfare reforms in different segments of the welfare state (Graziano, Jacquot & Palier, 2011b), but were mostly limited to political actors or elites. As the case of the CJEU rulings on cross-border healthcare and patient mobility has shown, Europe even offers resources to an individual patient who then becomes an actor in the moment he or she uses a legal resource to enlarge the medical treatment options beyond the boundaries of the national healthcare system. Given the variety of actors that are responsible for healthcare delivery, such as politicians, corporate actors (medical associations, employers' associations, labor unions, sickness funds, etc.), bureaucratic actors such as federal and regional ministries, the scope of analysis has to be enlarged. If we want to analyze how these actors mediate Europe and what effect this mediation of Europe has, these actors have to be approached from a specific angle: "what do they perceive to be the right and the wrong way of pursuing their goals (strategy) in a given social interaction. In other words, which ideas do they hold about what their interests are?" (Jenson & Mérand, 2010, p. 85).

This focus on actors alone, though, does not imply a certain outcome and would underestimate the institutional framework which surrounds actors. It would not do justice to national healthcare systems that are "built on strong historical and institutional legacies" (Sindbjerg Martinsen, 2005, p. 1031). It is therefore suggested to combine the sociological approach of "usages of Europe" with a historical institutionalist approach, especially since both approaches seem to be compatible: "Contemporary sociological approaches may in fact have more to do with institutionalism than with constructivism. Here, we are talking about two kinds of institutionalism in particular: historical and organizational institutionalism" (Saurugger & Mérand, 2010, p. 6). Introducing Historical Institutionalism into the picture of analyzing actors' usages of Europe will help to better understand what was called "national games" of social interaction. If we take Streeck and Thelen's (2005a) definition seriously, that institutions are building blocks of social order and that institutionalized national welfare *regimes* define what is possible and impossible for national actors, we must take these national institutional opportunity structures and their goal orientations into account when trying to analyze actors' usages of Europe. Also the stickiness of institutional *regimes* has to be taken into account. Welfare states have not been swept away by globalization, even though they have undergone gradual change that has accumulated significant change over the last decades. Similarly, we can assume that Europe might cut into the boundaries of the national welfare states and offer new spatial opportunities, but change might come about in incremental steps and will be evaluated by actors against their national resources, not to mention that actors might very well try to resist to European Integration to preserve the national status quo. Consequently, combining Historical Institutionalism with the usages of Europe approach might also close some conceptual gaps that open up once the scope of potential actors to be analyzed is enlarged.

The 'institution-prone' reasoning developed above does not change the original aim of analyzing actors' usages of Europe: The aim of adding a historical institutionalist perspective is to scrutinize the national conditions and opportunities that set the framework for the role that actors can and cannot play. Taking the example of a Bismarckian healthcare system supposes that such a system and the way it interacts with national structures of policy-making frame and allow for much different practices of actors than in other types of welfare regimes. These practices can be defined as follows: "A practice is not what someone says s/he thinks or says s/he wants; it is what someone does" (Mérand, 2011, p. 182). Actors develop routines in their everyday work, they "accumulate a great deal of practical knowledge; that is, they develop a repertoire of social networks, behavioral attitudes, standard operating procedures, rules of thumb, tactics and strategies that help them cope with the practical problems they face every day" (*ibid.*). Adding historical institutionalism to this sociological definition of practices means that we have to scrutinize how actors enact national institutional rules and how they interpret them, both of these mechanisms allowing for a certain leeway for change (Streeck & Thelen, 2005b, p. 15). If actors start to use Europe regularly and incorporate this into their existing practices, this change in practices that can have an influence on the norms that surround actors has been called from a sociological point of view *bricolage*: "Bricolage is a sort of making do.

Each step is caused by the desire to solve a local problem […]. New problems arise in the process which are also addressed by whatever comes to hand […]. *Bricolage* is the art of invention (*ars vivendi*) within the 'reasonable' limits set by practical knowledge" (Mérand, 2011, p. 183). From a historical institutionalist perspective one might want to add that these practices are a sort of making do within the limits of the national institutional regime in which actors are confronted with European constraints and possible opportunities for action. Actors' *bricolage* of practices means therefore that they will try to accommodate the challenges and opportunities that Europe offers within their institutional role that they are used to. However, this does not imply that national regulation is dismantled, it rather becomes more complex.

We could expect that *payers* such as sickness funds have a critical stance towards European Integration, given that the increased options for patients to seek medical treatment in another country represent the risk of rising costs. *Providers* of medical care, on the other hand, might show the most ambiguous attitude towards European rules on cross-border healthcare: increased access to healthcare across Europe can potentially entail new sources of revenue through an increase of demand for medical care by foreigners. At the same time they might be subject to competition with providers from other countries that offer medical services at a lower price or a higher quality. The ambiguity that is to be expected calls for careful analysis of this group of actors' perception. *Subnational governments* that are also involved in the delivery of healthcare can be expected to have an equally ambiguous stance towards European Integration in healthcare. On one hand they should be worried that potential additional costs can arise from potential foreign patient fluxes, which would be problematic. Yet, the EU provides financial subsidies for cross-border cooperation through a variety of European funds. These funds and enhanced cross-border cooperation could set incentives for an increased involvement with the European level. Therefore the subnational or regional level has to be scrutinized thoroughly.

Following this reasoning, it is expected that national healthcare actors will start to use Europe, and hence their strategies will change. Their interests however remain largely determined by the national institutional set-up of the healthcare system. Europe might render the institutional boundaries of the national healthcare system porous, but they should remain intact. In chapter 4 these hypotheses will be tested on the main actor groups of the Austrian healthcare system responsible for the delivery of healthcare. In order to better understand the institutional environment in which Austrian healthcare actors operate, the following chapter 2 describes the historical development of the Austrian welfare state and its healthcare system and will then elaborate the dynamics between institutions and actors' practices in Austrian healthcare governance. Chapter 3 will describe the development of European Integration and cross-border healthcare before turning to analysis of actors' usages of Europe in chapter 4.

2
Dynamics in the Austrian Healthcare System: History, Governance, Funding, and Provision

The different institutional paths of the development of the Austrian welfare state have left their imprint on the Austrian healthcare system. On the one hand, the healthcare system is part of a Bismarckian type of social insurance based welfare state with a corporatist tradition of self-administration linked to a consociational style of politics; on the other hand we can see the strong influence of federalism and party politics at federal level. These key characteristics set the larger institutional context for the healthcare system that also influences its inner dynamics. The overlapping or intertwining of these institutional features has led to a somewhat complex healthcare system with a multitude of actors being involved. Such complexity, however, is not uncommon in Bismarckian healthcare systems. This institutional complexity leads, as already theorized in chapter 1, to a dispersion of power among the actors involved in healthcare governance: "Funding from social insurance results in institutional complexity and often limits the degree of central integration of health systems" (Blank & Burau, 2010, p. 93), not to mention the system's embeddedness in a federal polity. The following figure summarizes the wider institutional context of the healthcare system.

While these institutional features have influenced the healthcare system, they need to be looked at more closely as the Austrian healthcare system is not only a sub-system of the Austrian welfare state in general, but an institutional regime in its own right (Moran, 1999, p. 6). The institutional structures of healthcare financing and provision can be considered as sub-systems of the healthcare system in aggregate, which together are linked to the system of healthcare governance (Blank & Burau, 2010, p. 69). The next section will present the "external" institutional developments that have influenced the Austrian healthcare system; the subsequent ones will then present the institutional set-up of the Austrian healthcare system itself.

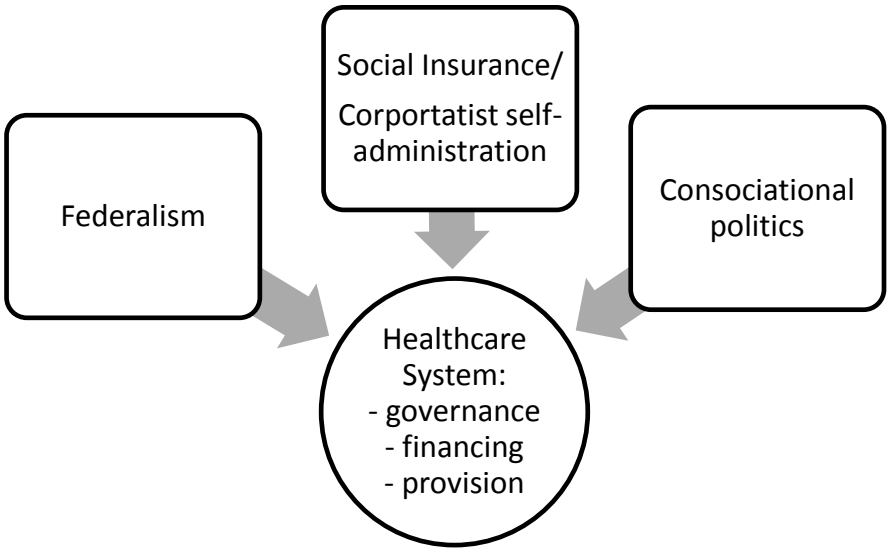

Figure 1. Wider institutional context of the Austrian Healthcare System

2.1 The Historical Development of the Austrian Welfare State and Healthcare System

This section will briefly retrace the historical development of the Austrian welfare state and its healthcare system in particular. As already theorized in the previous chapter, actors are not to be separated from the institutional environment that surrounds them and which has evolved over a period of more than a hundred years. The main aim of this chapter is therefore to put the institutional development of the Austrian healthcare system into the larger context of the origins and developments of Austrian polity and the Austrian welfare state in general. It should thus provide the historical background necessary to better understand the current highly complex governance structure of the Austrian healthcare system, its regulation of cross-border patient mobility (chapter 3), and the interests and strategies that key actors of the Austrian healthcare system follow nationally and at the European level when it comes to healthcare governance and European cross-border patient mobility (chapter 4). The historical development of the Austrian welfare state and healthcare system does not only provide an explanatory background for the current governance structure of the healthcare system, it also helps to put any influence of European integration into a larger historical context. Austria is a prime example of how social rights have become linked to national territory, how welfare institutions have been built, modified and have continued to exist through several changes of the political regime. The origins of the institutional set-up of the Austrian welfare state and healthcare system are to be found in the Austro-Hungarian Empire, which laid not only the cornerstones for the introduction of the Bismarckian type of social insurance institutions, but which also institutionalized several key characteristics that have influenced social policy

and the shape of the welfare state until today. Since their inception, these institutional characteristics have been remarkably stable, even in the light of political regime change and considerable policy changes over the last decades.

Several scholars have analysed the development of the Austrian welfare state from different angles taking the characteristics of today's Austrian polity as a starting point for analysis. The Second Austrian Republic (*Zweite Republik*) is a parliamentary democracy with two parliamentary chambers, the National Council (*Nationalrat*) and a much less influential Federal Council (*Bundesrat*). The parliamentary regime is complemented by elements of a presidential democracy with the Federal President (*Bundespräsident*) being directly elected by the people. Austria is also a centralized federal state with a majority of competencies residing at federal level. Austrian policy-making is furthermore based on consociational politics with strong corporatism (Social Partnership, *Sozialpartnerschaft*). And lastly, Austrian politics are mainly shaped by dominant political parties (Pelinka & Rosenberger, 2007; Ucakar & Gschiegl, 2012). A large part of the literature dealing with the Austrian welfare state thus addresses the role of corporatism in the form of the Austrian Social Partnership (Tálos, 1999; Tálos, 2005; Tálos, 2006; Tálos, 2008), the role of party politics (Seeleib-Kaiser, Dyk & Roggenkamp, 2008), and Austria as a federal state (Obinger, Leibfried & Castles, 2005) or as a "small" welfare state (Obinger *et al.*, 2010). Many of these studies have given only limited attention to the healthcare system, looking mainly at the developments of health policies or policy change. The healthcare system is not marked solely by the organizational principles of a Bismarckian healthcare system and a corporatist structure of governance (Obinger & Tálos, 2010, p. 101). A significant part of the general expenditure on healthcare is also funded through general taxation, which is mainly used to finance hospital infrastructure on the subnational level (Österle & Heitzmann, 2008, p. 53), something which is atypical for Bismarckian welfare states. This is linked to the development of Austria's federal structure, which explains the organizational separation between the ambulatory sector and the inpatient sector (Theurl, 1999, p. 334). It is thus necessary to take three key characteristics into account when scrutinizing the different phases of welfare state development in Austria: the role of political parties, the centre-periphery conflicts now institutionalized in a federal system, and corporate governance in a Bismarckian welfare state based on a system of social insurance.

Since the times of Austria-Hungary, Austria has seen several changes of its polity and many changes of social policy: while welfare institutions were created during the times of the multi-ethnic Austro-Hungarian Empire, they continued to exist – although sometimes enlarged, modified or temporarily abolished – throughout the First Austrian Republic (*Erste Republik*), the authoritarian Federal State of Austria (or "corporative state", *Ständestaat*), German occupation and annexation during the Nazi rule, and have been again consolidated and developed further in the Second Austrian Republic (*Zweite Republik*), which joined the EU in 1995. These significant historic changes of the polity illustrate the complexity of developments that influence the welfare state. While an overview of the political and historical contexts and developments that mark the institutional regime of the current Austrian healthcare system will be provided, an exhaustive analysis of welfare state developments or political regime change

in Austria would largely go beyond the aim of this chapter; especially since such work has been carried out in a more sophisticated and exhaustive way elsewhere [1]. However, particular attention will be given to cleavages, actors and institutions that have influenced the development of the Austrian welfare state over time and which have either left their traces in current Austrian policy-making or which still play an important role today with regard to actors' perceptions of interests and strategies. The Austrian welfare state did not develop in an institutional void and overnight; but what marks its difference vis-à-vis pre-existing structures of poor relief, is the involvement of and the link to the building of a nation state in the late 19th century. This development also represented a growing systemic response to social risks such as unemployment, work accidents, old-age, or sickness.

2.1.1 The Creation of Social Insurance under the Austro-Hungarian Empire (1880s-1918)

During the 1880s, when the first public health insurances were introduced, being sick could still threaten a worker's livelihood. If the typically male bread-winner fell ill, this usually meant unemployment, and as a result poverty for a whole family. Hence, most of the European countries started developing distinct welfare systems in the late 19th and at the beginning of the 20th century, trying to eliminate a risk that has existed since antiquity. In those times, sickness was an immediate threat to life if the patient did not receive any help from his family or social environment (Metz, 2008, pp. 190-193). During the 19th century, first attempts of *public health* policy creation could be witnessed in Europe, trying to maintain the work force of poorer citizens. Sickness became defined as a social phenomenon, linked to living conditions and which could best be fought with the help of medical prevention and treatment (*ibid*., pp. 194-199). Furthermore, an extensive public healthcare service enhances citizens' confidence in the state (Steffen, Lamping & Lehto, 2005, p. 1). It was the German chancellor Bismarck who first introduced a compulsory social insurance scheme for workers in 1883 by creating a health insurance financed by payroll contributions. For Bismarck, social policy was a sort of *realpolitik*: after a drastic recession in the late 1870s, workers' demands for basic financial and social security was increasing. This demand led to a rise in votes for the Social-Democratic party, which Bismarck considered as a "hostile army" (Metz, 2008, p. 89). The consequent introduction of health insurance in 1883 was followed by the introduction of work-accident insurance (1884), and pension insurance (1889). During the following years most European countries followed the German Empire by either introducing compulsory social insurance or by subsidizing the voluntary insurance of workers (Alber, 1982, p. 27). Similar developments can be observed for the Austro-Hungarian Empire. After the introduction of social insurance in Germany, Austria followed suit under

[1] With regard to the development of the European welfare state, amongst other seminal works: Alber, 1982 (in German), Flora & Heidenheimer, 1981; in English: Esping-Andersen, 1996 , Esping-Andersen, 1998, Ferrera, 2005, with regard to Austrian historical social, political and welfare state development; in German: Hanisch, 2005, Obinger, 2005, Obinger, Leibfried & Castles, 2005, Tálos, 1981, Weinzierl & Skalnik, 1983 for the First Republic; in French: Bruckmüller, 2003 (French translation of German original), Pasteur, 2011.

Prime Minister Graf von Taaffe by introducing work-accident insurance in 1887, health insurance in 1888, and pension insurance in 1906. The introduction of social insurance followed the goals of a "top-down" social policy (Alber, 1982, pp. 29ff) as envisaged by Bismarck (Obinger *et al.*, 2010, p. 25).

The creation of compulsory social insurance in Austria therefore aimed at stabilizing the state by fixing existing patterns of governance and actors' roles – in this case healthcare insurances. Institutions of social insurance would stabilize the system by creating domestic loyalty and initiate a process of 'system building' within the national territory (Ferrera, 2005, p. 21). A look at the domestic developments of the Austro-Hungarian Empire is therefore necessary: after the Austro-Hungarian Compromise (*Ausgleich*) a new constitution was introduced in December 1867. The constitution determined that the Empire would consist of two halves, one Austrian (*Cisleithanien*), one Hungarian (*Transleithanien*)[2]. Both halves were not ethnically homogenous entities, and the *Cisleithanian* half covered for example territories that belong nowadays to Austria, the Czech Republic, Poland, Ukraine and Italy. These territories of the Austrian part of the Empire were organized in 17 Crown Lands (*Kronländer*). While Emperor Franz-Josef I was the head of state for both halves of the Empire with a common foreign and defence policy as well as a common currency, a customs union and a joint budget, nearly all the other policies were determined independently by the respective halves of the Empire (Obinger, 2005, pp. 182ff).

Hanisch (2005, p. 209) describes the political system of Austria during the Empire as a "dynastic, bureaucratic authoritarian state" (*dynastischer, bürokratischer Obrigkeitsstaat*), even though the constitution of 1867 had granted the freedoms of association and assembly. These constitutionally granted rights led for example to the creation of an association of individual workers' sickness funds in 1873 (Hofmarcher & Rack, 2006, p. 14) and were the prerequisite for the foundation of political parties such as the Social Democrats in 1889 and the Christian Social Party in 1890 (Obinger, 2005, p. 183). The political priorities of Emperor Franz-Joseph I, however, were mainly to conserve the political order and to appease any kind of conflict (Hanisch, 2005, pp. 212-213). Consequently, political authority was assured by an administrative bureaucracy which quadrupled the number of its staff in the years from 1880 to 1910. Even though the different *Kronländer* had their own administration and municipalities had the right to self-administration, the bureaucratic Austrian administration had a centralized character which guaranteed political authority. Nevertheless, the central administration found a counter-balance in competencies of the *Kronländers'* responsibility for all matters that were not explicitly attributed to the central level pursuant to Article 12 of the constitution. This distinction of responsibilities remained valid even during the first six years of the First Austrian Republic (Obinger, 2005, p. 184). In the field of healthcare for example, the Imperial Sanitary Act of 1870 stipulated that public health was to large parts the responsibility of the *Kronländer*: while the central level was in charge of a "supreme health authority", the *Kronländer*

[2] The names of the two halves refer to the river Leitha which was the border between Lower Austria and Hungary. The geographical reference is however incorrect insofar as the Cisleithanian half of the country also covered geographical areas that were beyond the river.

oversaw epidemic hygiene, and municipalities were responsible for the sanitary police. Furthermore, it was the traditional task of municipalities to provide poor relief. This separation of responsibilities in healthcare and public health between the central, regional and local level is still valid today (Hofmarcher & Rack, 2006, p. 15; Obinger, 2005, p. 185).

Three main groupings of political parties were formed along various cleavages in the Empire: the Christian-Social Party (*Christlichsoziale*) was formed along the cleavage between industry and commerce with a rather anti-capitalist platform, later including positions favourable to the church and receiving increasing support from mainly farmers living in the periphery, even though the party's clientele was mainly residing in Vienna and its suburbs in its early years. The second political grouping were the German nationalists (*Deutschnationale*) which formed as a response to the foundation of Slavic parties in the Czech and Polish parts of the Empire. Even though the party had an economically liberal stance in the beginning, the ethnic/nationalist character was reinforced over the years. The third political grouping were the Social-Democrats (*Sozialdemokraten*) who, unsurprisingly, represented the cleavage between labour and capital. The party mainly represented workers in the growing urban centres of Austria, taking also a clear anti-clerical stance (Hanisch, 2005, pp. 118-124; Pelinka & Rosenberger, 2007, pp. 24ff). The importance of the parties was to be found in their capacity of binding citizens' loyalties, something which the multi-ethnic Empire as such was not capable of: political loyalties were directed towards the parties, and not towards the state (Pelinka & Rosenberger, 2007, p. 25). Furthermore, the very same parties outlived the Empire and influenced the fate of the First Austrian Republic after the Empire's breakdown. Citizens' loyalties belonged to political "camps" (*Lager*) and large numbers of the population were bound to the parties through organizations linked to them, such as labour unions (which only separated from the Social-Democrats in 1907) or catholic farmers organizations in rural areas (*ibid*., 2007, pp. 25ff; Hanisch, 2005, pp. 117ff). The model of political camps explaining large parts of Austrian politics would be even valid in the Second Republic after 1945.

In the light of the strong cleavages, the authoritarian character of the Austrian political system and its instability, creating social insurance was a welcome measure to stabilize the state and the government of Prime Minister von Taaffe: "[…] social policy legislation was the only way to provide the adhesive necessary to keep the monarchy together" (Obinger, 2005, p. 185). The government of Prime Minister von Taaffe introduced Austria's first obligatory social insurance for workers in 1887 by creating an accident insurance; healthcare insurance followed in 1888, and pension insurance in 1906 (*ibid*., p. 184; Tálos, 1981, pp. 43-45, 60). For the newly created insurances such as the accident insurance, insurance funds were created which were financed through payroll contributions from employers and employees; the degree of financial participation varied between the different funds. The healthcare insurance built however on already existing institutions that either companies or workers had created themselves previously. The difference vis-à-vis pre-existing arrangements was the obligatory character and the creation of local sickness funds for those workers who could not benefit from existing company or other insurance funds. Payroll contributions were paid to one third by employers and to two thirds

by employees. Six types of sickness funds were determined by law: district sickness funds (*Bezirkskrankenkassen*) created by the state for workers who could not find health insurance otherwise, company sickness funds (*Betriebskrankenkassen*), as well as three other types that covered workers for state infrastructure, craftsmen organized in guilds and sickness funds that worker associations had created, and lastly a sickness fund for miners. The pre-existing funds had to adjust their statutes according to the new legislation. All sickness funds were run on the principle of self-administration through representatives of employers and employees, but were under the supervision of the state (Tálos, 1981, pp. 67-69). The different types of sickness funds indicate that obligatory health insurance did not cover the whole population but was organized according to occupation. Mainly blue-collar industrial workers, craftsmen, miners and railway employees were covered, with the notable exception of farmers and forestry workers. Officially, the non-insurance of rural populations would have been due to the fact that in the agricultural sector it was difficult to determine who could be considered as an employer and who as an employee. It was finally left to the governments of the *Kronländer* to legislate on healthcare insurance for these populations (Tálos, 1981, p. 66) who initially were not usually covered by health insurance: "the exclusion of agricultural workers was not least a casualty of the strong federalist and agrarian feudal interests that prevailed within the *Reichsrat*" (Obinger, 2005, p. 186). This occupational fragmentation is still valid today, even though the insurance coverage of the population has been largely extended. The Austrian social insurance system shows therefore the characteristics of a conservative form of 'Bismarckian' welfare regime (Obinger, 2005, p. 187). Beyond trying to stabilize the state, social insurance created a "membership space" for Austrian citizens as social rights would become attached to their Austrian citizenship in the western part of the Empire (Ferrera, 2005, pp. 61ff).

The expectation to stabilize the political order of the Austrian Empire was not met by reality. The existing ethnic cleavage between the different nationalities was growing, and fuelled by World War I, outweighing all other cleavages towards the end of the Empire's existence (Hanisch, 2005, p. 126). After the military defeat, the Empire imploded in 1918 and the existing parties of the German-speaking population were to found the First Austrian Republic. Despite the breakdown of the Austro-Hungarian Empire in 1918, it left its imprint on the Austrian political system and today's welfare state by institutionalizing different paths: firstly, political parties were created and organized in "hostile" camps which bound the loyalties of large parts of the population. Secondly, the centre-periphery cleavage did not only materialize in the political arena: it also influenced the set-up of healthcare insurance (and to a lesser extent other social insurance bodies) by leaving insurance of rural populations to the sub-national level and by creating varying responsibilities for healthcare for the national, the sub-national and local levels of governance. The creation of social insurance thus institutionally channelled the centre-periphery cleavage. Thirdly, existing institutions of social insurance, such as workers' or companies' sickness funds were consolidated and complemented by sickness funds that were created by the state. Even though like the sickness funds all social insurance funds were put under general state supervision, the principle of self-administration was introduced, providing for an increased role of employers' and employees' representatives in social administration.

All of these institutionalized paths would influence the further development of the Austrian welfare state.

2.1.2 Social Insurance and Change(s) of the Political Regime (1918-1945)

2.1.2.1 The First Republic (1918-1934)

With the defeat of World War I, the Empire broke down and the different Slavic nationalities claimed their own independent states. The territory of the Empire was dissolved and its parts were divided into the new states of Hungary, Poland, Czechoslovakia, Romania, and the Kingdom of the Serbs, Croats and Slovenes. The remaining parts of the Empire that were not claimed by another nationality became the Republic of German-Austria (*Deutschösterreich*) (Pasteur, 2011, p. 186).

The political parties and the *Kronländer* (now called *Länder*) as well as the social insurance institutions were the main institutional features that survived the breakdown of the Austro-Hungarian Empire. The loss of the former central power in Vienna created an increased feeling of independence among the *Länder* (Hanisch, 2005, p. 265). In fact, in the beginning it was the political parties that founded and carried the Austrian Republic in order to avoid turmoil and anarchy (Pelinka & Rosenberger, 2007, p. 27; Pasteur, 2011, p. 188). In 1919, elections were held for a national assembly that should develop a constitution. The Christian-Social Party and the Social-Democrats afterwards formed a government which only lasted till 1920, when a final consensus was reached to pass a new constitution which made Austria a federal state (*Bundesverfassung*). While the Social-Democrats had preferred a centralized state and the Christian-Social party had pleaded for strong federalism, the compromise consisted in leaving a certain number of competencies to the *Länder,* and in the creation of a second chamber of Parliament (*Bundesrat*) with weak competencies, but representing the *Länders'* interest at the national level vis-à-vis the first chamber of Parliament (*Nationalrat*) (Pelinka & Rosenberger, 2007, pp. 27ff). The new Austrian constitution contained further elements that weakened federalism and gave significant power to the federal government: public finances were centrally organized by the so-called Fiscal Constitutional Law (*Finanzverfassungsgesetz*), and the *Länder* were supposed to carry out federal legislation through their own administrations. The distribution of competencies was furthermore largely inspired by the constitution of the Empire, thus giving more importance to the federal than the subnational level (Obinger, 2005, p. 189).

By the time the First Austrian Republic was founded, social insurance institutions had become territorially ingrained structures. Not only did the Republic inherit the social insurance institutions of the Empire, but also the newly founded states adopted similar systems (Ferrera, 2005, p. 59). The coalition government of the Christian-Social party and of Social Democrats could thus rely in their social policy on the existing social insurance institutions. The first measures of social policy that the government introduced were aimed at pacifying the political and social situation in the light of high inflation and economic breakdown. In 1920, unemployment insurance was introduced for all workers that had healthcare insurance. At the same time, healthcare insurance was extended to cover all employed persons including apprentices. The extension covered also agricultural workers and those working in

forestry. Also state employees and their family members were now covered by health insurance; a new sickness fund was created for them. State employees, though, had to pay a certain part of medical treatment themselves (*Selbstbehalt*), a system which is still valid today (Pasteur, 2011, pp. 189ff; Tálos, 1981, pp. 193ff; Hanisch, 2005, pp. 274ff). Overall, the extension of health insurance coverage and the fragmentation along occupational lines increased the number of sickness funds: "In 1925, there were still 186 health insurance institutions – apart from the agricultural health insurance institutions and the health insurance departments of the miners' welfare associations […]" (Hofmarcher & Rack, 2006, p. 19).

In 1924 the Constitutional Court declared the federal law that had extended health insurance to all salaried employees as unconstitutional. The law had been passed still using the distribution of competencies between the central government and subnational authorities of the 1867 constitution. In fact the constitution did not foresee a competence for the central government to regulate social insurance. As the government did not act upon this ruling, the healthcare reform became unconstitutional and the different Austrian *Länder* either continued healthcare insurance by implementing the former federal legislation themselves or by modifying it, resulting in the loss of healthcare insurance for agriculture workers in Upper Austria and Salzburg (Tálos, 1981, p. 205). Not until 1925 did the new distribution of competencies between the federal level and the *Länder* of the 1920 Constitution come into force. Pursuant to Article 10, it transferred all competencies for social insurance to the federal level, leaving however insurance for agricultural and forestry workers to the *Länder*. Furthermore, the shared competence between both levels of government concerning hospital care was institutionalized: Article 12 of the Constitution designates the areas in which the federal level can regulate policies through framework legislation, but where the *Länder* can issue implementation laws on the execution of such framework legislation. This constitutional provision is still valid today under the same Article 12. In 1928, the Christian-social government finally extended health insurance to encompass agricultural workers as they represented an important part of their electorate (Obinger, 2005, p. 191).

Meanwhile the ideological and political differences were growing between the Christian-Social Party and the German nationalists, on the one hand, and the Social-Democrats, on the other. Given the economic recession and the impact of the Great Depression on Austria, the numbers of strikes and social conflicts were growing. The conflicts were exacerbated by paramilitary groups (Pasteur, 2011, pp. 198-201). Despite the growing political radicalisation, the Christian-Social party and Social-Democrats found a compromise on reforming the Austrian constitution in 1929. The reform was initiated by the Christian-Social government and contained more centralist elements. The constitutional reform of 1929 was enacted with the approval of the Social-Democrats and introduced structural elements: The basic constitutional order of 1929 is still valid today and is marked by a directly elected president, a bi-cameral parliament with a weak second chamber which represents the *Länder*, and a centralised or unitary federal state which grants autonomy to the *Länder* only in certain policy areas, whereas the main competencies remain with the federal level (Pelinka & Rosenberger, 2007, p. 29; Hanisch, 2005, p. 285).

During the following years, the political elites of the different political camps eschewed or failed increasingly at finding political compromise. A "cold" civil war emerged between 1929 and 1934. The clashes between paramilitary groups led to a loss of the state's monopoly on the use of force (Hanisch, 2005, p. 287). Despite the violent demise of the First Austrian Republic in 1934, several developments took place that play an important role in today's Austria. Firstly, in terms of the political regime, the First Republic created the institutional set-up of a polity which is still valid today: a president who is directly elected, a centralized federal state with a weak second chamber and with the majority of legal competencies residing with the federal level. Secondly, the First Republic institutionalized several other important elements in terms of party politics and social policy: the importance of the political parties and their organization along three ideological "camps", the continuation of an occupationally fractured social insurance system, and the creation of the Chambers of Labour that represented workers interests additionally to the labour unions vis-à-vis the employers. Thirdly, the First Republic did not only continue the social insurance scheme, but also extended social insurance coverage to larger parts of the population, with the main example here being the extension of health insurance to all salaried workers and to agricultural workers. Furthermore, in the healthcare sector the First Republic institutionalized the shared competencies for hospital care between the federal level and the *Länder*. All of these elements would influence the political choices not only with regard to the social policy and healthcare politics of the Second Republic after 1945.

2.1.2.2 The Corporative State (*Ständestaat*) and Nazi Occupation (1934-1945)

The political regime that followed the demise of the Republic has been characterized as "authoritarian" or as "Austrofascism" (Pasteur, 2011, p. 223). The new regime, with the governing parties now absorbed in the Fatherland Front (*Vaterländische Front*) was under external and internal political pressure from the Nazis from the outset. While Adolf Hitler had already seized power in Germany, he was also president of the Austrian National Socialists, whose objective was annexation of Austria by the Third Reich (Pasteur, 2011, p. 227; Hanisch, 2005, pp. 316ff).

In terms of social policy, the main legislation of the authoritarian regime consisted of trying to tackle the problem of persistent unemployment caused by the economic impact of the Great Depression. The Social Insurance Act for the Self-Employed Law (*Gewerbliches Sozialversicherungsgesetz*) of 1935 also reduced the salaries of employees of the social insurance institutions and the principle of self-administration was abolished. The administration of unemployment, health, accident and pension insurance was streamlined and all social insurance institutions were re-grouped within a common *Reichsverband*. The state also tried to increase the financial base for health insurance by extending it to the self-employed and by obliging pensioners to pay contributions to health insurance. At the same time, spending on healthcare and other social insurances such as accident insurance were massively cut. The law also introduced obligatory "community groups" (*Arbeitsgemeinschaften*) to provide ambulatory healthcare and medication as well as to control the recipients of such

benefits (Hofmarcher & Rack, 2006, p. 20; Tálos, 1981, p. 267). In March 1938, the German army crossed the border and occupied Austria (Hanisch, 2005, pp. 337-341; Pasteur, 2011, pp. 238-241). After a massive propaganda campaign, a referendum was called for April 10th, 1938. With an official voter turnout of 99.7 per cent, the referendum approved the annexation of Austria by the German Reich with 99.6 per cent of yes votes, the result being typical for totalitarian regimes (Hanisch, 2005, p. 347).

The annexation of Austria, now called *Ostmark* – the name Austria (Österreich) had to be cancelled in official and geographical denominations – had various consequences for social and economic policies in general and for the social insurance institutions in particular. At the same time social insurance was partly streamlined along the lines of the organizational structure of the insurance system existing in Germany. On January 1st, 1939, the *Reichsversicherungsverordnung* [German Imperial Insurance Regulation] came into force for the former Austrian territory: notwithstanding, transitory provisions still allowed for the continuation of some specifications of Austrian social insurance legislation. As regards health insurance, the more generous Austrian provisions regulating sickness benefits and the existing sickness funds were maintained (Tálos, 1981, pp. 292ff). The Nazi ideology had its main impact on the governance of the sickness funds, though:

> "It was expressly declared that mandatory health insurance for pensioners from the white-collar workers' and the miners' insurance schemes, which did not exist in German imperial law, was to be continued […] The organization of health insurance according to occupational groups was abolished during national socialism, and the white- and blue-collar workers' (regional) health insurance funds were merged. Their self-governing structures were abolished. According to the "leadership principle", a leader was appointed for each body; he was supported by an advisory council and bore sole responsibility for management. Basically, only the organizational structure of the health insurance institutions remained intact" (Hofmarcher & Rack, 2006, p. 21).

Like the other social policies, health policy was made an instrument of Nazi ideology. Regulations provided that persons who could pass on hereditary diseases were to be sterilized or not allowed to marry (Tálos, 1981, p. 304). The 1933 "Law for the Prevention of Genetically Diseased Offspring" obliged Doctors to register and report persons with hereditary diseases or with physical or mental disabilities. Furthermore, thousands of disabled adults and children were killed in so-called "euthanasia" programmes [3].

In October 1943 the foreign ministers of the Soviet Union, the United Kingdom and the United States issued the so called Moscow Declaration. The document declared the occupation of Austria by the German Reich to be null and void and called for an independent Austrian state after the end of the war. The Declaration contributed to the development of an independent conception of the Austrian nation after the end of World War II (Pasteur, 2011, p. 255). As far as the development of social insurance and the Austrian healthcare system are concerned, the impact of Nazi rule on the

[3] A monument situated in the Viennese hospital complex Baumgartner Höhe commemorates the killing of up to 800 mentally disabled children in the former clinic for children "Am Spiegelgrund".

existing social insurance was significant as it changed the goal and the governance structure implementing social policy according to totalitarian and racist ideology. Yet, the existing insurance bodies like the sickness funds were not abolished. Given that the German social insurance had also been developed along similar principles (occupational fragmentation, financing through payroll contributions), a continuity of institutional existence can be observed without however downplaying the effects of Nazi rule on these institutions. In any case, the Second Austrian Republic did not have to develop a new system of social insurance, but could build on the historically grown social insurance institutions despite the changes made during occupation. It could furthermore rely on the continuing existence of the entrenched political parties and the existence of the re-established *Länder*. Already in 1947, the transition back to a genuine Austrian social insurance system was initiated by the Social Insurance Transition Act (Hofmarcher & Rack, 2006, p. 21).

2.1.3 Consolidation of the Welfare State in the Second Republic (1945-1980s)

During the three decades that followed World War II, welfare state consolidation and expansion occurred across all Western European countries, including Austria, in order to stabilize the democratic order of the post-World War II-era (Esping-Andersen, 1996, p. 2). During this "Golden Age of the Welfare State" the Gross Domestic Product of European states grew on average by 6% each year. Social policy was seen on the one hand as a result and on the other hand as the engine of this successful economic development. Therefore, social protection expanded from the traditionally insured workers to students, clerics as well as to part-time workers – not only in Austria, but also in Germany, France, the United Kingdom, the Benelux countries and Scandinavia. Towards the end of this Golden age in 1980, over 90% of the European population was covered by health and pension insurance (Merrien, Parchet & Kernen, 2005, p. 102). The expansion of social insurance coverage triggered further institutionalization and consolidation of the existing social security schemes in different European states (Ferrera, 2005, pp. 44-49). In Austria and in other European countries, this development took place on the basis of the historically developed social insurance institutions.

In Austria, the institutions of social security had been built around existing cleavages inherited from the times of the Austro-Hungarian Empire and started now to channel political and social interests with regard to welfare. Similar to other European countries, the efforts to strengthen the democratic political order and to expand the welfare state led to a process of "institutional freezing" (*ibid*., p. 72). This process in the decades following World War II meant also that the welfare state would become tightly linked to nation state and national identity as European states would each determine differently how extended welfare and social sharing should be regulated for their national population. According to Ferrera, welfare states are a highly institutionalized form of social sharing which are complementary to national identity and democratic participation rights in a state's territory (*ibid*., pp. 44ff). Once solidarity and social sharing are institutionalized and consolidated, citizens tend to consider nationality as the source of solidarity and the welfare state itself. The link between nationhood and social policy can be hence defined as follows:

> "It is generally true in sociology that the things which people believe are liable to be true in their consequences, and even if nationality is not based in any firm, objective truth, nationhood plays a major part in the formation of social policy […]. The impact of nationality on contact, status and the structure of obligation tends to identify solidarity closely with national identity. Nationality defines the nation as the root of a solidaristic community" (Spicker, 2000, p. 53).

The consolidation and the expansion of the Austrian welfare state and of the healthcare system are therefore closely linked to the foundation and development of the Second Austrian Republic. The Second Republic was founded while Austria was occupied by the Allied forces (USSR, United Kingdom, France) who stayed in the country till October 26th, 1955. The first years of the Second Republic were marked by the efforts to rebuild the country, to return to the democratic order of the First Republic, and to regain political, economic and social sovereignty (Unger & Heitzmann, 2003, p. 374). Consequently, one of the main goals of Austrian politics at the end of the 1940s was to make social insurance law "Austrian again" (Hofmarcher & Rack, 2006, p. 21). The process of developing the Austrian welfare state was influenced by and is linked to three processes of institutional consolidation of Austrian politics of the Second Republic. The first one is the foundation of the Second Republic by powerful political parties; the second one is the development of consociational and corporatist politics in form of the Social Partnership (*Sozialpartnerschaft*); and the third one is a process of centralization and codification of Austrian social insurance.

2.1.3.1 Political Consolidation and the Role of Political Parties

Similar to the creation of the First Republic, the political parties founded the Second Republic. The Social Democrats (*Sozialistische Partei Österreichs*, henceforth SPÖ), the Austrian People's Party (*Österreichische Volkspartei*, henceforth ÖVP) as successor of the Christian-Social Party, and the Communist party (*Kommunistische Partei Österreichs*, henceforth KPÖ) agreed on forming a transitory government in 1945 and proclaimed the independence of Austria. Since the two most influential parties, SPÖ and ÖVP, wanted to avoid a larger constitutional debate, they agreed on reinstating the constitutional order of 1933 (before the Corporative State). The constitution was only to be revised once the Republican and democratic order was consolidated (Ucakar & Gschiegl, 2012, p. 53). The elections for the *Nationalrat* of 1945 brought a majority of seats for the ÖVP and the SPÖ who formed a government with the KPÖ till 1947. After Austria's acceptance of the US Marshall-Plan aid, the KPÖ left the government. ÖVP and SPÖ formed a Grand Coalition government which lasted till 1966. Thus two of the three former political camps were present in the Austrian Parliament from the beginning of the Second Republic. The third camp, the German nationalists, was excluded from the first elections due to the fact that a large part of their adherents had been members of the Nazi party. In 1956 however, they founded the Freedom Party of Austria (*Freiheitliche Partei Österreichs*, henceforth FPÖ) whose leading ranks still mainly consisted of former National Socialists (Gehler, 2006, p. 36). The Social Democrats and the People's Party did not only play a crucial role in re-establishing the democratic political order inherited from the First Republic, but by forming a grand coalition government they also avoided the tensions that had

led to the First Republic's demise. During the Second Republic however, the political parties have also considerably extended their economic power by nationalizing those enterprises and industries that had been German property during the Nazi rule. Until the 1980s, when the privatisation of national industries and enterprises was started, Austria was the western democratic market economy with the highest degree of publicly owned industries and banks. The public ownership and governmental control over these important parts of the economy increased the power of the political parties and conferred on them direct economic power beyond their political role (Pasteur, 2011, pp. 263f; Unger & Heitzmann, 2003).

Austria regained political independence in 1955 by signing the Austrian State Treaty (*Staatsvertrag*). The treaty between Austria and the Allied forces determined that Austria would be fully sovereign; in return, Austria would have to guarantee amongst others that it would not seek any political or economic union with Germany, that it would have to guarantee the rights of the Slavic minorities, and that it would maintain a democratic order. Within 90 days the Allied troops would leave Austrian territory. The last step to full sovereignty was the constitutional amendment of October 26th, 1955 which obliged Austria to "everlasting neutrality" (*immerwährende Neutralität*). The following elections of 1956 confirmed the Grand Coalition of ÖVP and SPÖ (Gehler, 2006, p. 37). Both parties showed strong support for further expanding social policy. The cooperative party politics were complemented by two more important features of Austrian policy-making and welfare regulation, namely the strengthening of corporatist social policy-making through the so-called Social Partnership (*Sozialpartnerschaft*) and a unified regulation of social insurance through the General Social Security Act.

2.1.3.2 Social Partnership

Social policy-making through corporatist agreements between the Social Partners (*Sozialpartner*) represented by employers' organizations and employees' organizations in concertation with the government dominated large parts of Austrian economic and social policy-making till the late 1980s[4]. The first steps towards an institutionalized tripartite pattern of corporatist politics were taken in the late 1940s and early 1950s through five different agreements between the government and party representatives, employers and employees on salaries and prices in order to stimulate economic growth and rebuild the country. The different representatives met in several commissions that aimed at a coherent economic policy in order to improve the general economic output. Results of the negotiations between the representatives were usually published by ministerial decree, and thus became recognized by the state. In 1962, the government therefore asked the Paritarian Commission of employers and employees to develop an economic stabilization programme. By that time, various other commissions and conferences had been founded, all of which involved representatives from employers'

[4] The development and influence of the Sozialpartnerschaft/Social Partnership on Austrian politics has been the subject of numerous studies. Only a short and very general overview will be given in this chapter. For further reading the following key studies can be named amongst others: Karlhofer & Tálos, 1999; Tálos, 1999; Tálos, 2008; Falkner, 1999 (all in German); Falkner, 2003 (in English).

chambers, labour unions, parliament, government and experts from universities and research institutions. This formalized institutional framework was supplemented by confidential and informal contacts between the above mentioned actors on a regular basis. Along with the institutionalization of the Social Partnership, a growing number of policy issues became the subject of corporatist negotiations, thus representing a diversification of political involvement (Tálos, 2008, pp. 10-35;Tálos, 2006, pp. 426-428). Beyond a considerable number of measures in the realm of income and more general economic policies, the Social Partners significantly influenced the expansion and development of social policies between the 1950s and 1970s.

2.1.3.3 The General Social Security Act: Centralisation and Expansion of the Austrian Welfare State

The most significant measure of the 1950s concerning social insurance was the introduction of the General Social Security Act (*Allgemeines Sozialversicherungsgesetz*, henceforth ASVG) in 1955. The aim of the law was to replace the remaining legal provisions on social insurance institutions that had been introduced during the Nazi occupation and to streamline regulation. It was thus an effort to make social insurance law "Austrian" again. Therefore, the law's significance goes beyond the mere effort of coherent regulation of social insurance. It also represents the consolidation of Austrian social insurance and its corporatist governance. Furthermore, the law underlines the link between national identity and the welfare state by replacing the social insurance legislation that had been left over from the 1940s.

The first draft of the law by the Federal Ministry of Social Affairs contained more than 600 paragraphs. It was submitted for appraisal to the Social Partners and other corporate actors, including the Main Association of Austrian Social Security Institutions (*Hauptverband der österreichischen Sozialversicherungsträger*) which had represented the public sickness funds, pensions funds and work accident insurances since being founded in 1948. While most interest groups and Social Partners agreed on a codification of social insurance, especially the employers and the medical profession opposed certain regulations. Eventually, the ASVG was passed with the majority of the grand coalition government in a package deal together with a law regulating capital markets. The ASVG stipulated a paritarian structure of corporate self-governance of social insurance by the Social Partners, and introduced a coherent status of social insurance coverage for employees based on their payroll contributions. By now blue- and white-collar workers in commerce, industry, mining as well as in agriculture and forestry were insured through uniform rules concerning insurance coverage on work accidents, pension and healthcare. The law also codified the rules of administrative procedures, the relations between social insurance institutions, and introduced harmonized workers' benefits with regard to disability and old-age pensions with that of civil servants (Tálos, 1981, p. 346; Hofmarcher & Rack, 2006, p. 23). Due to its comprehensive range of application for all major branches of social insurance, the ASVG has become the cornerstone of regulation for welfare matters (Hofmarcher & Rack, 2006, p. 23).

The ASVG can be considered as the starting point for further expansion of insurance coverage to an encompassing welfare state. During the following decades it was

subject to numerous amendments (*Novellen*). Until the 1980s, the ASVG had seen 35 amendments, and by the 2000s it had been amended 65 times (Tálos, 1981, pp. 351ff; Hofmarcher & Rack, 2006, p. 23). Especially the political decisions made during the 1960s and 1970s meant an extension of insurance coverage or an improvement of benefits in the different branches of social insurance: the 29th amendment of 1965 aligned pension benefits with the increases of salaries and prices; the 32nd amendment of 1976 allowed for voluntary healthcare insurance and the inclusions of pupils and students in the work accident insurance (Tálos, 1981, p. 347). By way of example, at the beginning of the 1980s, nearly the entirety of the Austrian population was covered by healthcare insurance:

Table 2. Percentage of Austrian population covered by health insurance [5]

Year	1950	1960	1970	1980
Percentage	66.1	77.5	91.8	99.4

The ASVG was not only the starting point to codify and streamline existing social insurance regulation: it also enshrined the Bismarckian character of the Austrian welfare state. Most social insurance benefits were financed through payroll contributions (with the exception of public co-financing through taxes for some parts of pension benefits and hospitals). More importantly, the occupational fragmentation of social insurance institutions was continued, despite their representation by the Main Association of Austrian Social Security Institutions. Moreover, the principle of corporatist self-administration corresponded to the typical pattern of a Bismarckian welfare state (Obinger *et al.*, 2010, p. 31). Furthermore, the aims of the welfare policies corresponded to that of a Bismarckian or conservative welfare regime:

> "Austria's highly developed social policy featured traditional aspects of a conservative welfare state […]. It was primarily based on a status preserving insurance system, backed up by benefits to support familialism and to cover the (female) care-taker. Consequently, female labour force participation was modest compared with social-democratic and liberal welfare state regimes" (Unger & Heitzmann, 2003, p. 373).

The strong position of the Social Partners, who shared the conviction that labour and capital have a common responsibility for economic growth and social policy, together with the governing grand coalition formed a sound basis for expansion of the welfare state during the 1950s and 1960s: the "duopoly of pro-welfare state parties, consociationalism, and corporatism, a consequent lack of institutional veto points to reform, together with favourable economic conditions from the 1950s onwards constituted an environment that was highly conducive to welfare state expansion" (Obinger, 2005, p. 201). The developments that took place in Austria in the 1950s and 1960s thus go beyond a simple "repair" of the damage that World War II had left behind. These two decades consolidated the Austrian polity and introduced patterns of politics (not only with regard to social policy) that built on historically grown institutions. The consolidation of social insurance is an important part of this

[5] *Source*: Tálos, 1981, p. 352.

process. Politically, the pre-existing parties played yet again the role of re-founding the Republic after the War and during occupation by the Allies. The passage of the General Social Security Act (ASVG) did not only consolidate existing social insurance institutions, which had been carried over from the Empire to the Second Republic and which had to large extents even "survived" occupation. It also meant that social insurance would be linked to the Austrian nation state. Moreover, the development of a consociational democracy and the resulting politics of compromise between parties and the important role of Social Partners meant a dispersion of power among different actors that would influence social policy-making and the governance of the welfare state and its healthcare system.

The expansion of the welfare state strengthened the federal level of government as the grand coalition governments usually disposed of a two-third majority in Parliament and were able to change competencies in social policies as they saw fit. The second chamber of Parliament, the Federal Council (*Bundesrat*) only had a suspensive veto which could be overruled by the first chamber, the National Council (*Nationalrat*), but even this veto was rarely used. However, it has to be noted that at the same time the *Länder* retained their competencies in regulating social assistance, youth welfare, and parts of disability benefits (Obinger, 2005, pp. 205-207). And even in those areas where the federal level would have the right of framework legislation, like hospital care, the *Länder* still retained their right to regulate social policies within this framework. As a consequence, the next decade of the 1970s then saw a further expansion of the welfare state and an intertwining of the financial interests between the federal and the regional level.

2.1.3.4 The Welfare State and the Kreisky Era (1970-1983)

In October 1971, the SPÖ, receiving the absolute majority of seats in the *Nationalrat*, could form a single-party government. Under the leadership of Kreisky, the SPÖ moved towards the political centre and opened up to the middle-class electorate. Kreisky also succeeded in gaining continued political support and could secure two more absolute majorities in the *Nationalrat* during the elections of 1975 and 1979. The time of Kreisky's government has been named the "Kreisky Era" (*Ära Kreisky*), given the large number of economic and social reforms and due to his charismatic leadership (Gehler, 2006, pp. 39-41).

The reforms of the 1970s followed an agenda of political modernization of Austria, including amongst other societal reforms further expansion of the welfare state (Obinger *et al.*, 2010, p. 32). The following table provides a brief overview of the reforms of the Kreisky Era:

Table 3. Reforms of the 1970s [6]

Economic policies	– Paritarian governance of board of directors and work councils – Merger and reorganization of nationalized industries – 40-hour working week
Judicial policies	– Majority age lowered from 21 to 19 years – Reform of the Criminal Code – Legalization of abortion during the first three months of pregnancy – Equal rights for both genders in marriage
Educational policies	– Abolishment of university fees – Governance reforms of schools and universities – Abolishment of charges for schoolbooks

With regard to the branches of the welfare state, mainly the pension system, family policy and the healthcare system were reformed (Obinger *et al.*, 2010, pp. 33-34). The early 1970s also brought improvements in the healthcare sector, containing mainly measures for the improvement of public health. These measures included the introduction of a mother-and-child medical card aimed at lowering infant mortality, obligatory medical examinations for school-children and adolescents, as well as obligatory vaccination campaigns (Gottweis & Braumandl, 2006, pp. 755-756).

All of these reforms were possible despite a slowdown of economic growth due to the first OPEC oil crisis in 1973, which had a significant negative impact on all industrialized nations. Due to various economic and social policies which have been labelled as "Austro-Keynesianism", the policy response of Austrian politics could however avoid serious effects on the welfare state in the short run. The main goal of this Austro-Keynesianism was to maintain full employment (Unger & Heitzmann, 2003, p. 374). Most importantly, macroeconomic measures of Austro-Keynesianism followed the pattern of cooperation between the government and the Social Partners. The consequence of these policies was that the Austrian national debt increased from 20.4 per cent of GDP in 1970 to nearly 50 per cent in 1985 (Obinger, 2005, p. 209). The increasing state deficit and the rising payroll contributions to the welfare state in order to compensate for the loss of work-places induced by the crisis started to raise criticism – especially among employer's representatives. The Kreisky government did not react to this criticism, and welfare expenditure was not limited until 1983. Yet, the employers' increasingly critical stance towards rising welfare expenditure also meant a turning point in three decades of constant expansion of welfare benefits. The idea that the expansion of the welfare state and economic growth go hand in hand was seriously put into question (Obinger *et al.*, 2010, p. 38).

While austerity measures were not taken by the government before 1983, the efforts to offset the effects of the economic crises in the 1970s due to the two oil price shocks not only had a major impact on the state budget and on welfare benefits as such. The shifting of welfare benefits that were financed by the state's budget into social insurance also had an effect on the financing structure of the healthcare system. The result was an intertwining of financial interests of the federal level, the regional

[6] Contents taken from Gehler, 2006, p. 41.

level represented by the *Länder*, and the social insurance institutions. The next section will therefore deal with the changes that occurred during the 1970s in the Austrian "financial constitution" as its effects still largely inform reform debates and efforts with regard to the Austrian healthcare system today.

2.1.3.5 15a Agreements: Cooperative Federalism in Healthcare since the 1970s

The efforts of the Kreisky government to cope with the rising budget deficit also had an influence on the financing of the healthcare sector by shifting costs to the social insurance institutions: in 1978, the SPÖ government created together with the *Länder* the Hospital Cooperation Fund (*Krankenanstalten-Zusammenarbeits-Fonds*, henceforth KRAZAF). With the creation of KRAZAF the social insurance funds were obliged to co-finance hospitals that had been financed previously out of the state budget by federal grants to the *Länder*. This new regulation of common hospital financing by the federal level, the *Länder* and social insurance institutions, i.e. the sickness funds, has created a significant financial interdependence between them (Obinger *et al.*, 2010, p. 37; Obinger, 2005, p. 208) which still influences reform efforts of the healthcare system today.

While the creation of KRAZAF can be seen as a response to the growing federal budget deficit and was part of the strategy of shifting costs to the social insurance institutions, it also has to be interpreted with regard to Austrian federalism and the path-dependent development of the *Länders'* competencies concerning hospital care: the former *Kronländer* already had a competence to regulate health institutions under the Imperial Sanitary Act. The constitution of the First Republic then determined in its Article 12 that the federal level could regulate the principles of a certain number of policies through framework legislation. The execution and implementation would be however left to the *Länder*. The enumeration of the matters falling under Article 12 contained also the hospital sector. The same Article 12 was then carried over to the Second Republic, and the *Länder* hence continued to be responsible for the building of hospital infrastructure. At the same time, the building of hospital infrastructure had to be financed. In order to carry out their tasks, the *Länder* received grants from the federal government, which had the competence to collect most taxes. This system of centrally collecting taxes and later distribution of resources to the different *Länder* was also inherited from the times of the Empire and continued to exist throughout the First Republic and the Second Republic. The fiscal relations between the federal level and the *Länder* show therefore a path-dependency, too (see also Dirninger, 2003, pp. 232-233). The Kreisky government had initiated a reform of the fiscal relations between the federal level and the *Länder*, yet continued along the same path that had been enshrined by the Financial Constitutional Law (*Finanzverfassungsgesetz*) which is still valid today.

The Financial Constitutional Law stipulates that tax income is distributed by the federal government vertically through a fiscal equalization scheme (*Finanzausgleich*) codified in a bill presented to Parliament by the Federal Minister of Finance. He or she is only obliged to negotiate the financial allocation with the *Länder* by taking into account their economic performance. The bill that determines the allocations per quotas for a limited time period of usually five years is then voted by the National

Council with a simple majority and without needing any formal assent by the Federal Council representing the *Länder* (Fallend, 2006, p. 1030). The financial equalization laws thus limit the fiscal autonomy to the latter's capacity of negotiation with the federal level. The negotiations between the federal level and the *Länder* thus always tended to have a quite intense character and were sometimes used by subnational politicians as a public stage to manifest a firm federalist stance with a view to their electorate (Dirninger, 2003, p. 233).

With the growing role of state authorities in structural policies also involved an expansion of tasks for the *Länder*, they had asked already at the beginning of the 1970s for own competencies to collect taxes. While the federal government denied this request, a new Article 15a was introduced in the Austrian federal constitutional law in 1974. It was meant to provide a formal procedure to coordinate economic and infrastructure investments between the federal government and the *Länder* without, however, changing the competencies of the federal level to collect taxes. Article 15a of the constitution reads as follows:

> "**Article 15a.** (1) The Federation and the Länder may conclude agreements among themselves about matters within their respective sphere of competence. The conclusion of such agreements in the name of the Federation is, depending on the subject, incumbent on the Federal Government or the Federal Ministers […]; they shall be published in the Federal Law Gazette. (2) Agreements between the Länder can only be made about matters pertaining to their autonomous sphere of competence and must without delay be brought to the Federal Government's knowledge […]"[7].

The Article thus allows for agreements or contracts between the federal government and the *Länder* as well as among the *Länder* themselves. By publishing these so-called "15a-agreements" in the Federal Law Gazette, they become legally binding. Since 1974, numerous agreements have been negotiated between the respective federal and *Länder* governments. The introduction of this Article was therefore the cornerstone of what has been coined as "cooperative federalism" (*Kooperativer Föderalismus*) (Dirninger, 2003, p. 283). The *Länder* had a growing demand for coordination with the federal level as their debt was rising during the politics of Austro-Keynsianism as well. As a consequence of the oil price crises, the *Länder* engaged increasingly in projects that should improve the infrastructure to revitalize the economy. While the federal level could raise taxes, the *Länder* had to finance these projects by means of making debts. With the continuing economic downturn after the second oil price crisis, the regional governments faced increasing difficulties to pay back the credits as their income was determined through the financial equalization scheme (Dirninger, 2003, pp. 290-291).

The creation of KRAZAF was then one of the first measures of cooperative federalism based on 15a-agreements between the federal level and the *Länder* in healthcare. In 1978, and in an effort to reduce the deficit of the federal budget, the federal government reduced its share of direct financing in the hospital sector, which led to increasing financial pressure on the *Länder*. The existing system of federal

[7] *Source*: German to English translation of the Federal Constitutional Law provided by the Austrian Federal Chancellery's Judicial Information System (Bundeskanzleramt, 2013).

grants to finance hospitals was furthermore supporting inefficient hospitals: those who had the highest deficits would receive the largest grants. The newly created instrument of 15a-agreements was therefore a welcome opportunity to renegotiate the financial relations between the federal level and the *Länder* in the hospital sector. The 15a-agreement between the federal government and the *Länder* was backdated to January 1st, 1978. It was complemented by an agreement with the Main Association of Austrian Social Security Institutions and the Austrian municipalities. The task of KRAZAF as a fund was to provide grants to hospital operators in order to cover potential deficits, but also to finance structural reforms in order to provide more efficient hospital care. The federal government and the *Länder* succeeded in reducing their budget deficits by shifting parts of the costs to the social insurance: the fund consisted of financial contributions by the federal government, the *Länder* governments, the municipalities, and the social insurance institutions. The task of the fund was furthermore to create an Austrian hospital plan (*Krankenanstaltenplan*) that was meant to provide a coherent planning of hospitals for the national territory. While the fund was set up by a mechanism of cooperative federalism, the federal government conserved its leading role as KRAZAF was governed by an assembly which was located in the Federal Chancellery (*Bundeskanzleramt*) with the Federal Chancellor being the president of the assembly. The KRAZAF grants were then distributed to the different *Länder* according to quotas, and the amounts paid were made subject to the general negotiations of the financial equalization scheme. The grants were also paid under the condition that the *Länders'* hospitals had to provide efficient cost accounting (Dirninger, 2003, p. 293). The end of the 1970s saw therefore a first attempt to rationalize financing in the hospital sector in the light of growing welfare state expenditures. The obligations that hospitals had to take on in order to receive funds from KRAZAF subsequently meant that transparency was increased by the introduction of cost accounting, revenue-oriented hospital expenditures, and the beginning of efforts to systematically planning hospital infrastructure (Hofmarcher & Rack, 2006, p. 198). The most important significance of KRAZAF is, though, its role as part of cooperative federalism and the intertwining of financial interests of the federal level, the *Länder* and the social insurance institutions, which in itself has created a new path of health policy. This would influence reform efforts in later decades due to ever increasing spending on hospitals by the *Länder*. Moreover, the intertwining of these financial interests exacerbated a more general problem of the Austrian fiscal constitution, namely that the *Länder* spend tax money (not only in the hospital sector) which they do not collect themselves (Obinger, 2005, p. 208).

The Austrian – even though centralized – federal and consociational political system disperses power among the parties, the Social Partners and between the federal and the subnational level. In this respect the system of cooperative federalism in connection with the efforts of the Kreisky government to shift costs of social policies from the national budget to the social insurance institutions has even interlocked the financial interests of all of the mentioned actors. Healthcare and the creation of KRAZAF can be seen as a prime example of this process of interlocking. Since 1978, the federal government, the *Länder* and the social insurance institutions (whose boards of governors were staffed by the Social Partners) now all had a say and an

interest in financing the hospital sector. While a dispersion of power and interlocking of interests and financial contributions was not problematic during the years of welfare state expansion, it puts a heavy institutional brake on welfare state reforms in times of economic difficulties.

2.1.4 Austria and Initial Reforms of the Welfare State (1983-1995)

During the last years of the Kreisky government, welfare state expansion was halted in the light of the rising state debt. The main aim was to secure the status quo, and some further measures were taken to raise revenues. In healthcare, for example, co-payments on medical prescriptions by patients were raised and a first package of more general austerity measures was decided. In 1983, the SPÖ lost its absolute majority and Kreisky resigned. Following the results of the election, the SPÖ formed a government coalition with the FPÖ. Even though the new Federal Chancellor Sinowatz had recognized that reducing the state deficit should be his main goal, the SPÖ in general continued to aim at preserving the status quo of social policies (Gehler, 2006, pp. 42-43). The government started very slowly to abandon Austro-Keynesianism and to consider minor cut backs with regard to benefits. This change of social policy developed gradually, though, and can be interpreted as following a pattern of the "new politics of the welfare state" (Pierson, 1996). They rather pursued a way of gradual reforms that led to a partial welfare state retrenchment; instead of reforming the institutions of the welfare state completely, most states cut back benefits during the 1980s and 1990s, leaving the welfare state institutions intact (Pierson, 1996, p. 174).

The early 1980s were rather an attempt to cautiously manage the problems that were caused by the rising welfare costs, increasing state debt, as well as slowly rising unemployment. The government adopted a first pension reform in 1984 which changed the formula for the calculation of pension benefits, somewhat reducing future pensions; at the same time, payroll-contributions were increased. In healthcare, co-payments to medication were once more increased and family benefits were frozen. In so far "these measures were not designed to undercut the traditional core principles underpinning the welfare state. Neither its basic objectives nor its fundamental structures were contested in this period" (Obinger *et al.*, 2010, p. 41).

National elections were held in November 1986 leading to a new series of grand coalition governments till 1999. The results of the 1986 national elections brought about a loss of some mandates in the National Council for the SPÖ. The ÖVP however could not form a conservative government as the election results meant a loss of some mandates for them, too. The smaller parties benefited from these elections, with an alliance of two Green parties being present in the *Nationalrat* for the first time. This meant that a second left-wing party was now present in Parliament. The FPÖ was the other party that benefited from the elections and could increase its mandates. Given the results of the election, the SPÖ and ÖVP again formed a grand coalition led by Federal Chancellor Vranitzky. The main goal of the coalition was to reform social and economic policies. Especially the SPÖ led by Vranitzky was now aiming at budgetary consolidation, re-organization (if not privatization) of the nationalized industries, and at more market-oriented policies (Gehler, 2006, p. 44). The restructuring and

privatization of the industries owned by the public sector came at a cost for the SPÖ and helped the new populist strategy of the FPÖ, which tried to represent the workers who had lost their income through economic modernization[8] (Unger & Heitzmann, 2003, p. 376; Gehler, 2006, p. 44).

The main goal of the Vranitzky government continued to be the containment of rising debt and of the economic problems arising from long-term unemployment, coupled with a lower economic growth than during the previous decades. While Vranitzky pushed the SPÖ away from Keynesian politics, the ÖVP was exhibiting increasingly neo-liberalist positions, advocating privatization, deregulation and spending cuts (Obinger *et al.*, 2010, pp. 42-43). As far as the welfare state is concerned, not all reforms of the early 1990s meant a decrease in benefits; but they were rather ambiguous as they combined both expansive as well as restrictive reforms. The reforms that were implemented during 1989 and 1993 aimed at supporting families due to declining birth rates, controlling unemployment benefits due to rising unemployment, and at containing the rising costs of pension insurance (see Obinger *et al.*, 2010, pp. 43-46; Tálos, 2005, pp. 61-68).

The healthcare system was no exception to the increased reform activities of the government. Like many other industrialized countries, Austria faced (and faces) the problem of increasing costs of modern healthcare while the growing ageing population is increasingly in need of expensive and mostly intensive treatment. At the same time, the number of those paying into the insurance system was (and is) declining due to lower birth rates. In short, Austria like other states, had to address what has been called "healthcare inflation" (Giaimo, 2002, p. 16). However, the measures that were taken by the Vranitzky government in the healthcare sector followed the same ambiguous approach as the other reforms of welfare state branches. Nor did the government introduce at once path-changing structural reforms, but reforms rather continued to be based on 15a-agreements that started to incrementally increase the state's role in coordinating the healthcare system more efficiently. Reforms with similar goals, but at a quicker and more encompassing pace, can also be observed for this period in other Bismarckian healthcare systems. The healthcare reforms that were implemented in the early 1990s in France and Germany also aimed at increasing the state's influence over their respective healthcare systems and coordinating corporate governance more efficiently (Lepperhoff, 2004). One of the main measures of the Austrian government was to tackle increasing costs in the hospital sector by setting up a planning mechanism for hospital infrastructure and expensive hospital equipment:

> "The government policy statement of January 1990 listed as one of its aims "the drawing up of an Austrian-wide health plan together with the *Länder* and with the involvement of the social insurance institutions. This should particularly include a hospital plan and a major equipment plan". Nationwide health planning is an instrument to ensure structural quality and aims to optimize interfaces in the health care system" (Hofmarcher & Rack, 2006, p. 29).

The creation of the health plan was thus the only possibility to introduce more efficient planning without however touching upon the core of the *Länders'*

[8] For an analysis of Jörg Haider's populist strategy see for example Hobelt, 2002.

competencies in the hospital sector. As it was based on a 15a-agreement, it furthermore respected the different actors' role in the healthcare system and thus corresponded to the practices of cooperative federalism. Furthermore, regular 15a-agreements were used to reorient healthcare expenditures towards the revenues of the healthcare system (Hofmarcher & Rack, 2006, p. 223). This did not mean however that major cut-backs were introduced in the healthcare system. Rather, revenues were increased by raising the payroll-contributions. Only blue-collar workers were exempted from the increase of payroll-contributions. A further measure to improve revenues was one that previous governments had been using: co-payments were increased by obliging patients to participate in costs of hospital stays (so called "hospital costs"). These restrictive measures were accompanied at the same time by an extension of health insurance coverage of psychotherapy and prescribed medication by psychotherapists and nursing care at home. More importantly, a new system of long-term care for the elderly was introduced. This newly created long-term care allowance, based on seven categories of care needs, was to be financed through federal taxes. This expansive reform measure added therefore a new allowance which did not follow the traditional social insurance pattern, as it would not be financed through payroll contributions. By use of a separate 15a-agreement, the *Länder* consented to implement long-term care measures and to provide similar long-term care allowances to citizens who would not be covered under federal legislation (Obinger *et al.*, 2010, p. 47; Hofmarcher & Rack, 2006, p. 223).

Overall, the welfare state reforms that were implemented during the early 1990s thus saw some restrictive measures to consolidate the state's finances and to increase the revenues of the social insurance institutions. The restrictive measures were however largely offset in their effect by expansive measures that were taken at the same time (Obinger *et al.*, 2010, p. 47). Given the ambiguous and limited reform efforts in continuing economically difficult times, the reform pressure for the years to come increased further. This reform pressure was exacerbated by the plans of the Austrian government to join the European Union. After Austria had filed its application to join the European Union, negotiations on the different chapters of adapting Austrian legislation to the *acquis communautaire* started in 1993. As the federal government aimed at rather swift negotiations, an agreement could be reached by March 1994. The accession to the European Union had however to be approved by a nation-wide referendum in June 1994 (Gehler, 2006, pp. 45-46). All of the relevant actors were in support of becoming an EU Member State: all Social Partners, the *Länder* governments and the federal government expressed their support. Especially the federal government started a massive pro-European campaign. As a consequence, 66% of Austrians voted in favour of accession (Unger & Heitzmann, 2003, p. 380). However, the Austrian membership had consequences for welfare state reforms, as well as for the influence of the *Länder* and the Social Partners on policy-making.

2.1.5 Adaptations to Europe and Welfare State Reforms (1995-1999)

2.1.5.1 EU Membership and Welfare State Reforms

Austria's EU membership has on the one hand accelerated processes of welfare state reform and has changed, on the other hand, the opportunities for political and corporate actors to influence policy outcomes at the national and at the EU level. Therefore, not only a look at the reform processes which started in the early 1990s and which intensified during the second half of the 1990s is necessary, but also adaptations of welfare policies and structural Europeanization effects need to be taken into account in the following two sub-chapters.

Austria's accession to the EU meant that the country would have to comply with the Maastricht criteria on financial and monetary convergence. Therefore the state's debt had to be reduced to 60% of GDP. As the state debt had been constantly rising during the Kreisky Era and the ambiguous reform efforts of the Vranitzky government did not lead to any significant reduction of public debt, new efforts towards reforming the welfare system were made in order to contain the costs of social policies. In fact, in 1995 Austria's debt had risen to 69.2% of GDP (Obinger, 2005, p. 211). The need to tackle public finances and welfare state reforms as a consequence of EU membership caused tensions in the governing grand coalition. But not only did party politics become more conflict-laden: EU membership also became a turning point for social politics in that the Social Partners' influence on social policy-making was significantly reduced. Given the rising tension between the governing parties, the federal government aimed at facilitating reform efforts by strengthening its own agenda-setting powers in either avoiding agreements with the Social Partners by excluding them from the policy-making process or, where necessary, by recurring less frequently to tripartite agreements between the state, employers' and employees' representatives. The exclusion of the Social Partners from the policy-making processes meant also a more conflictuous relationship between the government and corporate actors (Tálos, 2008, p. 83).

The late 1990s saw two major austerity packages labelled as Structural Adaptation Acts I and II (*Strukturanpassungsgesetze*) which were passed in 1995 and 1996. These laws were designed as umbrella laws which would change provisions in more than 100 other laws regulating social and fiscal policies. As the grand coalition governments had a two-third majority in the *Nationalrat*, a part of the amendments were voted as a constitutional provision, thus avoiding any possible veto by the Constitutional Court (Obinger, 2005, p. 211). The first Structural Adaptation Act had already been drafted in 1994 by the Federal Minister of Finance by excluding the Social Partners from consultation and was passed in 1995. As the Act provided for major cutbacks in welfare spending, the Austrian Federation of Labour Unions (ÖGB) vigorously protested against it while the employers represented by the Austrian Chamber of Economy (WKÖ) greeted the austerity measures (Tálos, 2008, p. 83). Tensions were also rising inside the grand coalition between Social Democrats and Christian Democrats over the budget. In October 1995 the grand coalition broke up when the ÖVP quit the budget negotiations. The elections of 1995 were expected to strengthen conservative and liberal parties. The results, though, confirmed the status quo as the ÖVP could only win one more seat and the FPÖ under Jörg Haider even

lost a seat. Meanwhile the Social Democrats won 6 more seats. Even though the ÖVP did not exclude the possibility of forming a coalition with the ÖVP, the grand coalition of SPÖ and ÖVP was renewed. The ÖVP however demanded more leeway for pursuing its own political goals (Gehler, 2006, p. 46). As a result of the elections the grand coalition's two-third majority was confirmed. In 1996 the parties agreed on the budget and on the Structural Adaptation Act II, which combined an increase of state revenues with cutbacks in social expenditure. The reform measures of the two Structural Adaptation Acts introduced, among other measures, the tightening of eligibility criteria for pensions, cutbacks of family benefits and the introduction of activation policies for the unemployed (see Obinger *et al.*, 2010, pp. 48-51).

Healthcare was no exception to the reform efforts made by the government in order to achieve the Maastricht criteria. Mainly the hospital sector became the focus of reform efforts. The aim was to improve nation-wide planning of hospital infrastructure and to reduce an oversupply of hospital beds in different Austrian regions. Given the *Länders'* competence with regard to hospital care, the reforms were based on 15a-agreements and thus followed the established pattern of cooperative federalism. The KRAZAF, the hospital cooperation fund created during the Kreisky Era was dissolved, and replaced by nine different regional funds. Thus, each *Land* would have its own hospital fund. Furthermore, in order to shorten hospital stays a hospital payment system based on diagnosis-related groups was introduced. This new payment system meant that hospitals would no longer be paid according to the duration of treatment, but the payment would be performance-related with a payment linked to a certain diagnosis (Obinger, 2005, p. 51). The introduction of a more coordinated hospital planning has increased the role of the federal level as a "central coordinator for structural policy", but with the decentralisation of the hospital funds the reform efforts have also "fostered decentralization" (Hofmarcher & Rack, 2006, p. 196). Thus, even though the role of the federal level had been strengthened in its coordination role, no path-shift was achieved as the *Länder* would continue to have a large influence over steering the finances for their hospitals. It also meant that any further reform efforts would be based on the necessity to close 15a-agreements. Reform efforts did not only concentrate on the hospital infrastructure, but were also introduced in the outpatient sector. Here as well, reform efforts followed the institutionalized pattern of increasing co-payments for medication and for consultations. Eligibility criteria were tightened for family health insurance, lowering the age for co-insurance of children from 26 to 25 years (Obinger, 2005, p. 51). Overall, Austrian reform efforts followed the international trend of healthcare reform in OECD countries by introducing the performance-related payment scheme in hospital care which stabilized the growth rates of expenditure on the healthcare system, especially for hospital care (Hofmarcher & Rack, 2006, p. 197). Yet, these reforms did not mean a path-shift as they left the system of healthcare governance untouched.

While the federal government succeeded in passing its reforms through Parliament, the relationship between the two governing parties once more became increasingly strained. In 1997, Vranitzky resigned and the former Federal Minister of Finance, Social Democrat Viktor Klima, became Federal Chancellor in 1997 (Gehler, 2006, p. 46). After Klima had taken over as Federal Chancellor, the above mentioned

pension reform was to be enacted. The government continued the strategy of excluding the Social Partners from formulating the goals of the pension reform. This led to the most intense conflict between the government and the Austrian Federation of Labour Unions as well as with the Federal Chamber of Labour in the 1990s (Tálos, 2008, p. 84). As a consequence, the Social Partnership was weakened after Austria's accession to the EU and lost significant parts of its influence in comparison to its heydays in the 1970s. Yet, the 1990s did not witness a dismantlement of the Social Partnership.

The reforms of the grand coalition government in the late 1990s did not entail a departure from the Bismarckian principles of the welfare state as such. Indeed, many reforms were path-dependent as they relied on cutbacks or increase of revenues without touching upon the governance of the system. Nevertheless, EU accession and the Maastricht criteria meant an incentive to increase the speed and scope of reforms in comparison to previous decades. The introduction of regional health funds accompanied by an increased role for the federal government concerning central planning is a prime example. Most notably, however, the federal government strengthened its position by reducing the influence of the Social Partners on social policy-making, profiting from the dissent between employers and employees over the necessity of welfare state reform (Obinger, 2005, p. 52). The results of the 1999 national elections meant the end of the grand coalition. Austria's EU membership did not only set incentives to speed up reform processes via the Maastricht criteria, it also meant a Europeanization of various parts of the Austrian polity, including certain welfare measures. Thus, before addressing Austrian welfare politics in the 2000s, the next section will briefly outline the Europeanization effects on the Austrian welfare state.

2.1.5.2 Europeanization Effects

The effects of Austria's EU membership on the welfare state are not only visible through the general effects of the Maastricht criteria on speeding up restrictive welfare state reforms. They also touch institutional features such as Austria's corporatist style of policy-making (Tálos & Falkner, 1996; Falkner, 1999). Furthermore, EU membership meant a more general Europeanization of the Austrian polity which induced changes of the constitution, parliamentary powers, the *Länders'* influence on national policy-making, and the role of the government and its administration (Falkner, 2001; Falkner, 2006). As could be seen throughout the previous sections, all of these institutions have an influence on welfare state governance in general, and on the healthcare system in particular. While these institutional effects will be examined in more detail in chapter 4 when analysing different actors' response to European integration in healthcare, this section will limit itself to the immediate effects of European integration on Austrian social policy after joining the EU in 1995.

When Austria joined the European Union significant changes of the polity were anticipated by Austrian politicians (Falkner, 2001), yet it was not expected that Austrian EU membership would have any significant impact on the Austrian welfare state (Falkner, 2002, p. 189). Austria's main concerns with regard to necessary policy adaptations to the *acquis communautaire* were rather directed towards the national

regulation of Alpine transit, the agricultural sector and Austrian neutrality (Falkner, 2001). The Austrian expectation that EU membership would only have a limited impact on national social policy was based on the assumption that the Austrian welfare state was well developed and that any European standards would be easily met. Furthermore, national social policy was defined by the treaties as a national prerogative, and EU regulations with regard to social policy were mainly concerned with labour law, in which Austria seemed to have very advanced standards. Also Austria had been a member of the European Free Trade Area (EFTA), which had concluded the Agreement on the European Economic Area in 1993 that obliged EFTA members to implement already necessary adaptations to many EU policies (Falkner, 2003, p. 189).

Despite these expectations, EU membership did have some direct and indirect effects on Austrian social policy. The direct effects meant that Austria had to adapt certain regulations with regard to labour law to EU standards. One of the main fields was the equal treatment of men and women at the work place. Further adjustments concerned the alignment of Austrian regulations with EU provisions on equal pay for women and men and indirect gender discrimination. Besides these gender-related policy changes, Austria had to adapt some of its standards concerning health and safety regulations at the work place (*ibid*., pp. 190-191).

Beyond these direct effects, some indirect effects could be observed. It is however difficult to assess those indirect effects. The indirect effects concern social policy in a broader sense. When Austria was about to join the EU, the question was raised whether in the light of advanced market integration but relatively weak social integration EU membership could not lead to social dumping: since the Austrian welfare state granted exhaustive social protection with relatively high payroll contributions, it was feared that business could prefer to outsource production to other Member States with lower contribution rates. While possible consequences had been debated during Austria's accession negotiations, such debates were silenced during the campaign for the referendum that was to approve membership. Even the Social Partners preferred to underline the prospect of potential economic growth that would be stipulated by EU membership, and downplayed potential consequences for social policy. The Federal Ministry of Social Affairs even prevented a study on the consequences of EU membership for social policy (Falkner, 1996, pp. 242-245).

Albeit, the indirect effects of Austrian EU membership can be qualified as having strengthened the trends for restrictive welfare reforms that were already present before 1995, as has been shown in the previous sections. Once the referendum had approved EU membership, the Chamber of Economy (WKÖ) and the Association of Austrian Industries (*Industriellenvereiningung*, IV) put forward that wage moderation was necessary in the upcoming wage negotiations of different industrial branches. They argued that increased competition with producers from other EU Member States would have to be taken into account for wage setting. The Chamber of Economy also demanded a lowering of payroll contributions and put forward arguments to raise co-payments for certain social benefits. And as the previous section has shown, EU membership served indeed as a justification for cutbacks in social policy. The two Austerity packages of 1995 and 1996 were largely justified by having to comply with

the Maastricht convergence criteria for participation in the Monetary Union (*ibid*., p. 249). In so far, the Austrian welfare state was indirectly affected by EU membership as Europe now could be used by politicians to pursue their own domestic agenda. EU membership was an argument that supported those political and corporate actors who were in favour of restrictive welfare state reforms (Falkner, 2003, p. 197).

To conclude, Austria's EU membership did not have any immediate far-reaching direct consequences for Austrian social policy beyond some changes with regard to labour law, health and safety at work, and certain rules on equal treatment of women and men in the work realm. Otherwise, Austrian social policy remained untouched in its basic set-up, even though EU membership brought about changes for most of the actors involved in the governance of the welfare state, an aspect which will have to be discussed below. More important than the limited direct effects on the Austrian welfare state right after joining the EU is the indirect impact, even though this is difficult to assess: "One cannot really know what kind of budgetary reform the Austrian grand coalition government, in office during the first five years of EU membership, would have adopted if the EU had not provided an external *justifier*" (Falkner, 2002, p. 174). Yet, the measures taken by the Austrian government to speed up restrictive welfare state reforms with the austerity packages of 1995 and 1996 show that Europe already at the beginning of Austrian EU membership has served for legitimating usages of the federal government. At the same time, a Europeanization effect must not be overestimated in the sense that steps during the first half of the 1990s had already been taken towards austerity, and already in the 1980s support for Austro-Keynesianism was crumbling. EU membership served therefore as a means to strengthen the preferences for restrictive welfare state reforms already present among important Austrian actors such as the Christian Democrats or employers' representatives such as the Chamber of Labour and the Association of Austrian Industries.

The welfare state cutbacks that the grand coalition government had implemented right after EU membership were thus unsurprisingly accompanied by rising tensions between the government and the Social Partners, whose influence over social policy-making had been reduced. These conflicts between the actors (employers, industrialists) advocating for further austerity and deregulation and those preferring to reduce the budget deficit by raising taxes (labour unions, Chambers of Labour) spilled over to the governing parties of the grand coalition (Obinger & Tálos, 2010, p. 113). In general, the readiness of the parties tied together by the grand coalition to take further political decisions had been decreasing once the Structural Adaptation Acts had been passed, "in the end, there was no more productive atmosphere of cooperation between SPÖ and ÖVP" (Gehler, 2006, p. 47). The results of the national elections of October 1999 then also meant the end of the grand coalition and initiated a phase of further austerity-driven welfare state reforms.

2.1.6 Austerity and Reforms of the Welfare State during the 2000s

The results of the national election of October 1999 meant a majority for a coalition between the Christian Democrats and the right-wing FPÖ. Even though the Social Democrats had received the largest share of votes, negotiations for a renewal of a grand coalition between SPÖ and ÖVP had failed. The new ÖVP-FPÖ government

was sworn in on February 4th, 2000 and Wolfgang Schüssel (ÖVP) became Federal Chancellor. The new government had a difficult start as the FPÖ's electoral campaign had exhibited xenophobic and racist slogans. The new government had caused suspicion with most EU Member State governments and the Austrian Federal President Klestil, who had favoured a grand coalition, joined the criticism of other EU governments. As a consequence, the other 14 EU Member States decided on a set of measures which included the freezing of bilateral contacts with the Austrian government (so-called "EU-sanctions"). The result of these sanctions was that FPÖ leader Jörg Haider resigned officially as party leader, but continued to significantly influence the government in the parties' coalition committee. The EU sanctions were lifted half a year later (Gehler, 2006, p. 47).

The new government meant a watershed for welfare politics in Austria. As a result of the struggles between the grand coalition and the labour unions and Chambers of Labour over the pension reforms of the late 1990s, the ÖVP was convinced that policy-making with the Social Partners, especially the labour unions, had to be avoided: "[…] reforms were literally pushed through so that the opposition and the unions were repeatedly confronted with a series of *faits accomplis*. As a consequence, consociational democracy and corporatism virtually came to an end at the turn of the new millennium" (Obinger & Tálos, 2010, p. 113).

The government's reforms were marked by economic and budgetary considerations rather than by a more general political coherent plan for reforms. Yet, the 'speed kills' style of policy-making was successful from the government's point of view, despite difficult relations between the governing parties. The centralised policy-making style was furthermore consolidated by replacing leading positions in several Austrian key institutions, which before had been divided traditionally between the Christian Democrats and the Social Democrats for decades (Gehler, 2006, pp. 48-49). The ÖVP-FPÖ government's main reform efforts were the most effective where they reduced the informal veto points, namely in the legislative arena. The remainders of Austro-Keynesianism were to be stopped, the competitiveness of the Austrian economy to be increased, and social expenditure was put under the aim of achieving a balanced budget (Obinger & Tálos, 2010, p. 114). The reforms of the ÖVP-FPÖ coalition governments abolished several early retirement benefits, introduced a demography factor for the calculation of pensions, and lowered the replacement rates for unemployment benefits. Furthermore tax subsidies for private individual pension saving plans were introduced (see *ibid*., pp. 114-120).

Most of these reforms thus continued a reform agenda that had been already partly emerging in the early 1990s, yet now with the clear aim of austerity mainly by tightening eligibility criteria and the reduction of benefits. As with previous reform efforts, the healthcare system was not exempted. The most notable reform effort concerning health insurance which constituted a slight path-shift was the government's decision to reduce the insurance contribution by employers of blue-collar workers. The result was a reduction of non-wage labour-costs for employers, but it also meant a departure from the principle of employers and employees participating equally in paying health insurance contributions. Further reform measures followed an approach similar to previous reforms: in order to contain costs, private co-payments by patients

for hospital stays and prescribed medication were raised. A novelty was also the introduction of the so-called e-card, replacing the old paper version of the health insurance certificate. The insured would however have to pay 10 € per year for the card as a 'service fee' (Obinger & Tálos, 2010, pp. 118-119). In 2003, the government implemented a harmonization of the different contribution rates of all occupational categories, thus following a similar approach as in the pension insurance. The harmonization was however accompanied by an increase of contribution rates for working citizens as well as for pensioners (Hofmarcher & Rack, 2006, p. 205).

Besides these measures, the financing of hospitals once again became a focus of healthcare reform. The reform pressure on hospital financing was especially intense since the costs for acute beds in hospitals had been increasing by 5% per bed each year since 1993, meaning that the price of an acute hospital bed in Austria had increased between 1993 and 2005 by 65% (Hofmarcher & Rack, 2006, p. 184). Following the usual pattern of cooperative federalism, the reform was enacted by closing a 15a-agreement which was adopted in 2004. The Health Care Reform Act of 2005 that was based on this agreement stipulated several measures: as far as revenues are concerned, the federal government agreed with the *Länder* governments that for the period between 2005 and 2008 cost-containment measures would have to be taken which would amount to 300 million €. At the same time, an increase of revenues was to be achieved by raising revenue through additional tobacco taxes (*ibid*., p. 206; Obinger & Tálos, 2010, p. 119). The federal government, as during the previous reforms, reinforced its role as a coordinator. It was agreed that the Austrian Structural Plan for Health would be developed further in order to include ambulatory, hospital and long-term care. It would thus permit an integrated health planning (Hofmarcher & Rack, 2006, p. 209). Further structural reform measures consisted of creating new institutional bodies at federal and *Länder* level in order to enhance coordination between the inpatient and the outpatient sector, which will be looked at in more detail in section 2.2 on the governance structure of the Austrian healthcare system. Generally speaking, these reforms did not bring about a path change in so far as they even added new institutional bodies to the already existing pattern of cooperative federalism, even though trying to increase efficient coordination of the hospital sector with other sectors of the healthcare system.

While the healthcare reform measures of 2005 represent to a large extent the continuation of reforms that had already been started in the 1990s (change in payroll contributions, increased role of the federal level in hospital planning), Austria's EU membership provided a new impetus for reforms. The EU served as a means of legitimizing these reforms insofar as the Lisbon Strategy contained measures on the 'European Social Model'. Member States were to ensure the financial viability of public health care provision in the long run. Based on the Open Method of Coordination, Member States agreed to aim at achieving full access to healthcare, raising quality standards, and guaranteeing financial stability (Hofmarcher & Rack, 2006, p. 200). Austria's healthcare reform was thus not necessarily Europeanized as far as the concrete measures were concerned, but Europe could be used to legitimize the push of the federal government for further reforms, as in 1995 when Austria just had joined the EU.

The ÖVP-FPÖ coalition's reforms meant welfare state retrenchment in some areas (Tálos, 2005). The most notable fact about these reforms is, however, how they have been decided upon and implemented. Instead of relying on consensual negotiations with the Social Partners, the ÖVP-FPÖ government relied on simple majority decisions. And these reforms meant in some areas of the welfare state a path-change away from the principles of Bismarckian welfare policies. The first change concerns the harmonization of the different pension schemes that were occupationally fractioned. Furthermore, the healthcare system, despite being marked by corporatist negotiations and cooperative federalism, has seen a harmonization of contribution rates. And the introduction of activation policies and cutbacks of passive unemployment benefits also mean a departure from the insurance logic of a Bismarckian system. On the other hand, two decades of welfare reforms have been even reinforcing the Bismarckian character of the welfare state: e.g. family policy still follows an approach based on the "classical" family model with the male-breadwinner providing insurance coverage for the whole family. Despite the harmonization of the contributions for health insurance, the different sickness funds continue to exist along geographical and occupational lines. In terms of financing, too, the traditional insurance logic of funding welfare benefits through payroll contributions continues to play the main role, despite the introduction of tax-funded benefits such as the long-term care allowance. Thus, even after major welfare reforms, the trajectory of the Austrian welfare state can be considered as "janus-faced" given the preservation of classical institutional structures (Obinger & Tálos, 2010, pp. 126-128). While Austria generally followed trends of other European – and Bismarckian – welfare states of introducing supply-side oriented reforms, it lags behind almost a decade with these measures (Unger & Heitzmann, 2003, p. 384). The centre-right coalition was furthermore succeeded by a new grand coalition in 2007 led by the SPÖ. Despite the grand coalition's attempts to aim at further reforms, the new government stopped welfare state retrenchment and started to return to a corporatist policy-making with the Social Partners in different areas of the welfare state. The grand coalition government concentrated amongst others on the harmonization of social assistance benefits and long-term care. Some of these reforms, especially those with regard to the harmonization of social assistance benefits were meant to help cushion the effects of the previous reforms taken by the ÖVP-FPÖ coalition (Obinger & Tálos, 2010, p. 123).

2.1.7 Interim Conclusion: the Different Phases of Welfare State Development

The historical development of the Austrian welfare state and its healthcare system has been dependent on the greater developments of the Austrian polity, its party system, corporatist policy-making and centre-periphery relationships in a (centralized) federal system. Each of these characteristics has left its mark on the Austrian welfare state and the healthcare system in particular. The basic institutional creations of the Austro-Hungarian Empire have been developed further, extended, modified, and partly abolished during dictatorship and occupation. The Second Republic has however returned to these institutional paths and has consolidated them. Despite the different changes of the Austrian polity and considerable social policy

changes these basic institutional paths have seen modifications, but their *principles* have been remarkably stable.

Following welfare state development from the Austro-Hungarian Empire up to today shows how the healthcare system has been influenced by party political preferences, by principles of corporatist self-administration, and by distribution of competencies between the centre and the periphery. The basic principles of Bismarckian type welfare states manifest themselves in the healthcare system through the continuing fragmentation of sickness funds financed by payroll contributions along occupational (and geographical) lines. Also the principle of corporate self-administration – with the exception of the times of authoritarian and totalitarian rule – has been adhered to and extended since the introduction of social insurance in Austria. More importantly, the post-World War II governments returned to previous institutional choices; not only in terms of re-enacting the constitutional order of the First Republic, but also by consolidating social insurance principles in the General Social Security Act. Furthermore, a historical feature of the Austrian healthcare system has been enshrined over the years: the separation between the outpatient sector which is financed by the sickness funds and the inpatient sector, being to a considerable extent a competence of the regional governments (despite the federal government's right to framework legislation). The result of this historical development is a considerable number of actors involved in the governance of the healthcare system: the federal government, *Länder* governments, social insurance institutions, and various corporate actors exercising influence and various functions in the healthcare system. The introduction of cooperative federalism in healthcare, which interlocked the financial interests of the federal and regional governments, has contributed to even more complexity besides the already existing relationship between corporate actors and social insurance institutions. While reform efforts of the last decades have mainly touched upon the financial aspects of health insurance, the basic institutional structure has been left intact. Nevertheless, incremental change can be observed since the 1990s, when the federal government started to aim at increasing its role in coordinating hospital planning. The welfare state reforms of the federal governments since the 1990s have thus also had an impact on the healthcare system. Yet, in comparison with other branches of the welfare state such as unemployment insurance and pension insurance, the reforms show a much lesser extent and are largely path-dependent in so far as they did not bring about major institutional changes, although they have been accompanied by a considerable development of health policy. This has to be interpreted against the background of the historical development that contributed to a complex system of healthcare governance. The next section will therefore examine in more detail the governance structure of the current Austrian healthcare system.

2.2 Austrian Healthcare Governance: a Complex and Fragmented System

2.2.1 Main Actors in Healthcare Governance

Typologies of healthcare systems classify healthcare systems often not only along the lines of the general welfare regime, but also according to the extent the 'state', i.e. the national executive, exerts control over the provision of healthcare. While countries with National Health Services such as the United Kingdom, but also the Scandinavian

countries come close to government monopolies and thus a maximum of executive control over the provision of healthcare, countries like the United States of America leave large parts of the healthcare system to free market regulation with private insurers and independent providers. Bismarckian type healthcare systems – like the Austrian system – are based on the social insurance principle and usually located between these two hypothetical extremes (*ibid*., pp. 12-17). In Bismarckian systems the social insurance institutions, i.e. the sickness funds, can contract public and private providers to deliver healthcare: this has important implications for the governance of the healthcare system (Freeman, 2000, p. 8). Yet, even if social insurance based healthcare systems share these common institutional traits, the exact interplay of governance, provision and funding are not the same for each and every country: "[…] individual health systems combine different models of [governance,] funding and provision, and even rely on a mix of several models of funding or provision. This directs the attention to the country-specific context in which health systems are embedded […]" (Blank & Burau, 2010, pp. 69-70). While Austria's welfare state is a prototypical Bismarckian welfare state (Obinger & Tálos, 2010), the governance of the healthcare system is not left to social insurance institutions: rather, as demonstrated in section 2.1, federalism plays an important role in the governance of Austrian healthcare. The key feature of the Austrian healthcare system is therefore an organizational separation between the ambulatory (outpatient) sector, where competencies have been delegated to corporate actors, and the hospital (inpatient) sector, which is governed to large extent by the *Länders'* regional executives (Theurl, 1999, p. 334). This historical separation between inpatient and outpatient sector is rather atypical for Bismarckian healthcare systems. The separation of healthcare delivery and its embeddedness in a federal system has important consequences for the governance of healthcare. It also indicates one of the main tensions of the Austrian healthcare system that underpins all governance structures of healthcare systems, namely the tension between the centre, i.e. the national government, and locality, i.e. the regional (or local) level (Blank & Burau, 2010, p. 91). While several government agencies and stakeholders play a role in regulating and delivering healthcare in Austria[9], this section will limit itself to the presentation of those actors and institutions that either have decision-making power in healthcare politics and/or are the main representatives of the four groups of actors present in healthcare systems, namely the state (executive and legislative actors), payers, providers, and users of the healthcare system (cf. chapter 1).

The main competence of the *federal level of government* is the legislation on Social Security and thus on determining the legal framework for social insurance institutions including health insurance. According to Article 10 of the Austrian constitution, the federal level has not only the right to legislate but also to execute social insurance legislation (Brodil & Windisch-Graetz, 2009, p. 19): "Social insurance contributions are nationally uniform and set by Parliament. The extent of social protection and the fairness of its distribution are thus regulated at federal government level" (Hofmarcher & Rack, 2006, p. 48). The General Social Security Act (ASVG) (see section 2.1.3), which also regulates health insurance, is thus part

[9] Cf. Ladurner *et al.*, 2011, pp. 42ff and Hofmarcher & Rack, 2006, pp. 31-69.

of federal legislation. The agreements that are negotiated every four to five years between the federal government and the Austrian *Länder* according to Article 15a of the Austrian constitution (see section 2.1.3) in order to regulate the hospital sector are also part of federal legislation insofar as they are published in the Federal Law Gazette (*Bundesgesetzblatt*). Starting thus at the federal level of the Austrian polity, both chambers of Parliament, the National Council (*Nationalrat*) and the Federal Council (*Bundesrat*) have to be mentioned as state actors in healthcare. Both chambers, despite the dominance of the National Council vis-à-vis the Federal Council, have to vote on healthcare legislation concerning the regulation, delivery and reform of healthcare (Ladurner *et al.*, 2011, p. 44; Hofmarcher & Rack, 2006, p. 33). The National Council has a permanent health committee (*Gesundheitsausschuss*) which discusses and prepares parliamentary debates and votes on all bills, motions and government reports concerning health issues. Additional topics of healthcare include food safety, genetic engineering, and animal protection (Parlament Österreich, 2013). The Austrian parties present in the National Council are represented in the health committee according to the numeral strength of their parliamentary groups (*Klubs*). The health affairs spokespersons (*Gesundheitssprecher*) of the different parliamentary groups are members of the committee. The second key state actor in healthcare is the Federal Ministry of Health (*Bundesministerium für Gesundheit*, abbreviated BMG). Politically, the Ministry has a key role in policy-making concerning healthcare as it usually drafts and submits healthcare bills to Parliament. It functions also as the main regulatory body for healthcare. The Federal Ministry's tasks are defined by the Federal Ministries Act (*Bundesministeriengesetz*), and include amongst others general health policy, the protection of the population, cross-border health crisis management, health infrastructure, reporting on health, public hygiene and vaccination, supervising and fighting communicable diseases, health at the workplace, supervising and fighting drug addiction, and education and further training of health professionals (Bundeskanzleramt, 2013, p. 20). However, many of the Ministry's tasks have been delegated either to the system of corporatist self-administration of the social insurance system or to the Austrian *Länder*, especially when it comes to the implementation of regulatory measures (Ladurner *et al.*, 2011, p. 45). While this delegation of powers weakens the position of the Federal Ministry in healthcare governance, it still acts as a supervisory authority for social insurance institutions and service providers and monitors their implementation of legal provisions. Given that many tasks of the Federal Ministry have been delegated to other actors, one of its more important functions besides drafting legislation is to coordinate and to bring together different actors and stakeholders of the healthcare system (Hofmarcher & Rack, 2006, p. 34; Ladurner *et al.*, 2011, p. 45). While the Federal Ministry for Health is certainly the most important ministry when it comes to healthcare, other ministries such as the Federal Ministry for Work, Social Security, and Consumer Protection (*Bundesministerium für Arbeit, Soziales und Konsumentenschutz*, abbreviated BMASK), which is responsible for wider issues of social insurance and citizens with disabilities, and the Federal Ministry of Finances (*Bundesministerium für Finanzen*), which is involved in negotiating financial equalization and the distribution of funds in negotiations on 15a agreements

for hospital infrastructure, play a role in healthcare governance (Hofmarcher & Rack, 2006, p. 38).

After the federal level of government, the nine Austrian *Länder* form a second group of subnational key actors in the Austrian healthcare system. Given the historical development of the Austrian welfare state and the underlying centre-periphery relations, they play most notably a triple role as state regulators, as payers and as providers of healthcare. Based on Article 12 of the Austrian constitution – which has been carried over from the First Republic – the *Länder* have the competency to regulate the details of inpatient care, while the federal level has the right to framework legislation (*Bundeskanzleramt*). Besides this constitutional competence, the *Länder* also carry out other regulatory and supervisory tasks which have been delegated to them by the federal level. The *Länder* governments supported by their respective government offices (*Amt der Landesregierung*), act as the supreme regional health authorities in their function as *state supervisors*. As supervisory authorities they have established departments with regard to disease control and vaccination, and they monitor the implementation of training regulations for medical staff and physicians. Inside each *Land*, administrative districts (*Bezirke*) may carry out further healthcare related tasks. In their role as *providers*, the *Länder* provide hospital infrastructure. They are obliged to do so by federal law (Federal Hospital Act, *Bundesgesetz über Krankenanstalten und Kuranstalten*, abbreviated KAKuG). Since 2006, inpatient acute care has to be provided according to the Austrian Structural Plan for Health (*ibid*., p. 40). Most *Länder* have re-organised their hospital sector since the reform of 2005. Hospitals have been formally privatised: an operating company runs the hospitals while the *Länder* – as owners of these companies – act as guarantors through "*Land* health funds" (*Landesgesundheitsfonds*). The operating companies then fulfil the *Länders'* role as *providers* of inpatient care in the Austrian healthcare system: the organizational forms of the operating companies can differ from one *Land* to the other, yet they share the same purpose; namely to provide inpatient care via their hospitals and to make the necessary decisions on regional hospital infrastructure. The *Land* health funds are thus formally the clients of the operating companies. The aim of this model is to have an organizational separation between the payment (health fund) and provision (operating company) of inpatient care (*ibid*., pp. 40, 57, 127).

The third group of key actors in the healthcare system are the *corporate actors* that are mainly in charge of organizing outpatient care. These actors can be divided into two sub-groups: payers and providers. The former group of *payers* is represented by the social insurance institutions. While legislation on social insurance matters is a competence of the federal level, the implementation of the system has been delegated to the social insurance institutions. Given the historical development of the Austrian healthcare system, there are several social insurance institutions responsible for insuring citizens and for financing healthcare provision. These institutions are regionally and occupationally fragmented. In the healthcare system there are nine district health insurance funds / sickness funds (*Gebietskrankenkassen*)[10], six occupational health insurance funds (*Betriebskrankenkassen*), one insurance fund

[10] One in each of the Austrian *Länder*.

for employees of the public sector (*Versicherungsanstalt öffentlicher Bediensteter*), one social insurance fund for farmers, one social insurance fund for trade and industry (*Sozialversicherungsanstalt der gewerblichen Wirtschaft*) which covers self-employed persons, and one social insurance fund for railway and mining industries (*Versicherungsanstalt für Eisenbahnen und Bergbau*) (*Bundesministerium für Gesundheit*, June 2010). All of these health insurance and social insurance funds are bodies governed by public law. They have the possibility of issuing their own norms and regulations, mostly in the form of statutes or directives which they can enforce vis-à-vis their insured members. They are thus not bound by directives from public authorities. This independence is only limited by the right of the Federal Ministries of Health and Social Security to supervise the activities of the healthcare and social insurance funds. The Ministries monitor that the funds act lawfully and according to their purpose (Brodil & Windisch-Graetz, 2009, p. 20). The funds are governed by the principle of corporate self-governance, meaning that they are "administered by those groups of individuals who have a direct interest in them. Through self-governance, insured people, recipients of services and those who pay contributions participate directly in social insurance" (Hofmarcher & Rack, 2006, p. 41). This means that employees' and employers' representatives, i.e. the Social Partners, are responsible for the governance of social insurance institutions. Health insurance is based on a mandatory insurance system and citizens are insured with one of the above mentioned health insurance funds depending on their profession or family status (with some professions having the right to opt out of the public insurance system).

The sickness funds, like the other social insurance institutions, are members of the Main Association of Austrian Social Security Institutions (*Hauptverband*), which represents social insurance institutions with regard to their common interests and vis-à-vis institutions from abroad. It also concludes agreements with providers and is involved in the division of funding among social insurance funds, the provision of services such as issuing insurance cards and numbers for the different social insurance institutions. The Board of the Main Association (*Verbandsvorstand*) comprising employees' and employers' representatives is responsible for its management and the Main Association is thus being governed by the Social Partners (Hofmarcher & Rack, 2006, p. 43).

The providers of healthcare, i.e. the medical profession, are represented by the Austrian Physicians' Chamber (*Österreichische Ärztekammer*). The Physicians' Chamber "represents all occupational, social and economic interests of physicians practicing in Austria. [The Chamber] ensures the reputation, the rights and the compliance to the duties of physicians. Its members are nine *Länder* Physicians' Chambers, the Austrian Physicians' Chamber functions as their umbrella association governed by public law"[11] (Österreichische Ärztekammer, 2013). The organization of the Austrian Physicians' Chamber thus corresponds to that of a holding company. Membership is mandatory for every physician practicing in Austria. The tasks delegated to the chamber include the development of standards for medical education, organizing the examinations for doctors to exercise their profession, keeping the

[11] Translated by the author from German into English.

register of physicians, deciding on physicians' codes of ethics, organizing continuing education, deciding on the "health policy" concept of physicians, and representing Austrian physicians at national and international levels (Hofmarcher & Rack, 2006, p. 45; Österreichische Ärztekammer, 2013). Insofar, the Physicians' Chamber also exercises political influence through lobbying activities (Gottweis & Braumandl, 2006, p. 762). Until 2006, the Austrian Physicians' Chamber also represented dentists practicing in Austria. Since January 1st 2006, the Austrian Dentists' Chamber (*Zahnärztekammer*) fulfils the role of representing dentists. The tasks of the Dentists' Chamber are similar to those of the Physicians' Chamber. Other medical providers such as pharmacists and midwives have their own professional associations.

In the ambulatory sector, the main governance role for the above mentioned corporate actors is to negotiate the provision of healthcare. The provision of healthcare is organized between the health insurance funds and provider associations by general agreements. The Main Association of Austrian Social Security Institutions negotiates these general agreements with the regional Physicians' Chambers, to which the respective regional or occupational health insurance fund has to agree. These general agreements also stipulate a location plan which determines the number of doctors who can close contracts within a certain region. The agreements determine the rights and duties of each doctor who concludes contracts with health insurance funds based on the general agreements. The contracts regulate the fees for the services provided to patients by physicians. Health funds as payers and Physicians' Chambers are thus the main regulators of ambulatory care: "The health insurance funds and/or the [Main Association of Austrian Social Security Institutions] have a collective monopoly of demand, while the professional associations have a collective monopoly of supply" (Hofmarcher & Rack, 2006, p. 58).

In comparison to the state, payers and providers, representation on the part of users in the Austrian healthcare system is much less influential in terms of governance. The main representatives of users are the patient ombudsmen (*Patientenanwaltschaften*). In each of the nine Austrian *Länder*, a patient ombudsman is responsible for representing patients in case conflicts that arise mainly between users and providers over the medical treatment patients have received. As users usually lack the necessary medical knowledge to object to the quality of the treatment they have received, the ombudsmen should provide the necessary support. The offices of the patient ombudsmen are usually independent bodies. In some of the Austrian *Länder* the patient ombudsmen are also responsible for representing inhabitants of long-term care facilities. In the event patients have a complaint, they have to address the patient ombudsman responsible for the Austrian *Land* where the provider exercises medical practice. The mediation in cases of conflict should avoid lengthy and potentially unsuccessful legal litigation, even though patients do retain the right to go to court. Patient ombudsmen however cannot represent patients in court. Beyond their role as mediators, the ombudsmen can also give feedback to providers in order to enhance the quality of medical services. The services of the patient ombudsmen are free of charge to users (Öffentliches Gesundheitsportal Österreichs, 2013).

Table 4. Main actor groups in Austrian healthcare governance

	Users	*Payers*	*Providers*	*State actors*
Outpatient care	*Patient Ombudsmen*	*Sickness Funds* (corporate actors)	*Austrian Chamber of Physicians* (corporate actors)	*Parliament* (legislation) *Federal Ministry of Health* (regulation and coordination)
Inpatient care		*Länder* (as payers via health fund, as regulators via holding companies, as a state actor for hospital supervision/regulation at regional level)		

Given the considerable number of actors involved in governance of the Austrian healthcare system, decision-making power is rather dispersed. Even though complexity of healthcare governance is inherent to the Bismarckian type of healthcare system, the separation between inpatient and outpatient care embedded in a federal polity makes the Austrian healthcare system "much more complex and fragmented than in other OECD countries" (Gönenç, Hofmarcher & Wörgötter, 2011, p. 7). This fragmented governance structure thus has important implications for the possibilities of policy change in healthcare.

2.2.2 Inert Structures and Practices: Path-dependent Governance Reforms

With the end of Austro-Keynesianism and the attempt of federal governments to introduce welfare state reforms from the 1990s onwards, the complex governance structure of the healthcare system has also become an object of reform efforts. As in other branches of the Austrian welfare state, reform efforts tend to follow an incremental pattern of policy change (Österle & Heitzmann, 2008, p. 67). On the one hand this is due to the wider institutional context of the healthcare system, but at the same time institutional inertia is reinforced by the complex governance structure of the healthcare system itself. If we consider that the different actors such as the executive, providers and payers tend to show different preferences as regards access, quality and cost efficiency of the healthcare system (see chapter 1), the difficulty of reaching consensus between these actors involved in the healthcare system becomes evident. The reforms since the 1990s that also concerned the healthcare system therefore do not only have to be interpreted against the general development of the welfare state, but their outcomes need also to be interpreted in the light of the institutional dynamics inside the Austrian healthcare system.

The institutional inertia of the governance structure becomes evident in view of the fact that debates about reforming the governance structure of the healthcare system arose as early as the 1920s, when they also concerned the possible fusion of sickness funds in order to streamline health insurance (Österle, 2004, p. 15). Some 70 years later and despite all reform efforts, the separation between a corporatist governance of the outpatient sector and the governance of the inpatient sector by the *Länder* has not changed in principle; even though from 1990s onwards the healthcare system had to face the same expenditure-driven reform pressures. In the light of these reform efforts, especially economists have been pointing to the complexity of the governance structure of the healthcare system, mostly criticising the split between in-

and outpatient care as "dysfunctional" (Theurl, 1999, p. 336). While it could be shown that cost containment measures in National Healthcare Systems such as the British, the Swedish or the Danish systems could be implemented more easily due to greater capacity of executive state intervention in healthcare governance, the capacity of the executive in Bismarckian type healthcare systems is much more limited, as the federal level's capacity in Austria to change healthcare policy is limited by the delegation of governance competencies to the corporate actors and the *Länder* (Ivansits, 2000, p. 353). Given the economic context of welfare state reforms from the 1990s onwards, this complex governance structure lacking executive leadership and its contribution to the rising costs of healthcare has become in itself a focus of reform debates.

Table 5. Healthcare Expenditure 1990-2010 [12]

Healthcare Expenditure	*1990*	*1995*	*2000*	*2005*	*2010*
As % of GDP (public + private)	8.4	9.6	10.0	10.4	11.0
Public expenditure in Million €	7,863	11,762	15,002	18,390	23,014
Public expenditure as % of total expenditure	72.9	73.5	75.6	75.3	75.8

The rising healthcare expenditure can be at least partly attributed to the fragmented structure of the system insofar as "there is limited room for strategic prioritization and priority-setting […]. In this environment, public health spending has grown more rapidly than in most other OECD countries and the share of public health spending in GDP reached one of the highest levels in the OECD" (Gönenç, Hofmarcher & Wörgötter, 2011, p. 5). Ivansits underlines the role of several institutional factors. The first one is the relatively large number of actors in healthcare governance which per se increases difficulty to reach consensus on regulating expenditure on healthcare. Due to the dispersion of power and the different competencies of actors in healthcare governance, none of the actors involved is capable of steering the system beyond each actor's particular interests. Secondly, the embeddedness of these actors in a federal structure adds to problems of policy-coordination as regional interests superpose each actor's interest and competency in healthcare governance. And thirdly, the corporate bargaining between health insurance funds and providers does lead to a situation where providers such as doctors have better possibilities for determining the number (quantity) of medical treatments needed, while the health insurance funds can only try to influence the price per medical treatment, but not the quantity itself. The result is that only ex-post measures can be taken to regulate price-setting for medical treatment and that the health insurance funds have limited capacity of regulation (Ivansits, 2000, pp. 354-355). In case of healthcare reforms that would tackle spending on healthcare, actors will orient their strategies according to a bounded rationality that is provided by the Austrian system of healthcare governance: actors will rather prefer to try to put off potential spending cuts to other sectors or actors of the healthcare system, e.g. corporate actors might insist on reforming inpatient care governed by the *Länder*, and

[12] Data taken from Statistik Austria (Statistik Austria, 2013a).

vice versa. The general dilemma of the governance structure of the Austria healthcare system can be thus summarized as follows: "In this context, the situation occurs that those making the decisions are not always those that have to finance the respective measures at the end of the day" (Fink, 2010, p. 21).

Inpatient Care

Given this institutional healthcare regime, subsequent governments since the mid-1990s onwards have aimed at increasing their capacity of coordinating the central planning healthcare structure more efficiently, thus trying to minimize resistance on the part of the different actors involved. These reforms have, however, led at the same time to a further decentralization of the system, and are thus path-dependent. Each of the reforms introduced by federal governments have not touched significantly upon the competencies of individual actors but have introduced new institutions and instruments mainly with regard to facilitating efficient hospital infrastructure across levels of government – i.e. between the federal and the regional level – and between capacities of inpatient and outpatient care – i.e. including corporate actors that govern the outpatient sector of healthcare. As part of the 1997 reforms, the KRAZAF, the common hospital fund which had been the starting point for a pattern of 'cooperative federalism' in healthcare, was dissolved and was replaced by a structural fund and nine regional funds for each of the *Länder*. At the same time a Structural Commission at federal level and nine regional structural commissions were created. The main tasks of these commissions in which representatives of the federal government, the regional government, municipalities and health insurance funds were coming together was the improvement of hospital planning by developing amongst other tasks an Austrian hospital plan, an ambulatory healthcare plan and administering a sanction mechanism which could have been used if actors did not comply with the developed planning mechanisms (Hofmarcher & Rack, 2001, p. 96). This reform was the starting point for decentralizing outpatient care even further (creation of nine regional funds and commissions), yet aiming at increasing the central planning of infrastructure. In 2005, the subsequent reform by the centre-right government continued on this path of creating new institutional mechanisms to enhance the coordination of planning hospital infrastructure. This reform can be regarded as a "milestone" of further decentralization of the system, enhancing at the same time central coordination [13]. The reform created the Federal Health Agency and its executive body the Federal Health Commission, which are both accompanied by re-founded *Länder* health funds and Health Platforms that are the executive bodies of the health funds. Both, at federal and *Länder* level, the executive bodies of the respective institutions are composed of representatives from the different levels of governance and include the concerned corporate actors such as health insurance funds and representatives from the Physicians' Chamber. Their tasks are summarized in the following table.

[13] Interview 48, Director Health and Care, European Centre for Social Welfare Policy and Research, Vienna, 30 July 2012.

Table 6. Structural reforms in the inpatient sector, 2005 reform [14]

Governance Level	*Body*	*Task (selection)*
Federal	Federal Health Agency	– Framework planning for health services – Further development of performance-oriented reimbursement systems – Guidelines for interface management between ambulatory, hospital and long-term care…
	Federal Health Commission	– Executive Body of the Health Agency – Representatives from social insurance, chambers of physicians
Regional (Länder)	Health Funds/ Health Platforms	– Cooperation and monitoring of quality guidelines – Representation of the framework for public expenditure on inpatient and outpatient care – Cooperation in planning provision of outpatient and inpatient care – Interface management between the different sectors of healthcare

The Federal Health Agency has then replaced the Structural Commission created by the previous reforms of 1997. The federal government also increased its influence insofar as it has the majority of votes in the Federal Health Commission; however, important decisions need to be based on a *consensus* of all actors involved. The Federal Health Commission can also withhold parts of funding, which are transferred to the *Länder* health funds if these do not comply with the decisions of the Federal Health Commission (*ibid*., p. 208). From an institutionalist point-of-view, this creation of new institutions – especially at federal level to increase cooperation – corresponds to a strategy that Streeck and Thelen call *layering*. In order to overcome institutional inertia, a new institution is created, and with every new reform the new institution's competencies are increased while the other institutional competencies are kept at their status quo. Institutional layering thus works by *differential growth* of institutions: the new ones are expanded at the edge of old ones. The long-term aim of the creation of those new institutions is then to slowly break down older institutional arrangements (Streeck & Thelen, 2005b). While from the federal government's position in healthcare governance this strategy seems the only effective option to overcome deficiencies in controlling expenditure of the hospital sector, the creation of the Federal Health Agency is too recent to evaluate whether it will successfully overcome the division of competencies that govern the Austrian healthcare system. This sequence of incremental reforms has, though, the potential for a path-change in the long-run. Yet, institutionalized practices of actors remain stable and should also to be taken into account when looking at the reforms of governance. These practices are considered further below, as other reform efforts also concerned the outpatient sector.

[14] Content taken from Hofmarcher & Rack, 2006, pp. 207-210.

Outpatient Care

While the above described reforms have mainly tackled the governance of inpatient care, the outpatient sector has also been the object of reform attempts in order to improve governance in terms of cost-control. These attempts by federal governments are however more recent than those of the hospital sector which had been at the centre of reforms since the 1970s. During the 1990s, governments in other European countries operating Bismarckian type healthcare systems such as Germany and the Netherlands, but also Switzerland, have introduced reforms that aimed at strengthening the role of health insurance funds as payers of medical treatment by extending their leeway for contracting with selected providers of healthcare and by setting up mechanisms of competition between health insurance funds. These reforms aimed at strengthening the most economically efficient health insurance funds and at reducing the role of "expensive" sickness funds. Given the strong role of the Austrian Social Partners, such reform approaches have been discussed in Austria but have not been implemented, as such a measure would impact on the Social Partners' capacity of self-administration and would thus be met with significant resistance: "Although reduced in intensity and form, the steering of economic processes via the institution of Social Partnership is important. The introduction of competition between the social insurance funds would diminish the role of this form of steering in the health care sector in a short time" (Theurl, 1999, p. 352). In the framework of its "speed kills" reforms, however, the centre-right government led by ÖVP and FPÖ aimed in 2003 at an organizational reform of Social Insurance Institutions. While one part of the reform was the attempt to increase the governments' influence over the executive board of the Main Association of Austrian Social Insurance Institutions, the other part of the reform also aimed at structural reform of the Main Association and of sickness funds. The reform included measures that were to direct patient streams from emergency departments of hospitals towards ambulatory care by introducing a fee for using emergency departments. Other measures aimed at safeguarding the financial liquidity of health insurance funds by modifying transfer payments between those funds with a financial surplus towards those with debts. These reforms were however annulled by the Austrian Constitutional Court. The Court declared that the provisions of the reform were against the principles of self-administration of the Main Association by the Social Partners. The Court estimated that the planned exclusion of representatives of the labour unions from the governing board was an excessive measure and factually unfounded. The Court annulled also the planned fee for emergency department visits as the law had been incorrectly published. Planned raises of insurance contributions were also annulled. One of the main factual reasons for the Court's decision was that the laws were not thoroughly prepared by government (Mosler, 2004, p. 132). From an institutionalist perspective, however, one can add that these failed reform efforts show the limits of what was possible for the centre-right ÖVP-FPÖ government by carrying out their "speed kills" tactics. While they could reduce the influence of the Social Partners in the legislative arena, the contents of the reform transgressed the institutional rules of Austrian politics and welfare governance in general. The government tried not only to avoid the traditional style of Austrian politics, but also aimed at touching upon the principle of welfare governance by corporate actors.

The Constitutional Court functioned then as an institutional veto player, limiting effectively the government's possibilities for reform according to what institutional rules would prescribe, namely to leave the principles of self-administration intact. It thus also did not allow to indirectly avoid the obligation of consensually steering the outpatient sector between the executive and Social Partners. The reform failure was hence not only a result of institutional dynamics inherent to the healthcare system, but due to the government failing to comply even with the more general institutional rules of Austrian welfare governance and consensual politics.

In 2008, the new grand coalition of SPÖ and ÖVP tried again to tackle a governance reform of the outpatient sector. Given the rising debt of sickness funds, the planned reform of 2008 was also to address "structural" aspects of outpatient healthcare governance, focusing especially on financial aspects. The reform plans were however met by "fierce opposition by doctors and their interest groups, some by health insurance funds and the fact that the Government failed to find a common position on the issue" (Fink, 2009, p. 19). Contrary to the previous centre-right government, the renewed grand coalition government included the Social Partners in their reform plans. A draft reform proposal was presented in 2008 that was largely inspired by the proposal made by the Social Partners. The drafted reform legislation aimed mainly at reducing debts of the sickness funds and at controlling expenses for drug prescriptions. It also foresaw a strengthening of the payers' role in ambulatory care by providing that sickness funds would be able to close agreements with individual medical providers in case a collective agreement with the medical profession could not be reached. The sickness funds would thus be able to influence price-setting for ambulatory care more effectively in case of conflicts over the costs of treatment. Besides other measures, the draft reform also included an obligation for physicians to prescribe certain types of drugs instead of drug brands, a measure which would allow increasing the number of prescriptions of cheaper generic drugs rather than more expensive "original" drugs. The debt of sickness funds were to be cleared by a single payment of 450 million € in the form of tax-financed subsidies from the federal budget, and sickness funds were to receive a refund of value-added-tax each year. More importantly from an institutional point of view was the plan to create a "holding" as a new body of the Main Association of Social Security Organisations. This holding would be subject to the principle of self-administration by the Social Partners but should at the same time centralize decision-making (*ibid*., p. 15).

Given the power shift in favour of the sickness funds with regard to their contracting power and planned centralization, the reform was met with significant resistance from medical providers, i.e. the Chambers of Physicians. Two months after the draft reform had been presented to Parliament, physicians organized strikes, criticizing the attempt to limit their professional autonomy in prescribing drugs. Yet, not only providers were opposed to the reform; also the payers side, namely individual sickness funds, opposed the organizational aspects of the planned reform. Regional sickness funds feared an increased control as well as a loss of independence as a consequence of the new holding. Given the opposition by both payers and providers, the governing parties could not agree on the final measures of the reform when the draft legislation was discussed in Parliament in summer of 2008. Shortly after discussions started, the

coalition was ended by the ÖVP and new elections were called for early autumn 2008. With the end of the coalition the reform also failed (*ibid*.).

After the elections of 2008, the grand coalition was renewed and the federal government decided to introduce a "rescue package" aiming at debt relief and securing the financial liquidity of sickness funds. The organizational measures that were foreseen in the failed reform package were however dropped. The new reform created a Structural Fund for Health Insurance that should manage cash subsidies to sickness funds from the federal budget. Furthermore, a law was passed that would gradually write off the debt that sickness funds had accumulated previously. Between 2010 and 2012, 150 million € of debt was written off by the federal government, and 100 million € per year was transferred to the sickness funds as subsidies. While in 2011 the government had reduced annual subsidies to 40 million €, the measure has been planned to continue till 2014. In return for the financial subsidies, the Main Association of Austrian Social Insurance Institutions had to develop a plan to contain costs in the outpatient sector. The savings plan was negotiated with providers' representatives. It foresaw savings of 1.7 billion € in costs between 2010 and 2013 (Gönenç, Hofmarcher & Wörgötter, 2011, p. 16).

The failed reform efforts in respect of the governance of outpatient care by the grand coalition government highlight the institutional inertia of health system governance. Even though the government cooperated with the Social Partners, both payers (individual sickness funds) and providers (Chamber of Physicians) opposed the centralization of decision-making and the intervention in professional practices of prescribing drugs. Given this opposition by two main actor groups in outpatient care, the governing parties refrained from structural reforms, and instead continued with path dependent supply side reforms by obliging corporate actors to negotiate savings and, secondly, by providing additional subsidies to the budget of sickness funds. This result of the 2009 reform of the outpatient sector is even more noticeable as the reform did not take into account the inpatient sector which had already been criticized by the opposition and health experts. Yet, even reducing the scope of reform by avoiding the inpatient sector and thus reducing the number of actors involved did not allow for any "structural reform". The renewed grand coalition has thus been keen to avoid any further conflict (Fink, 2010, p. 18).

The path dependent character of reforms can be explained to a large extent by the historical development of the Austrian welfare state in general and by the considerable numbers of influential actors, be it the Social Partners or provider associations, or the governments of the Austrian *Länder*. The opposition to change that could mean a limitation of the role of any of the involved actors through a centralization of competencies is however not only due to the historically grown decentralized character of the system, but rather it is exacerbated by the separation of inpatient and outpatient care. The failed reform attempts of the centre-right government that tried to circumvent the Social Partners are an example for the limits of executive control over the reform agenda when negotiations with the Social Partners are still an important part of Austrian policy-making, despite the latter's weakened position since the 1990s. Therefore institutionalized practices of negotiations in healthcare governance need to be taken into account when looking at Austrian healthcare governance.

Institutionalized Practices of Healthcare Governance

The historically grown institutional regime of the Austrian welfare state and the institutional context of the system of healthcare governance set incentives for actors to exert their respective roles in the system either as the state executive, as payers, providers, or as users. As theorized in chapter 1, actors develop a practical knowledge about their roles; they develop routines and practices, i.e. the things actors do in governing the healthcare system: "[i]f we observe practices carefully enough, we see patterns emerging that tell us a great deal more than official documents, organizational rules, or self-justifications" (Mérand, 2011, p. 182). The main argument, based on interviews with senior health researchers and journalists, is that key practices found in Austrian healthcare governance can be explained on the one hand against the background of the historical development of the welfare state as developed in section 2.1, but that these practices on the other hand also explain why the federal level as main regulator of the healthcare system cannot simply enact changes in healthcare governance, as illustrated by the failed reform efforts presented in this chapter. This argument, though, does not defend an overly deterministic view of Austrian welfare institutions on the possibilities of changing healthcare governance. The reforms of inpatient care in which the federal level has strengthened its role as coordinator of healthcare governance without changing the institutional responsibilities of actors illustrate "[…] the fact that rules are not just designed but also have to be applied and enforced, often by actors other than the designers, opens up space […] for change to occur in a rule's implementation or enactment" (Mahoney & Thelen, 2010, p. 12). The following paragraphs will therefore take a closer look at several institutionalized key practices that form a pattern of interaction in Austrian healthcare governance.

The first key pattern that actors follow in Austrian healthcare governance is the consensual style of negotiations, e.g. between the government and corporate actors, between corporate actors, or between the regional governments and the federal level. Practices thus follow the consensual institutional regime that determines Austrian policy-making in general. The consensual pattern that actors follow includes the tendency of trying to avoid conflicts over the historically grown complex governance structure. This can be explained to some extent against the background of consensual politics as an answer to the political "trench warfare" of the First Republic:

> "In Vienna we would say that everybody has a bit of displeasure [Austrian German: "*Grant*"] with the healthcare system; it creates costs, it is a strain and nobody looks through [the complex system] and everything is so complicated. So they [the actors] prefer to leave everything as it is. […] Every conflict in health politics is one that throws [actors] back into that camp mentality [of the First Republic]. […] We have institutions that succeeded in overcoming distrust. But when [conflicts] get hot, they really get hot. It immediately ends up in camp mentality, even concerning sickness funds or social insurance. [Actors] assume immediately that either reactionary or neoliberal forces try to take over and vice versa" [15].

The institutionalised practice of consensual decision-making is however not only determined by the collective commemoration of the conflictual past, but also

[15] Interview 48, *loc. cit*.

by the continuing importance of political parties that cut across different levels of government. While the parties founded the First and the Second Republic, the Austrian constitution did not take their role fully into account until 1975 when the Parties Act (*Parteiengesetz*) enshrined the principle of party-democracy in the constitution. The importance of party politics that bind executive actors for example across levels of governance is part of what Austrian Political Science calls the "*Realverfassung*" (literally "real constitution") (Ucakar & Gschiegl, 2012, p. 146). This is also the case for health politics:

> "Austrian politics has this specification that nobody really wants to hurt anyone else. Especially the [federal] government needs the powerful *Länder* [party] representatives when it comes to elections. And you somehow would like to satisfy those [*Länder* representatives]. That's a specification of Austrian politics in general. And this is also the case for health politics. And then […] there is the Federal Minister [of Health] who has a very difficult role, who can only coordinate and try to motivate [actors] to find a compromise" [16].

It is thus not only the institutional divide between inpatient and outpatient care in Austrian healthcare governance that favours path-dependent reforms. While the institutional divide as such sets incentives for actors in one of the two parts of the healthcare system to try to shove reform measures onto the other part and vice versa, not only preferences of the actors inside of the healthcare system have to be taken into account. In fact, having to rely on regional party preferences – and the Austrian *Länder* are the most significant actors in regulating inpatient care – also increases the numbers of preferences that need to be accommodated in consensual negotiations over healthcare reforms. This in turn increases complexity and favours incrementalism, and it highlights the limited power of the federal level of the executive which might be able to initiate a reform agenda, but at the same time must merely act as a coordinator when it comes to drafting and implementing reforms. The practice of trying to accommodate a significant number of actors' preferences and interests in a consensual style of governance and politics also means that the Social Partners' preferences, despite the reduced significance of their former leading role in welfare politics, are taken into account by the federal government: "I am a hundred per cent sure that it wouldn't be politically realistic [for the federal government to unilaterally impose a reform against the Social Partners]. The Social Partners are sitting in the Social Insurance Institutions which traditionally play a really important role in Austria. And to alienate them would be the end of a Federal Minister. That would possibly be even the end of a federal government" [17].

Not only is the inclusion of a large number of actors in decision-making in and on healthcare governance institutionalised, but also the *form* of reaching consensus despite possible disputes is institutionalised: in case of conflict, actors try to resolve them by negotiating informally. An example would be the negotiations between the Chamber of Physicians and the social insurance fund for trade and industry

[16] Interview 40, journalist (healthcare, federalism), *Der Standard* newspaper, Vienna, 17 January 2012.

[17] *Ibid*.

(*Sozialversicherungsanstalt der gewerblichen Wirtschaft*) over remunerations for physicians in 2010. When it became apparent that an agreement over tariffs for treatment was difficult to reach and the current contract was running out (thus risking a situation in which insured patients would have to pay for treatment themselves), the involved actors settled the conflict informally:

> "They solved it [the dispute] by the both Directors of the Chamber of Economy and the one of the social insurance fund meeting with the head of the Chamber of Physicians in a wine tavern [Austrian German: "*Heuriger*"] where they spoke out [on the tariffs]. [They did it] according to Austrian custom" [18].

This informal way of settling disputes and reaching consensus in negotiations offers an additional explanation for the limited scope of reforms, as the actors involved in these negotiations do not only try to respect the other's preferences, but each actor aims also at saving face in negotiations – which is guaranteed by an informal and confidential setting of settling disputes. The advantage for actors consists of finding a compromise that might be satisfactory for all involved parties: "That is generally a feature of health politics in Austria, everything [every decision] takes an awfully long time, but once it is implemented, it is supported by everyone" [19]. A disadvantage of confidential and informal practices of reaching compromise consists of conveying an impression of opacity to the public [20]. The requirement of informality and confidentiality can, however, also be used by actors to *avoid* a consensual solution of conflicts, to prevent reform efforts, or to disavow other actors' positions. An example would be the publication by the Main Association of Austrian Social Insurance Institutions: in 2010, the Main Association published a "Master Plan for Health" (*Masterplan Gesundheit*) in which it presented "strategic options for action for the advancement of the Austrian healthcare system as seen by the Social Insurance" (Hauptverband der österreichischen Sozialversicherung, 2010). The paper more generally called for a strengthening of central planning capacities and for more competencies at the federal level of governance and Social Partnership. However, the paper was however published without informing the Federal Minister of Health, Alois Stöger, about its content:

> "In 2010 […], the Main Association published its Master Plan for Health after the debt relief for sickness funds had been implemented […]. And Stöger [the Federal Minister] hated that when the paper was published, because they did not directly but indirectly criticize federal policies. […] The document had some good qualities and was also well-thought-out. They [the Main Association] would have had to negotiate it [with the Ministry] instead of publishing it. That was an act against Stöger. And then it starts: they [the Federal Ministry] fended it off, fended it off, and fended it off" [21].

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[18] Interview 19, Senior Researcher (Public Health and Health Economics), Institute for Advanced Studies, Vienna, 2 December 2010.

[19] Interview 48, *loc. cit*.

[20] Interview 21, Independent healthcare expert, healthcare columnist, Vienna, 17 January 2011.

[21] Interview 48, *loc. cit*.

In fact, the federal Minister for Health had announced his own reform plan for hospital financing two weeks before the publication of the Main Association's "Master Plan". Following the Federal Minister and the Main Association, the Austrian *Länder* themselves then published a "crude plan for reform". The result was a "struggle about a hegemony in healthcare reform on various fronts", resulting in an agreement between all actors to postpone reform efforts (Trukeschitz, Schneider & Czypionka, 2013, p. 183).

The examples illustrate that no actor alone in the healthcare system is capable of pushing far reaching reform efforts in a direction according to their own interest. While disputes may appear among actors, consensual decision-making even beyond the boundaries of the healthcare system is necessary to decide and more importantly implement any reforms of healthcare governance. Change in healthcare governance is therefore incremental, and the practices of actors rather support the status quo of the institutional regime than deviate from it. As incremental as it may be, change occurs nonetheless, as the increasing role of planning capacities for the federal level in inpatient care show. Beyond the governance of healthcare, its financing structure has been the object of reform efforts as well. The next section will therefore address the financing of healthcare in Austria.

2.3 The Financing Structure of Austrian Healthcare

2.3.1 Financial Flows and Actors' Interests in the Healthcare System

The system of financing healthcare mirrors the fragmented governance structure. By scrutinizing the financial resources allocated to and by actors, we can also induce the institutionally defined interests that an actor has in healthcare governance and decision-making. Moreover, the structure of financing healthcare highlights the possible scope of reforming healthcare governance, as financial flows represent and determine an actor's resources and thus their financial room for manoeuvre in healthcare governance. However, the system of financial resource allocation in Austria (and hence not only in healthcare) shows a significant path-dependence, as it is in many parts a "heritage of the centralist Habsburg Monarchy" (Thöni, 2010, p. 103) and a heritage of the compromise on the constitutional order carried over from the First Austrian Republic (see section 2.1). Consequently, governance reforms find an additional path-dependent counterweight in the existing system of financial resource allocation. The system of financing healthcare in Austria must furthermore also be interpreted against the general background of financial resource allocation for the welfare state and between different levels of governance in the Austrian polity.

The overall expenditure on healthcare in 2010 was around 31.4 billion €, out of which ca. 77% was public expenditure (Hofmarcher, 2013, p. 85). Main payers for healthcare were the social insurance institutions and sickness funds, covering 44% of medical costs. A further 33% was general government expenditure funded mainly through taxes. The remaining percentages comprise costs that are covered by patients' private payments and co-payments, as well as by private insurances funds. Furthermore, healthcare financing follows the organizational split between outpatient and inpatient care in healthcare governance, but also mirrors the intertwining of different actors' responsibilities: hospital treatment / inpatient care is mainly funded

by tax money from the federal and *Länder* governments, involving municipalities as well. Outpatient care and pharmaceutical costs are paid by sickness funds, which however also intervene in paying hospital costs (Gönenç, Hofmarcher & Wörgötter, 2011, pp. 9-10).

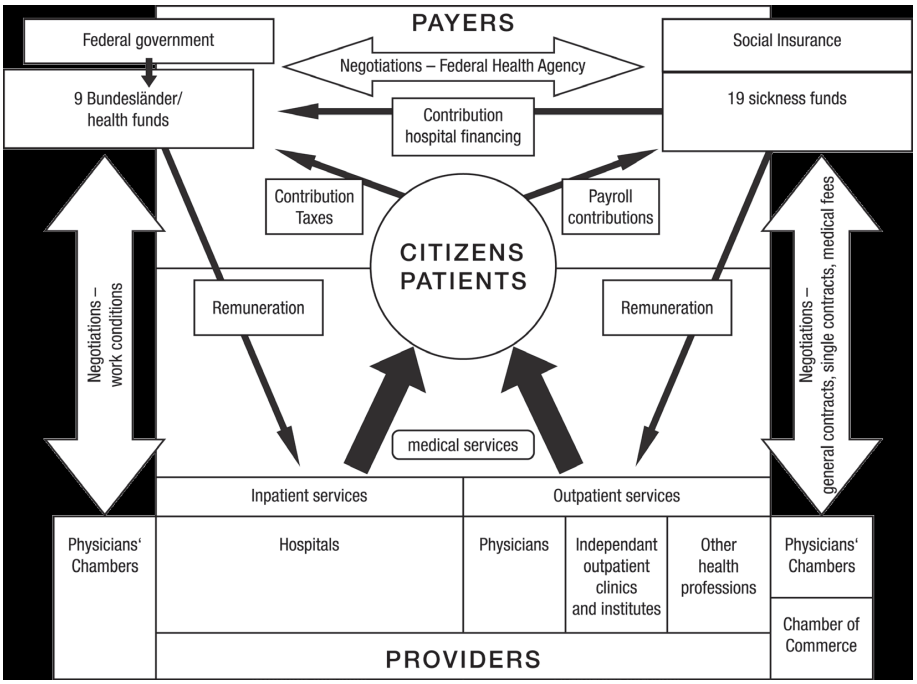

Figure 2. Financing structure of the Austrian healthcare system [22]

Figure 2 illustrates the different governance tasks of different actors (see previous section on governance) and adds the financial flows between patients, payers and providers. Contributions are either collected through payroll contributions or taxes by citizens. While the *Länder* are mainly financing hospital care through their health funds, sickness funds mainly finance outpatient care, but also participate in the financing of hospital care. The federal level of government coordinates negotiations but also allocates negotiated resources through the Federal Health Agency. Providers then offer medical treatment to insured patients. While figure 2 already illustrates the fragmentation of healthcare financing at an aggregated, national level, the financial flows of healthcare become even more complex when considering the interplay between the national, the regional and local level, i.e. where the delivery of healthcare takes place. The system then unfolds into a web of financial flows between the different levels of governance (federal, regional, local), the different payers (regional, municipal and social insurance), and finally the providers. Moreover, these financial flows differ from one Austrian *Land* to another due to the decentralization of inpatient

[22] Figure translated and modified by the author, *source* : Gesundheit Österreich GmbH.

healthcare as described before [23]. Similar to the governance structure, the fragmented system of financing healthcare has become an object of reform efforts and criticism, mainly by health economists and the OECD: "In this setting, no party [i.e. healthcare actor] plays the role of a 'principal', to strategically steer the system. An illusion is also created, notably among local policymakers and populations, that health services are free and the health sector can ultimately operate outside economic constraints" (Gönenç, Hofmarcher & Wörgötter, 2011, p. 9). As a consequence, not only the usual factors that contribute to healthcare inflation, such as population ageing and technological advancement in healthcare, are identified as responsible for the rising costs of healthcare, but it is the system of financing in itself which is seen as in need of reform to increase the efficiency of public spending of healthcare. While split between financing outpatient care mainly through payroll-contributions and inpatient care mainly through tax subsidies (despite the contribution of sickness funds) can be explained through the historically institutionalized competencies of the regional level for inpatient care (see section 2.1), the split between different financing flows for outpatient and inpatient care is unusual for Bismarckian healthcare system. The side-effects of the split financing structure are similar to those in healthcare governance: the different flows of finance set incentives for actors of one sector of the healthcare system to shove financial burdens onto the other, and vice versa. Depending on a patient's condition, i.e. whether treating a certain category of patients generates revenues or comes with additional costs, the payers of outpatient care might want to "shift" patients to the inpatient sector, and vice versa. These incentives have been called a "dishonourable game which is sometimes played, in which one [sector of the healthcare system] constantly accuses the other to push patients towards them or, as the case may be, to take them away" [24] (Moritz, 2004, p. 40). The different reforms have therefore tackled the aspect of spending on medical treatment, and reform debates revolve around the creation of a single source of financing for healthcare.

Reforms of Remuneration and Spending

Given the split of governing and financing healthcare, governance and financing reforms have usually tackled each sector separately. As far as financial aspects are concerned, the governance reforms of the outpatient sector, and especially those since the early 2000s as described before, also aimed at consolidating the finances of sickness funds. The creation of a structural fund for health insurances has increased the federal government's influence over the finances of sickness funds. The 2009 rescue package had allocated an annual additional subsidy of 100 million € to sickness funds coupled with an obligation for sickness funds to annually reduce their debts by 150 million €. In case the sickness funds would not reach the promised savings, the federal government would be able to withhold the tax-funded subsidies through the structural fund. In 2011, sickness funds had even over-achieved their saving goals, mainly by insisting on the prescription of generic medicaments which are sold at lower prices (Hofmarcher, 2013, p. 247). The federal level has thus increased its

[23] For an elaborate chart of financial flows see Czypionka *et al.*, 2008, p. 16.

[24] Citation translated into English by the author.

influence in healthcare by using financial incentives, yet without changing the general principle of corporatist self-administration, nor by reforming the structure of financing outpatient care as such. Yet, the main focus of reform debates has concentrated on inpatient care and on the financing of hospital infrastructure. This is mainly due to the fact that costs for hospital infrastructure and treatment have been rising more quickly than the contribution of sickness funds to the financing of hospitals (Pöttler, 2012, p. 189). The slower increase of sickness funds' contribution to hospital financing means, though, that the financial pressure on the federal and *Länder* governments is increasing accordingly, as the main part of hospital financing is generated through tax revenue. Debates about reforming the financing of inpatient care date back to the 1990s period of welfare reforms (see section 2.1.4.). In 1995, Mazal stated in his legal and economic study of hospital financing in Austria: "It is a commonplace if one calls the financing of hospitals one of the most serious economic problem areas"[25] (Mazal, 1995, p. III).

The first reforms of hospital financing did not concern streams of financial allocation, but rather the remuneration of inpatient care. With the introduction of the Hospital Cooperation Fund (KRAZAF, see section 2.1.3), the federal government already tried to increase financial efficiency by negotiating with the *Länder* special subsidies according to performance criteria concerning the education of doctors, complicated medical interventions, or patients moving from one *Land* to the other for hospital treatment. During subsequent decades the renewed agreements based on Article 15a of the Austrian constitution between the federal government and the *Länder* introduced further accounting measures that were aimed at increasing the efficiency of financial allocations for hospitals (Embacher & Gaugg, 1995, pp. 3-4) and which prepared a change of remuneration for hospital treatment. Until 1996, the remuneration for hospital treatment was based on lump-sums paid for each day a patient was treated in hospital, regardless of the kind of medical treatment necessary. Sickness funds paid a fixed contribution while remaining costs were covered by tax-funded subsidies. This kind of remuneration can however set incentives for providers of the inpatient sector to keep patients in hospitals as long as possible in order to maximize their revenues. After nearly a decade of transition, a new remuneration scheme was introduced which was based on the American DRG-System (Diagnosis Related Groups). The principle of this system is to create statistical groups of medical conditions that require a comparable effort and quality of medical treatment and hence require similar remuneration. Financing of hospital care thus switched from a time-oriented form towards a performance related financing (Pöttler, 2012, pp. 210-211). The Austrian system is a modified DRG system called the LKF system (*Leistungsorientierte Krankenanstaltenfinanzierung*, performance-oriented hospital financing). The LKF system[26] is based on a global budget which is allocated to the *Länders'* health funds. Hospitals then receive an annual budget and each medical treatment receives "points". By the end of an accounting period the global budget is divided by the points that regional hospitals have been achieving. The fixed budget is

[25] Citation translated into English by the author.

[26] For the technical aspects of the LKF-system see Hagenbichler, 2010 (in German).

then divided by the points that hospitals have accumulated (prospective budgeting). This system thus sets incentives for controlling better expenditure in hospitals, as it introduces a competitive logic of hospital tariffs. The LKF system provides a core area with rules that have to be applied nationally when attributing points to a group of medical treatments. The core area is supplemented by a modifiable area of LKF points which should allow the different Austrian *Länder* to set own priorities for certain organizations (i.e. specialized centres), equipment or staffing of medical treatment (Gönenç, Hofmarcher & Wörgötter, 2011, p. 29; Hofmarcher, 2013, p. 141; Pöttler, 2012, pp. 212-213).

The introduction of the LKF payment system has insofar achieved its goals, as the average stay of patients in hospitals has drastically declined: the economic efficiency of treatment has thus increased, lowering the financial pressure regional and federal payers. The consequence of the LKF system is, however, that it has set incentives for hospitals to try to safeguard the annually allocated budget, and they have thus been trying to increase the point values they can generate. Consequently, while the length of stay has decreased, the number of patients admitted to hospitals has increased significantly [27]. Another consequence is that the modifiable area of LKF points contributes to the decentralization effects already described in the section on governance reforms. The costs for hospital treatment have not necessarily converged nationally, but the development of costs varies according to each *Land* in Austria. And significant differences have arisen among the *Länder* concerning the allocation of annual budgets, e.g. some regions putting more emphasis on ambulatory treatment, others more on specialized treatment. Remuneration models for medical staff vary accordingly. One of the main objections to this financing model is that it sets incentives for regional actors to develop nine different healthcare systems (mainly regarding the inpatient sector), and hence that more competencies for governing the healthcare system at federal level are needed (Hofmarcher, 2013, p. 141; Pöttler, 2012, p. 221; Moritz, 2004, p. 43). While the system of remuneration for inpatient care has been aligned with trends of OECD countries by adopting a system based on DRGs, the development of hospital remuneration follows the institutionalized pattern of hospital governance: the reform created a path-shift concerning the form of remuneration, but the application of the system follows the fragmented governance structure and mirrors the institutionalized regional competencies in inpatient care, which foils to some extent the federal level's interest in increasing coordination and capacities of steering the healthcare system. One of the main debates that have been revolving around healthcare reforms in Austria in the last years has therefore been to change the structure of financing flows itself and to overcome the separation between inpatient and outpatient care by creating a single source of financing for healthcare ("*Finanzierung aus einer Hand*") (Czypionka *et al.*, 2008; Czypionka *et al.*, 2009b). Such a major path-shift of financial institutions would however also entail a significant change in governance responsibilities and competencies of healthcare actors. The *Länder* governments have therefore opposed the idea of a single source

[27] For a further discussion on the effects of the LKF system see Theurl & Winner, 2007 and Stepan & Sommersguter-Reichmann, 1999.

for financing of healthcare "as for them policy regarding hospitals appears to be an important instrument of 'credit claiming' in day-to-day politics" (Fink, 2010, p. 19). The negative reaction of the *Länder* governments thus highlights the importance of hospital infrastructure for regional governments and parties (cf. practices in healthcare governance in the previous section) in order to win in regional elections. This debate invites us further to scrutinize the interplay between the federal executive and regional executives inside the healthcare system, taking into account Austrian fiscal federalism more generally and the system of 15a agreements that are used to negotiate financial allocations for inpatient care.

2.3.2 The Financial Interplay between the National and the Regional Level in Inpatient Care

As the reform debates about creating a single source for financing healthcare services reveal, hospital infrastructure is one of the key issues for credit-claiming of Austrian regional governments. The financing of these hospitals and the control over financial allocations are therefore tightly linked to the exertion of political power (Mazal, 1995, p. III). The introduction of the Hospital Cooperation Fund (KRAZAF) in 1978 was the beginning of an institutionalised pattern of "cooperative federalism" – and thus intertwined power relations – between the federal government and *Länder* executives in healthcare. From 1978 onwards, using the Article 15a of the Austrian constitution, the federal government would negotiate agreements with the *Länder* and their share in allocating financial resource for inpatient care, supplementing the existing system of vertical fiscal equalization between the federal and regional level (see section 2.1.3). While negotiations on healthcare take place on a dedicated 15a agreement for healthcare, debates on financial equalization and the respective financial interests between the federal government and *Länder* executives have spilled over into health politics. They thus influence also the strategies and practices of financial negotiations on regional hospital financing: negotiations on financial equalization and negotiations on 15a agreements for hospital financing are carried out independently from each other, but are nonetheless factually interwoven [28].

The Austrian System of Financial Equalization

Austrian fiscal relations show a high degree of centrality, as the federal government receives the major part of tax income. A system of financial equalization is then used to allocate these financial resources between the federal level, the *Länder* and the municipalities. As described in section 2.1.3 the Financial Constitutional Law (*Finanzverfassungsgesetz*) attributes a key role to the Federal Minister of Finances who has an obligation to negotiate financial allocations with the *Länder* and municipalities, taking into account their financial performance. However, this vague obligation leaves a large room for manoeuvre for the federal government when initiating negotiations. During the last decades a system of mixed financing of structural policies (mainly roads and other public infrastructure) has been forming, intertwining federal and

[28] Interview 48, *loc. cit*.

regional interests (Fallend, 2006, p. 1030)[29]. The financial equalization is negotiated every six years and is published in the Austrian Federal Law Gazette in form of Financial Equalization Law (*Finanzausgleichsgesetz*). While the law as such is only voted on by the National Council (*Nationalrat*) without participation of the Federal Council (*Bundesrat*) that represents the *Länder*, the content of the law is based on a consensually negotiated agreement between the federal government and *Länder* governments. This practice has been followed since the beginning of the Second Austrian Republic. Even though the negotiated agreement as such is not legally binding, the Austrian Constitutional Court has institutionalized these agreements in several rulings. The necessity of consensus results furthermore from the legal provisions of the Financial Constitutional Law: the *Länder* and municipalities have to consensually negotiate with the federal government, as it would otherwise be capable of drafting a financial equalization law by itself without the consent of the *Länder* (Bußjäger, 2006b, pp. 18-19).

As result of the periodicity of negotiations on fiscal equalization, complex legal provisions have been developing around the financial relations between the federal and the regional level. These are less based on economic considerations than rather mirroring a path-dependent development. While the structure of financial equalization as such has not changed since the beginning of the Second Republic, the system has grown beyond the simple distribution of tax income. The instrument of 15a agreements used in the healthcare sector to negotiate the financial allocations for hospitals operated by the *Länder* is also used for other policies, and is thus part of a system of "secondary financial equalization". When the general agreement for financial equalization is then negotiated, it is usually based on a *package deal* which takes also into account the 15a agreements that distribute financial allocations for hospital infrastructure as well as different policy areas such as administrative reforms, public housing and subsidies for regional education. The result is that the Austrian system of financial equalization is marked by manifold interdependencies between the federal government and the *Länder* governments (Bröthaler, 2008, pp. 171-174).

A consequence of the intertwining of financial responsibilities and interests is that different instruments used for Austrian financial equalization have become barely identifiable anymore (Thöni, 2010, p. 113), and debates about reforming the financial relations between levels of governance have been marking Austrian politics. One of the main demands of the *Länder* in these debates is to decentralize finances and transfer competencies that would allow them to collect their own taxes (Bußjäger, 2006a). Until now the *Länder* can only cover 2% of their expenses with tax income that they have collected themselves; 98% of their expenses are covered by profit shares from federal taxes and transfers via the system of financial equalization. Advocates of a decentralization of financial competencies argue that the current system leads to a situation in which the *Länder* finance structural policies such as hospital infrastructure

[29] For a comprehensive historical account of the development of fiscal relations between the federal and the regional level see also Dirninger, 2003 (in German). For an analysis of centre-periphery fiscal relations in Germany, Austria and Switzerland see Braun, 2011 (in English).

without however being responsible for the collection of these taxes. The main argument for decentralization would be therefore that spending efficiency could be increased if the *Länder* themselves were also responsible for collecting taxes instead of receiving allocations from the federal level. Decentralization would furthermore mean a decrease of the number of complicated mechanisms for allocating money and would hence reduce the existing "chaos of [financial] transfers" (Schratzenstaller, 2007, pp. 37, 46).

Consequences for Inpatient Care and Practices of Negotiating 15a Agreements

The complex system of financial equalization and the reform debates about decentralization impact on the system of hospital financing based on 15a agreements. As the subsidies paid by the sickness funds for hospital treatment do not cover all incurred costs, the *Länder* have to pay operating deficits for each of their hospitals (*Betriebsabgang*) through their health funds. The rather centralized financing structure combined with a decentralized system of health governance leads however to a situation in which the double role of Austrian *Länder* as payers and providers of inpatient care results in some side-effects: while the federal level allocates the money, the *Länder* decide mainly *how* they spend the allocated money on the provision of hospital healthcare and have thus only few financial incentives to financially optimize healthcare provision (Gönenç, Hofmarcher & Wörgötter, 2011, p. 7). This evaluation of the OECD thus concurs with the arguments of those demanding more responsibility for the *Länder* to generate their own tax income. Scrutinizing the system of financing inpatient care in Austria thus reveals another institutional element which creates obstacles to changing the status quo of healthcare policies: while the federal level can allocate financial subsidies – however limited in its room for manoeuvre by the obligation to consensually negotiate these allocations – it has very limited competencies concerning how these allocations are spent on hospital infrastructure. This explains also the federal government's ambition in its governance reforms to improve the planning of hospital infrastructure. From the perspective of the Austrian *Länder*, however, one of their key competencies – even though it is a shared competency according to Article 12 of the Austrian constitution – depends on financial allocations from the federal level which run counter to the importance of hospital infrastructure for regional governments as an element of credit claiming for successful regional policies. The more centralized system of financing combined with the decentralized system of inpatient care therefore reinforce the necessity for consensus between both levels of government concerning reforms of the hospital sector and hence institutionally favour incrementalism, if not a reinforcement of the status quo. Given the link between the system of allocating subsidies for hospitals through 15a agreements and the system of financial equalization based on package deals concerning funding of different policies, reform efforts to change hospital financing can consequently easily turn into a more general debate about financial centre-periphery relations in Austria.

A path-shift in the financing structure would, as has been described in the proposals for a single source of financing of healthcare, come at a cost as it would put

into question actors' practices which have developed around the negotiation of the 15a agreements. The agreements are usually negotiated every five years by representatives of the respective levels of government and the Social Insurance, showing a dominance of the executive in federal relations. The *Länder* prepare their demands and positions in a series of conferences which are informal; in so far as they are not foreseen by the Austrian constitution. The most important conference is the Conference of Governors (*Landeshauptleutekonferenz*). Each Governor of the nine *Länder* and high-ranking regional officials participate in these Conferences. Representatives of the federal government can also participate as observers, yet without being able to take part in the negotiations amongst the regional representatives. The *Länder* use the Conferences to develop a common position vis-à-vis the federal government e.g. in the negotiations of the 15a agreements based on the principle of unanimity. As result of the principle of unanimity, the *Länders'* common position is based a consensus-oriented bargaining in order to accommodate all regional interests (Fallend, 2003, pp. 49-51). The common positions developed by the Governors' Conferences are then used to negotiate the financial allocations that will be part of the 15a agreement. Negotiations usually take several months, involving also public position taking by all involved actors several months ahead of the start of the official negotiations. Furthermore informal contacts and negotiations usually take place before the start of the official negotiations for the next 15a agreement (Karlhofer, 2010, p. 132).

The 15a agreements for the financing of healthcare are negotiated every five years and usually contain detailed and complex regulations and the partial amounts that are dedicated for financing purposes show a path-dependent character. Given the importance of the financial allocations, negotiations usually take several months and come to a conclusion after several negotiation rounds, even during the night time, two days before Christmas, just in time to present a new agreement before the old one expires. The 15a agreements are complex insofar as they are not only used to determine the financial allocations but also serve as a contractual basis for healthcare reforms. For example, the introduction of the DRG based system of financing or the reform measures of healthcare governance of 2005 have been included[30] [31]. Consequently, 15a agreements are more subject to political bargaining and political considerations of competencies and influence in healthcare governance than only to the financial needs of the hospital sector. Moreover, the general fiscal equalization is taken into account: "I would say this is something typically Austrian […]. I take some [money] from you and in return I give you some [in another policy area]. This is extremely delicate, extremely difficult, because these [processes of bargaining] take place in all possible [policy] areas"[32]. As negotiations take place on a formal and informal consensual basis, the results of the negotiations and financial allocations are not always easily comprehensible: "When you read these financial agreements, which you can download, you will not understand them the first time. If you read them a second,

[30] Interview 11, former Federal Minister of Health, ÖVP Party Headquarter, Vienna, 8 July 2010.

[31] Interview 48, *loc. cit*.

[32] Interview 40, *loc. cit*.

third or fourth time, you might get a clue […]. There are sometimes fixed allocations, percentages of the turnover tax, then there are percentages of other tax income. It is all confusing" [33]. As in reforms of healthcare governance, party politics also play a role and might overlap with regional interests in financing hospital infrastructure when it comes to financial negotiations. Thus the effective number of interests which have to be accommodated in negotiating the finances of inpatient care surpass the limits of the healthcare system [34].

As a result of the different actors' interests, the financial allocations have been locked-in over the past decades, are path-dependent in their nature, and hence difficult to change. It is thus not only the evolution of the structure of healthcare financing itself which is prone towards incrementalism, but also the actual amounts to be distributed are difficult to change. Hence, in case of reforms, actors involved in the negotiations rather prefer to add new financial allocations to the existing ones. The costs incurred from inner-Austrian patient mobility, i.e. patients from one region using hospitals of another, but also taking into account foreign patients in regions with a large number tourists, can be used as an illustration:

> "They try to consider flows of guest patients [from other regions or countries in the 15a agreements], but not in an objectivized procedure. Meanwhile we have five different financing keys. These are the different parts that come from the federal government, from the Social Insurance, from the *Länder*, from shares of the turnover tax, [and] from the municipalities. These are not all pooled together, but parts are taken out [for negotiations]. […] And then there are the so-called predetermined payments, this means that before allocations are distributed […] some regions already receive fixed payments, before other regions are even considered according to financing keys. That means that guest patients are not considered systematically […]. In the antepenultimate 15a agreement, predetermined payments were decided [for compensating regions with guest patients] which were more or less substantiated. And of course, you cannot reverse these payments in the next agreement. [The allocations] are never adjusted, instead a new one and yet another one are added. Nor are the financing keys changed […]. Rather they invent yet other financing keys, which means with new [financial] means money is redistributed [in the next 15a agreement]. The result is thus not based anymore on objective criteria, but geared towards bargaining outcomes" [35].

As financial negotiations – similar to those in other areas of healthcare governance – are confidential, some allocations that are negotiated for 15a agreements are no longer retraceable. The last 15a agreement which was valid from 2008 to 2013 stipulated that the federal government would agree to additional transfers of 100 million € that would be allocated for hospitals "just like that", the confidential political bargain behind this payment staying unclear for healthcare analysts [36] [37].

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[33] Interview 21, *loc. cit.*
[34] Interview 40, *loc. cit*.
[35] Interview 19, *loc. cit*.
[36] Interview 48, *loc. cit*.
[37] Interview 19, *loc. cit*.

The interplay of the fragmented governance structure and the complex system of financing of each of the parts of the healthcare system (outpatient care/inpatient care) therefore contribute to incrementalism in healthcare reforms. Actors' interests and practices are similar in healthcare governance and financing despite different arenas of decision-making. The underlying tensions in health policy-making thus run firstly across the divide between inpatient and outpatient care, i.e. between corporatist self-administration and government. Secondly they run between the centre (federal government) and the periphery (*Länder*), and thirdly they overlap with party politics and other public policies across different levels of government. The large number of actors and the variable geometry of interests in healthcare contribute to path-dependent developments and to incremental reforms. Political discourse and reform proposals therefore also revolve around the effects of the fragmentation of healthcare governance and financing on the provision of healthcare which are "supposed to go ahead with substantial inefficiencies, especially regarding the hospital sector" (Fink, 2011, p. 3). The next section will therefore address the provision of healthcare in Austria.

2.4 The Provision of Healthcare in Austria

2.4.1 The Structure of Healthcare Provision

The development of the provision of healthcare to the general population[38] in Austria is closely linked to the development of the Austrian welfare state after World War II. While the first years of the Second Republic were marked by repairing the damages of World War II, the consolidation phase that followed with the introduction of the General Social Security Act (ASVG) in 1955 aimed at building up new capacities, providing effective healthcare, and extending health insurance coverage. Typical measures of this period included vaccination campaigns, medical check-ups for juveniles, regular medical examinations for pregnant women, and most importantly the construction of new health facilities such as hospitals. The aim was to improve significantly the health status of the population by fighting communicable diseases and improving family health. After the oil price shocks of the late 1970s, the economic aspects of healthcare were increasingly taken into account by policy-makers concerning the provision of healthcare. The decades following the 1970s saw the introduction of significant technological and medical improvements, leading to a "medicalization" of society – more and more health conditions could be medically defined and treated. Together with the other factors of health care inflation (see section 2.1.4), costs were rising, while the economic and financial situation had been declining since the end of the 1970s, hence the introduction of the first reforms concerning hospital financing. Along with the attempts at structural reforms, the provision of healthcare became increasingly an object of reform debates relating to economic and medical efficiency. Elements of managed medical care, i.e. legally or contractually defined mechanisms to reduce costs and to optimize the provision of healthcare, but also co-payments for medication were introduced. From the 1990s onwards this trend

[38] The chapter will mainly focus on inpatient and outpatient care in Austria, and hence the structural core area of healthcare provision.

also included the introduction of day clinics (to reduce the length of hospital stays), measures of evidence-based medicine (treatments that rely on an empirically proven probability of success), and the introduction of diagnosis related groups for hospital financing. At the same time, measures of public health such as prevention programmes in order to avoid costly treatments were introduced. While these trends of aiming at an increase of economic and medical efficiency have been marking reforms of healthcare provision, the demand for medical treatment in the population has also changed. Austrians increasingly use "alternative medicine" such as acupuncture, homeopathy or Traditional Chinese Medicine, which are however to a large extent not covered by the health insurance and are usually paid for by patients themselves in private practices of physicians (Gottweis & Braumandl, 2006, pp. 755-758).

Insurance and Healthcare Provision

The public provision of healthcare in Austria is based on the principles of social insurance and follows at the same time the organizational split between outpatient and inpatient care. Both factors have concrete consequences for patients which will be discussed further below. By 2011, 99.9% of the Austrian population were insured by one of the 19 sickness funds. Most of the population (80%) is insured with one of the nine regional sickness funds based on their status as workers, apprentices or being recipients of welfare benefits (e.g. pensioners, unemployed). The remaining part of the population is insured with those sickness funds that have been created for certain professions. Members of certain liberal professions such as physcians, architects, veterinaries, pharmacists and lawyers have the right to opt out of the public insurance system, but are obliged to insure themselves with a private insurance that must at least provide the same insurance coverage as the public insurance. The members of these professions are thus oftentimes insured through 'group contracts' of their professional organizations (Chamber of Physicians, bar association…) with private health insurances. For the insured, healthcare is provided by physicians as benefits in kind, i.e. patients do not have to pay medical treatment themselves as sickness funds pay providers directly. Co-payments by patients exist however for drugs and adjuvants or other accessory charges for hospital treatments. Rules on co-payments might vary between the types of sickness funds (Hofmarcher, 2013, pp. 98-103). Public health insurance comprehensively covers medical treatments inpatient and outpatient care. The insured population can benefit from medical treatment by hospitals, General Practitioners and specialists alike. The insurance coverage also encompasses treatments by physiotherapists, psychologists and other paramedical professions. A certain number of dental treatments are covered as rehabilitation and transport costs, adjuvants, short-term home-care, and sick-pay. Around 91% of healthcare is delivered as benefits in kind, while transportation costs or sick-pay are either reimbursed or paid directly to the insured (*ibid*., pp. 103-105).

Delivery of Outpatient and Inpatient Care

Outpatient or ambulatory care is delivered by around 19,000 physicians in their practices, and insured patients have the right to choose freely their physicians for medical treatment. While General Practitioners usually treat patients in their

practice, specialist treatment is available in practices, but also in walk-in clinics (*Ambulatorium*) and outpatient clinics operated by hospitals. With 4.8 physicians per 1,000 inhabitants, Austria has the second highest number of physicians in Europe (*ibid*., pp. 152-186). In the ambulatory sector, patients can consult with their insurance card (*E-Card*) either physicians who adhere to the contracts negotiated between the Chambers of Physicians and sickness funds and who provide medical services and who are then remunerated according to the negotiated tariffs by sickness funds. Physicians can however also open private practices without having a contract with sickness funds (*Wahlarzt/Wahlärztin*) where patients can receive medical treatment. The patients that are treated in such a private practice have to pay for the treatment themselves and are then reimbursed at 80% of the official tariff (Hofmarcher & Rack, 2006, p. 45). The reduction of 20% is justified by additional administrative costs for the sickness funds and has been confirmed by Austrian high courts (Obermaier, 2009, pp. 79-80). Patients usually address themselves to general practitioners who adhere to the contracts with sickness funds before seeking the help of a specialist or before being referred to a specialist. However, as already mentioned, patients also increasingly seek medical treatment from independent physicians. These *Wahlärzte* mostly contribute to the high density of physicians per 1,000 inhabitants in Austria, and the number of independent physicians has been growing above average. Most independent physicians work as general practitioners, internal specialists and gynecologists. The payments for these treatments add up to 24% of the private payments by patients for medical care, thus indicating an increasing propensity of the population to seek treatment with an independent physician. While the general density of physicians per 1,000 inhabitants is relatively high, it varies significantly according to regions. The system of contracts negotiated by sickness funds and Chambers of Physicians have therefore the task to create networks of ambulatory care that allow a basically equal access to ambulatory medical treatment across the country. While the density of general practitioners shows lower variation across Austria, the density of specialists varies more significantly: given its important number of inhabitants, Vienna has the highest density of specialists, while *Länder* with more rural or mountainous areas do not even have half of the number of specialists per 1,000 inhabitants as Vienna (Hofmarcher, 2013, pp. 199-201).

Outpatient clinics and emergency departments of the hospitals also play an important role in the delivery of ambulatory care. Every hospital offering emergency services provides outpatient care in these clinics. Their legally defined task is to provide ambulatory care which is not sufficiently available in individual practices (e.g. necessitating technological equipment such as magnetic resonance imaging or tomography) beyond providing emergency services. The number of patients and the frequency of visits to these clinics have been rising constantly over the years (*ibid*., pp. 201-202). Patients oftentimes visit the outpatient clinics of hospitals without consulting their general practitioner beforehand, as these clinics have the advantage of delivering healthcare 24 hours – also during weekends. Furthermore, ambulatory patients like to profit from the comprehensive hospital infrastructure in case a complicated treatment might be necessary. The costs of these treatments are however paid like inpatient treatments, i.e. sickness funds only pay a fixed amount while the

rest of the treatment costs are paid via the *Länders'* tax-financed health funds. In 2007, 16.6 million patient visits in these clinics amounted to around 1.2 billion € of treatment costs (Pöttler, 2012, pp. 132-137).

Inpatient care is delivered in Austria by around 270 hospitals, of which 178 are emergency hospitals, thus providing care for acute medical conditions (*Akutkrankenanstalten*). The spread of hospitals across Austria is – like the governance of inpatient care – decentralized. There are different types of hospitals: most of the hospitals offer "standard provision" of medical care also in rural areas, while in towns and greater urban centres other types of hospitals also provide specialized treatments. Hospitals in bigger cities, including university hospitals, have a "central function of provision", offering the largest range of medical treatments available. The decentralization of the hospital sector has the advantage for patients that they are easy to reach, even in rural areas (Hofmarcher, 2013, pp. 208f).

Infrastructure of Healthcare Provision, Actors' Interests and Reform Debates

From a patient's perspective, the Austrian healthcare system offers a relatively unrestricted access to high-quality medical care for the whole population. The free choice of physicians is on the one hand an asset for patients, but demands at the same time an active search for adequate doctors for their treatment (Hofmarcher, 2013, pp. 196f). A 2010 reform in the outpatient sector has created the possibility for physicians to open "group practices" where general practitioners and specialists can be found and in which they can share on the one hand medical equipment and supplies, and on the other hand can more easily refer patients between them. The reform is therefore oriented towards improving the structure of outpatient provision (Pöttler, 2012, p. 139). Most of the reform debates which result from the organizational split between inpatient and outpatient care as well as from the decentralization of inpatient care concern a better integration between hospital and ambulatory care and the number of existing hospital capacities (in terms of available beds for acute medical care) in Austria. Since the 1990s, Austria, like other OECD and EU member countries, has been aiming at reducing the numbers of beds available in Austrian hospitals. While between 2000 and 2010, available beds for acute medical care in hospitals have been reduced by around 10%, the reduction of beds available per 1,000 inhabitants has been slower than in other EU member countries. And the number of available beds for acute care per 1,000 inhabitants is still one of the highest in Europe (Hofmarcher, 2013, p. 155). Yet, not only the number of available beds for acute care is the object of reform efforts and debates, but also the number and size of existing hospitals in Austria. In a study carried out in 2010, the Austrian Court of Auditors criticized the relatively large number of hospitals that have been constructed by the *Länder*. 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. In the same report, the Court of Auditors also criticized the relatively high number of hospital beds for (Rechnungshof, 2010, p. 12). Furthermore, political guarantees by several *Länder* governments that local hospitals will not have to close despite reform efforts were said to prevent saving effects. The tabloid press even used this allegation to call

small and less efficient hospitals "political hospitals" (*Kronenzeitung*, 8 June 2010). A suggestion by a federal secretary of state to think about the closure of smaller hospitals was immediately refuted by several *Länder* governors. These debates link back to the financing structure and the fragmentation of healthcare governance. They mirror the opposing interests between the Federal Government and the *Länder* governments which have been described in the reforms of governance and the bargaining structure of hospital financing (Trukeschitz, Schneider & Czypionka, 2013, p. 185).

Hospitals are important measures of structural policy for the *Länder* governments in electoral campaigns, but as the citation shows, beyond the provision of healthcare, hospitals are also an important economic factor for *Länder* governments, providing additional employment in rural areas. The political calculations by *Länder* governments are thus co-determined by two other economic and political factors only aimed at maximizing efficiency in the provision of hospital care. Some of the *Länder* have even carried out studies that highlight the economic impact of hospitals for their regions [39]. Besides the economic interests of the *Länder* in keeping hospital sites intact, a certain hospital capacity is also needed in rural areas or mountainous region in order to keep inpatient care accessible. As the *Länder* play a dual role as payers and providers of healthcare, their interests are thus of an ambiguous nature: as payers they have an interest in maximizing economic efficiency, even though the allocation of subsidies for inpatient care based on political bargaining alleviates some of the financial pressure. As providers of healthcare they have an interest in maximizing capacity beyond economic considerations, be it to improve access to healthcare in rural areas or be it to enhance their role as public employers. These interests are thus partly opposed to the efforts since the 1990s of the different federal governments to reform the provision of inpatient care according to economic criteria. Federalism, though, has another side-effect on hospital infrastructure. *Länder* governments have oftentimes reasoned within their own territory when building hospitals, thus somewhat neglecting hospital capacities which are available across inner-Austrian regional borders [40].

The decentralized healthcare system thus sets incentives to provide a maximum of inpatient care within the boundaries of one *Land*, but not necessarily across the *Länder*. Several interviewees have also indicated 'off the record' that party competition yet again superposes these structural interests: while for example Vienna is traditionally governed by the SPÖ, Lower Austria which surrounds Vienna is traditionally governed by the ÖVP. Vienna as Austria's biggest urban center plays an important role in providing healthcare to those who commute on a daily basis to work in Vienna. However both *Länder* governments have each their own interests in providing hospital capacities and buying complex medical equipment for electoral reasons, not necessarily taking into account available capacities and equipment in the other *Land*. Each regional ruling party in government can then claim credit for providing the most comprehensive inpatient care. The political salience of hospital infrastructure for *Länder* governments also becomes apparent even without taking into account the internal Austrian regional "cross-border" provision of inpatient

[39] Interview 40, *loc. cit*.
[40] Interview 21, *loc. cit*.

care. In the past closings of hospitals or single hospital wards have been met with resistance by the local population, thus putting pressure on *Länder* governments to keep capacities [41].

In addition to electoral consequences that reforms of inpatient care can entail for regional governments, the organizational and financial split between inpatient care and outpatient care has further implications for actors' interests and reforms. This concerns mainly the integration between inpatient and outpatient care. The split between the financing of inpatient and outpatient care sets incentives for sickness funds to prefer that patients seek medical treatment in the walk-in clinics of hospitals. The reason is that sickness funds only pay a fixed amount for this kind of treatment, where the larger part is paid through the *Länders'* hospital funds. Additional capacities in the outpatient sector on the other hand would mean an increase in spending for sickness funds where they pay the full amount for treatments. The operators of hospitals have at the same time have an interest in taking up patients in hospitals to justify financial allocations for hospitals, which in turn sets incentives to keep the status quo of the number of beds available for intensive medical care (Pöttler, 2012, p. 153). The federal government has therefore taken initiatives to reduce patients' usage of hospitals and to give preference to ambulatory treatments instead. Several of these initiatives have not succeeded, however, given the main conflict between payers of inpatient and outpatient care over financing the costs of such a shift in provision between hospitals and ambulatory care (Hofmarcher, 2013, p. 209).

Given the above examples, the provision of inpatient care has been one of the focal points of reform efforts. During the reform period of the late 1990s, the federal government took an initiative of introducing in 1997, together with the introduction of DRG based financing of hospital care, the Austrian plan for hospitals and major medical equipment (*Österreichischer Krankenanstalten- und Großgeräteplan*) which set caps for the available number of hospital beds in each region. The governance reform of 2005 (see section on governance) then developed the existing plan further into the Austrian structural plan for health (*Österreichischer Strukturplan Gesundheit*, ÖSG) which has become the main regulatory instrument for the Federal Health Agency to develop a binding framework plan for hospital capacities in Austria. From 1997 onwards the quantity of beds was already fixed in the planning of hospital capacities; from 2005 onwards the plan also included framework requirements for the quality standards of hospital care, and the reform of 2008 has enlarged the scope of the plan, which now also takes into account the provision of rehabilitation centres, long-term care, and capacities of the outpatient sector. While the planning of capacities takes into account cost-benefit calculations, it is however more based on indicators for the demand of hospital infrastructure in defined areas (*ibid*., pp. 53, 250). The timing and development of the central planning capacities by the means of structural plans thus mirror the incremental but constant way reforms are negotiated in 15a agreements between healthcare actors. While the system of governance has been decentralized since 2005, central planning capacities have been enhanced in the

[41] Interview 24, Patient Ombudsman (*Patientenanwalt*) Vorarlberg, Feldkirch, 19 January 2011.

framework of an increased coordination between actors in the field of outpatient and inpatient care. Yet, while change, even though it is incremental, is to be witnessed from a structural point-of-view, the implementation of centralized structural planning is largely determined by the traditional tension between the centre and periphery: the structural plan theoretically foresees mechanisms to sanction regional governments for not complying with the structural plan and provides also for an evaluation to be carried out concerning hospital capacities and efficiency. While sanctions have never been enacted, the implementation of an integrated planning of inpatient and outpatient care according to the plan lags behind. An evaluation was carried out in 2008 in order to provide the necessary input for the periodical revision of the structural plan. The results and data based on the performance of each *Land* have however not been made public due to "political reasons" (Trukeschitz, Schneider & Czypionka, 2013, p. 176), but inspection reports of the Austrian Court of Auditors indicate that the planned targets have not been reached (Hofmarcher, 2013, p. 252). The results of the evaluation are therefore kept confidential, as they would attest to the lacking implementation of the foreseen integrated planning of healthcare provision [42].

The above described reform efforts and actors' interests in reforming the provision of inpatient and outpatient care show that users, i.e. patients, are largely absent from decision-making processes. While patient ombudsmen (*Patientenanwälte*) represent patients' interests in concrete cases of medical errors or can publicly remind policy-makers of deficits in healthcare provision, users lack complementary actors that would represent their interests in decision-making processes. Oftentimes the corporate actors such as the sickness funds or the Chamber of Physicians but also government representatives claim instead that their own reform proposals or interests would be 'in the best interest of patients' [43]. Yet, the described reforms directly concern the users of the healthcare system; and as the section on healthcare financing has shown, patient flows as well as foreign patients using the Austrian healthcare system, are taken into account when negotiating financial allocations.

2.4.2 Interim Conclusion: Institutional Dynamics, Actors' Practices and Cross-border Healthcare

The Austrian healthcare system is dependent on the general features of Austrian social policy making and on the institutional set-up of the Austrian welfare state. A consociational style of politics with influential parties, corporatism and federalism are the institutional landmarks of the healthcare system. However, in the field of healthcare these elements intertwine in a particular manner, and the Austrian healthcare system follows its own institutional rules due to the separation of outpatient and inpatient care which determines governance, financing and delivery of healthcare. The separation between inpatient and outpatient care also determines general patterns of actors' strategies and interests. While the healthcare system has followed much of the general reform trends of the welfare state during the last two decades, it is its very institutional set-up that has become the object of reforms itself, aiming mainly at an increase of

[42] Interview 48, *loc. cit*.

[43] *Ibid*. and interview 40, *loc. cit*.

economic and governance efficiency of the system. These reform debates and efforts – mainly pointing towards increased planning capacities at the central state level, financial reorganization, and efficient delivery of healthcare – reveal the "tectonic break lines" between actors' institutionally shaped interests and strategies. Furthermore, the number of actors participating in healthcare governance is considerable, and it increases when it comes to healthcare policy-making, making the Austrian healthcare system one of the most complex healthcare systems of OECD member states. The two major tensions that underpin healthcare governance and healthcare policy-making run vertically across two levels of government – i.e. between the federal government and the *Länder* governments – and horizontally between corporatist actors and state actors – i.e. between payers (social insurance funds), providers (physicians) and the federal government as well as the *Länder*, who have a powerful position as regulators, providers and payers of healthcare. These institutionally regulated tensions result from a path-dependent historical institutional development which can be traced back to the last decades of the Austrian-Hungarian Empire and which have been carried over from the Empire to the First Republic and then to the Second Republic.

Centre-Periphery Relations and Hospital Infrastructure

The first line of institutional tension, namely that between centre and periphery, becomes clear when looking at reform efforts of inpatient care. While several federal governments have been trying to enhance the efficiency and planning of hospital infrastructure and financing, *Länder* executives have been insisting on their competencies for regulating inpatient care. Especially hospital infrastructure is politically salient as regional governments' electoral successes are influenced by providing easy access to healthcare even in remote rural areas. Even at the regional level competition between different areas of the *Länder* exists concerning hospitals, as hospital infrastructure is an economic factor providing for employment. Additionally, party politics play a role when it comes to the planning of hospital infrastructure. Planning was and is oftentimes carried out inside the own regional borders, not necessarily taking into account available capacities in adjacent regions. In terms of policy-making, the federal level and the regional level are bound together by a mechanism of "cooperative federalism" in the form of 15a agreements which are negotiated every five years: both levels of government have to consensually negotiate a general policy framework for inpatient care. Especially the financial arrangements of these 15a agreements are not independent from other policies, as they are influenced by the mechanism of financial equalization between the federal government and the Austrian *Länder*.

As a result, the enacted healthcare policy reforms show an incremental but constant character. They include the reform of financing of healthcare based on modified DRG groups, the introduction of a general plan for hospital infrastructure and the creation of a federal platform bringing relevant actors together when it comes to governing inpatient and outpatient care. These reforms reveal where the interests of the federal government as main regulator and main financier of welfare policies coincide with the *Länders'* interest as payers of healthcare, namely to increase efficiency of healthcare. As providers, the *Länder* have been however opposed to sharp reductions or

encompassing structural reforms of hospital infrastructure. Nevertheless, especially smaller regional hospitals have come under pressure during the last decades, given their limited economic efficiency.

At the same time, the federal governments' and the *Länders'* financial and governance interests have also been opposed: while different federal governments have aimed at an increased competence for regulating healthcare, the *Länder* demand more competencies to independently govern inpatient care. These opposed interests are mirrored mainly by negotiations on the distribution of financial allocations. While the federal government has significant power when it comes to allocating financial resources, it has only limited – if any – influence on the ways how the money is spent. On the other hand, it could be argued that the *Länder* would spend money on hospital infrastructure more efficiently if they had more competencies in collecting and spending taxes. This inherent tension is unlikely to be solved as it is not only institutionalized by cooperative federalism in form of 15a agreements, but also depends on the system of fiscal equalization which in itself has institutionally grown into a complex system. The result is thus a path-dependent structure of hospital financing in which new financing keys are added with every 15a agreement, instead of reforming the existing financial flows. And financial allocations do not necessary reflect a calculated need for certain financial allocations.

Relationships between State and Corporatist Actors in Outpatient Care

As regards outpatient care, corporatist actors such as the Social Partners and representatives of providers such as the Austrian Chamber of Physicians play the main role when it comes to governance of outpatient care. While sickness funds have been aiming at controlling rising costs for medical treatment, providers have been advocating easy access to outpatient care. The split in governance between inpatient and outpatient care has, though, been a major obstacle to reforms aiming at a better integration between both sectors of healthcare. On the one hand, the *Länder* have an interest in generating sufficient numbers of patients especially in their emergency departments or outpatient clinics, while the sickness funds on the other hand have no interest in increasing the numbers of patients in outpatient care. This is due to the fact that sickness funds only pay fixed lump sums for treatments in hospital, while they would have to cover the complete treatment with a physician in outpatient care. During the last decade however, 15a agreements provided for so-called reform pools that should support projects providing for a better integration between inpatient and outpatient care at regional level.

Reform Strategies and Practices of Negotiations and Governance

As far as the structure of healthcare governance itself is concerned, reforms have not touched on the issue of financing flows themselves, even where reform proposals exist. As far as governance is concerned, strategies of institutional *layering* can be observed. Instead of touching upon the competencies of involved actors, planning capacities concerning healthcare have been increased by creating new institutions which have been added to the existing ones: these include the Federal Health Agency and the Federal Health Commission, which serve as institutional platforms for the

different actors of outpatient and inpatient care to coordinate amongst themselves. At the same time the federal level's influence is slightly strengthened in healthcare governance through the agency, as the number of votes for the federal government has been increased vis-à-vis the other actors. Yet, in terms of policy-making the federal government's competencies remain limited to that of a regulator, and corporatist actors as well as the *Länder* remain powerful actors.

Given the lack of a "principal" in healthcare politics, negotiations in the different sectors in healthcare thus usually involve all major actors in a consensual manner: Formal and informal meetings, conferences and negotiations are based on bargaining which does not always fully take into account the "hard facts" of financial aspects, but which aims at satisfying all actors involved. Attempts of majoritarian rule, especially by the ÖVP-FPÖ coalition in federal government, have been limited in their success. While the influence of corporatist actors during the time of this government has been somewhat reduced, parts of the reforms have been annulled by the Austrian constitutional court, which acted as a veto player and as a guarantor of institutionalised consensual politics. Users of healthcare, i.e. the patients, are however the least influential group in healthcare governance, not to mention decision-making on financing of healthcare. As far as healthcare provision is concerned, they are represented by ombudsmen and thus can voice dissatisfaction if needed. However, the overall picture shows that from the users' perspective, the Austrian healthcare system performs quite well, even though waiting times do exist. How, then, does the Austrian healthcare system deal EU involvement in cross-border healthcare?

3
European Integration and Cross-border Healthcare

3.1 European Limits to Member States' Social Sovereignty

Advancing European Integration in the field of healthcare has the potential to threaten the institutional boundaries of national welfare states that have been constituted in a complex historical process. According to Ferrera (2005), the EU has become a direct challenge to Member States' social sovereignty: It threatens the capacity of Member States to "lock in" and exercise command and control over the actors in the institutional set up of the welfare states, and by the same token has decreased their capacity to prevent the EU from interfering with the national social space by challenging the national demarcations of the welfare state (*ibid.*, p. 12). The European Communities that were founded in the 1950s supported the economic upswing after World War II: the six founding Member States France, Germany, Belgium, the Netherlands, Luxemburg and Italy could start to manage key areas of their interdependent economies such as coal and steel industries. The creation of the European Coal and Steel Community in 1952 and of the European Economic Community has started a process of supranational integration that has unfolded over the last five decades. In the beginning, political founding fathers were actually convinced that an open economy and a closed welfare state would benefit each other. This dictum can be summarized in allusion to two famous economists as "Smith abroad, Keynes at home" (*ibid.*, p. 2). Even though there was no intention that the Communities should impact the national welfare systems, these institutions soon developed a life of their own leading to practical consequences that were not intended by their creators. The most important developments were the *constitutionalization* [1]

[1] The term to define the European Treaties as a "constitution" was first used by the Court of Justice of the European Union. The two main aspects of this constitutional character of the

of European legal rules and the growing coordination of social security schemes in order to enhance economic cooperation (*ibid*., p. 95). Both contribute to a reduction of national sovereignty over welfare states.

In 1995, Leibfried and Pierson coined the notion of "semisovereign welfare states" (Leibfried & Pierson, 1995, p. 44) to describe the impact of European integration on Member States' welfare states. In the absence of a single European welfare state that would provide social benefits and because of the non-existence of a European system of funding social policy, it seemed for a long time that a territorial conception with closed boundaries of welfare state policies subsisted despite growing European integration. They claim however:

> "The process of European Integration has eroded both the sovereignty (by which we mean legal authority) and autonomy (by which we mean de facto capacity) of Member States in the realm of social policy. National welfare states remain the primary institutions of European social policy, but they do so in the context of an increasingly constraining multitiered polity" (Leibfried & Pierson, 1995, p. 44).

European Integration as such, though, does not need to constitute a problem for the welfare state: during the economic upswing of the post-war era and due to the new mobility granted by the European Communities workers became more mobile, and by the end of the 1960s around 830,000 European citizens were living in another Member State. Since the Founding Treaties stipulated that workers moving from one Member State to another should not be penalized in terms of social protection, the coordination of social security schemes became necessary. In 1971, Regulation 1408/71 was passed which left Member States' prerogative to define membership boundaries of their insurance spaces untouched, but allowed workers living in another Member State to be eligible for insurance and to export their benefits from one Member State to another regarding pension rights and healthcare. The main principle of the Regulation is the non-discrimination on the basis of nationality (Ferrera, 2005, pp. 100-103). While the Regulation created an opening of social security systems, it kept Member States' sovereignty intact by delimitating the rights of benefiting from other Member States' social security system.

Creating such a system of coordination between Member States' social security systems was an act of 'positive integration' where Member States agreed to grant rights to workers moving from one Member State to another in the light of deepening European economic integration. Positive integration is hence a measure correcting the impact of the European internal market on individual citizens. Member States are generally reluctant to cede any competencies in regulating welfare policies to the European level, while they have been in favor of European economic integration. After the Maastricht Treaty had entered into force in 1993, employment was the first social policy field put on the European agenda by the European Commission as Member States were all facing rising unemployment rates. Member State governments agreed to a closer coordination of employment policies at European level involving employers

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European treaties are the direct effect of EU law at national level and the supremacy of EU law over national law. Both of these principles are usually to be found in federal polities (Hix & Høyland, 2011, p. 83).

and trade unions. In 1997, with the Amsterdam Treaty, a formal employment chapter was added granting an official status to social partners at EU level (Hemmerijck *et al.*, 2006, pp. 276ff). This inclusion of employment policies led to the development of a "corporatist policy community" at European level in the subsequent years (Falkner, 1998). Since the late 1990s, however, Member States have mostly agreed that any further social policy coordination should be based on so-called "soft law" mechanisms, developing social policy goals at European level through common target setting and by developing benchmarks. The Treaty of Lisbon, which came into force in 2009, legally formalized these mechanisms of a new mode of social policy governance, named the Open Method of Coordination (OMC). The OMC tries to promote the development of European approaches to social policy by mutual learning strategies amongst Member States, by common dialogue, and by drawing lessons from each other with the help of common benchmarks (Hemmerijck *et al.*, 2006, p. 277). In the light of Member States' resistance to ceding competencies concerning welfare matters, positive European integration has therefore been marked by an "institutional creativity" (Cochoy & Goetschy, 2009). While the market-correcting mechanisms of positive integration seem less problematic for Member Sates' social sovereignty, processes of negative European Integration that remove obstacles to the free movement of persons, goods and services at national level have a detrimental effect on national welfare boundaries.

Oftentimes the Court of Justice of the European Union (CJEU) triggers such negative integration through its rulings. European legal requirements limit the room of manoeuvre for Member States in formulating their social policies. Usually Member States exert complete control of their welfare states in terms of spatial controls of consumption, types of benefits and who would be eligible to receive benefits. During the last decades however the CJEU has mainly contributed to a reduction of Member State sovereignty over this territorial control. While Member States had already foreseen in the founding Treaties to provide a coordination of social security arrangements in order to ensure the free movement of workers, these did not play a significant role until the late 1980s, when conflicts between national welfare state regulations and this principle became more and more evident (Leibfried & Pierson, 1995, pp. 55-61). Especially the principles of European law concerning the free movement of workers and market competition have been limiting Member States' social sovereignty. Many prominent cases in front of the CJEU regarding labour law, public employment, granting rights to welfare benefits for migrant workers, or how Member States might determine the provision of welfare services have been limiting Member States' say in welfare regulation. Negative integration has therefore been shaping the social dimension of European integration as much as positive integration (Leibfried, 2010, pp. 265/270).

Healthcare systems have not been any exception to these developments, as areas of public health, the fight against communicable diseases, but also rules of public procurement, mobility of health work force, and the mutual recognition of diplomas have been subject to either positive or negative integration (Mossialos, McKee & Palm, 2004; McKee, 2003; Hatzopoulos, 2003; Hervey & McHale, 2004). With the Treaty of Maastricht the new Article 152 (now Article 168) was created concerning

European competencies with regard to healthcare. The Article was mainly aimed at helping Member States to coordinate the fight against certain diseases such as HIV/AIDS but also BSE as well as measures of preventing drug dependence or cancer. The Article limits European competencies to coordination measures and is "essentially concerned with public health, in the sense of health protection and promotion of good health carried out on a collective basis, rather than individual-health related entitlements" (Hervey & McHale, 2004, p. 74). The Treaties therefore excluded any European competence relating to the actual delivery of healthcare to individuals and stated that European institutions "shall fully respect the responsibilities of the member states for the organization and delivery of health services and medical care", therefore differentiating between European competencies for certain areas of public health and Member States' competencies for the delivery of healthcare services (Steffen, Lamping & Lehto, 2005, p. 5). Besides this rather restrictive legal basis, soft law mechanisms also concern healthcare. The Open Method of Coordination (OMC) under which Member States agreed in 2004 to set up National Action Plans relating to common employment policy goals defined at European level has an impact on healthcare. From the beginning on, it was stressed that the OMC could be used as a means to increase the efficiency of healthcare provision in Member States. At the same time the impact of the OMC on national healthcare systems has been limited and no signs were found that it would be undermining Member States' various healthcare systems (Hervey, 2008).

In terms of negative integration, the CJEU has issued different important rulings based on the principle of free movement of citizens and services as well as the freedom of establishment concerning the public character of healthcare provision, professional regulation or the regulation of pharmacies. However, in its rulings the CJEU did not show a consistent position of potentially favouring European market rules over Member States' definition of healthcare as national social services (Hancher & Sauter, 2010). Given the various forms that European integration has taken concerning different aspects of healthcare, it can be said that European integration has been showing "chaordic" dynamics, as no coherent pattern between clear legal rules and soft law mechanisms can be detected (Lamping & Steffen, 2009). In the mid-1990s however, the CJEU started to issue a series of landmark rulings on cross-border healthcare which have touched upon the core area of healthcare systems, namely the access to and delivery of healthcare for Member States' citizens, and which have made healthcare a prominent and politically salient issue on the EU's political agenda. European rules on cross-border healthcare can therefore be considered to be a prime example of conflicts between national social sovereignty and European integration.

3.2 European Integration and Healthcare

The Court of Justice of the European Union's Rulings on Cross-border Healthcare

The only European legislation which concerned the access by citizens of one Member State to healthcare services in another was a secondary legislative act, namely Regulation 1408/71 (now 883/2004) on the coordination of Member States' social security systems. The Regulation aims at safeguarding European citizens'

right to receive healthcare benefits in another Member State, mainly in the case of medical emergency. The Regulation provides for two distinct procedures: in cases of emergency medical treatment, citizens insured in an EU Member State could request the E111 form from their national health insurance – which has now been replaced by the European Health Insurance Card (EHIC) – granting them the right to receive free medical care in another Member State while travelling. The second procedure, based on the E112 form, aims at granting EU nationals the right of medical treatment in another Member State in case the home Member State is not able to provide a specific necessary medical treatment (mostly inpatient care). To receive the E112 form, citizens have to undergo a prior authorization procedure by their national health insurance. In case authorization is granted, the patient can use the E112 form to receive medical treatment in another Member State paid by the healthcare insurance in the home Member State (Hervey & McHale, 2004, p. 115). The rules set out in the European Regulation thus restrict access to healthcare in another Member State to urgent medical treatment and leave the right to control access for specific medical treatment in another Member State at national level. Furthermore, the Regulation does not provide for possibilities of elective medical treatment in other Member States, i.e. a patient travelling on purpose abroad to receive medical treatment at his or her own discretion. The CJEU has however created new ways to access healthcare across borders of Member States in a series of landmark rulings beyond the scope of the Regulation, challenging national control over the access to healthcare.

Starting with the *Kohll-Decker* preliminary rulings in 1998 (Court of Justice of the European Union, 28 April 1998), which had been referred to the CJEU by national courts in Luxembourg, the CJEU intervened in the regulation of access to healthcare. The first plaintiff, Mr. Kohll's daughter had received orthodontic treatment in Germany, while the second one, Mr. Decker had bought spectacles prescribed by a Luxemburg ophthalmologist in Belgium. Both plaintiffs demanded from their national sickness funds in Luxembourg a reimbursement for receiving medical services abroad, even though in both cases no emergency care had been necessary and no prior authorization had been granted. In fact Mr. Kohll's request for prior authorization had been refused by the national sickness fund on the grounds that dental treatment was neither urgent nor would it be unavailable in Luxembourg. Mr. Decker had not asked for prior authorization (Mossialos & Palm, 2003, p. 8). While Mr. Decker claimed that a prior authorization would have infringed upon the right of free movement of goods under European Treaty rules, Mr. Kohll argued that the denied prior authorization had prevented him from purchasing a service in another Member State which would infringe upon European Treaty rules prohibiting national restrictions on the provision of services (*ibid*., p. 9). The government of Luxembourg invoked its right to regulate access to healthcare as it would be necessary to secure the equity of access to healthcare for its citizens. The government argued furthermore that prior authorization procedures would be necessary to make sure that providers of medical care in other Member States would meet necessary quality standards, and that huge numbers of patients seeking healthcare in other Member States could threaten the financial stability of the national healthcare system (*ibid*.).

Notwithstanding, the CJEU followed the plaintiffs arguments. It ruled that the Luxembourg's sickness funds would not have to pay to Mr. Kohll more than they would have paid for treatment at home. The Court thus refuted the argument that elective healthcare in another Member State would automatically lead to financial problems for national sickness funds. Based on the rules of the EU's internal market, the Court ruled therefore that prior authorization would not be necessary for dental treatment in another Member State. The Court also found that in the case of Mr. Decker national rules infringed upon the right to receive services in other Member States (*ibid*., p. 9). More importantly, though, the CJEU made clear that the rules set out in Regulation 1408/71 do not take legal precedence over the constitutional rules of the European Treaties, and thus subjected healthcare systems to "the constitutional construct of the internal market" (Hervey & McHale, 2004, p. 90). The CJEU thus created an additional way to receive medical treatment in another Member State by allowing EU citizens to travel abroad, where patients would pay the medical treatment upfront and then subsequently receive reimbursement of the costs for medical treatment in another Member State from their national health insurance as if the treatment had been carried out at home (Nickless, 2003, pp. 61f).

The implications of the CJEU's *Kohll-Decker* rulings for Member States' healthcare systems were however not clear. Many Member States worried about the potential impact of increased patient flows across borders for their capacity of planning national healthcare delivery, and hence preferred to interpret the rulings narrowly. As the rulings concerned two cases related to outpatient medical care, it was not clear whether the rulings would also apply to potentially much more expensive inpatient care. Luxembourg also has an insurance based Bismarckian healthcare system providing for reimbursement of medical costs to its insured citizens. Member States' governments operating national health services, such as the United Kingdom doubted therefore that the rulings would also apply to them. Other Member States operating Bismarckian type health insurance systems also doubted that the rulings would apply to them if their healthcare system would not be based on the reimbursement of costs after medical treatment, but if treatment was received as a benefit of kind, i.e. where sickness funds directly pay providers (Mossialos & Palm, 2003, pp. 11ff; Nickless, 2003, p. 62). Once the first two rulings had been issued, they paved the way for further litigations putting into question Member States' control over healthcare systems (Kaczorowska, 2006, p. 351).

In subsequent rulings, the CJEU 'fine-tuned' its legal position (Obermaier, 2008): In 2001 the CJEU issued two further rulings in the *Vanbraekel* (Court of Justice of the European Union, 12 July 2001) and the *Geraets-Smits/Peerbooms* (Court of Justice of the European Union, 12 July 2001) cases concerning a Belgian citizen receiving orthopedic surgery in France and two Dutch citizens, one of them receiving a multidisciplinary inpatient treatment against Parkinson's disease in Germany and the other receiving a neurostimulation treatment in an Austrian hospital after having fallen into a coma after an accident. The CJEU ruled in these cases that its previous rulings were also applicable to inpatient care and considered that health services based on the benefits in kind logic would constitute an economic activity, and hence the rulings would also apply to these healthcare systems. The CJEU ruled furthermore

that if medical costs in another Member State are less expensive than in the home Member State, national health insurances will have to reimburse the difference between the home tariff and the foreign tariff as well. Member States could however restrict the reimbursement of the difference. Nevertheless, the CJEU accepted the necessity for prior authorization as far as inpatient care abroad is concerned, in order to permit Member States the necessary planning of hospital provision and be able to ensure equitable access to high-quality hospital treatment. Even though the CJEU allowed Member States to retain the right of imposing prior authorization procedures on citizens, it ruled that decisions on the prior authorization must be taken on non-discriminatory and objective criteria, allowing for judicial review. Prior authorization procedures would also have to take international medical standards into account when evaluating whether a medical treatment in another Member State is really necessary (Hervey & McHale, 2004, pp. 124-130).

In the subsequent years, two more rulings were issued by the CJEU, clarifying its legal position. In the cases of *Müller-Fauré* and *Van Riet* in 2003 (Court of Justice of the European Union, 13 May 2003), the Court clearly distinguished between inpatient and outpatient care. As far as outpatient care in another Member State was concerned, Member States would no longer be able to impose prior authorizations on citizens. Confirming its previous rulings, the CJEU confirmed however that for inpatient care prior authorization procedures would be permitted. The Court refused some Member States' arguments concerning waiting lists for receiving inpatient care. Some governments had argued that patients could try to used cross-border healthcare to circumvent waiting times for medical interventions at home, and that this would lead to a wastage of capacities at national level. This argument was refuted by the CJEU as a purely economic aspect (Hervey & McHale, 2004, p. 132). The ruling of 2006 concerned a citizen from the United Kingdom, Yvonne Watts (Court of Justice of the European Union, 16 May 2006). In this case, the CJEU decided that prior rulings would also apply to National Health Systems as operated by the United Kingdom, and that a prior authorization for inpatient care in another Member State could only be denied if the patient's medical condition was to be assessed in an objective way. If the result of the assessment would indicate that national waiting lists could lead to an 'undue delay' of medical treatment, prior authorization would have to be granted (*ibid*., p. 133).

Limits to Member States Social Sovereignty in Healthcare

From a patient's perspective, the CJEU's rulings have led to a complicated and somewhat confusing system that determines in which specific situations a European citizen seeking treatment abroad is entitled to do so with or without prior authorization by his sickness fund. Despite this confusing system, the Court's rulings have a more general importance: "The judgments of the Court of Justice concerning the patients' rights to cross-border health and long-term care caused not only an increase of personal rights but even more a fundamental change in understanding what European health policy reciprocal to the European and national level in the future really could mean" (Sieveking, 2007, p. 40).

The case law developed by the CJEU based on the principles of the EU's internal market have therefore limited the logic of public healthcare provision with different rules and regulations concerning the access to healthcare across Member States. With its rulings the CJEU did not only limit Member States' room for manoeuvre to regulate access to healthcare for European citizens, it also intervened in medical standard setting, by stipulating that Member States have to take international medical standards into account when deciding which treatment would be liable to reimbursement of costs. European integration would thus lead to an "uninvited Europeanization" of healthcare as no Member State was in favor of furthering European integration in this policy field (Greer, 2006). The role of the Court has therefore even been criticized by legal scholars for having decided that healthcare services that are delivered to citizens as part of national welfare states are subject to the economic rules of the European Treaties, even though Article 152 had limited the EU's competencies in healthcare: "The Court of Justice has used strong wording in its judgments […] but has failed to put forward arguments supporting that wording" (Kaczorowska, 2006, p. 352). Given the largely economic reasoning of the CJEU, one can also argue that the rulings were less concerned with individual patients than with preventing Member States from obliging patients to use national healthcare providers, i.e. Member States would not be able to "discriminate" in favour of their own providers against healthcare providers form other Member States (Greer & Rauscher, 2011b, p. 4).

The different rulings on cross-border healthcare have unsurprisingly created concerns in Member States. The first and foremost concern of Member States was that they could lose control over the boundaries of their respective healthcare systems. As the healthcare systems are closely linked to the national welfare state, they have been created in correspondence with the national borders. Member State's obligation to reimburse patients without prior authorization for medical treatment of a physician in another Member State jeopardizes this conception of healthcare services (Lamping, 2005, p. 31). Resulting from this reduced control over national boundaries, Member States feared a declining control over the beneficiaries of national healthcare benefits as they would have to grant increased access to medical care to citizens from other Member States. More importantly, the status of who is a beneficiary of the healthcare system is usually defined by each Member State according to its own criteria. Due to the CJEU's jurisprudence, Member States would have to accept in certain cases that the rules of other Member States might define who is a beneficiary and hence entitled to public healthcare. The same argument also relates to the control of consumption of health services which would not be bound anymore to national borders. And lastly the national control over providers' quality of treatment was reduced as Member States could not easily discriminate against providers from other Member States delivering healthcare (*ibid*.).

The rulings mean therefore 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 (Baeten, Coucheir & Vanhercke, 2010). The EU provides therefore 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 in the long run (Ferrera, 2005, pp. 219ff). Member States' healthcare systems have hence come under adaptive pressure resulting from negative European integration. It has been argued in previous research that Bismarckian healthcare systems would be subject to a relatively lower adaptive pressure concerning the EU rules on cross-border healthcare in comparison to National Health Systems as operated by the United Kingdom or the Scandinavian Member States. This argument relates to the institutional features of Bismarckian healthcare systems, namely the financing structure and the insurance principle: "Free movement and the right to cross-border social security are first and foremost compatible with an individualistic insurance principle, where there is a direct relationship between social entitlements and contributions" (Sindbjerg Martinsen, 2005, p. 1033).

In terms of *relative* compatibility of national healthcare systems with increased exit options for medical treatment in another EU Member State, this argument might hold true. National Health Systems offer medical treatment on the basis of residence and citizenship, but not on the basis of an individual contractual basis between citizens and sickness fund as well as between sickness funds and providers. Without contradicting this reasoning, it can be pushed further in terms of compatibility in *absolute* terms. Not despite but *because* of its compatibility with the individualistic principles of the EU's rules on cross-border healthcare, Bismarckian healthcare systems should be even more liable to processes that threaten the national conception of welfare institutions. The dispersion of power between different actors and the leeway they have for agency due to their relative financial independence from the state would make it rather easier for them to interact with the European level and use Europe-wide spatial options than for those actors who operate in National Health Systems under tighter state control. A Bismarckian healthcare system like Austria's should thus show national effects of European integration earlier than other types of healthcare systems.

In fact, the involvement of the EU in welfare state issues bears similarities to the developments of national welfare states in federal systems. It is therefore suggested to define the opportunities and constraints that the EU offers to national healthcare actors as that of a quasi-federal system. This is not to say that the EU is transforming itself into a federal state nor does it denote that we will necessarily witness the exact same type of development. It helps however to designate opportunity structures beyond the national welfare sphere which also involves subnational authorities, i.e. it offers to take into account the supra-national, the national and the subnational level for analysis. Looking at various levels of governance is especially important since the CJEU's rulings on access to healthcare in other Member States have not only threatened national boundaries and hence institutional regimes. They have also triggered a political process lasting longer than a decade to codify the case law on cross-border healthcare in a European Directive.

3.3 The EU as a Quasi-Federal Opportunity Structure in Healthcare

Quasi-Federal European Opportunities

The CJEU's rulings on cross-border healthcare have opened a Europe-wide space of action for national healthcare actors. From a theoretical perspective, this additional layer of governance creates a multi-tiered membership in the EU which can be seen as a quasi-federal institutional arrangement, especially for states that already have a federal system and that are subject to mechanisms of negative integration (Leibfried, Castles & Obinger, 2005, p. 20). Obinger, Leibfried and Castles define federalism as "an institutional device designed to secure unity by allowing a certain degree of diversity" (*ibid*., p. 2). This can create a somewhat conflictive relationship between the EU and welfare states, since social policy usually aims at creating equal benefits for all citizens inside a given state. This tension then necessarily influences the policy-making of social policies (*ibid*., p. 9). Following this 'federal' line of argument, the development of negative integration at the European level can also be described from a 'federal' angle: As the requirement for unanimity on the EU level for most social policies and a large number of possible veto-players, i.e. the Member States, reduces possibilities to formulate uniform European social policies, the EU has to circumvent its institutional rigidity by creating 'bypasses'. Obinger, Leibfried and Castles see integration through European law as such a bypass for an "evolving democratic federal system" (*ibid*., p. 348). A second bypass structure from a bottom-up perspective is then the possibility for sub-state units to get involved directly with the European level, giving them an opportunity to bypass their national governments (*ibid*., p. 351).

The federal approach underlines therefore that not only different actors such as patients and healthcare providers will have new opportunities arising from the advancement of European Integration in the field of healthcare, but that subnational actors such as regions have to be taken into account. The subnational level is in many Member States responsible for certain welfare policies such as the provision of healthcare: The decentralization process of competencies that has taken place in many European nation states 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. The subnational level is for example institutionally 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 and structural funds for the subnational level to engage directly with other subnational authorities across their national border. The budget of these funds represented in 2000 35% of the EU's budget, while it was only at 5% in the 1970s. Most notably these funds offer opportunities of direct contacts between the regional level and the European Commission (*ibid*., pp. 180-187). It was estimated that roughly 1.5 per cent of the total amount available through the different Structural Funds operated under the EU's Regional Policy have been allocated to planned health investments for the period between 2007 and 2013. This estimate equals around 5 billion € for the mentioned period being allocated for

regional projects on health infrastructure, access to healthcare, emergency care but also to disease prevention and education of health professionals (Watson, 2011).

Considering the EU as a quasi-federal system means that it offers welfare states actors an opportunity structure for political games between the different levels of government, which add a layer of governance on the national welfare state. This does not necessarily imply that regulation on the national is necessarily dismantled. It rather increases the complexity of governance. Therefore, considering the EU as a quasi-federal system could lead to patterns of what has been called multi-level governance also in healthcare where national actors gain access to the European level as a result of European integration:

> "The point of departure for this multi-level governance (MLG) approach is the existence of overlapping competencies among multiple levels of governments and the interaction of political actors across those levels. […] The presumption of multi-level governance is that these actors participate in diverse policy networks and this may involve subnational actors – interest groups and subnational governments – dealing directly with supranational actors" (Marks *et al.*, 1996, p. 167).

Just as policy-making in federal states can be difficult, given the necessity of reaching agreements between the federal level and the subnational level, shifts of policy-responsibilities to the EU-level can either be used to blame the own state or to blame the EU for policy-outcomes that are not necessary welcomed by all actors. Such institutional set-ups shape opportunity structures, but do not necessarily predict a certain policy-outcome. National and European institutions alike set the incentives for certain strategies in social policy-making and provide the resources of the involved actors regarding financial and political power. Ultimately, though, it is the choice of actors how to use their resources to determine the outcome of further policy-development (Leibfried, Castles & Obinger, 2005, p. 21).

Policy Development on Cross-border Healthcare at European Level

Even though the CJEU's rulings had opened the possibility of political involvement of various healthcare actors at European level, a political process at European level only developed slowly. As Member States feared the consequences of the first *Kohll-Decker* rulings in 1998, they tried to limit the political impact of the rulings by a narrow interpretation of the rules that the CJEU had created for cross-border healthcare. In the Council of Ministers, various Council presidencies reacted by holding conferences on cross-border healthcare, or by commissioning legal research, but did not take further initiatives (Greer, 2008, p. 222). The first conferences by Member States held on the issue of European rules on access to healthcare across Member States' border were held in 2001 and 2002, at which the Council of Ministers eventually decided to initiate a so-called "high-level process of reflection on healthcare services and patient mobility" (Rosenmöller, Baeten & McKee, 2006, p. 3). While Member States hoped that the outcome of the reflection would show solutions for Member States to reassert control over healthcare (Greer, 2008, p. 223), the European Commission issued a report recommending that Member States needed to enhance their cooperation to clarify what the rulings meant for patients. The European Commission also encouraged Member States to enhance their collaboration in healthcare in border regions and suggested

to create European centers of reference for certain diseases, and argued that patients would be in need of knowledge about the availability and quality of medical treatment in the various Member States. The European Commission also called upon Member States to respect the rules set out by the CJEU in its jurisprudence (Rosenmöller, Baeten & McKee, 2006, pp. 3f). The European Commission was therefore using the CJEU's rulings to extend its competencies to also have a say concerning cross-border healthcare, trying to develop its own health policy (Greer, 2006, p. 146).

Member States were however reluctant to implement the CJEU's rulings and the European Commission noted in a report on implementation in 2003 that Member States did not show any common interpretation of the case law (Commission of the European Communities, 28 July 2003). Following this diagnosis, the European Commission tried to codify the CJEU's rulings in the contested Services Directive which had been developed under European Commissioner Bolkestein. It is noteworthy that the European Commission's Directorate General Internal Market took the lead in inserting European rules on health services in the Services Directive. Member States as well as representatives of the health sector ferociously opposed this attempt by the European Commission. In the end, health services were deleted from the Services Directive (Greer, 2008, p. 225), as "health ministers however refused to have their policy area regulated as part of a general Directive on services, placed under the DG Internal Market" (Sindbjerg Martinsen, March 2009, p. 8). Member States adopted furthermore in the Council of Ministers a wording which stated that they share 'common values and principles' concerning their health systems including the universality of healthcare, high quality standards, ethics, patient involvement, confidentiality, equity and solidarity (Commission of the European Communities, June 2007, p. 33), therefore underlining the social character of health services.

During these years of political stalemate between Member States and the European Commission, the CJEU issued further rulings on cross-border healthcare, and the ruling in the case of Yvonne Watts of 2006 initiated once again political bargaining between Member States and the European Commission. Alarmed by the *Watts* ruling, Member States' health ministers called for a solution at European level. Following Member States' call for a solution, the European Commission published a communication in September 2006 suggesting a mix of different measures in response to the CJEU's jurisprudence, one of them was to develop a European legislative act: "There are a wide range of possible tools for action at Community level on health services. Legal certainty would be best ensured by a binding legal instrument. This could be a regulation or a directive […]" (Commission of the European Communities, 26 June 2006, p. 10). At the same time the European Parliament's Committee on the Environment, Public Health and Food Safety issued a report which called for different measures in order to clarify the legal issues around cross-border healthcare. The report encouraged the Commission to collect and evaluate data on the actual cross-border movements of patients. Furthermore the Committee asked the European Commission to publish the results of such an evaluation and to develop a clear framework on cross-border healthcare (Sieveking, 2007, p. 48). In May 2007, the European Commission published the results of a survey which indicated that actually 4% of European citizens had received medical treatment in another EU Member State and that more than half

of European citizens would be open to travel for medical treatment to another Member State (Commission of the European Communities, May 2007). Besides this report, the European Commission had opened a public consultation in September 2006 (Commission of the European Communities, 26 September 2006) which highlighted the concrete problems related to the case law on cross-border healthcare created by the CJEU.

One of the most important problems was the lack of a definition what "health services" would mean under European rules on cross-border healthcare ; further terms such as what constitutes a "necessary treatment" were defined differently by Member States. With increased access to medical care in another Member State, patients would furthermore require information about quality and availability of healthcare abroad and about the rights granted by the CJEU. Another open question was which authority in which Member State would be responsible for the clinical oversight of medical treatments carried out. This question again is linked to the issue of the quality of healthcare: which standards of medical treatment can European patients expect in another Member State? And the final problem concerned financial aspects of healthcare. How would Member States be able to control the flow of patients from one country to another? The distinction which the CJEU had made between inpatient and outpatient care with regard to the requirement of prior authorization care posed another problem for Member States' governments (Commission of the European Communities, 2007). The difference between both forms of medical treatment is not as clear cut as it might seem at first sight: in order to reduce the number of patients unnecessarily occupying hospital beds, several Member States had introduced a variety of forms of outpatient care and polyclinic treatments. This kind of treatment belongs neither to the category of inpatient care nor does it clearly belong to the category of outpatient care (Hervey & McHale, 2004, p. 126).

The consultation procedure opened in 2006 finally paved the way to the negotiations on codifying the CJEU's rulings on cross-border healthcare in a Directive in order to address these open questions. The consultation itself opened a concrete channel for national healthcare actors to become involved in European policy-making and thus reaching directly the 'federal level'. European integration in healthcare has therefore started to offer various resources for national actors to go beyond the boundaries of their national healthcare system. Firstly, the CJEU's rulings themselves can constitute a resource for actors to legitimize own policy demands at national level. Secondly the EU provides financial subsidies through its Structural Funds under its Regional Policy for cross-border collaboration in healthcare. And thirdly, the consultation process opened the opportunity for national actors to directly upload their own policy preferences to the European level, possibly circumventing Member States' governments. These openings to a new layer of European opportunity structure hence offer ample possibilities for the Europeanization of actors' interests and strategies, which in turn might have an impact on national healthcare *regimes*. The possibility of directly accessing European resources however does not predict whether actors in a national healthcare system necessarily want to *use* these new spatial options. For the scope of this research it thus seems much more important to scrutinize whether and how actors in a national healthcare system react to the new opportunities

and constraints that the EU is prescribing in healthcare. The national institutional structure of healthcare systems, however, cannot be ignored when carrying out such an analysis. If Ferrera (2005) emphasizes the threat to national boundaries of welfare states, it seems that the institutions that are in place inside these boundaries are somewhat neglected. National welfare institutions represent a strong historical legacy that determines actors' roles in the welfare state and in their healthcare systems. Over more than a century these institutions have gained an important legitimacy. Even if European Integration is limiting the room of manoeuvre for the operation of these institutions and the EU is offering ways of exiting from institutional welfare *regimes*, this does not equal an increased legitimacy of EU arrangements vis-à-vis longstanding national welfare state institutions. The next section will therefore look at the actual data concerning cross-border healthcare in Austria.

3.4 Cross-border Patient Mobility in Austria

The Austrian healthcare system was ranked in 2000 by the World Health Organization (WHO) in terms of performance at the ninth rank of all Member States of the WHO (World Health Organization, 2000). And in 2012, the European Health Consumer Powerhouse index ranked the Austrian healthcare system as the eleventh out of 27 EU Member State healthcare systems at that time (Health Consumer Powerhouse, 2012). These rankings use different statistical indicators to measure either performance or perception of healthcare systems, and are not only seen as controversial by scholars but also by politicians, given their potential impact on electoral competition. However, both rankings indicate that the Austrian healthcare system is quite high performing, or put differently: the system is "highly regarded" even if "costly" (Gönenç, Hofmarcher & Wörgötter, 2011). Overall, Austrian patients show a constant rate of significant satisfaction with the Austrian healthcare system (Hofmarcher, 2013, p. 196).

In 2008, the Main Association of Austrian Social Insurance Institutions carried out a survey of 40,000 Austrian users of healthcare concerning patient satisfaction of the outpatient sector. The survey took into account waiting times for treatment. It turned out that the majority of patients is however satisfied with those waiting times; only around 20% of patients find waiting times for general practitioners and specialists too long. These waiting times concern physicians that have a contract with the sickness funds. Waiting times for those patients who visit a *Wahlarzt* (physician in a private practice without a contract with sickness funds) have shorter waiting times for specialists, but not concerning visits of general practitioners. Taken together, ambulatory care is rather easily accessible in Austria and patients are on average satisfied with the provision of outpatient healthcare (Fischer, 2009)[2].

As far as the inpatient sector is concerned, around 600,000 patients aged above 15 years receive inpatient medical treatment per year, i.e. a planned operation. Waiting times for operations differ by type of operation and by the insurance status of the patient. Patients with a supplementary private health insurance usually have four times

[2] For a general discussion and analysis of the institutional determinants of patient satisfaction see Wendt *et al.*, 2010.

shorter waiting times than those with only public health insurance. There is however nearly no difference in waiting times when it comes to important operations such as heart surgery. Waiting times for patients are generally quite moderate, even though they can reach up to three months for certain operations. Patients have to wait less for medically more major operations such as arterial bypasses of the heart, requiring a waiting time of around 39 days (Statistik Austria, 2007, p. 47). Taken together with the figures of the outpatient sector, one can conclude that Austrian patients have access to necessary healthcare, even though waiting times do exist. These waiting times, however, do not seem to lower patient satisfaction with healthcare and access to medically necessary interventions is provided by the public healthcare system. Patients with a private supplementary insurance, though, have the advantage of reduced waiting times given the higher intervention of private health insurance in hospital costs in respect of catering and single-room stays of patients.

While the general satisfaction of patients with the healthcare system is rather high and there are only moderate waiting times (which can even be reduced by having private supplementary insurance), Austrian patients also receive medical treatment in bordering EU countries. And given that Austria is a main European tourism destination, European patients are also treated in the Austrian healthcare system. However, statistics are oftentimes only available in an aggregated manner or are scattered across different regional sickness funds. The split European regulation of patient mobility is an additional factor contributing to complexity concerning the data collection and patient flows for all EU Member States (van Ginneken & Busse, 2011, p. 289). The statistical and anecdotal data that will be provided here concerns mainly the general aspects of patient flows, while administrative procedures and patients' motivation to receive medical treatment abroad will be treated in chapter 4. The main source of data stems either from the available secondary literature or is based on statistics provided by interviewed actors[3]. Given the scattered availability of data, only limited conclusions can be drawn. The following tables can however provide an indication of main inflows and outflows of patients from and to other EU Member States.

A General Overview of Patient Fluxes

The following table provides the latest available data as provided by the Main Association of Austrian Social Insurance Institutions[4]. Based on figures of 2009 it considers the Member States with the highest number of cases (Member States with a case number below 1,000 have not been included). Member States have been classified according to the number of Austrian patients treated in other EU Member States. The calculations of the Main Association also include the states of the European Economic Area (Norway, Liechtenstein, Switzerland) whose patients benefit from the same rules as EU Member States under Regulation 883/2004.

[3] Statistical Data has been provided on request of the author by courtesy of the following institutions: Main Association of Austrian Social Security Institutions, Vienna Regional Sickness Fund, Vorarlberg Health Fund, Austrian Accident Insurance Fund (AUVA) and UNIQA health insurance (provider of private health insurance).

[4] Data provided by letter which is in possession of the author.

Table 7. Patient flows to / from Austria (inpatient and outpatient care) in 2009

EU Member State	*From Austria to…*		*To Austria from…*	
	Number of cases	*Amount (€)*	*Number of cases*	*Amount (€)*
Germany	61,555	26,767,337.39	186,660	60,399,588.84
Hungary	11,154	700,004.25	2,299	2,031,369.50
Slovakia	10,504	773,804.25	1,374	642,890.13
Czech Republic	9,528	1,018,763.90	2,889	1,519,897.55
Slovenia	3,558	795,988.59	821	800,721.78
Poland	2,075	186,924.62	1,288	637,007.09
Italy	1,594	6,802,902.32	12,826	5,851,004.98
Spain	1,274	274,525	1,740	601,156.03
Switzerland	1,130	1,249,166.92	7,212	2,869,854.47
…	…	…	…	…
Netherlands	470	453,779.21	3,800	1,877,034.57
United Kingdom	11	53,803.51	13,168	5,645,753.27
Total (all EU/EEA)	*104,965*	*40,830,810.74*	*246,029*	*87,932,373.12*

The table presents aggregate data containing cases of medical emergency under Regulation 883/2004 (EC) (former Regulation 1408/71) and reimbursements according to the judgments by the Court of Justice of the European Union on cross-border healthcare. The judgements' rules for reimbursement on cross-border healthcare did not challenge the Austrian rules on reimbursement. Austria was in fact the only EU Member State which was already in line with European requirements. In case patients seek elective medical treatment abroad, Austrian social insurance law provides that patients receive the same reimbursement as if they had visited a physician in Austria without a contract with sickness funds (*Wahlarzt*). Patients thus receive 80% of what sickness funds would have paid to a physician who has a contract with them: "[a]ccording to Austrian health care law, a foreign physician [is] thus treated like any other 'out-of-network' physician" (Obermaier, 2009, p. 79).

While the number of cases seems to be quite considerable – more than 100,000 cases of treatments in other countries and more than 240,000 cases of treatments of EU/EEA nationals in Austria – these figures have to relativized firstly by the number of patients. The number of "cases" indicates here the number of bills that have been processed by sickness funds, and not necessarily the exact number of patients, as one patient might have needed different treatments. Secondly, the large number of incoming patients has to be relativized according to the total number of medical treatments in Austria. In 2009, the number of foreign patients (including even third-country nationals) that have undergone medical treatment, account for 1.69 per cent[5] of all patients that have received treatment in Austria. Given that the global public expenses on healthcare accounted for 22.46 billion € (Statistik Austria, 2013a), the

[5] Data provided by the Hospital Corporation (Krankenanstaltenverbund) Vienna.

amount that health insurances of other EU/EEA states owed to Austria represents 0.42% of the overall expenses. The percentage of total healthcare expenditure that Austria owed to other European health insurances represents 0.18%. In terms of the general number of patients treated in Austria and in terms of expenditure on general public healthcare, European patients do not seem to represent a major factor. This has to be distinguished however from the fact that the figures indicate that Austrian sickness funds nonetheless deal on a regular basis with patients going to and patients leaving Austria for medical treatment. Furthermore, healthcare providers in Austria are faced with more than 240,000 cases a year in their daily routines.

The table also hints at the direction of patient fluxes. Most countries which have not been included in the table show an exchange of cases between European states and Austria that most of the time does not even reach a hundred cases. The interestingly high patient fluxes can be explained by the fact that Austria is a major European tourist destination (Statistik Austria, 2012, p. 30). This can be illustrated by the high number of incoming patients from the Netherlands (3,800 cases) and from the United Kingdom (more than 13,000 cases), whereas the number of Austrian patients in these countries is considerably lower. At the same time the table largely correlates with touristic visits of Austrians to their neighbouring or nearby tourist destinations such as the Czech Republic, Hungary, Slovenia, Italy and Croatia. The ratio between the number of cases and the amount due to the medical treatments also generally implies that except for Italy, Switzerland and Germany, Austria is surrounded by EU Member States where the costs of medical treatment are considerably lower than in Austria, even if this interpretation must be qualified as the table does not provide information about the quality of treatment (outpatient or much more expensive inpatient treatment).

Tourism and Cross-border Healthcare

That tourism is a major factor which is responsible for the higher number of foreign patients treated in Austria than the number of Austrians treated in other European countries can be corroborated by a disaggregation of available data according to regions. While the overall percentage of foreign patients in Austria amounts 1.69%, Austrian *Länder* which are tourist destinations for mainly ski tourism show a much higher percentage of foreign patients. For example foreign patients account for ca. 5% in Salzburg. 80% of these patients come from EU Member States[6]. Ski tourism is furthermore an important factor determining the types of medical interventions that have to be carried out in those regions. As an illustration, data provided by the Health Fund Vorarlberg is presented in the following table. Around four to five million tourists per year visit Vorarlberg, a considerable part of those tourists coming for winter sports such as skiing[7].

[6] Data also provided by the Hospital Corporation (Krankenanstaltenverbund) Vienna.

[7] Interview 25, Senior Desk Officer, Vorarlberg Health Fund, Coordinator of *Länder* position on Patients' Rights Directive, Bregenz, 19 January 2011.

Table 8. Most important diagnoses for EU patients in hospitals in Vorarlberg (2009)

Diagnosis	*Number of cases*
Craniocerebral injury	180
Surgical interventions knee/lower leg	132
Complex surgical interventions knee/lower leg	98
Complex surgical interventions shoulder/upper arm/elbow	75
Other affections of female genitalia	67
Luxation, contortion, contusion	56
Surgical interventions hip/thigh	51
Acute heart diseases	49
Surgical interventions forearm, carpus, hand	47

The majority of these interventions had to be carried out in hospitals due to winter sport and skiing related accidents which oftentimes result in bone injuries or to sicknesses related to physical activity in cold winter weather. Patients that are treated for other sicknesses reaching from severe tonsillitis to appendicitis occur with much lesser frequency (3 to 20 cases in 2009). Some of the European patients treated in Austria have to be transported to specialized accident hospitals (*Unfallkrankenhaus*) which are operated by the Austrian Accident Insurance Fund (AUVA). Generally speaking, important or serious accidents (not necessarily related to winter tourism) of EU citizens in Austria happen rarely in comparison with the overall number of cases. In 2009 around 790 cases had to be treated in accident hospitals; similar numbers of cases occurred during the following two years [8].

Germany – Austria and Border Regions

The highest number of EU nationals treated in Austria are Germans. At the same time, Germany is the most important destination for Austrians being treated in another EU Member State. The figures reflect the close ties between both countries which share a common language. While Austria is not only an important tourist destination for Germans, the number of Germans living in Austria has doubled over the last decade. While in 2002 ca. 75,000 Germans lived in Austria, in 2013 their number had grown to more than 157,000 (Statistik Austria, 2013b). Many of these German citizens in Austria work there and hence are insured with Austrian sickness funds. The number of Germans working in Austria highlights the important exchange of visitors between both countries. However, students without work contracts or jobs not liable for payroll contributions to social insurance also represent a large part of the Germans living in Austria. Students are oftentimes insured by their parent's social insurance in Germany. In fact, the number of German students studying at Austrian universities or institutes of higher education has nearly quadrupled over the last decade. In 2000, nearly 5,900 German students lived in Austria; in 2010 this number had grown to

[8] Data provided by the Austrian Accident Insurance Fund (AUVA).

more than 27,000 students (Statistisches Bundesamt, 2012, p. 29). They thus might represent an important share of Germans being treated in Austria.

German and Austrian patients oftentimes also make a frequent use of physicians or other therapists across the border for reasons of geographical proximity. Moreover, Austrian patients from border areas are sent to nearby hospitals in Southern Germany in the event that an urgent or specialized treatment in Austria would not be possible due to problems of transport, weather conditions (i.e. helicopter transport), or too great geographic distance. These cases do not concern elective treatments by patients under the rulings by the Court of Justice of the European Union. A special case would be also the Kleinwalsertal, a mountainous valley in Vorarlberg which can only be reached from German territory. Patients are regularly sent for treatment to Germany and reimbursement for treatment is based on bi-national agreement between German and Austrian sickness funds [9]. Border regions show a higher patient mobility across borders in general. Oftentimes patients who for example work in Austria and who are insured with Austrian sickness funds might live across the border and receive treatment from foreign healthcare providers. They are then reimbursed by the Austrian sickness funds. The most important border areas concern regions bordering on Hungary (Hungarian citizens working in Burgenland or even commuting to Vienna) or bordering on Germany [10]. Other medical treatments of Austrians from border regions are also regulated by bi-national agreements. Seriously burnt patients from Southern Austria (Styria) are for example transported for treatment to a specialized hospital in Ljubljana (Slovenia) [11]. Furthermore a bilateral agreement exists between Austria and Slovenia for the outpatient and inpatient treatment of both countries' nationals. Most Austrians that have been treated in Slovenian hospitals were men aged between 30 and 60, which indicates that most of these patients are cross-border workers who are insured in Austria, but live in Slovenia (Österle, 2007, p. 118).

Even though the aggregate statistics provided by the Main Association of Austrian Social Insurance Institutions do not differentiate according to emergencies, medical treatments with prior authorizations (former E112 procedure) and elective treatments according to the patients' rights directive, many of the Austrian patients are treated in Germany on the basis of prior authorization procedures. Austrian patients are mainly sent to Germany for inpatient treatments in cases where there is either no treatment possible in Austria due to a low number of cases per year, very specialized treatment is needed where the only expert resides in Germany or – in a fewer number of cases – where waiting times in Austria for an operation would be too long [12] [13].

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[9] Interview 27, Head of Contracting Department, Vorarlberg Sickness Fund, Dornbirn, 20 January 2011.

[10] Interview 42, Director of Judicial Affairs, General Affairs and Medical Services Directorate General; Chief Medical Officer; Vienna Sickness Fund, Vienna, 18 January 2012.

[11] Interview 14, Professor, Institute for Social and Labour Law, University of Vienna, Vienna, 17 September 2010.

[12] Interview 42, *loc. cit*.

[13] Interview 41, Patients' Ombudsman Vienna (*Patientenanwalt*); Vienna, 18 January 2012.

Historically Grown Cross-border Care

Historically grown ties with regions of other EU Member States also play an important role for patient-mobility to and from Austria. As far as cross-border patient mobility to Austria is concerned, the Italian region of Alto Adige/South Tyrol is significant. The region, which was part of the Austrian-Hungarian Empire till the end of World War I, has a majority German-speaking population. Patients from this region are treated on a frequent basis in the university hospital of Innsbruck, thus representing a considerable number of Italian citizens treated in Austria. Cross-border healthcare and movements of patients between the North of Italy and Tyrol in Austria have therefore been existing a long time before the Court of Justice of the European Union issued its rulings and before Austria had joined the EU. The second historically grown flux of patients concerns Austrians who go to Hungary for dental treatment, especially in the urban areas close to the Austrian border[14]. Like cross-border healthcare between Northern Italy and Austria, "dental tourism" to Hungary existed already before Austria had joined the EU, the increasingly open borders since Hungary's EU membership have facilitated cross-border dental care. Austrians usually seek dental care in Hungary since the Austrian health insurance coverage of these treatments is rather limited in comparison to other outpatient or inpatient care. For many treatments, citizens insured in Austria have to provide out-of-pocket payments and hence choose dental treatment in Hungary where treatment is available at considerably lower prices. Given the Austrian legislation on reimbursement, patients then hand in their bills in Austria and receive 80% of the tariff which would have been paid in Austria. The co-payments for Austrian patients in Hungary are thus significantly reduced. While Austrian patients could theoretically also benefit from lower price levels of treatment in other European Member States, the entrepreneurial activities of Hungarian dentists who offer additional services which make the stay in Hungary more enjoyable explain why Hungary has become the preferred destination in cases where Austrians leave the country for dental treatment (Österle, 2007, p. 121). However, only few reliable data exist about the exact number of Austrian patients going to Hungary for dental treatment. This is due to the fact that not all patients hand in their bills for reimbursement to Austrian sickness funds, since Austrian health insurance might generally only cover a rather small amount of dental treatment. In 2005, an Austrian journal speculated that about 160,000 Austrians would travel each year to Hungary for dental treatment. This number is however based on anecdotal evidence and cannot be verified, as around 80% of patients that have been interviewed in a study would prefer to pay their treatment out-of-pocket, while only 20% would seek partial reimbursement. Dental tourism to Hungary thus happens mainly outside of any European regulations on healthcare (Obermaier, January 2009, p. 17).

[14] Interview 6, Austrian Federal Institute for Public Health Service (ÖBIG), Vienna, 18 January 2010.

Patients with Private Health Insurance

Austrian patients with a complementary private health insurance also travel abroad for medical treatment. Since more than 99% of Austrians are insured with public health insurances, private health insurances only play a complementary role. Private health insurances usually pay supplementary costs for single rooms in hospitals and other additional services. Only a small amount of payments concerns supplementary payments for hospital costs that would not be covered by public health insurance (e.g. reimbursement of co-payments). Most of the costs paid by private health insurances concern medical emergencies in other EU Member States and Switzerland which are also covered by the European Health Insurance Card. A considerably smaller percentage of reimbursement concerns elective treatments in other European countries. These cases are mainly severe illnesses or "desperate" cases such as patients seeking a specialist for cancer therapy. Those patients insured with UNIQA private health insurance – one of the biggest private health insurers in Austria – have the free choice of European hospitals, and additional costs are reimbursed if public health insurance pays the normal hospital costs according to Austrian legislation [15].

The data and percentages provided in this chapter are sketchy, and many of the aspects of cross-border healthcare are based on anecdotal evidence. Insofar, available data for Austria shows no difference to other available data for other EU Member States. Generally speaking, cross-border healthcare has quite a limited share in terms of the overall public healthcare budget. The examples provided show however that cross-border healthcare is part of public healthcare provision in Austria, and that it nonetheless adds up to several hundred thousand cases either concerning ingoing or outgoing patients. As the historically grown dental tourism with Hungary shows, many cases might not even be captured by statistics as patients use cross-border healthcare outside national or European regulations. Furthermore, tourism is one of the main causes for cross-border healthcare for European citizens in Austria and percentages of foreign patients are thus unevenly distributed across the national territory. Especially regions with ski tourism are concerned. Immigration, linguistic and cultural ties also play an important role, which can be seen from the large number of cross-border healthcare cases with Germany. Additionally, border regions show a much higher share of cross-border healthcare due to workers who commute to their workplace in neighbouring Member States but who are insured in Austria or vice versa. While cross-border healthcare is a reality in the Austrian healthcare system, even at low percentage levels, it is an increasing phenomenon. According to estimations, the costs of healthcare provided in other EU Member States under Regulation 883/2004 (former Regulation 1408/71) have grown from 0.48 € per inhabitant in 1997 to 2.96 € in 2004 (van Ginneken & Busse, 2011, p. 313). Austrian actors in healthcare are therefore faced with an increasingly important phenomenon in financial and numeral terms. Oftentimes, border regions are the avant-garde for cross-border healthcare and regional actors have already initiated cross-border healthcare projects which will be analysed in chapter 4.

[15] Interview 39, Member of the executive board of UNIQA insurance, responsible for healthcare, UNIQA Insurance Group, Vienna, 13 January 2012.

4
Usages of Europe in the Austrian Healthcare System

4.1 Challenging Boundaries? Cross-border Hospital Collaboration and Regional Experiences

Cross-border Collaboration

Following the bottom-up logic of the research design, the analysis of healthcare actors' usages of Europe starts from the lowest level of governance, namely the cooperation between local hospitals across borders. Given the importance of hospitals for the Austrian *Länder*, the following section will be addressing one of the core issues of the Austrian healthcare system: the regional provision of inpatient care. The context of cross-border collaboration by Austrian hospitals is marked by the recurring debate about the reform and efficiency of smaller hospitals. Especially border regions are concerned by this debate, given their remote location from political, economic and populated centres of the country. At the same time, border areas show more important numbers of cross-border patient mobility (see chapter 3). Cross-border hospital collaboration is thus situated at the cross-roads between important national reform debates in Austria and European involvement since the EU does not only offer legal resources (i.e. rules on cross-border patient mobility), but also funding through its Regional Policy (see chapter 1).

Cross-border hospital collaboration is certainly the most intensive form of cross-border healthcare in comparison to other forms such as medical treatment of foreigners in tourist areas. Different variations of cross-border hospital collaboration exist across Europe, such as between France, Luxemburg and Belgium or between the Netherlands, Belgium and Germany where university hospitals either exchange patients or treat patients from across the border. More generally, "cross-border collaboration is understood as an activity or arrangement in the field of healthcare

undertaken by two or more cooperating *actors*, located in different systems/countries, with the *aim* of transferring or exchanging (or easing the *transfer/exchange* of) patients, providers, products, services, funding or health care knowledge across the *border* which separates them" (Glinos, 2011, p. 219). Most of these projects are situated in border regions, even though cases exist where an exchange is also organized between non-neighbouring regions. Furthermore, the ways in which such collaboration is organized and funded differ widely amongst existing projects. Most of these projects have been developed at local level, but many others have been supported, co-organized or developed further by regional authorities. Oftentimes these projects are linked to wider frameworks of existing economic or infrastructural cross-border co-operation funded by the EU:

> "These forms of cooperation are often within a broader framework of cross-border cooperation, often supported by EU Interreg funds […]. These projects often seek to achieve optimal use of capacity on both sides of the border, with patients and health professionals crossing in both directions [… and] projects frequently provide pragmatic solutions to specific local problems […]" (Rosenmöller, Baeten & McKee, 2006, p. 181).

Differences in the forms of cross-border hospital collaboration in border areas are oftentimes determined by the border itself. Even if border regions of two different EU Member States are part of the Schengen Area, especially cultural and linguistic factors play an important role:

> "Where border-region populations share a common identity, one can consider that they form a cross-border community based on multidimensional proximity. The importance of cultural and historical ties, language, the geographical landscape and distance contribute to making borders *fluid* or *rigid*, the former being characterized by few or no obstacles to cross-border collaboration and exchanges, the latter by the presence of administrative, physical or cultural barriers which make the borders more impenetrable to transfers" (Glinos, 2011, p. 221).

Beyond the nature of the border, the number of bordering countries is also an important factor for potential cross-border hospital collaboration. Austria is one of the Member States with many neighbouring countries as it borders on five EU Member States (Germany, the Czech Republic, Slovakia, Hungary, Slovenia, and Italy) as well as on two Member States of the European Economic Area (Liechtenstein and Switzerland). Out of these countries, three (Germany, Switzerland and Liechtenstein) share a common language with Austria, and the northern Italian region of South Tyrol has a considerable German-speaking population. Beyond language and cultural aspects, very general economic differences can also impact cross-border hospital collaboration: many of the new Member States show considerably lower costs of medical treatments, which could represent an advantage for those providers from old Member States in collaboration with providers from new Member States. At the same time, possible financial gains are partly set-off due to necessary investment in measures concerning the quality of care in new Member States (Österle, 2007, p. 119). Austria thus shares borders with other Member States which might either facilitate cross-border hospital collaboration based on linguistic characteristics (Germany) or because of existing price differences with new Member States (Czech Republic,

Hungary, Slovakia). Furthermore, urban centres in these new Member States are not located very far from Austrian medical institutions, which can also favour cross-border collaboration. This favourable context is even strengthened by existing patient flows across the border, for example between Vienna and the Slovak capital Bratislava; and different smaller projects already exist between Lower Austria and Southern Bohemia in the Czech Republic [1]. Furthermore, studies have been carried out by regional authorities to evaluate which medical facilities exist on both sides of the border in Eastern Austria, i.e. between Burgenland and Lower Austria on the Austrian side and Hungarian, Slovak and Czech border regions (healthregio, 2006).

Several projects exist on a smaller scale in Austria which are mainly based on bilateral agreements or which are regularly using prior authorizations for treatments of specific patient groups. These projects usually address precise medical needs, for example for specialised treatment or geographical reasons. These include the transport of patients with heavy burns from Southern Austria to Slovenia [2], heart surgeries for Croatian children in Linz [3], or regular treatments of Austrian children with eye cancer in the German university hospital of Essen [4]. Austrian healthcare providers thus already use Europe according to their nationally defined tasks, namely to improve access to high-quality medical care. Such a usage happens however within the national boundaries, first of all because of the specific focus of such collaboration on a case-by-case basis and secondly because of negotiated bilateral agreements. While the above mentioned examples show that there is already existing Europeanization, the following sections will analyse more deeply two concrete projects of structured hospital cross-border collaboration in Austrian border regions. Both examples either have treated or aim at treating two different "patient nationalities" on a regular basis. They are therefore best suited to testing whether their potential usages of Europe threaten the national boundaries of the Austrian healthcare system. The analysis of both projects is then followed by a section on the more general experience of regional authorities dealing with cross-border healthcare and how this experience influences their perception of European Integration in healthcare.

National Reform Contexts for Cross-border Collaboration (2008-2012)

Both cross-border hospital projects operate or have been operating in the specific national context of on-going debates about reforming the hospital sector and reducing the number of available beds in smaller hospitals. While these reform debates about the number of Austrian hospitals have been continuing for a decade, they have gained momentum during the last four years. The debate has become more intensive in the two years preceding the end of the 15a-agreement which was valid from 2008 to 2013, already anticipating the negotiations of a hospital reform plan for the upcoming 15a-agreement. The reform debates have also been marked by the Eurozone economic

[1] Interview 6, *loc. cit*.

[2] Interview 14, *loc. cit*.

[3] Interview 15, Head of unit, Upper Austrian Health Fund, Department for Intramural Care, Linz, 29 October 2010

[4] Interview 8, Head of unit, Unit for Hospital Care, Main Association of Austrian Social Insurance Institutions, Vienna, 25 January 2010.

crisis since 2009. In 2010, a report on administrative reform issued by the Court of Auditors triggered a larger debate about reducing economic and administrative inefficiencies in the hospital sector. The State Secretaries of Finance of both governing parties, ÖVP and SPÖ, announced in June 2010 the beginning of talks between the federal government and *Länder* governments to find ways how to create "synergies" and how to reduce the number of available acute care beds for inpatient care. The politicians from the federal level underlined however that talks would not concern the closing of hospitals, but rather that intra-regional borders "should not play a role anymore" when it comes to the planning of hospital infrastructure (*Der Standard*, 9 June 2010). A survey revealed that a majority of 62.1% of Austrians would not necessarily oppose closings of hospitals if structural reforms were to be implemented (*ibid.*, 14 June 2010). The debate was fuelled towards the end of August 2010, when the Main Association of Austrian Insurance Institutions released a study which predicted that expenditures on inpatient care would rise by 1 billion € from 10.9 billion € in 2009 to 11.35 billion € in 2010, which the head of the Main Association called a "dramatic increase" as payroll contributions to sickness funds would not increase at the same pace. The press cited healthcare experts who blamed the *Länder* governors and their "megalomania" for the rise of costs and pointed at the large number of smaller, economically inefficient hospitals (*ibid.*, 25 August 2010).

Given the traditional split between inpatient and outpatient care as well as the tension between the federal level and the *Länder* governments concerning the regulation of inpatient care, the criticism of *Länder* governments was immediately refuted and the Main Association was called upon to "mind their own business" by the health city councillor of Vienna. The health minister of Lower Austria underlined on-going restructuring measures and pointed at the lack of integration between outpatient and inpatient care. It was also pointed out that *Länder* governments would find solutions by using "detours" while at federal level all involved actors would simply blame each other without implementing reforms (*ibid.*, 26 August 2010). In November 2010, Federal Minister of Health Alois Stöger called for a reform of the hospital sector and suggested a uniform federal law for the planning of hospitals. At the same time he underlined that closings of hospitals would not be foreseen. The reform plan included the measure of creating a single fund for inpatient care in which the contributions of sickness funds and tax subsidies would be pooled. The planning of hospitals would be coupled with the possibilities of sanctioning *Länder* governments that would not attain a certain reduction of acute care beds or other goals set by law. The immediate response by *Länder* ministers was that the suggested measures were "not a reform, but a belch" or "a provocation, a senseless bureaucratic idea". The Minister planned to negotiate with the *Länder* on a possible reform by the end of 2012, in order to implement it with a new 15a-agreement (*ibid.*, 4 november 2010). Reform negotiations continued during 2011 and were often coupled with a discussion of reform of public secondary education, where similar tensions between the federal level and the *Länder* exist about regulatory competencies.

In May 2011, the nine *Länder* governments presented a commonly drafted paper which signalled a general agreement to create unified "federal hospital law", pointing out that a decentralized administration of hospitals would permit a cost-efficient and

qualitatively high provision of inpatient are. The paper took up the idea of pooling contributions by sickness funds and tax subsidies for hospitals, the direct financing of hospitals would however be financed by the nine different regional budgets (*ibid.*, 23 May 2011). The paper thus suggested on the one hand a single source for financing (but keeping decentralized control of subsidies for hospitals). The move by *Länder* governments was however part of a more general political bargaining which has to be seen against the background of the Euro crisis. In 2010, *Länder* politicians still reproached the federal government that due to the crisis potential reforms of inpatient care were used as a means of diverting attention away from the budgetary problems of the federal level. In December 2011, the governing coalition passed a balanced budget amendment through the National Council, setting a limit for the maximum annual debt that the federal and regional level can generate in their budgets. While the government aimed at amending the constitution like Germany, after several months of bargaining opposition parties refused to give their agreement. The amendment was then passed into law. At the beginning of 2012 discussions about the state budget were still continuing. A more general debate about limiting public spending and reforming the system of tax subsidies dominated Austrian politics. A general plan for reforming the system of public tax subsidies was suggested by the ÖVP Vice-Chancellor Spindelegger. Suggested measures included amongst others reforms of subsidies (mainly cutbacks) in agriculture, administration, federal railways and pensions. However, *Länder* governments called the reform plans an "attack on federalism (*ibid.*, 8 January 2012). During the course of 2012, confidential negotiations on a healthcare reform continued and by the end of 2012, just before the current 15a-agreement's validity would come to an end, the federal government and the *Länder* as well as the Main Association of Austrian Social Insurance Institutions agreed on a reform package, which was however opposed by the medical profession. The result of negotiations followed the path that was created by the reform of 2005 and aimed at an increase of planning capacities. Actors could not agree on creating a single source for financing of healthcare but set the target of aligning the increase of inpatient care costs with the average economic growth forecasted until 2016. Yet another institution was created, thus once more following a process of institutional layering. The new Federal Commission for Target Control supported by corresponding regional commission will have to ensure a joint planning and control of hospital infrastructure between both levels of government. The existing Federal Health Commission received additional competencies in developing further the Austrian DRG system of remuneration for inpatient care (Bundesministerium für Gesundheit, 1 March 2013). Austrian cross-border hospital cooperation thus took and still takes place in an institutional context which has been marked by on-going reform attempts of inpatient care, mainly putting pressure on regional governments and especially on their smaller hospitals.

The following sections will analyse the potential usages of Europe of two different projects concerning structured cross-border hospital collaboration. The first example is a project which has been running for over a decade but which was recently terminated. It operated between Austria and Germany. The second project has been developing over the last five years and has been incrementally expanding its activities between Austria and the Czech Republic. Both projects concern (plans for) providing

medical treatment for two different "patient nationalities", thus potential effects on national institutional boundaries by actors' usages of Europe should be visible. The different Member States involved provide also a possibility for comparison: the first project is situated in a border region where people share the same language across the border and where price-levels of medical treatment are similar. The second project operates in a border region where people do not share a common language across borders and where important price differentials for medical treatments exist between the two Member States involved.

4.1.1 Cross-border Collaboration between Austria and Germany

Motivation and Project Development [5]

The first example of cross-border hospital collaboration concerns a project which has been running for over a decade between Austria and Germany. It was located more specifically on the border between Upper Austria and Bavaria. The respective Austrian and German regions are separated by the river Inn. The town of Braunau is located on the Austrian side of the river, facing its 'counter-part' – the German town of Simbach – on the other side. Both towns operate hospitals. Their collaboration began in 1994, and Austria's accession to the EU in 1995 helped to intensify cooperation between the hospitals. The project lasted for more than a decade but was abruptly terminated at the end of 2011. While both hospitals operate in particular national contexts, in the following analysis the focus will be put on the Austrian context.

The hospital in Simbach, on the German side of the border, is operated by the Bavarian administrative district Rottal-Inn in form of a non-profit-making limited liability company under German law. The Austrian hospital in Braunau is one of the smaller Austrian hospitals that have been subject to reform pressures. Braunau hospital is operated by the Franciscan nuns of Vöcklabruck, who set up as a limited liability company (GmbH) under Austrian law. Even though the hospital in Braunau is operated by a religious order, it has a public status and is part of the regional hospital plan. Like other Austrian hospitals, treatments are financed on the basis of a fixed sum by sickness funds and by tax subsidies through the Upper Austrian health fund. Operating deficits (*Betriebsabgang*) that might occur have to be co-financed by tax subsidies from the health fund. Contrary to hospitals operated directly by the regional government or by municipalities, the hospitals operated by religious orders find themselves in a weaker position. The hospitals operated by religious orders in Upper Austria have to politically negotiate a part of potentially occurring operational deficits with the regional government, while operational deficits of publicly run regional hospitals are covered automatically [6].

The cross-border hospital collaboration thus took place not only in a context of on-going hospital reforms on the Austrian side, but also in a framework where the Austrian hospital found itself subject to ongoing financial pressures. The first phase of cross-border collaboration was however initiated by a request from the German side in 1994. Regional Bavarian sickness funds made a request to the hospital in Braunau to

[5] Parts of this section have been published in Kostera, 2012.

[6] Interview 19, *loc. cit*.

purchase ambulatory medical services for the locally insured population. The German healthcare system allowed sickness funds to purchase those services. The German hospital in Simbach underwent a restructuring which resulted in the closure of one of its wards, and the Austrian hospital was asked to cooperate on emergency care because of its geographic proximity just across the river. The German sickness funds and the Austrian hospital in Braunau negotiated a contract that handed responsibility for an emergency care unit for trauma surgical patients to the Austrian hospital. The motivation for the Austrian hospital to engage in cross-border collaboration was the extension of its catchment area across the border, thus potentially increasing the number of patients to be treated (and thus generating a higher income)[7]. When KKH Simbach's paediatric ward also closed in 1996, the contract was extended to cover paediatric treatment. The cooperation thus developed gradually over the years and was limited to a range of specific hospital services that were exchanged between both hospitals. The range of services exchanged between the two hospitals increased, though, and a collaboration of the local German and Austrian emergency dispatch centres was arranged to transport patients more effectively (healthacross, 2010, pp. 85ff).

The cross-border collaboration became more structured when it entered a second phase in 1999. The Austrian hospital underwent a general refurbishment in 2004, having to close several of its own wards during these works. A whole internal medicine ward was relocated to the German hospital. The relocation was based on a lease contract for a period of five years. An in 2005, a second internal ward was relocated to the German hospital. As a result, it was the first EU-wide project to treat two different 'patient nationalities' within a common structure. Overall, the German hospital in Simbach admitted some 1,900 inpatients from the Austrian hospital in Braunau between May 2004 and July 2005. During the same period the number of German patients treated in the Austrian hospital continued to rise (*ibid*., p. 87). While in 1998, 240 patients from the German side had been treated as inpatients on an annual basis in Braunau, this number rose to 500 in 2009. The number of German patients who received ambulatory care in the Austrian hospital's accident and emergency department on an annual basis rose from 1,535 in 1998 to 2,400 in 2009[8].

While the first two phases of cross-border hospital collaboration were based on bilateral agreements, the third phase showed a Europeanisation of the project. Both hospitals started to use Europe strategically by receiving financial subsidies. In 2005, the cross-border project received additional funds from the EU's Interreg IIIA programme, which is part of the EU's Regional Policy. These funds were used to reduce barriers for patients travelling from one hospital to another. As a result of the successful co-funding by the EU, the two hospitals developed plans to establish a "Braunau-Simbach European clinical centre". In November 2005, a surgical day clinic was set up in the German hospital by relocating a surgical ward from the Austrian hospital to the German one (*ibid*., p. 88). Thus, while the first phases were based on an

[7] Interview 20, Financial and Administrative Director, Hospital St. Josef Braunau, Braunau/Inn, 12 January 2011.

[8] Data provided by Hospital St. Josef Braunau.

exchange of services, the third phase saw an increase in exchanging complete hospital wards. Furthermore, both hospitals started a joint venture in treating cardio-vascular diseases in commonly operated coronary angiography unit.

In 2010, plans were also developed to extend the cross-border collaboration. It was planned to integrate further regional hospitals on the German side of the border in order to develop the joint "European Clinical Centre". It was planned to set medical priorities in each of the hospitals and to increase the efficiency of medical treatment. Such an extended form of cross-border collaboration was also meant to preserve the existing hospitals and to reduce costs. A common hospital planning was meant to integrate the services offered by the involved hospitals with the reimbursement of costs handled according to the country of origin of the patient. Despite this plan, negotiations with sickness funds on both sides of the border did not take place. And eventually the project was terminated in a fourth phase when an abrupt change on the German side of the project occurred. The German district of Rottal-Inn decided in 2011 to close down a ward in the German hospital for economic reasons, and the hospital wards leased by the Austrian hospital had to treat German patients. This meant additional work for the Austrian hospital in order to avoid a loss of patients (Krankenhaus St. Josef Braunau, March 2011).

In June 2011, the regional government of Upper Austria implemented a hospital reform which aimed at reducing the number of available beds for acute care by 778 in the region and the closure of several wards in Upper Austrian hospitals, reducing effectively the regional capacity by 9% for inpatient care. From a financial perspective, the regional reform should create savings of 366 million € each year and reduced costs for inpatient care by 2.3 billion € till 2020. Given the political salience of hospital infrastructure for the regional electorate, the regional government carried out a survey in which 82% of those interviewed considered a reform of inpatient care to be very important (*Der Standard*, 20 July 2011). As a result, the Austrian hospital in Braunau was ordered by the regional government to repatriate the wards which had been relocated to the German hospital. The hospital in Braunau was also ordered to reduce organizational costs and to concentrate available beds for acute care more efficiently. By the end of 2011, the joint venture between the German and the Austrian hospital concerning cardio-vascular treatment had to be stopped (Krankenhaus St. Josef Braunau, June 2011). Due to the regional reform, the cross-border collaboration was effectively terminated at the end of 2011.

Usages of Europe and National Institutional Limits

Despite its termination in 2011, the project of cross-border hospital collaboration between the Austrian and the German hospitals expanded successfully in terms of scope and intensity for over a decade. The involved actors running both hospitals did not only make a financial usage of Europe, but also attempted at using Europe strategically for gaining political support. At the same time, these usages were limited by national institutions and the allocated capacities of those actors. Different nationally defined obstacles related to cross-border care appeared from the beginning of the cross-border collaboration.

The first obstacle based on the principle of territoriality of health services manifested itself when Upper Austrian authorities insisted on the fact that Austrian patients should be treated by Austrian physicians, even if they are in a German hospital. The managers of the Austrian hospital tried to transfer their physicians permanently to Germany, strategically using European regulations analogous to those regarding workers who are seconded to other EU countries for construction work. This would have been a possibility for the physicians to be insured by Austrian social security while working in the 'Austrian' departments in the German Simbach hospital. The authorization was, however, refused by Upper Austrian authorities, obliging the hospital to allow physicians to rotate between the Austrian and the German side to make sure that the Austrian physicians would not lose their Austrian pension and health insurance benefits:

> "There are those marvelous [European] regulations for industries, when they construct complexes in other [EU] countries and where they second their employees for a year. There is a clear regulation. But that was not granted to us. The consequence was during the first four years, I believe, that [hospital] employees who worked [for us] exclusively in Simbach had to rotate back once a month to Braunau so that they would not lose their claims to qualifying periods for pension benefits" [9].

Other obstacles occurred, underscoring the importance of national boundaries when it comes to financial aspects. Austrian hospitals charge only the costs for medical treatment to Austrian sickness funds, while the costs for investment and potential budget deficits are covered by taxes paid through the Upper Austrian health fund, which amounts to circa 50% of the treatment costs. When the rulings of the CJEU on cross-border healthcare were issued, Germany also allowed its sickness funds to contract foreign healthcare providers in the ambulatory sector. Yet the rule of prior authorization for hospital treatment continues to exist. The German sickness funds therefore had to continue to authorize treatment for German patients in the 'Austrian' departments or in the Austrian hospital. The Austrian hospital then billed the German sickness funds for an official tariff that covers the medical treatment *and* the part of the cost that would have been covered in Austria by taxes. The bill for German sickness funds was hence nearly twice as high as the bill for Austrian sickness funds. The German sickness funds reacted by granting authorization with the remark that the bill must not exceed the price an Austrian sickness fund would have paid. Up to the termination of the project, however, without any explanation the payments had not been cut. Given the role as local providers of inpatient care, the national system of cross-border payments became inscrutable for the Austrian hospital [10].

Further problems also existed concerning the use of blood products, hygienic standards and infections that are subject to report to medical authorities. For all of these aspects, double procedures that satisfy both German and Austrian legal requirements had to be set up. In order to solve the payment problem for German patients who require prior authorization for medical treatment, informal agreements were applied on a case-by-case basis:

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[9] Interview 20, *loc. cit*.

[10] *Ibid*.

> "For certain individual cases, when German patients would like to receive treatment in Austria, I call the German sickness fund and ask them what they would pay for the treatment, and then provide the tariff and give my authorisation or not. I should not do this, as there is an official tariff regulation that determines the cost for foreign patients, but sometimes we bypass regulations" [11].

Out of 26,000 treatments each year, these cases amounted to a maximum of approximately 500 patients, and this 'informal' procedure could not be used on a regular basis. The partners of the hospital project had therefore thought about taking legal action and trying to get a clarification from the Court of Justice of the European Union. Using Europe the legal way was, however, not integrated in their strategic actions, as a lawsuit would have to be set up against the German sickness funds, and this "would not have been especially beneficial for the existing collaboration" [12]. In order to overcome nationally defined rules and thus obstacles to cross-border hospital collaboration, the involved hospital managers also tried to use Europe cognitively in order to find de facto solutions. They underlined the international or more precisely the European character of their project by appearing together at all negotiations:

> "What we have been always using is that we appeared always together. When there are Austrian guests around while being at the Bavarian Ministry of Finance or the Bavarian State Ministry, it has another significance contrary to only Germans being around and vice versa. When we showed up with the Bavarian district administrator in Linz [capital of Upper Austria] or in Vienna it was something like a state visit" [13].

Yet, these visits did not necessarily provide for solutions to the above mentioned practical problems of cross-border hospital collaboration. Recognizing that European regulations on secondment of workers were not usable and given that legal action using European law would have been counter-productive for the existing cross-border collaboration, the Austrian hospital manager contacted the Director General of the Legal Department in the Austrian Federal Ministry of Health. The Director General suggested finding a legal solution and supported the request by drafting a bill that would change the Austrian federal law regulating hospital operations (*Bundesgesetz über Krankenanstalten und Kuransatalten*, KaKuG) [14].

The drafted bill aimed at changing the federal Austrian framework law on hospital operations, which provided for the possibility of opening "dislodged" wards in hospitals of neighbouring countries, provided Austrian medical standards and the financing system were respected (Bundesministerium für Gesundheit und Frauen, 18 January 2006). The Federal Minister of Health at the time supported the bill [15], but during the parliamentary process and in informal talks with the minister, the Chamber of Physicians and the Association of Private hospitals lobbied against the law. The Chamber of Physicians pointed out that if the law envisaged general solutions for

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[11] *Ibid*.

[12] *Ibid*.

[13] *Ibid*.

[14] Interview 29, Director General of legal affairs and health related consumer protection, Federal Ministry of Health, Vienna, 10 March 2011.

[15] Interview 11, *loc. cit*.

cross-border cooperation, it could incite future cooperation with new Member States where salaries are lower, and hence lead to a situation where 'cheaper' physicians could treat Austrian patients (Österreichische Ärztekammer, 10 April 2011). The initiative by the managers of the cross-border hospital collaboration was thus not only hindered by nationally defined rules and regulations but also by other national actors' institutionally shaped interests and by their influence on national politics. As a consequence, the law was passed but provided that only Austrian patients could be treated by Austrian physicians in hospital departments in another country close to the border. However, there are also German patients who were treated in the 'Austrian' wards in the German hospital. The 'national' strategy to improve the working conditions for the cross-border project was therefore unsuccessful vis-à-vis the interests and strategies of other stakeholders in the healthcare system. Before the law came into effect the project partners could ask regional officials for exceptional permission to treat Austrian and German patients within a common structure because there were no regulations covering this area; this legal void made a pragmatic approach possible. Afterwards, however, tight legal provisions that did not allow any exceptions bound officials. A strategy aimed at facilitating cross-border cooperation instead limited such activities, as other national stakeholders' interests effectively circumscribed the regional actors' room for manoeuvre. More generally, the eastern enlargement of the EU seems to have changed the attitude of several national actors vis-à-vis potential competition coming from the new Member States, given that medical staff from the new Member States usually receive lower salaries. This changed perception of potential competition resulted in a diminished political support of cross-border hospital collaboration [16].

Given the limited national support for cross-border collaboration, strategic usages of Europe were made once again by the managers of the project. While the EU had already co-funded the project with roughly 200,000 € for the regular patient transport between the Austrian and the German hospital, European funding as such played a somewhat limited role, but conferred a European legitimacy on the project, as the name that was given to the proposed "European clinical centre" indicated. The hospital managers also tried to contact their local representatives in the European Parliament to outline their concerns about the different legal requirements in the two countries. For example, in 2007 the Bavarian Member of the European Parliament addressed a written question to the European Commission, pointing out the obstacles to cooperation arising from Austrian personnel requirements and asking for support (European Parliament, 15 May 2007). Despite this effort the managers felt that they were not sufficiently important players in the political process and that lobbying structures at the European level were beyond their reach: "I now get invitations to official evening receptions […] You can go there a hundred times, this is such a different lobbyism there and we have tried it before in Austria […] but no one sees [cross-border cooperation] as an opportunity" [17].

When from 2010 onwards the project partners planned to reinforce the cross-border collaboration by extending it to several other German hospitals, the project

[16] Interview 20, *loc. cit*.

[17] *Ibid*.

development reached the limits of what was possible given national boundaries. An Austrian official responsible for the inpatient sector at the regional health fund confirmed that cross-border cooperation definitely "made sense", but highlighted the territorial conception of hospital planning the fund had to follow: "Austrian hospitals are planned for Austrian patients: if there is an influx of foreign patients this has to be integrated. But in general such cooperation is positive, where they say this is one region that connects geographically and where no true border exists anymore" [18]. In 2011, the national reform context, which had set incentives for the Austrian hospital to extend its catchment area beyond the national border, became an obstacle as the authorities decided to make hospital capacities within the region of Upper Austria more efficient. The responsible member for healthcare of the regional government also made clear that in the government's perception foreign patients could potentially increase costs, leading to higher operational deficits [19]. Political support was therefore suspended. And when the regional government decided on its reform of inpatient care in June 2011, the regional authorities left no latitude for individual hospitals' attempts at cross-border cooperation and the Braunau-Simbach collaboration was terminated.

The example of terminated Austrian-German cross-border hospital collaboration shows that actors' strategies have been clearly Europeanized and that these actors have been attempting to use Europe at national and European level. Their usages of Europe are however defined by their role as providers of healthcare and by the national reform context: the main motive of the smaller Austrian hospital was to extend its catchment area beyond national borders in order to lower reform pressure. Yet, the strategic and cognitive usages of Europe found their limits in national institutional boundaries, which can be disaggregated in national rules and regulations that govern inpatient care on the one hand, and other national actors' institutional interests on the other. Certain usages, such as using legal resources by challenging national regulations were not possible given actors' limited nationally defined resources and the potential impact on the then still existing cross-border collaboration. While the EU has provided other resources, such as co-funding, its main impact can be described as a legitimizing effect of cross-border collaboration in the eyes of the local public which profited from inpatient treatment. The cognitive usage of local actors also guaranteed political support up to the point where politicians' electoral calculations and recurring historically institutionalized disparities between two different national health systems effectively set limits on how far national boundaries can be crossed, and this despite the lack of linguistic disparities between the two regions involved in the cross-border project. More important, though, is the ambiguous impact on national reforms. While at the beginning reform pressure set incentives to collaborate with a hospital across the border, they had the opposite effect in the end: due to economic considerations cross-border collaboration was terminated.

The opposition of other national actors to a national legal change which largely would have facilitated cross-border hospital collaboration for Austrian actors revealed a clash between interests at different levels of governance: national corporate actors

[18] Interview 15, *loc. cit*.
[19] Interview 20, *loc. cit*.

effectively resisted such a legal change and have undercut the local attempts at extending and intensifying cross-border collaboration. Moreover, the perception of European integration in general seems to have changed due to the eastern enlargement of the EU. While cross-border collaboration as such between Austria and Germany has not been seen as problematic, potential competition with regard to salaries in the medical sector due to lower incomes in Eastern European Member States has led to a more sceptical perception of European integration and to an insistence on national protection of the healthcare sector concerning inpatient care. Given the importance of economic differences between old and new Member States, the next section will analyse a cross-border hospital project involving Austria and the Czech Republic.

4.1.2 Cross-border Collaboration between Austria and the Czech Republic

Motivation and Institutional Context [20]

The second Austrian project of hospital cross-border collaboration is situated at the border between one of Austria's largest *Länder*, Lower Austria, and the Czech Republic region of Southern Bohemia. While the Austrian-German collaboration had been working for 18 years, the Austrian-Czech collaboration was still in its initial phase in 2012. The latter project is situated in a very different regional context, especially as far as linguistic and economic factors are concerned. The participating Austrian hospital is located in Gmünd, in the northern part of Lower Austria which borders directly on its Czech "twin town" České Velenice. In fact, the two towns were separated after World War I after the demise of the Austrian-Hungarian Empire. While the hospital in Gmünd had once been run by the municipality, following a reform in 2004 it became part of the Lower Austrian 'hospital holding', which now operates all regional hospitals. Contrary to other Austrian *Länder*, the hospital operator has been merged with the Lower Austrian health fund (*Niederösterreichischer Gesundheitsfonds*, henceforth NÖGUS) that acts as payer of inpatient care. The hospital of Gmünd has 180 beds and is thus one of those rather small hospitals that have come under reform pressure. The hospital is part of a cross-border healthcare project named 'healthacross'. The project is aimed at developing cross-border collaboration between the Lower Austrian hospital holding and the Czech hospital operator in South Bohemia in order to optimise the population's access to medical care on either side of the border. It began in 2008, even though local initiatives by the hospital manager who also participates in municipal politics date back to the late 1990s, when the Czech Republic had not yet joined the European Union. This precursor to the project already involved a strategic usage of Europe by using financial subsidies from the EU's PHARE program, which were funds to support the adhesion of Central and Eastern European Member States to the EU [21].

The motivation from the Austrian side for cross-border collaboration is thus similar to that of the Austrian-German collaboration following the increased reform pressure on smaller hospitals. And the initiative emanates from the activities of the

[20] Parts of this section have been published in Kostera, 2012 and Kostera & Burger, 2013.

[21] Interview 13, Financial and Administrative Director, Regional Hospital Gmünd, Gmünd (NÖ), 16 July 2010.

financial and administrative director of the local hospital, as in the terminated Upper Austrian project. Contrary to the Austrian-German collaboration there is however no hospital on the other side of the border. The motivation for the Czech side to cooperate with health providers across the border is thus based not on criteria of economic efficiency but of improving local provision of healthcare. On the Austrian side the main motivation is to continue offering the same local provision of inpatient care and to extend the catchment area of the hospital. These motives correspond to the classical goal orientations of providers of healthcare, namely to improve access to medical care (see chapter 1).

While on the Lower Austrian side the motivation for cross-border hospital collaboration is comparable to that of the terminated Austrian-German project, the regional political context differs significantly. Given the electoral stakes for regional governments concerning inpatient provision, the Lower Austrian regional government has in fact not only been reforming smaller hospitals but has at the same time been building new hospitals in the commuter belt of Vienna which is surrounded by Lower Austria. This has happened despite the extensive offer for inpatient care in Vienna, given that both *Länder* run their hospitals separately, yet are governed by different parties: Vienna is governed by a coalition of the SPÖ and the Greens and the Lower Austrian government is dominated by the ÖVP. The Austrian Court of Auditors has criticized for example the building of two new hospitals in Lower Austria, claiming that one hospital in Vienna's commuter belt would have been sufficient. The criticism was however refuted by the responsible member of the regional government Sobotka, who claimed that the Court of Auditor's criticism was politically motivated (*Der Standard*, 17 January 2012). Given the political priorities set in Lower Austria for reforming but yet keeping regional hospital infrastructure at a certain level even in less densely populated border regions, from its outset the project for Austrian-Czech cross-border hospital collaboration has received regional political support [22].

The political support for cross-border collaboration has even led to the creation of an "EU affairs" unit in the Lower Austrian Health Fund (NÖGUS), which not only supports local initiatives, but also conceptualizes and co-manages different cross-border projects for hospital collaboration in the region's border areas; the unit also develops the necessary funding applications (NÖ Gesundheits- und Sozialfonds, 17 October 2013). The development of cross-border projects concerning inpatient care has thus been centralized by the regional administration. This process does not only increase administrative capacities of single cross-border projects, it also allows to keep (regional) state control over the scope of projects and the actions that project managers take [23]. Due to the involvement of regional politics in cross-border hospital collaboration, the aims of such collaboration also go beyond the improvement of inpatient care in border regions and relate to wider economic interests regarding employment and regional economic development. For the Medical Chief Executive

[22] Interview 2, consultant / project manager healthacross, Gesundheitsmanagement consultancy, Vienna, 10 August 2009.

[23] Interview 5, Head of unit, EU affairs unit, Lower Austrian Health Fund (NÖGUS), St. Pölten, 13 January 2010.

of the NÖGUS, cross-border hospital collaboration is thus a means to revive a border area which was 'economically dead' because of the iron curtain that existed for decades between Austria and the Czech Republic. It would also be a means to improve 'human, neighbourly contacts' which in the end would help to improve regional economic development across the border.[24] The aims of the cross-border collaboration are thus in line with the institutionally entrenched economic interest of regional governments with regard to inpatient care.

After the first initiative of extending the catchment area of the Austrian hospital across the border was prevented by the fact that the Czech Republic had not yet joined the EU, the collaboration was taken up again in 2004, seeing the adhesion of the Czech Republic to the EU as an incentive to cooperate more intensely. The initial goal of the project was to build a new hospital that would cater for the medical needs of the local population on both the Austrian and the Czech sides of the border. The involved regional and local actors had however learned about the institutional obstacles of the Austrian-German cross-border hospital collaboration. They therefore started an initial project to develop guidelines drawing on existing practices of hospital cross-border collaboration either between Austria and Germany or between other EU Member States. This first phase of the project named 'healthacross' started in 2008 and was co-funded by the European Regional Development Fund. It thus involves from the beginning a strategic usage of Europe on the part of regional actors enhancing their own financial capacities with the help of European funds (healthacross, 2010, pp. 10-13).

Usages of Europe and National Institutional Limits

While the Austrian-Czech cross-border project now receives political support from the regional level, in the beginning the project managers involved had to use Europe cognitively and strategically by invoking the judgments of the Court of Justice of the European Union with regard to cross-border patient mobility:

> "Yes [these judgments] have been very important. In the framework of the project they have been presented several times. […] You can use them to support the argument that 'this is now a European judgment and you cannot close your eyes, as this will be everyday life in the future'. […] Now we can still build something. One has to be well prepared regarding information […]. One has to see what to do and how to get the best out of it, for the country and the system"[25].

However, getting the initial support and raising awareness about the possible economic benefits of cross-border collaboration can be difficult since there is already quite considerable competition among the *Länder* regarding the best medical care within Austria. Oftentimes it was questioned how cross-border collaboration should work if collaboration across regional borders *inside* Austria proves difficult to

[24] Interview 4, Chief Medical Executive Officer, Lower Austrian Hospital Holding (NÖ Landeskliniken-Holding), St. Pölten, 13 January 2010.

[25] Interview 1, consultant / project manager 'healthacross', Gesundheitsmanagement consultancy, Vienna, 5 August 2009.

achieve [26]. Once the European dimension of such a project had been invoked to get political support, Europe was also used cognitively to underline a strong regional identity whenever the question of a possible coordination with the federal level arises: it is seen as a Lower Austrian lead project in regional cooperation and the *Land* should be responsible. Cooperation with the federal level would neither be necessary nor really wanted. The responsible manager of the Hospital Holding also hopes that with respect to other Austrian *Länder*, Lower Austria would be cutting-edge in cross-border healthcare cooperation [27]. And again, the CJEU's rulings on cross-border patient-mobility play a role in defining the general interests of the regional stakeholders, even though Austrian citizens have not taken legal action: "I would say that [the rulings] help. One can see that there are needs of individuals and that these rulings would not exist otherwise. This means that there is an indication of what citizens and individuals want. This is not something imposed by the government" [28]. A cognitive usage of Europe is thus integrated in an already existing regional identity, and is accommodated by bureaucratic practices of historically institutionalized regional healthcare governance.

Even though the idea for cross-border hospital collaboration was – just as in Upper Austria – based on a 'grass-roots' initiative, the involvement of the regional hospital administration led to a more systematic approach to cross-border hospital collaboration than in the Austrian-German project. The first phase of 'healthacross', co-financed by the EU, was the development of a systematic study about the infrastructure of medical and long-term care on both sides of the border region covering Lower Austria and Southern Bohemia. The strategic usage of European financial resources helped, therefore, to identify the various differences in healthcare provision and possible strategies to accommodate these differences in the project (healthacross, 2010, pp. 115-123, 170ff). The historically developed national rules have thus been a major concern for actors involved in the project:

> "Certainly, there are a lot of discussions. At the beginning we discussed if an ambulance could cross a border with flashing blue lights. What about […] pain killers? Can they be carried across [the border]? […] You should not forget, in our ministries they still use to breathe the Monarchy's [i.e. Austrian-Hungarian Empire] deep breath, just like in the Vatican: they [in the ministries] think in centuries. […] I don't think that it is any better in Italy or in France and also Germany has some [administrative] pitfalls as far as I know. I would say this is a historic administrative tradition which isn't necessarily national [i.e. not typically Austrian]" [29].

The citation not only highlights the different national regulations: it also shows the traditional regional stance vis-à-vis the central state administration. The federal administration is rather perceived as being an obstacle to regional governance of healthcare. This perception can be traced to the historically developed tensions in healthcare governance between the centre and the periphery in Austria (see

[26] Interview 2, *loc. cit*.
[27] Interview 5, *loc. cit*.
[28] *Ibid*.
[29] Interview 4, *loc. cit*.

section 2.1). More generally, it seems that regional administrations are perceived to be more flexible than national ones. Yet, when it comes to cross-border collaboration between two regions in two Member States it is exactly this 'administrative tradition' which also plays a role at the regional level. On the Austrian side, actors had to get used to the different practices of Czech administration and healthcare governance: "We work quite well with them [the South Bohemian Region]. It always worked quite well with them, even though their [administrative] structures are even more bureaucratic and inert than in Austria. And that means quite something" [30]. These perceptions of another Member State's administration also extend to the perception of the quality of inpatient care delivered in the other Member State. In comparison to the Austrian-German project, where crossing the border for the regional population was easily possible even before Austria had joined the EU, the exchange between Austria and the Czech Republic had been prevented for decades by the Iron Curtain. The process of setting up a project for cross-border hospital collaboration was thus also marked by a learning process where regional actors from both sides of the border had to learn about the respective reservations concerning either historical issues (especially the division of the town where the hospital is located) or the perception of the standards of hospital care in the two involved Member States [31]. More generally, the linguistic differences between Austria and the Czech Republic create an additional obstacle which has to be overcome in cross-border collaboration. The local population might thus be much more sceptical when it comes to using a cross-border healthcare facility [32].

These differences in Austrian-Czech cross-border collaboration compared to the one between Austria and Germany thus require a longer learning process between actors. The strategic usage of Europe involving the financial resources of the EU's Regional Policy has, however, contributed to putting reservations aside as regional administrations also benefit from the additional funds: the European co-funding helps to create additional regional administrative capacities in the form of positions or the possibility to hire additional administrative staff [33]. While the co-funding by European funds permits a more structured approach of regional administrations to cross-border hospital collaboration, such co-funding would be limited to the project development and does not extend to the operation of a cross-border hospital on a daily basis in the long run. National financing structures – especially the more general differences in tariffs between Austria and the Czech Republic – prove to be both an incentive and at the same time an obstacle to putting effective cross-border healthcare into practice. Financial aspects are at the core of the cross-border hospital collaboration for the regional administration, given their role as payers and providers of inpatient care: "And of course, there is always the question as to who will finance this" [34]. The regional authorities could imagine purchasing auxiliary services for the operation of a planned cross-border hospital, such as laboratory analyses and other medical or paramedical

[30] Interview 1, *loc. cit*
[31] Interview 5, *loc. cit*.
[32] Interview 4, *loc. cit*.
[33] Interview 1, *loc. cit*.
[34] Interview 5, *loc. cit*.

services in the Czech Republic [35]. Such purchasing of services in the Czech Republic might be an economic advantage of planned cross-border collaboration. The building costs and the coverage of the treatment costs for Czech patients are however the most obvious factors when Europe is *not* used, and when the respective countries' own healthcare system plays the leading role in cross-border healthcare. Europe might even become something to worry about:

> "We observe the developments in Brussels very attentively and also have some worries. […] Certainly, Brussels provides financial support for the project and that helps us, but in general, EU politics is not really transparent for a lot of people. […] Our worries are quite simple: […] Whose prices will be applied? […] I believe that we must bill the prices in effect where the treatment is provided. It is unthinkable to provide treatments in Austria at Czech rates because of the higher price levels [in Austria] and the higher costs of material" [36].

The Austrian-Czech project thus faces similar financial obstacles as those occurring during the Austrian-German cross-border collaboration. More generally, the necessary administrative procedures on both sides of the border for prior authorisation for hospital treatment bring "some administrative obstacles and uncertainty regarding the decision with them", as the study resulting from the first phase of the project concluded, and negotiations on bilateral state agreements with all stakeholders are therefore necessary (healthacross, 2010, p. 25): "If there is a clear, satisfactory agreement by both parties, then it [cross-border collaboration] is no problem" [37]. Such a bilateral agreement, which would have to take the form of an interstate treaty, thus means that stakeholders are not able to make use of Europe in a way that threatens the national boundaries, since the bilateral agreements will need to involve the providers and sickness funds on both sides of the border. There is thus no bypassing the national set-up of the healthcare system. However, compared to the Austrian-German project, cross-border healthcare between the Czech Republic and Austria faces more important financial obstacles: "differences in remuneration schemes and the related question of financing and administrative hurdles have so far hindered the development of formalised cooperation" (Österle, 2007, p. 119), as has been observed also for other cross-border healthcare initiatives between "old" and "new" EU Member States.

Having learned from the difficulties of the Austrian-German project, and given the differences in tariffs for medical care in both countries, a feasibility study was commissioned in 2010 to address the legal and economic issues in the second phase of the Austrian-Czech project. Different scenarios for the operation, building and location of a cross-border hospital were analysed. The study came to the conclusion that a commonly operated hospital would not be possible, and that a new Austrian hospital on the border could offer rooms for a dispensary that Czech physicians could rent. This is due to economic considerations which pointed at the possible loss of revenue for existing Czech hospitals and to doubts that Czech sickness funds would cancel their long-term contracts with Czech providers in order to set up new contracts

[35] Interview 4, *loc. cit*.
[36] *Ibid*.
[37] *Ibid*.

with an Austrian-Czech hospital (healthacross, 2011, p. 73). National institutionalized structures of financing inpatient care thus represent the most significant limits to potential usages of Europe in cross-border healthcare. Given these results, the respective regional Austrian and Czech authorities have decided to continue their collaboration in a follow-up project. The project, which is called "healthacross in practice", is based again on a strategic usage of European financial resources by regional actors. Starting in 2012, the follow-up project started to implement a three-month pilot program in which the existing Austrian hospital would provide planned ambulatory care to around one hundred patients from the Czech side of the border. The costs of treatment would be covered by the respective regional authorities of both countries, and patients would not be charged for the treatment. The pilot program has established cooperation between the Austrian hospitals and Czech general practitioners who can refer patients to the hospital. Contact would be established directly between specially trained Czech-speaking staff in the hospital and the physician. The program also put collaboration between the Austrian and the Czech ambulance services into practice: patients who are treated in the outpatient department of the hospital would be transported directly to the hospital. Furthermore Czech health professionals or an available translation service would ensure communication between hospital staff and Czech patients (healthacross, 2012). The follow-up project thus tries with the help of a strategic usage of Europe to elaborate a strategy of how to treat two patient-nationalities with different native languages within a commonly operated structure. Given that nationally institutionalized financing structures of inpatient care put limits on the scope of cross-border hospital collaboration, the project has only been evolving incrementally, and whether a commonly operated cross-border health will be built is still uncertain. While the Austrian-German project has been unsuccessful in making usages of Europe at European level, the Austrian-Czech project could benefit from the regional administrative support to also make usages of Europe in Brussels.

4.1.3 Lower Austrian Usages of Europe at European Level

When the European Commission initiated the consultation process in 2006 as a follow-up to the withdrawal of healthcare from the Services Directive and suggested in its Commission Communication possible measures to regulate access to cross-border healthcare for EU citizens (Commission of the European Communities, 26 September 2006), the Lower Austrian Health Fund (NÖGUS) requested a response to the consultation process from the consultancy responsible for the cross-border project. The response was based on the previous studies that had been carried out in the border regions surrounding Lower Austria and which provided an overview of available cross-border healthcare in these areas. In their response to the consultation, the NÖGUS underlined the concerns of payers of inpatient care that European cross-border healthcare might lead to a situation where the fees paid by patients would not entirely cover treatment costs, and thus that the hosting Member States could face financial losses. They furthermore pointed out that especially border regions neighboring on Member States with lower income levels would face the challenge created by the CJEU's judgments. The response called for the creation of specialized European hospital centers that would coordinate treatments of certain diseases.

Such hospitals would ensure certain quality standards, and given their Europe-wide specialization could contribute to a more cost-effective treatment. The most important demand contained in the consultation response was however to create European framework legislation for cross-border healthcare to avoid distortions of competition between different Member States' healthcare systems due to different price levels of inpatient care. As a consequence, tighter European regulation concerning the quality of care, professional standards and reimbursement of treatment costs was demanded, including a control system and potential sanctions in case of infringement of such rules (NÖ Gesundheits- und Sozialfonds, 2007). Regional actors thus made a strategic usage of Europe by using the European Commission's offer to various actors and stakeholders in healthcare to influence potential European regulation of cross-border healthcare. This usage of Europe is however largely determined by the regional authorities' role as payers of healthcare and their experiences of engaging in cross-border healthcare collaboration. The response to the consultation shows that potentially damaging effects to national boundaries that could result from European integration in healthcare should be avoided by regulation at European level. The focus on the financial aspects highlights the importance of the national systems of financing healthcare, and to this end the usage of Europe actually aims at calling for European regulation which prevents any negative effects. This strategic usage of Europe also aims at demanding European regulation which would guarantee the potential medical benefits of cross-border healthcare collaboration.

Lower Austria has not only responded to the consultation procedure: it also uses Europe strategically in healthcare via its regional office in Brussels. In fact, all of the Austrian *Länder* have opened such liaison offices in Brussels. While the political significance of most liaison offices is of a rather symbolic nature (Fallend, 2002, pp. 210-213), the liaison office of Lower Austria has a variety of tasks. One of the main tasks is to inform the regional administration, enterprises and research institutions about available co-funding of the EU's Regional Policy programs, as well as to process and analyse this information. This information is either obtained through formal channels or through informal channels such as personal talks, conferences and by lobbyists. The liaison's office's tasks include furthermore regional interest representation covering those areas where the national Permanent Representation would not take into account the specific regional interests of Lower Austria. The profile and the tasks of the Lower Austrian liaison office in Brussels are thus not different from many other European regions' liaison offices. While most of these offices have the task of being "listening posts" that "alert regional decision makers to upcoming legislation, to gain information about funding opportunities and promote awareness of their region", they also try to influence policy-making at EU level when looking at policy development flows (Marks, Haesly & Mbaye, 2002, p. 15). These strategic usages of Europe via regional representations in Brussels can be thus interpreted against the background of the quasi-federal opportunity structure that the EU is offering to regional actors. These aims and Lower Austrian representation in Brussels are one means of safeguarding regional interests at European level, a goal which is shared with other European regions. Yet, even these activities are determined by nationally institutionalized competencies and politics:

> "Subnational governments are institutionally determined in their respective domestic arenas. The action for subnational offices is rooted in their respective domestic polities where we find subnational governments operating alongside – and sometimes against – national governments to increase their resources, to gain greater political autonomy, or to avoid being outflanked by the imposition of EU policies that national governments have bargained over their heads. What matters to subnational actors is how the European Union impinges on their authoritative competencies, and these competencies find their meaning in national polities" (*ibid*., p. 16).

The main activities of the Lower Austrian office in Brussels are primarily determined by the political priorities of the governor (*Landeshauptmann*) of Lower Austria and his portfolio of responsibilities in the regional government. Yet, since healthcare is a responsibility of the Lower Austrian deputy governor (*Landeshauptmannstellvertreter*), it has also become one of the key issues in the regional Brussels office. Since European integration in healthcare is rather recent compared to other policy fields, the regional level still has a rather weak position as regards its involvement in healthcare at European level [38]. Most policy-related work is done at national level, and regional involvement is limited by national policy preferences. However, this does not preclude that regions can become involved in the Brussels arena on their own. The regional office in Brussels has for example been informed and updated about the NÖGUS' response to the Commission's consultation procedure and participates in the European Regional and Local Health Authorities network (EUREGHA). This network was initiated by the Danish regions, which are also competent for healthcare delivery at national level. The idea behind EUREGHA was to create a network that would permit regional and local authorities to exchange information about healthcare delivery, public health, and organisational aspects of healthcare governance at European level. The primary purposes of the network are thus to gather and exchange best practices in healthcare delivery, but also to set up common projects. Moreover, the network aims at providing a platform for regional interest representation in healthcare [39]. To this extent the network also strives for collaboration with other stakeholders, but also underlines that it aims at solidarity with European regions that show low income levels (European Regional and Local Health Authorities, 28 November 2012). Its aims thus also accommodate to the aims of the EU's Regional Policies. As the network has only been in existence for a couple of years, the main challenges are still to create a sustainable structure in order to continue and expand its activities. Until 2011, the network existed informally, where different regional offices would participate in meetings, but not contribute to the development of projects nor be willing to invest financial resources. Since 2012 however, the network has created a secretariat and set priorities on topics that have become part of Brussels' political agenda, such as cross-border healthcare. The membership [40], and

[38] Interview 34, Head of representation, Regional Representation of Lower Austria in Brussels, Brussels, 17 November 2011.

[39] *Ibid*.

[40] Members Lower Austria, the Veneto Region (Italy), Catalonia (Spain), two English regions, Flanders (Belgium) and other regions from Italy, Poland and Sweden; see http://www.euregha.net.

thus regional strategic usage of Europe via the network, is however clearly determined by the competencies and resulting interests that regions have at national level, such as Lower Austria which has taken over the network's presidency from the Italian Veneto Region [41]. The Lower Austrian involvement highlights that this usage of Europe is not only determined by nationally institutionalized responsibilities and that it also follows its own regional priority setting: to date it is the only Austrian region which is a full member of EUREGHA. Insofar, usages of Europe do not only depend on nationally defined competencies, but also on the priorities of individual politicians or of the regional government [42].

While regional involvement in healthcare at European level is still limited in its scope in comparison to other tradition fields of European Regional Policy, these regional activities have the most important potential to transcend national boundaries, even if regions' interests and corresponding usages of Europe stay nationally shaped: the European Commission and its desk officers do consult members of the network when it comes to European policy-making. While regional officials might not allow European desk officers in the Commission to use their input in official documents, the Commission can establish contacts even though Member State governments are reticent to back European policy initiatives in healthcare. At the same time, EUREGHA still has to determine its position as a network of regional actors in the Brussels arena. This is mainly due to the fact that in federal states where regions are also competent for healthcare, the regional level usually also has a possibility to formally influence the national position on European policy-making [43]. Thus, while regions could use the quasi-federal structure of the EU to promote their own interests in healthcare at European level by potentially even circumventing or contradicting Member States' governments, the leeway for regional usages of Europe in healthcare still remains circumscribed by national competencies and possibilities for influencing national positions in Brussels. How European regions will position themselves as a grouping of actors at European level is therefore still an open question. Furthermore, regions might not always perceive European involvement in healthcare as an opportunity, but also as a burden. What is clear, however, is that regional governments' interests and corresponding agency in healthcare have been Europeanized.

4.1.4 Cross-border Healthcare: More of a Burden than an Opportunity for Regions?

Even though cross-border healthcare has become a salient object of European Integration since the rulings of the CJEU from the 1990s onwards, the Austrian *Länder* in their role as providers, payers and regulators of inpatient care have already extensive experience with the treatment of EU citizens under Regulation 1408/71 (now 883/2004 in its revised version) [44]. EU patients have been treated in Austrian

[41] Interview 34, *loc. cit*.

[42] *Ibid*.

[43] *Ibid*.

[44] Regulation 1408/71 has been applicable in Austria already before its accession to the EU in 1995. As a former EFTA member, Austria counted as a country of the European Economic Area where Regulation 1408/71 was applicable from 1992 onwards.

hospitals for over two decades, and hence administrative practices have been adjusted accordingly to manage treatments and payments for EU nationals insured in other Member States. As chapter 3 has shown, patient mobility is a reality in many Austrian hospitals. This experience of cross-border patient mobility extends, however, to the period before Austria's accession to the EU as bilateral agreements with other states had already been closed for either the treatment of foreign patients in Austria or for the treatment of Austrian patients abroad. Additionally, private patients – often coming from Arabian countries – had been treated in Vienna's specialized hospitals during the 1970s, i.e. during the Kreisky Era. Furthermore, difficult medical cases which could not be treated in Austria were sent to Germany in the decades before Austria's EU membership [45].

Today, the Austrian *Länder* do not necessarily face the same types of cross-border healthcare depending on their geographical location. The experiences of regional authorities and hospitals with the administration of cross-border patient mobility under Regulation 1408/71 (883/2004) will thus differ accordingly. While hospitals in Vorarlberg (see also statistics in chapter 3) treat mainly tourists with injuries related to ski-tourism [46], the situation in Vienna is very different. Vienna, the Austrian capital, has with its considerably high population compared to other urban centres in Austria a much more comprehensive medical offer than other cities. For example, the number of contracted physicians is nearly 50% higher in Vienna than in Austria as a whole, and there are also twice as many specialists per capita than in the rest of the country (Hofmarcher & Rack, 2006, p. 86). Vienna has also one of the largest hospitals in Europe, the Vienna General Hospital (*Allgemeines Krankenhaus*) which also serves as University medical centre of the Medical University of Vienna. Therefore Viennese hospitals more often have foreign EU patients that have been granted prior authorization for treatment abroad by their home sickness funds. Especially the General Hospital provides specialized medical treatment for patients requiring organ transplantations and suffering from rare diseases. However, the number of foreign patients being treated in Viennese hospitals is considerably lower than in the other *Länder* such as Tyrol or Salzburg where tourists victims of ski accidents have to be treated. The most notable difference is therefore that foreign EU patients rather undergo specialized and thus much more cost-intensive treatments. Viennese regional authorities therefore have an interest in "balanced [cross-border] patient mobility which respects our [i.e. Vienna's existing public hospital] capacities" [47]. This is related to the self-conception concerning the task of the public hospitals run by the Viennese hospital corporation: "[Our task is] the best provision [of inpatient care] with a high quality and close to [patients'] residence […], thus [to provide] for the whole city and its population the best medical care and that regardless of which class you are coming from […]" [48]. Despite this task, Austrian citizens from other *Länder* frequently undergo specialized medical treatment in Viennese hospitals, especially when these treatments are not

[45] Interview 47, desk officers, Directorate General, Vienna Hospital Corporation (Krankenanstaltenverbund), Vienna, 26 January 2011.

[46] Interview 25, *loc. cit*.

[47] Interview 17 with a desk officer, Vienna Magistrate, Vienna, 4 November 2010.

[48] Interview 47, *loc. cit.*

available elsewhere in Austria. This is however at least partly taken into account by compensational payments to Vienna in the 15a agreements. Irrespective of the number of EU citizens and the quality of medical treatment they receive, all Austrian *Länder* have to bring to account their bills for the medical care that their hospitals provide with other European sickness funds following the rules of Regulation 1408/71 (883/2004).

Delayed Payments, Administrative Procedures and Potential Abuse of European Regulations

The Austrian administrative processes have been adapted to the necessity of cross-border payments for health funds and sickness funds. The settlement of accounts with foreign providers follows a bottom-up logic and is centrally executed: bills for treatments of EU citizens are issued by the regional health funds, and generally follow similar administrative procedures in every region. Hospitals inform the respective health funds about the costs of inpatient care for each case. This information is then transferred to the regional sickness fund, which collects the bills for outpatient and inpatient care for foreign patients and then submits them to the Main Association of Austrian Social Insurance Institutions in Vienna. Finally, the Main Association has to collect the treatment costs from other Member States' sickness funds or social insurance institutions. In the last stage, regional health funds receive a reimbursement of the costs that they have incurred from the Main Association. Yet, not all the real costs that are incurred by health funds are included in these bills. The bills cover the medical treatment per se and a respective share of the running costs of hospitals; however a share that would also cover investments in hospital buildings or other annual costs are not included and thus not covered by the bills. As far as the administrative work for these billing procedures is concerned, it is not perceived as an additional administrative effort in comparison to issuing bills for patients from the own region [49].

Over the years during which European Regulations for cross-border medical payments have been handled by regional health funds, several of these funds have been facing noticeable problems with the reimbursement of costs by other Member States' sickness funds. While with many EU Member States the settlement of accounts does not pose any problem, especially Italian social insurance has been delaying payments for years. Depending on how each Austrian *Land* has been organizing the financing of its hospitals, these delays have created financial difficulties. While for example the health fund of Lower Austria has organized the financing of hospitals centrally, and thus at regional level, hospitals in the *Land* Salzburg manage their own allocated annual budget. As a consequence, delayed payments by foreign sickness funds are less of a financial burden to regions where the budget for inpatient care is managed centrally, given the pooling of regional financial resources. But for regions where hospitals receive their own annual budget, delayed payments can cause significant problems as the individual hospital has to cover the treatment costs until the reimbursement by foreign sickness funds arrives. And individual hospital administrations have reacted to these delayed payments from other EU Member States. The reaction of the hospitals

[49] Interview 15, *loc. cit.*

has made an agreement between Austria and Italy necessary in order to guarantee timely payments [50].

The revision of Regulation 1408/71 in 2004 (Regulation 883/2004) addressed these issues: it has reduced the period of acceptable delay for reimbursement by sickness funds from other Member States and also provides for the possibility to demand default interest. The Viennese health fund hopes, therefore, that payment practices of other Member States will improve in the future [51]. Yet, even with the reformed payment deadlines, reimbursement of costs by foreign sickness funds can still take up to 18 months from the moment the bill for treatment has been issued by the Main Association of Austrian Social Insurance Institutions. Given the Austrian administrative procedure, hospitals and sickness funds might have to wait up to two years until they receive reimbursement. Since the period of acceptable delay for payments were even longer before revision of Regulation 1408/71, some regional authorities found it unacceptable "that we virtually advance the financial means for healthcare provision in other states" [52]. As has been shown in cross-border hospital collaboration, questions of payment and financing are therefore at the core of cross-border healthcare for regional authorities. In their role as payers, the Austrian *Länder* thus sometimes perceive the process of European integration in respect of cross-border healthcare rather as a burden. This perception is even reinforced by the impression that Austrian authorities follow European regulations, while other Member States' administrations might not.

While the responsible regional state officials do acknowledge that these experiences are individual cases, their repeated occurrence and the sometimes incorrect application of European law in other Member States create scepticism towards other Member States' healthcare administrations. As could be observed in Austrian-German cross-border hospital collaboration, the accession of Central and Eastern European Member States which have lower income levels contributes to this scepticism, especially when it comes to potential abuses of European regulations on cross-border healthcare. Rumours and anecdotes exist about groups that have been bringing patients from Bulgaria and other new Member States to Austria for medical treatment. These groups would then pretend that the patients are in need of emergency treatment and inpatient care. These patients could then use their European Health Insurance Card in order to supposedly be treated at a better quality than in their home Member States by using Austrian healthcare facilities. Afterwards patients would be transported back to their home Member States [53]. Given the perceived higher quality of treatments that the Austrian healthcare system provides in comparison to Eastern European Member States, administrations see the danger of an increased influx of patients to Austria. It is feared that other Member States could avoid building hospital infrastructure and instead send their patients to Austria for specialized medical treatment. This in turn would mean that Austrian patients could face longer waiting

[50] Interview 10, *loc. cit*.
[51] Interview 17, *loc. cit*.
[52] Interview 25, *loc. cit*.
[53] Interview 20, *loc. cit*.

times for an operation. Such fears are based on experience with organ transplantations: Vienna's General Hospital has a specialized centre for organ transplantations, and in the case of lung transplantations new Member States have increasingly been trying to send patients to Vienna [54]. In these cases the Austrian healthcare system would nonetheless receive the reimbursement of costs of medical treatment. The worries of Austrian authorities therefore concern mainly expensive and very specialized treatment. Anecdotal evidence suggests again that individual cases of circumventing European regulations have occurred: in Upper Austria, cases occurred where patients from Poland had used their European Health Insurance card instead of the necessary prior authorization of their home sickness funds to receive regular chemotherapy [55]. Even if these problematic cases represent only a small number of medical treatments of EU citizens, they leave the impression that European integration in healthcare can have side effects which collide with regional authorities' self-conception as providers of inpatient care; namely to offer quality inpatient care to the national population. The perception that European integration can also have negative side-effects also limits regional authorities' interests in actively using European integration to actively offer inpatient care to foreign patients.

Cross-border Healthcare as an Opportunity?

Even though there is a problematic side to cross-border healthcare, the described projects of cross-border hospital collaboration imply that regional authorities and hospitals could potentially use Europe strategically more actively to offer cross-border inpatient care even in other regional hospitals. Hypothetically, the rules that have been created by the CJEU could also open up an opportunity beyond collaboration in border regions. Such potential usages of Europe are however prevented by two factors: first, the national planning of hospital infrastructure and second, the way accounts are settled between providers and sickness funds in other EU Member States under Regulation 883/2004. There is thus on the one hand a major national limit to potential usages of Europe, and on the other hand European regulations on cross-border healthcare prove to be of limited usefulness: "Given the current rules of financing [inpatient care] there will be probably no efforts [to actively offer cross-border healthcare], because it is simply not cost-effective, or simply because the investments [in infrastructure] are not covered [by payments of foreign sickness funds]" [56]. While active usages of Europe are not an option, the number of European guest patients in tourism areas has nonetheless been included in planning the Austrian Structural Plan for health by the Austrian Federal Institute for Health, a think tank financed by the Federal Ministry of Health [57]. The hospital infrastructure has been adapted as a reaction to existing cross-border healthcare due to tourism, but is not being actively changed in order to offer additional cross-border healthcare.

Beyond the question of necessary infrastructure for the provision of inpatient care, concrete specialized medical treatments for foreigners could also be an opportunity

[54] Interview 10, *loc. cit*.
[55] Interview 15, *loc. cit*.
[56] *Ibid*.
[57] Interview 6, *loc. cit*.

for usages of Europe. The Viennese hospital corporation that operates Vienna's hospitals, for example, makes a strategic usage of Europe when it comes to cross-border collaboration in medical research, and where European co-funding is available. Available European financial resources are used because research is one of the most cost-intensive parts of Vienna's hospitals. Given their self-conception as providers of quality inpatient care, research allows to develop new treatments or to provide state of the art medical treatments. The usage of Europe is thus determined by the role of the hospital corporation as a regional provider. While bilateral agreements exist with other countries in the field of organ transplantations, Viennese hospitals seem to be too far away from the national border for regional authorities to consider any active offer of cross-border healthcare [58]. From a more general perspective, specialised Viennese hospitals would have an interest in becoming European centres of reference for certain medical treatments or in establishing networks of centres of reference. But such an opportunity has to respect the mandate of the regional hospital provider to offer inpatient care first and foremost for the national and regional population [59]. Regional actors in their role as providers of healthcare consequently do take into account the resources that Europe could be offering for improving the provision of healthcare and are on the lookout for opportunities. While there is a potential for usages of Europe, these are sometimes prevented by national institutional factors such as the national conception of planning infrastructure, or even by European regulations themselves as they do not provide for satisfactory financial remuneration. The self-conception of regional actors as providers of healthcare not only sets incentives to look for European opportunities: it also constitutes limits for potential usages of Europe as priority is "naturally" given to the treatment of the national population or to those citizens who reside in the respective region before any possibilities of offering cross-border healthcare to foreigners can be considered.

Cross-border Healthcare: Ambiguous Regional Perceptions

Despite the activities by single Austrian *Länder* in cross-border healthcare such as cross-border hospital collaboration or research, European integration in the field of healthcare is perceived as highly ambiguous. European integration might provide possibilities for regional agency beyond the boundaries of the national healthcare system, yet these opportunities are always measured against the self-conception of regional authorities as providers and payers of healthcare. The experience that regional authorities have with cross-border healthcare under Regulation 883/2004 has made them sceptical about the potential impact of the rules created by the CJEU. The financial concerns of regional authorities that are already under reform pressure at national level seem to be the focal point of these concerns, although these worries should not hide the fact that regional authorities role as providers of inpatient care is equally important, making it necessary to retain the means of controlling patient flows, be they national or international [60].

[58] Interview 47, *loc. cit*.
[59] Interview 17, *loc. cit*.
[60] *Ibid*.

Given that European regulation of cross-border healthcare might impact the national planning of capacities, regional authorities are thus anxious to also retain their nationally defined role as regulators of inpatient care, while the usefulness of the possibility for patients to access cross-border healthcare in certain cases is not put into question. One of the main criticisms that regional authorities have thus been putting forward is that the policy process initiated by the rulings of the CJEU concerning cross-border healthcare set incentives for the European institutions to "pretend that there was no possibility before to receive medical treatment abroad" [61]. To this extent, regional officials do not perceive the increased possibilities for patients to receive medical treatment in other Member States beyond the options provided by Regulation 883/2004 as an added value, but rather as an additional administrative burden which has been created by a (perceived) unnecessary involvement of the European Union in healthcare.

This perception of European involvement in cross-border healthcare as an additional burden correlates with most of the Austrian healthcare actors' perception that national healthcare governance and reform debates are already highly complex to which no additional complexity should be added by having to deal with the effects of European integration on top of national policy and governance processes. This perception is at the same time in contradiction with the existing cross-border collaborations by some regions and the strategic usages of Europe in the Brussels arena. Perceptions and reactions to cross-border healthcare vary among European regions – depending on their geographical, financial and economic situation – as much as perceptions and reactions vary inside Austria:

> "So I think it is rather a complex issue, depending on what you are talking about and who you are talking about. It is really on an individual [regional] basis. But most of the time it is about the quality of services, the money available and the organisation of your services. […] Money is a key issue. When you have a very well developed healthcare system and when you know that you might get… I don't really like that terminology, but when you get a lot of 'patient tourism' and it means that you will have to cover a part of the payments or you have over-crowded hospitals, because you have hospitals which are known as good, then you have a negative attitude" [62].

From a global point of view, regional authorities that have competencies in healthcare governance do not necessarily all hold the same views about European integration and cross-border healthcare. Border regions are certainly more active in developing projects of cross-border collaboration, as a certain number of different cross-border projects related to inpatient care illustrates: these projects are implemented between France and Spain, Belgium and France, Germany and Denmark or even between Finland and Norway as a member of the European Economic Area, to name a few (Glinos & Wismar, 2013b). EU regulation of cross-border healthcare is thus both an opportunity and a challenge for European regions.

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[61] Interview 47, *loc. cit*.

[62] Interview 31 with a European official, Committee of the Regions, Brussels, 7 October 2011.

4.1.5 Discussion: Regional Usages of Europe and Cross-border Healthcare *Cross-border Collaboration* [63]

The Austrian *Länder* make different usages of Europe in their role as providers, payers and regulators of inpatient care. These usages are however not coherent, do not necessarily follow the same goals, and they mirror the various national competencies and corresponding interests of the Austrian regional level of healthcare governance. In addition to the nationally institutionalized competencies of the *Länder*, political priorities of regional governments play a considerable role in determining which usages of Europe are made. These preferences are in turn shaped according to the role of the *Länder* as providers of inpatient care and the way they react to national reform pressure concerning the reduction of hospital beds. These factors are especially visible when it comes to the analysed projects of cross-border hospital collaboration. The Austrian-German project had been successfully operating for more than a decade before it was terminated, while the Austrian-Czech project was still in its initial phase of implementation in 2012. Both projects concern different countries, and are thus facing different challenges from the outset. Yet in both projects the financing of inpatient care either has been or is the most acute institutional obstacle to cross-border collaboration. It is even more important for the second project, given the large differences between Czech and Austrian tariffs for inpatient treatment. The Austrian-German project did not have a problem with price differences, but it was the financing structure – mixed financing by sickness funds and taxes in Austria, and sole financing by sickness funds in Germany – that puts constraints on the project. At the same time, other nationally defined regulations concerning quality standards, reporting systems, building regulations and labor law constitute major institutional limitations to cross-border hospital collaboration. The Austrian-Czech project faces moreover a linguistic problem and the weight of historically difficult relations which necessitated a longer learning process of actors when it comes to negotiations and familiarization with administrative practices in the neighboring Member State. The Austrian-German project, on the other hand, could rely on a historically grown cross-border exchange where the border was 'permeable' even before Austria had joined the European Union. It is thus also worth noting that the Austrian-German project started a year before Austria's EU membership, showing that cross-border collaboration is not necessarily based on European integration, even though the EU provides additional resources for agency.

To overcome the institutional obstacles that both projects were or are facing, the local and regional healthcare providers used different strategies: the first project tried to use national strategies and attempted to use 'European' strategies in a similar way for its cross-border hospital collaboration. Having learned from the former project, the Austrian-Czech project has had a more European strategy from the outset, and has also been supported more actively at regional level, given the political preferences of the regional government. This support, however, meant at the same time that regional executive control over the project was present from the outset. While the aims and

[63] Parts of this section have been published in Kostera, 2012; Kostera & Burger, 2013.

forms of usages of Europe that actors made or make have been similar, their scope and success show noticeable differences.

Table 9. Usages of Europe in Cross-border Hospital Collaboration

Actors	*European opportunities*	*Institutional constraints*	*Usages of Europe*
Austrian-German project	CJEU rulings on cross-border care Co-funding (Regional Policy) European parliamentary representation	Regions as providers and payers of healthcare Reform pressure and regional political preferences Financing of inpatient care National regulation of labour law, medical standards, medicinal products, building regulations, reporting…	Cognitive (at national level) Strategic (at national level) Strategic (attempt at European level)
Austrian-Czech project	Co-funding (Regional Policy) CJEU rulings on cross-border care Regional representation in Brussels		Cognitive (at national level) Strategic (at national level) Strategic (at European level)

The first common point refers to the *goal* of the usage that is or has been made in both regional projects, namely to perpetuate a path that is present in the Austrian healthcare system: both projects aim at saving smaller hospitals by extending their catchment area beyond the national borders. In order to secure regional political support on both sides of the border, actors who initiated cross-border hospital collaboration have been making a cognitive usage of Europe. The reference to a common European context provides additional legitimacy and international visibility to projects which are mainly based on the above mentioned nationally defined goals of regional healthcare providers in cross-border hospital collaboration. More importantly, both projects have also been using Europe strategically, mostly to receive funds for cross-border collaboration. The main difference between the Austrian-German project and the Austrian-Czech project is that in the former, financial subsidies by the EU played a minor role. The Austrian-Czech project, which has been integrated in the traditional practice of the *Länder* using hospital infrastructure as a means of economic investment, relied on much more co-funding by European Regional Policy. This difference can be explained by the fact that the collaboration with Germany has not been actively supported by the regional level, whereas regional administrative resources dedicated to the collaboration with the Czech Republic have been decisive in applying for and receiving European co-funding. The scope of strategic usages of Europe by regional actors is thus largely determined by national, and in this case, regional political preferences: Lower Austria has been much more active in using hospital infrastructure for electoral purposes than Upper Austria, where a reduction of

capacities has been on the political agenda. Additionally, even if the Upper Austrian hospital was financed by the regional health fund, it was not owned by the regional authorities but by a religious order. It thus had much weaker administrative and political resources than the Lower Austrian hospital, which is operated directly by regional authorities. The Lower Austrian authorities went even so far as to create a dedicated unit for cross-border collaboration concerning inpatient care, and have been trying to extend cross-border collaboration to other regional hospitals, therefore also integrating usages of Europe in their institutional structure.

The national reform pressure on smaller Austrian hospitals has thus been playing an ambiguous role in cross-border hospital collaboration. On the one hand, reform pressure set incentives to 'save' existing hospital infrastructure in border regions by extending the respective hospitals' catchment area across the border; but at the same time it can be a major obstacle to cross-border collaboration, as the termination of the Austrian-German project illustrates. Which usages of Europe local and regional actors in hospital governance can make use of are thus not only determined by actors' own administrative and financial capacities, but also to what extent other actors in healthcare governance support, ignore or oppose cross-border hospital collaboration. As the Austrian-German collaboration shows, the limits of potential usages of Europe at national level are to be found in the institutionally defined interests of other national actors. And these interests can conflict with cross-border hospital collaboration, as was the case with the national law concerning the operation of "dislodged wards" across the border. In this case influential corporate actors such as the Austrian Chamber of Physicians and the Association of Private Hospitals effectively circumscribed the room of manoeuvre of the actors involved in Austrian-German cross-border hospital collaboration. The Austrian-Czech project has also been facing similar opposition: the commissioned feasibility study concluded that a fully developed cross-border hospital could not be built as it would put into question existing contracts of Czech hospitals with Czech sickness funds for inpatient treatment in the concerned border region. As a consequence, plans for collaboration had to be adjusted and the scale of the intended building had to be downsized to a medical centre on the Czech side of the border.

Both projects also prove that the rulings of the CJEU on cross-border healthcare are not sufficient to overcome other aforementioned legal issues that are bound by the principle of territoriality, such as labour law, hygienic standards and other aspects of medical law. Actors thus have to adapt their strategy according to their path-dependent position in the system. This is not to say that actors do not try to make usages of Europe – they do in fact scan for potential opportunities provided by European law, such as rules on the secondment of workers from one Member State to the other. Yet, these legal opportunities are not always suitable for healthcare systems and actors have to learn in a sort of 'try and error' approach where the institutional limits to potential usages of Europe are. The Austrian-German project also shows that when usages of Europe are not able to overcome national institutional limits, informal agreements and the bypassing of national law on a case-by-case basis needed to be used: payments between the German sickness funds and the Austrian hospital sometimes have been agreed informally. Such informal agreements would nonetheless not have been possible on a larger scale and were also not covered by European regulations. To

what extent such practices might have played a role in regional authorities taking the decision to terminate Austrian-German cross-border hospital collaboration remains however unclear. One may therefore say that actors try to make a strategic use of Europe and that there is a potential for destructuring effects on national boundaries, but that actors cannot 'escape' their system in cross-border hospital collaboration. This conclusion refers to a complexity that is a barrier to negative European integration according to the rules of the EU's internal market in healthcare: the historically grown healthcare systems show a high degree of institutional complexity, and the services they provide are bound by these institutional rules. Such complex healthcare services can impede "attractive market opportunities" (Greer & Rauscher, 2011a, p. 21). An example here would be the Austrian-Czech cross-border hospital collaboration, where the differences in tariffs could potentially provide an economic advantage to the planned cross-border healthcare center at the Czech border: European rules could be used to purchase auxiliary services such as laboratory analyses or medical devices, which could be bought in the Czech Republic. At the same time these differences in tariffs are a major obstacle when it comes to the significantly higher prices of inpatient care in Austria.

Similar experiences of national institutional obstacles to cross-border hospital collaboration can be found in other projects across Europe, too (Rosenmöller, Baeten & McKee, 2006, pp. 180-187): many of these projects face either challenges that relate to the different systems of financing of inpatient care between Member States or face administrative obstacles like those shown in the Austrian-German project of cross-border hospital collaboration. Furthermore, many projects of cross-border hospital collaboration find it difficult to determine a legal framework which would guarantee long-term collaboration (Glinos, 2011, pp. 246-248). In the end, usages of Europe do not provide regional actors that collaborate across border with sufficient resources to dissolve these borders. Rather, domestic institutions and other national actors' institutionally shaped interests provide for the incentives and limits of such projects. An argument which is corroborated by the findings of public health research on cross-border hospital collaboration:

> "Nevertheless, border regions do not escape the domestic health system of which they are part. First, institutions are domestic. Health care actors are bound by the rules, regulations and standards of the domestic health system […]. Second, incentives are often domestic. Despite the particularities of border regions, most of the reasons […] to explain why collaboration takes place, or not, are rooted in domestic contexts […]" (Glinos & Wismar, 2013a, pp. 21-22)

EU membership thus provides for increased possibilities of cross-border collaboration, and actors' strategies are Europeanized when they make use of the resources that the EU provides. The goals of these usages are nationally defined, which in Austria is related to the pressure on smaller hospitals due to national reforms. What is even more noticeable is that the goals of the usages of Europe that are present in the Austrian-German and the Austrian-Czech projects are to save a historical path (the existence of smaller hospitals) which national reforms try to overcome. These motives also explain at least partly why regional governments might oppose such cross-border hospital collaboration once they have decided on reducing available

beds in the region, as was the case with the Austrian-German project. And even in the Austrian-Czech project, where regional political support is present, the regional authorities ensure control precisely through their active involvement.

That national institutions prevail over potential "loopholes" that European integration might cut into national boundaries, even when actors try to use European resources, is also linked to the very nature of the resources that Europe provides. While cognitive usages based on a "European idea" of cross-border collaboration can confer additional legitimacy on cross-border collaboration and might even help to receive political support – as both analyzed projects have been showing at national level – this additional legitimacy is not sufficient to outplay the legitimacy that national institutions have. While national institutional rules guarantee a defined level of standards and regulations of quality of medical treatment as well as its financing, Europe provides for an idea of collaboration across borders which might be linked to either existing experiences of crossing national borders (Austrian-German project) or to tries to overcome historical separation due to the Iron Curtain (Austrian-Czech project). Yet, this ideational resource is not sufficient when it comes to the practical operation of a hospital across borders.

A second resource consists of financial subsidies by the EU's Regional Policy, which allowed actors to make strategic usages of Europe. As the Austrian-German project has shown however, financial subsidies played a more minor role than the individual involvement of the actors running the Austrian and the German hospitals. The major part of financing the cross-border collaboration between the Austrian and the German hospital has been provided by nationally generated funds, and Europe merely contributed 200,000 Euros for a part of the measures implemented during cross-border hospital collaboration. The availability of financing alone, therefore, did not set the incentive to collaborate across borders. The Austrian-Czech cross-border project has been using European financial resources much more extensively and the project (and follow-up phases) has been co-funded by European Regional Funds up to 50%. Yet, the funds that the Austrian-Czech project received did not set the incentive for cross-border collaboration: it was based on individuals' initiatives in both bordering towns. The subsequent strategic usages are moreover in line with Austrian *Länders'* nationally defined interest, namely to generate additional funds for their competencies in structural policies. This links back to the hopes that the Austrian *Länder* had when supporting Austria's accession to the EU. Available co-financing and resulting usages of Europe can contribute to cross-border collaboration, but are not their root cause. A similar observation has been made when comparing different projects of cross-border hospital collaboration between other European Member States: "[…] no amount of funding or official support can, for example, foster the need for cross-border collaboration, shared interests between partners or dedication among individuals" (Glinos & Wismar, 2013a, p. 29). Strategic usages of Europe can thus contribute to stabilizing or extending cross-border hospital collaboration, but these usages run up against their limits when national regulations on financing and other national actors' interests have to be respected. How far the nationally defined capacities of an actor influence the potential strategic use of Europe becomes clear

when looking at the usages of Europe and the attempts to use Europe that have been made at European level.

Usages of Europe at European Level

When it comes to political resources that the EU provides for a potential strategic usage, as has been the case with the attempts of the Austrian-German project to involve their representative in the European Parliament, these might not be fully usable for different actors. The actors involved in the Austrian-German project, which tried to use Europe strategically to overcome national regulations that represented obstacles to cross-border collaboration, felt to be "too small" in comparison to other actors that are present at European level, and even though their local Member of the European Parliament did address a written question to the European Commission, the actors involved in the cross-border project could not derive a practical benefit since the continuation of the cross-border collaboration was mainly dependent on regional authorities' decisions.

The Austrian-Czech project, on the other hand, could use Europe strategically given the political support of regional authorities. The responsible officials from the Lower Austrian health fund communicated their experiences and demands to the European Commission in the consultation procedure of 2007. Based on the content of this strategic usage of Europe, it shows the ambiguous interests that the Austrian *Land* has. This is related to the regional competencies of payers and providers of inpatient care. As providers of inpatient care the usage of Europe aims at underlining the potential benefits of cross-border hospital collaboration. As a payer of inpatient care, the Lower Austrian response shows that the *Land* tries to avoid any potential destabilizing effects of the rights created under the rulings of the CJEU. Given that these rights are destabilization rights (Greer & Rauscher, 2011a, p. 221), regional authorities call for mechanisms that permit to avoid competition between healthcare systems, and pointed out that especially patients in border regions might face financial difficulties if their home healthcare system remunerates inpatient care at lower tariffs. The response even called for possible sanctions if national regulation of healthcare was to be undercut in cross-border healthcare. The usage of Europe thus aimed at a restabilization of healthcare systems in their border areas. What seems to be a contradiction at first sight – usages of Europe to foster cross-border hospital collaboration and a usage of Europe at European level to restabilize healthcare systems – can be explained by the nationally defined regional interests. As providers of healthcare, European integration seems to be an advantage to facilitate access to healthcare and to keep up a certain level of inpatient care provision in border areas. As payers of healthcare, regional authorities underline the necessity of control remaining with them. In both cases it is clear, however, that national institutional structures should be kept intact while Europeanized strategies of actors aim at deriving the largest possible benefit from European integration.

This Europeanized interest of regional authorities is also illustrated by the strategic usage of Europe that Lower Austria is making in healthcare by its involvement in the network of European Regional and Local Health Authorities (EUREGHA) via its own regional representation in Brussels. The *Land* is actively using the network to

position itself in the developing policy field in Brussels. It therefore takes advantage of the additional quasi-federal layer of governance that the EU is providing. Despite different European regions' activities at European level in the field of healthcare, a complete loss of national boundaries seems unlikely. Rather, the boundaries have become porous, but are however still present given that mainly regions are involved that have the necessary competencies in healthcare governance at national level. Furthermore, the clear interests of regional providers of healthcare are at the core of such European cooperation within a network: the exchange of best practices of providing inpatient care and applying for common projects which might be co-funded by the European Regional Policy. What is furthermore noticeable is that up to date only one Austrian *Land* is actively participating in the network which is related to the regional political priorities set by member of the regional government responsible for healthcare. The other Austrian *Länder* do not share the same interest in becoming involved in European healthcare policies. The different regional members of the network come from Member States in which either the regional level has important competencies in healthcare, or which are federal states already providing their regions with much more leeway for setting their own political agenda regarding certain policies. Regional involvement in healthcare at European level is therefore largely determined by national institutional rules of the game. That Member States actually lose healthcare sovereignty seems therefore rather questionable.

The possibility for regions to make usages of Europe via the quasi-federal opportunity structure that is offered by the EU thus seems to co-exist with national territorial governance rather than replacing it. This argument can be corroborated by the stance that the *Land* took in its reply to the Commission's consultation, where it insisted on sufficient control mechanisms for cross-border healthcare. Healthcare governance might thus become more complex due to this nascent co-existence of different forms of governance which also involve the European level, a phenomenon which has been observed in other policy fields where regions and non-governmental actors follow their own political agenda at European level: national hierarchical governance structures co-exist with a developing "multi-level governance" [64] (Hooghe & Marks, 2003) in which voluntary cooperation dominates among actors. European integration thus leads to more complexity in the healthcare sector. It is however impossible to draw a coherent picture, especially if different policy areas and the variable involvement of Member States' regions are taken into account (Fallend, 2002, p. 204). It therefore seems fair to say that at this point in time the selective usages of Europe of regional healthcare actors do not lead to a stable system of "multi-level governance", especially given their interests which are deeply rooted in their nationally institutionalized competencies and functions. We can rather witness an 'à la carte usage' of the opportunity structure that the EU as a supranational level of governance is offering.

[64] The term multi-level governance in itself is unclear as it might refer to "processes or to situations, to strategies or to structures" (Piattoni, 2009, p. 163). Given the analytical focus on regional actors' usages of Europe, it will be understood here rather as a strategy.

Regional Regulation of Cross-border Healthcare

The importance for regional actors of defending and actively uploading regional policy preferences to European level also becomes clear against the background of regional experience with cross-border healthcare related to the role of the *Länder* as regulators of inpatient care. Austrian regional authorities have a significant experience with cross-border patient mobility, especially in regions where winter tourism is present. Many of them have adapted the capacity of hospital infrastructure, mainly in terms of available beds, to the need of regularly treating foreign patients. Financial compensation for regions with many foreign patients is even part of the 15a agreements. These adaptations to cross-border patient mobility are, though, not directly related to European integration: foreign patients already had to be treated in Austrian hospitals long before Austria's accession to the EU. The occurrence of cross-border healthcare is thus more related to Austria as a tourism destination than to European integration. With Austria's accession to the EU, however, administrative procedures had to be adapted to the reimbursement of costs between Member States due to Regulation 1408/71 (883/2004). While this represents an institutional adaptation to European regulations, such procedures existed before Austria's EU membership given that Austria had several bilateral agreements for treating foreign patients with surrounding countries, especially Germany.

The experiences of regional authorities with the reimbursement procedures in accordance with the EU's regulations for the coordination of social security systems in the field of healthcare influence however the perception of further European integration due to the CJEU's ruling regarding cross-border healthcare. As chapter 3 has shown, the numbers of treatments for foreign patients carried out in Austria do not seem problematic. In terms of public healthcare expenses, cross-border healthcare represents a rather limited cost factor. Yet negative experiences with delayed payments are the first factor that leads to a negative perception of increased European integration with regard to cross-border healthcare. The second factor which has contributed to a sceptical perception of European integration with regard to cross-border healthcare is the enlargement process: while regional authorities do not put into question that cross-border healthcare can provide *per se* for better access to specialized medical care when this care is not available at home, control mechanisms to regulate patient flows at national level are of utmost importance to them. And Austria has been rather restrictive with issuing prior authorizations for inpatient treatment in other Member States in the past (Österle, 2007). European integration therefore does not have a detrimental effect on a territorial conception of healthcare, but it rather leads to scepticism and resistance if European requirements lead to more institutional "openness" than seems acceptable to Austrian regional actors.

Interim Conclusion [65]

From the above discussion we can derive the conclusion that interests, perceptions and forms of usages of Europe by Austrian regional actors do not follow a coherent pattern and that European rules on cross-border healthcare do not have a uniform

[65] Parts of this section have been published in Kostera, 2012.

effect, even on the same set of actors. These differences can be explained by the triple role of the Austrian *Länder* in healthcare governance: they are providers, payers and regulators of inpatient care. When it comes to cross-border hospital collaboration, two forms of usages of Europe can be witnessed: cognitive and strategic uses. Cognitive usages are mainly present when it comes to generating political support for cross-border hospital collaboration. While these usages mainly dominate in the beginning of cross-border collaboration, strategic usages are of much more importance to actually initiate collaboration or to implement it. The dominance of strategic usages of Europe in both the analyzed projects and the mere absence of legitimating usages of Europe are interesting from a theoretical perspective. The lack of other than limited cognitive and dominant strategic usages of Europe in the two projects underlines the necessity of not only looking at which resources the EU provides for potential usages, but also of taking into account which nationally institutionalized competencies enable actors to actually access European resources.

The absence of legitimating usages shows that bureaucratic actors such as regional health authorities or hospital operators have a limited access to the public and thus use Europe mainly strategically instead of seeking public legitimation through European resources. Public legitimation of policy choices becomes more relevant when it comes to regional hospital reforms; but this is not related to Europe (see introduction to section 4.1). Using Europe in this case would not be of interest for regional actors. Strategic usages are mainly sought once the decision to start implementing a cross-border collaboration project has actually been made. These strategic usages are based mostly on the financial resources that the EU is providing through its Regional Policy. Yet, as a comparison between the two projects reveals, these financial subsidies can only be used extensively if the project is actively supported by the regional administration, and hence additional administrative resources to generate such subsidies are forthcoming at national level. In the case of Lower Austria, strategic usages also serve the interest of the *Land* to underline and maintain its role as principal provider of inpatient care. The same argument relating to necessary national resources for usages of Europe also applies for European political resources such as representation in Brussels or active uploading of political preferences to the European level. If an actor has limited resources or competencies at national level, as the termination of the Austrian-German project illustrates, access to European resources and transformation of these resources into usages of Europe are also limited.

This is not to say that actors do not try to squeeze a ‘maximum’ out of Europe: they scan for possibilities to actively use Europe, they learn how to make these usages, and they integrate these usages into their practices, but they also learn where the national institutional limits are. Another example of the present case would be the consideration of the Austrian-German project regarding a lawsuit in order to overcome national obstacles. A successful lawsuit could have a significant destructuring effect on national boundaries, but a strategic usage of European courts also seems to be the most costly option in terms of an actor’s administrative and financial capacities, not to mention the detrimental effect a lawsuit could have had on the existing cross-border collaboration at that time. In comparison to such a strategic usage, other forms of usage such as a cognitive usage are less costly, but might also be less effective, and even the

latter is not necessarily a viable option for every actor. Hence, the combination of the usages of Europe approach with historical institutionalism provides a possibility to take into account national institutions, resources and paths that bind actors when they decide on making use of Europe.

Taking institutionalized competencies and resulting interests and strategies into account also provides for an explanation about the aims of the usages of Europe that actors make. As both cross-border hospital projects show, the involved actors make usages of Europe based on an inherited institutional path of trying to save smaller hospitals. These strategic usages of Europe are thus directed against a slowly evolving path shift due to national reform pressure. Yet, such a usage is not always successful. And as the decision-making process on the Austrian bill on operating "dislocated wards" across the border has shown, other more powerful national actors' interests can easily prevail over the interests and strategies via a single project of cross-border collaboration. Thus, while especially in border areas cross-border hospital collaboration might have the potential to further cut into the national boundaries of healthcare provision, these boundaries are not threatened substantially, even when Europe provides for additional resources for national actors to pursue their interests beyond the national system. A conclusion that can also be drawn for other projects of cross-border hospital collaboration in the EU:

> "The bulk of healthcare will continue to be provided and consumed within national territories. The national logic underpinning health systems may show its limitations in border regions where cross border logic is often better suited, but local and regional actors stand against the forces and interests that try to uphold the coherence of health systems. While cross-border collaboration may not be a rarity in Europe, it is still the exception rather than the rule" (Glinos & Wismar, 2013a, p. 27).

Looking at the roles of the *Länder* as providers, payers and regulators of healthcare allows furthermore to explain why on the one hand, regional authorities use Europe to collaborate across borders and why, on the other hand, they use Europe to insist on preventing further European integration in healthcare: regional actors use Europe to increase access to inpatient care as providers, and they use Europe as payers and regulators to avoid being 'overrun' by European integration which would erode their capabilities of financing inpatient care and controlling patient flows. The triple role of the *Länder* thus explains a sort of 'à la carte' interest in European integration and resulting usages of Europe, providing for some further openness of the healthcare system when Europe is in their view an "added value" in border areas or when it comes to the exchange of best practices. This strategy certainly adds complexity in terms of governance, but it is more of a nascent pattern of "multi-level governance" that starts to co-exist with traditional national governance rather than replacing the latter. And regional authorities still defend national boundaries and the territorial principle of healthcare provision when European integration touches upon their core competencies. The empirical results of this section thus show that regional actors' strategies and interests have been Europeanized even at the lowest governance level of the healthcare system, but that institutional structures of the healthcare system stay largely untouched, even though minor institutional adaptations may occur in parts of the administration. These institutional structures are supplemented by additional

European opportunity structures that the *Länder* use to follow their nationally defined interests. These conclusions for regional actors do not contradict Ferrera's (2005) assertion that European Integration can have a detrimental effect on national welfare state boundaries in the long run, but they show that national institutional set-ups retain significant power to channel actors' interests and strategies. The Austrian *Länder* are however not the only group of actors in healthcare governance. Payers and providers of ambulatory care as well as other corporate actors play an important role. The next section will therefore analyze whether and if so how these groups of actors might use Europe.

4.2 Usages of Europe by Corporate Actors

Diverging Interests of Payers and Providers

The outpatient sector of the Austrian healthcare system is governed by corporate actors such as the Chamber of Physicians and the Chamber of Dentists in their role as providers, while sickness funds act as payers. While their general competencies have been described in chapter 2, this section will analyze how the above mentioned actors either use or do not make use of Europe with regard to cross-border healthcare. Given that payers and providers tend to have different goal orientations in healthcare delivery (see also chapter 1), their interests and positions towards European regulation of cross-border patient mobility should vary accordingly. Providers usually have a greater interest in facilitating the access to high quality medical treatment. Payers such as sickness funds on the other hand share similar interests with the state, advocating usually for the efficient use of financial means for medical treatment (Blank & Burau, 2010, p. 246). However, the decentralization of Austrian outpatient care governance to sickness funds governed by the Social Partners and to the medical profession leads to a common interest of payers and providers, namely that of avoiding centralization of healthcare governance by the state executive. The (failed) reform efforts of outpatient care whereby federal governments either attempted to increase control over sickness funds' boards (and hence reduce the role of the Social Partners) or in which the role of sickness funds in negotiating tariffs with the medical profession should have been strengthened illustrate this point. Especially the latter reform attempt failed due to the resistance of the medical profession.

The sickness funds are members of the Main Association of Austrian Social Insurance Institutions, which often shares interests with the federal government when it comes to regulating ambulatory care, as both can be seen as representatives of the central level of governance. The Main Association's power is however circumscribed by the regulatory independence of each regional or professional sickness fund[66]. At the same time it would also be impossible for the federal government to unilaterally impose reforms against the will of the Social Partners. The shared interest in increasing efficiency of spending on healthcare between the federal government and the sickness funds or the Mains Association of Austrian Social Insurance Institutions vis-à-vis providers of medical care is not an Austrian exception. As has been observed for other European countries, the medical profession is usually the most important actor that is

[66] Interview 48, *loc. cit*.

concerned by healthcare reforms: "[…] Policy is focused on more effective control of resources at both the macro and micro level; doctors are the single most important group in allocating resources; the effort to control resources by states soon leads to efforts to reform the medical profession" (Moran, 2001, p. 176).

Regulation, the Medical Profession and Potential for Usages of Europe

Physicians (and dentists) play a key role in all healthcare systems and have been described as "Healers. Scientists. Professionals. Entrepreneurs. Politicians" (Moran & Wood, 1993, p. 1). This key role of the medical profession is not only based on physicians' and dentists' competence of defining precisely what treatment of patients is medically necessary, but also on their capacity to regulate themselves the contents and the standards of their profession (Giaimo, 2002, p. 12). This power of auto-regulation of the medical profession stems on the one hand from the advancement of medical science since the Middle Ages, and on the other hand from the role of physicians as healers: doctors have an obligation to put the patient's interest above their own and have therefore a wider societal function of contributing to a healthy population. The ethical obligation of physicians as healers is therefore a core part of their professional identity, and autonomous self-regulation of the medical profession can be seen as the major accomplishment of this professional identity (Hassenteufel, 1997, p. 29). The organisation of the medical profession as corporate actors developed simultaneously in most Western countries with the introduction of mandatory public health insurance. Whereas before the introduction of sickness funds users paid physicians directly, contracting with social insurance institutions now meant not only increased regulation by the state, but also increasing dependency on those newly created sickness funds who would pay for medical treatment. Public provision of healthcare thus also touched upon the professional autonomy of the medical profession and the economic interests of physicians. As a result doctors in all Western countries organized themselves in various forms of medical associations. Trying to protect their professional autonomy, physicians usually demanded a payment based on a fee-for-service principle, free determination of these fees and the free choice of doctors by insured patients. In the end however, it was state regulation that guaranteed the medical profession its right to autonomous self-regulation and thus physicians' capacity to negotiate collectively their tariffs with sickness funds (Hassenteufel, 1997, pp. 60-72). In many countries such as France or Switzerland, doctors often even tried to resist or delay the introduction of social insurance institutions like sickness funds for several decades, which also explains why in many health systems significant parts of dental treatment are not covered by public health insurance. Austria was no exception to this attempt of defending professional autonomy from dependency on sickness funds' payments, as during the Austrian-Hungarian Empire the medical profession took a rather hostile stance towards the introduction of health insurance (see chapter 2). The different goal orientations of sickness funds as payers of healthcare and the medical profession as providers thus relate to a much deeper divide between these two types of actors in respect of their understanding of regulating healthcare, with the medical profession having a much more liberal understanding of medical market regulation and defending their professional autonomy. This is not to say that the medical profession would be

against any kind of regulation, but from their perspective regulation should rather contribute to their professional status (Moran & Wood, 1993, p. 100).

Meanwhile, however, every public health system – while granting considerable autonomy to the medical profession – regulates the market entry of doctors (i.e. fixing the numbers of practitioners and specialists in certain regions), competitive practices (regulated versus unregulated patient choice of doctors), and the medical market structure, i.e. how healthcare is provided. As chapter 2 has shown, regulation of these aspects in the outpatient sector has been largely delegated in Austria to sickness funds and to the Physicians' Chamber: in all of the nine Austrian *Länder* the sickness funds negotiate together with the Main Association of Austrian Social Insurance Institutions the costs of medical treatments as well as the places available for doctors to practice directly with the Physicians' Chambers: "the health insurance funds […] have a collective monopoly of demand, while the professional associations have a collective monopoly of supply" (Hofmarcher & Rack, 2006, p. 58). While these actors usually follow consensual and oftentimes also informal practices of negotiating, negotiations are not always free from potential conflict. Different examples and the more recent debates on Austrian healthcare reforms reveal the diverging interests of payers and providers in regulating healthcare: when it comes to negotiations of tariffs, these negotiations are not always consensual, but can also result in open conflicts.

When in 2010, the sickness fund for the self-employed – the social insurance fund for trade and industry (*Sozialversicherungsanstalt der gewerblichen Wirtschaft*) – did not accept the negotiated increase of 4% of tariffs and a reduction of laboratory costs, the Chamber of Physicians terminated the agreement with the sickness fund. Especially the subsequent wish of the sickness fund to introduce a "managed care" model, which would reduce doctors' autonomy and which would bind them to certain rules for the referral and treatment of patients, was refused by the Physicians' Chamber. In June 2010, the former agreement between the sickness fund and the Physicians' Chamber came to an end, so that the insured self-employed would not receive benefits in kind anymore but had to ask for reimbursement of their treatment costs. The Physicians' Chamber called upon doctors to not accept the insurance cards of patients insured with the insurance fund for trade and industry and even threatened those doctors who would accept the insurance card with legal action. The Federal Minister for Health then asked both involved parties to take up again the negotiations as both corporate actors would have a legal obligation to come to an agreement. Users, i.e. the insured patients, were nonetheless obliged to continue paying their payroll contributions and also had to advance treatment costs themselves during the time in which no new agreement could be reached (*Der Standard*, 27 May 2010, 1 and 2 June 2010). The disagreement between the sickness fund and the Physicians' Chamber could only be settled after a few weeks, when the heads of both institutions agreed on a new contract in informal talks. This example shows that usually consensual "routine" negotiations of renewing contracts between sickness funds and doctors can also become conflictual once one of the actors involved tries to increase its control over the regulation of medical costs. These situations are however resolved by informal negotiations which are then formalized at a later point, actually returning to consensually negotiated outcomes. Thus, while relations in healthcare governance between payers and providers can

become conflictual, both actors are bound in the end by institutionalized practices of consensual negotiations, even if they may take up to several years or if a series of informal negotiations is needed to avoid any (further) conflict.

A similar development can also be witnessed concerning the negotiations of the 15a-agreement in 2012 which was aimed at better linking the inpatient and the outpatient sector (see also section 4.1). While the Federal Ministry of Health, the *Länder* and the Main Association of Austrian Social Insurance Institutions were negotiating on more efficient planning of hospital infrastructure and on reducing costs in the inpatient and outpatient sector, doctors opposed the reform effort. The newly elected president of the Austrian Physicians' Chamber said in June 2012 that his goal would be to "avoid attacks on the autonomy of the medical profession" and to "improve the working conditions of hospital doctors", whereas the planned healthcare reform based on new 15a-agreement would simply try to save costs (*Der Standard*, 22 June 2012). This opposition led to an open letter addressed to the Physicians' Chamber jointly written by Federal and regional ministers and by representatives of the sickness funds and the Main Association. The letter called upon the Physicians' Chamber to moderate its opposition and "not to abuse the relationship of trust between patients and doctors to create distrust against the healthcare reform" (*ibid.*, 21 November 2012). In the end the medical profession had to accept the economies foreseen by the renewed 15a-agreement which came into effect in January 2013. While unilateral reforms are impossible to impose in the consensus oriented system of Austrian healthcare governance, unilateral resistance to reforms does not necessarily succeed either. This is especially the case when the other actors involved – federal, regional governments and the Main Association of Austrian Social Insurance Institutions – all have a shared interest in further developing planning of hospital infrastructure and more stringent regulation of medical practices in order to increase cost-efficiency. Despite important differences in healthcare governance, this development of increased state intervention in Bismarckian healthcare systems is however not limited to Austria: in France, the Netherlands and Germany, all countries with an important role of corporate actors in healthcare governance, intervention by the executive in healthcare governance (often coupled with either increased central planning or increased market competition) has been increasing since the 1990s, mostly to keep increasing healthcare costs at bay (Hassenteufel, 1997; Hassenteufel & Palier, 2007; Lepperhoff, 2004).

Against this background of sickness funds favouring regulation of the medical profession in pursuit of more cost efficiency, while doctors favour a more unregulated access to healthcare and defend their autonomy, the CJEU's rulings on cross-border healthcare should have a differential impact on actors. While for users, the choice of and the access to healthcare have been increased, payers of healthcare such as sickness funds that have to pay treatment undergone in another Member State, will rather perceive them as a destabilization of rights as their control over patient fluxes is reduced (Greer & Rauscher, 2011a, p. 221). Providers on the other hand might benefit from the rulings as other Member States are not able to discriminate against foreign providers of healthcare in favour of providers in their home country (Greer & Rauscher, 2011b, p. 4). As the dental tourism by Austrians to Hungary however shows, cross-border healthcare might also increase competition. Especially the relationship between

payers and providers can become more conflictual: in Luxemburg, for example the *Kohll-Decker* rulings created demands in the late 1990s for higher remuneration of contracted doctors, in order not to have a disadvantage regarding tariffs in comparison to neighbouring countries which might charge lower tariffs for medical treatment (Baeten, Coucheir & Vanhercke, 2010, p. 10). It is therefore necessary to scrutinize the perceptions of European rules on cross-border healthcare on the part of different actors and how these might translate into subsequent usages of Europe.

4.2.1 Payers: Perception and Management of Cross-border Healthcare [67]

Perception of the European Rulings on Cross-border Healthcare

Sickness funds and their umbrella organization are the first group of actors to be considered as they play a key role in Austria's healthcare system as payers for medical care and as main insurers of the population. All sickness funds are members of the Main Association of Austrian Social Insurance Institutions that coordinates their administrative activities and represents them at the governmental level and towards other countries. Moreover, the CJEU rulings on cross-border healthcare concerned first and foremost the sickness funds as these have to authorize and pay for medical treatments abroad, either for outpatient or for inpatient care. When the first rulings of the CJEU on the *Kohll-Decker* case were issued, they caused some concern over the principles of European law potentially impacting national regulations. As a legal expert working for the Main Association states: "I can remember that there was a lot of excitement when these first rulings *Kohll-Decker* [were issued]. It was not that easy to explain 'people, stay calm, relax, we are not concerned by this'. Nothing is changing. […] The legal situation has not changed and there was no reason to change the legal situation" [68] [69].

Indeed, Austria did not show a legal misfit with the rulings of the CJEU since patients receive 80% of the Austrian tariff as reimbursement when they seek medical treatment with a doctor that has no contract with sickness funds. The same rule applies for patients seeking outpatient treatment without using their European Health Insurance Card in another EU Member State. This means that sickness funds do not discriminate between patients receiving medical treatment from doctors without a contract with the sickness funds inside or outside Austria, the "cut of 20% [is] justified with the additional administrative burden caused by bills from out-of-network physicians" (Obermaier, 2009, p. 79). This regulation also applies to the lump sum payments that sickness funds pay to hospitals for inpatient treatment. Patients have the possibility of a reimbursement of these so-called subsidies for nursing expenses (*Pflegekostenzuschuss*). If an Austrian citizen insured with a sickness fund receives necessary medical treatment in a hospital which is not financed by the regional health

[67] Parts of the following sections of chapter 4.2 have been published in French in Kostera, 2013b.

[68] Interview 8, Head of unit, Unit for Hospital Care, Main Association of Austrian Social Insurance Institutions, Vienna, 25 January 2010.

[69] An article published in the Main Association's journal "Soziale Sicherheit" discussing the *Kohll-Decker* rulings from a legal perspective came to a similar conclusion (Spiegel, 1998) (in German).

funds, the patient receives 90% of this subsidy which is fixed at 185,30 € per day of hospital stay. Patients thus get around 166 € per day of hospital stay refunded if they are treated in an out-of-network hospital (Sozialversicherungsanstalt der Bauern, 2011). Such reimbursement would also be paid for planned hospital treatment in another EU Member State if the patient has not applied for prior authorization. In reality such reimbursement would however not be covering the whole cost of inpatient treatment even in another EU Member State, given that the major part of operation costs are usually covered inside Austria by the regional health funds. Austrian law, however, does not foresee any discrimination between out-of-network treatments inside Austria or outside Austria in European Member States.

Yet, the reduction of 20% or 10% for out-of-network treatments in the outpatient or the inpatient sector respectively has caused sickness funds and the federal government to worry whether citizens might not try to legally challenge such reductions. In 2000, the Austrian Constitutional Court ruled that the differential treatment of out-of-network patients would be justified given the increased administrative expenditure incurred by sickness funds having to process out-of-network bills (Obermaier, 2009, p. 79). And individual patients have not been trying to use European law to legally attack the reduction of reimbursement for out-of-network treatments [70]. The potential destabilizing effects on Austrian payers have therefore been more of a potential nature than reality. Nevertheless, even if concerns could be dispelled in the short run, sickness funds shared the concerns of the *Länder* (see previous sections) relating to the experience of the existing payment mechanisms under Regulation 883/2004 (1408/71): the length of reimbursement procedures and delays in payments by other Member States did not contribute to a positive perception of European integration in cross-border healthcare. An additional aspect for sickness funds was that it would not be very transparent for their own insured citizens which treatments would usually be covered by health insurances in other Member States and thus be covered under European regulations even in emergency cases [71].

Experience with regulations already valid before the CJEU facilitated the access to outpatient care in other Member States thus raised additional concerns whether patients would understand the financial risks of seeking medical care abroad under the rules set out by the CJEU, where patients would have to advance the full costs beforehand and then would receive reimbursement only once they return to their home Member State. In the end however, sickness funds were less concerned than the *Länder* about potentially increasing patient fluxes given the legal provisions of equally reimbursing patients for outpatient treatment in another Member State as would be the case when patients see an out-of-network doctor in Austria [72].

Austrian sickness funds thus found themselves in a relatively 'comfortable' position as Austria was the only country at the time allowing sickness funds not to discriminate between outpatient treatments inside and outside Austria. The limits of

[70] Interview 10, *loc. cit*.

[71] Interview 8, *loc. cit*.

[72] Interview 3, Deputy Head of unit, Unit for EU Affairs, Federal Ministry of Health, Vienna, 12 January 2010.

what would be acceptable as payments for treatments abroad are thus rather defined by more abstract calculations and potential numbers of patients leaving the Austrian healthcare system which would put the system at risk. Additionally, it can be argued that even though sickness funds can reimburse patients for outpatient in other EU Member States at the same tariff as though they had been seeing an out-of-network doctor in the national system, sickness funds have an interest in keeping the growth rate of the number of out-of-network practices at bay: while the number of available places for physicians with contracts is negotiated consensually with the Physicians' Chambers in order to regulate the medical offer, a growing number of out-of-network physicians is not subject to regulation. Given that demand for treatment in the medical market is often determined by the offer (thus an inverse relationship in comparison to 'normal' markets), sickness funds fear rising costs. This phenomenon has however been mainly limited to the offer of psychotherapy for the time being [73]. Thus an additional European market for medical treatment is not necessarily a positive development for sickness funds as it could have the potential for accelerating a development which is already present in the national system. This example underlines that even though European integration related to cross-border healthcare is not an immediate threat, payers still have an intrinsic interest in regulating the amount of medical treatment that is on offer and for which they might have to pay. From a payer's perspective however, a very steep increase in the numbers of patients trying to exit or coming to the national system for medical treatment does not seem likely, even though numbers have been rising. This is mainly due to the economic differences between Austria and neighbouring Member States as well as the obligation of patients to advance payments if they seek medical treatment under the rules set out by the CJEU. Advance payments of medical fees in Austria might prove to be especially burdensome for citizens from new Member States [74].

Thus, while the Austrian system already allows for a certain flexibility, given that it is a Bismarckian type of healthcare system and that it also provides for the possibility of treatment outside of the public network of health insurance, European cross-border patient mobility poses less of a problem in terms of potential numbers of patients crossing borders. Moreover, as far as Austrian patients going abroad for treatment are concerned, they usually seek cheaper treatment for dental care in neighboring countries such as Hungary, and the amount that sickness funds would pay to patients would be the same either inside or outside the country. Rather, it is the side-effects of European regulation of cross-border patient mobility that might become visible in the long run, namely that insured citizens who already have more important financial means could leave the respective national system under the CJEU's rules for cross-border healthcare. Thus, in the end European rules on cross-border healthcare are as destabilizing for Austrian sickness funds as for other Member States' payers that do not have similar legal provisions as Austria. Nevertheless, Austrian Social Insurance Institutions and sickness funds need and want provisions that allow them to set limits of what is acceptable as cross-border patient mobility. Ultimately this relates to their

[73] Interview 14, *loc. cit*.
[74] Interview 8, *loc. cit*.

role as an institutionalized form of national solidarity, as each insured citizen has the same right to medical treatment even if payroll contributions vary according to each and every insured citizen's salary. A development which leads to inequality beyond the flexibility that the Austrian healthcare system already provides would thus lead to opposition from payers. Beyond the perception of European integration in cross-border healthcare, sickness funds have had to adapt to managing treatments of EU nationals in Austria and of Austrians in other EU Member States.

Europeanized Practices of Managing Cross-border Healthcare

Despite the rather "comfortable" institutional position of Austrian sickness funds, they control prior authorization procedures for patients who seek treatment abroad. Even in border regions where hospital treatment might be less expensive in the neighboring country, authorization to go abroad for treatment is only granted if the treatment is not available in other parts of Austria or if the patient faces, in rare cases, an excessive waiting time. If patients nevertheless want to go abroad, they receive the reimbursement according to a lump sum subsidy that Austrian sickness funds would pay in Austria. In order to receive prior authorization for inpatient care in another EU Member State, regional hospitals have to endorse the patient's request for authorization and have to certify that the same inpatient treatment would not be available at home. Sickness funds subsequently verify the patient's request for prior authorization and the hospital's statement. If the prior authorization for inpatient care abroad is granted, sickness funds will settle the bill directly according to the procedure for inpatient treatment abroad (see section 4.2.4) [75]. The control that Austrian sickness funds have to exert through the authorization procedure can prove to be rather complex as each case has to be individually examined [76]. Sickness funds have to check not only whether a provider abroad is capable of carrying out the medical treatment requested by the patient, but they also have to check thoroughly whether the same treatment is not available anywhere in Austria. While users can simply try to find providers abroad who they think would be best for their own treatment. The procedure is therefore designed to reach a decision which mediates between the sickness funds' interest in controlling expenses and patient flows and users' interest in an easy access to medical treatment. While requests for specialists occur more often, requests because of an 'undue delay' of medical treatment in Austria are rare. When this is the case, sickness funds have to check available capacity in Austrian hospitals in order to see whether treatment would be possible in a shorter time period. The CJEU's rulings did however not bring about any noticeable change to this procedure as prior authorization was already necessary under Regulation 883/2004 [77].

Due to the Austrian legislation, outpatient treatment of Austrians abroad is much less of an administrative burden for sickness funds. Yet, even in cases where Austrians want to use their European Health Insurance card abroad for emergency medical treatment, oftentimes foreign providers in other EU Member States do not accept the

[75] Interview 27, *loc. cit*.
[76] Interview 42, *loc. cit*.
[77] *Ibid*.

European Health Insurance Card, and patients then request reimbursement. In these cases Austrian sickness funds still have to verify whether the received treatment would have been covered by health insurance in the other Member State [78]. The practice of reimbursement of costs for outpatient treatment of Austrian sickness funds therefore does not only follow Austrian legislation: practices were corresponding to European rules even before the CJEU's judgments [79].

As far as incoming patients are concerned, the number of cases has not raised concerns with sickness funds. As described in chapter 3, it is the geographical position which determines which types of incoming foreign patients receive medical treatment. While in regions with ski tourism, mainly tourists with corresponding accidents receive medical treatment, Vienna with Austria's major universities has more foreign students who need to receive medical treatment. Additionally, students' relatives often seek emergency medical treatment during family visits. Even in these cases, sickness funds watch attentively what qualifies as necessary urgent treatment and what not: "if there is someone on a family visit and has a cardiac arrest, then there is no questions, [he is treated according to] the [EU] Regulation. But if he has a chronic coronary disease and wants to get a coronary computer tomography or another heart examination which is not necessary, this would not be the case. [Only] if it is an emergency [and needs treatment] without delay" [80]. At the same time, the Vienna sickness fund for example sees a growing 'internationalisation' due to the free movement of workers and the fall of the Iron Curtain. Given Vienna's geographical location, workers commute across borders from Hungary and Slovakia to work in Vienna. Oftentimes these workers live in their home countries, are insured due to their work in Austria, but receive medical treatment once they are back again in their home countries after work. These constellations did not exist before the fall of the Iron Curtain [81]. While this growing complexity of the relationship between insured persons and sickness funds does not seem to be a major problem, given that Bismarckian systems are based on this type of individual insurance relationship, the CJEU's rulings have nevertheless increased the administrative burden on Austrian sickness funds to the extent that decisions have to be made on increasingly complex cases, mirroring the living conditions of European citizens who might have been insured in various Member States during their working lives. Such cases occur especially in large urban centers like Vienna, even though only occurring sporadically:

> "These are special cases […]. So, for example, a German citizen moves to Austria for reasons of marriage or for professional reasons, his or her main residence is here. [This person's] arm has been operated in Germany years ago because of a complex fracture. Theoretically we could treat that here, but nobody will do it, because [the Austrian] surgeon will say that he does not want to treat a 'pre-baked' situation. In such cases, we decide in the favour of the patient, because we say that it makes sense if

[78] Interview 27, *loc. cit*.

[79] Upon accession of Austria to the European Communities/European Union in 1995, single cases of non-compliance with European rules could also be found in Austria (e.g. Landesschiedskommission für Tirol, 20 March 1996, in German).

[80] Interview 42, *loc. cit*.

[81] *Ibid*.

> the previous [German] surgeon treats the patient again. Another example: an Austrian [medical] Professor gets tenure in a German university with his special knowledge. Either only he has this special knowledge, goes to Germany and then this [knowledge] is lacking here, or he has previously operated or treated patients here and then goes to Germany. Patients then will follow him for follow-up care. We usually authorize this. […] It does not make sense to establish something [i.e. treatment facilities or capacities] where you have a case once every ten years. You cannot provide that expertise [all of the time in Austria]" [82].

Sickness funds thus have to adapt to more complex situations as the movement of citizens across the EU increases. That the example of Germany has been chosen by the interviewee is insofar not unusual, given that no language barrier exists between the two countries and that the exchange of workers between both countries is more important than with other EU Member States. Furthermore, price levels and tariffs for medical treatments do not on average vary significantly between the two countries (see also section 3.3.2). The Viennese sickness fund receives furthermore a subsidy by the regional government for such cases as the region has the obligation of providing inpatient care to its inhabitants. Once a year, the sickness fund is controlled by the regional administration concerning its practices of granting prior authorization. There are however limits to sickness funds' flexibility when it comes to patients' requests for medical treatment in other EU Member States. Oftentimes patients use the internet to find the "world's best specialist" for the treatment of their disease. If treatment can be provided in Austria, these requests are usually denied, unless children are concerned. In these cases, for example, the Viennese sickness funds handle requests "in a very generous manner, but in consensus with pediatricians" [83]. Similar limits are set when religious reasons are at the core of patients' request to go abroad for medical treatment [84]. These examples show that cross-border patient mobility is not necessarily a question of the quantity of patients looking for medical treatment in other EU Member States, but that it also contains an important qualitative and subjective aspect. With every request, sickness funds have to investigate thoroughly the justification of the request for treatment abroad and to weigh the subjective medical interest of the patient against the interest of the sickness fund acting as a payer for all its insured citizens in the framework of national and European legislation. Hence, the sickness funds had to adapt human resources and procedures to meet these demands and thus include 'European constraints' into their practices. Given the change in practices and administrative procedures, sickness funds also show an institutional accommodation of European rules, which is however due to European coordination of social security systems under Regulation 883/2004. The CJEU's rulings on cross-border healthcare, though, did not change any practices or institutional arrangements.

[82] *Ibid*.
[83] *Ibid*.
[84] *Ibid*.

Statistics of Cross-border Healthcare

It would be statistically possible for sickness funds to generate information about how many patients are treated medically abroad either using their European Health Insurance Card or going abroad under the CJEU rulings. These statistics are however usually only generated on an aggregate level for the whole country: "We do not see a need for action here. […] We do provide the reimbursements to patients [for medical treatment abroad], but the reimbursement is independent from the fact if the treatment was delivered inside Austria or abroad" [85]. This reflects on the one hand the national legal provisions that allow reimbursement for medical treatments either abroad or on national territory. On the other hand, sickness funds rather plan for a certain amount of services and medical infrastructure which has to be financed. As long as cross-border patient mobility does not pose an immediate problem to such planning, taking thoroughly into account differentiated statistics is not necessary. Thus, aggregated statistics as provided in chapter 3 remain sufficient, even though more detailed statistics could be generated. The CJEU's rulings therefore did not introduce a new statistical criterion for statistical evaluation as patients already had the possibility of receiving treatment abroad before. More importantly, more expensive hospital treatments that would require prior authorization are for sickness funds "a minor fractional amount compared to what we usually offer as services" [86].

It is thus the general amount of costs of medical treatments which is important to sickness funds rather than the exact reason why a patient receives medical treatment abroad. While this attitude might change if patient streams were significantly increasing to other EU Member States, especially more expensive inpatient treatments in other countries are calculable for Austrian sickness funds given the size of the country and sickness funds' ability to research available capacity for the treatment of certain medical conditions either inside or outside Austria:

> "Look, the bulk of E112 [prior authorization for inpatient treatment abroad] cases happens in border regions […] like the Kleinwalstertal [valley in the border region of Vorarlberg]. There is no hospital for the three small villages, but there is a hospital in Germany. And then there are some special treatments which are covered under E112. The classical example that I always cite is: in the whole German speaking area there is one centre of excellence for early infantile cancer of the eye […]. This centre is the university hospital of Essen [Germany]. Sickness funds know that and issue immediately the E112 [prior authorization] form. That makes sense. It does not make sense to provide medical infrastructure for a few cases [in Austria]" [87].

Sickness funds thus rather support cross-border healthcare in areas where cross-border healthcare has traditionally been developing, given that individual treatments abroad are less costly than financing their own infrastructure in Austria where certain medical conditions appear less often. Given that Germany has a larger population and that no language barrier exists, sickness funds have even developed a routine of cross-border healthcare with Germany. The probability that the rules stipulated in

[85] Interview 27, *loc. cit*.
[86] Interview 42, *loc. cit*.
[87] Interview 8, *loc. cit*.

the CJEU's rulings change anything about that already existing Europeanization of healthcare is thus rather unlikely. Nor does cross-border healthcare represent in this sense a destabilization of payers' control mechanisms. Rather, the Austrian healthcare system shows an openness for cross-border healthcare where it is necessary and even advantageous for a smaller country.

Sickness funds' interest in avoiding steep increases in treatment costs for inpatient treatment abroad becomes rather obvious when the split in Austrian healthcare governance between the outpatient sector and the inpatient sector is taken into account: since sickness funds pay a lump sum subsidy for hospital treatments, sickness funds were concerned that the *Länder* would lower their capacities, which in turn might oblige patients to go to other EU Member States for medical treatment. Such a scenario would thus result in an increase of reimbursements for sickness funds. Given the decade-long existing trend of patients receiving treatment in bordering countries, these considerations were due less to European regulations than to the introduction of the financing system for hospitals based on diagnosis related groups. The solution found at the time was that sickness funds reimburse patients for inpatient treatment abroad up to a level of 60 million Austrian Schillings (around 4.36 million €) per year. Treatment costs that go beyond this amount have to be reimbursed by the *Länder* to sickness funds. Therefore, aggregate statistics are of importance to determine whether the agreed amount has been exceeded or not [88]. For patients receiving inpatient care abroad under Regulation 883/2004, sickness funds only receive an aggregate bill by the Main Association of Austrian Social Insurance Institutions without knowing in which hospital abroad the Austrian patient has been treated, nor for how long, and without the diagnosis. If sickness funds need to know any details they have to make a detailed request, which however only happens seldom in cases where problems occur concerning the reimbursement of costs between sickness funds with other Member States or when sickness funds have to deny the payment following the authorization procedure [89].

Insofar the rules for internal reimbursement between sickness funds and the *Länder* resemble the more general separation of financing flows between inpatient and outpatient care. Given the separation, the system provides for a possibility to avoid that one sector potentially profits from cross-border healthcare by shifting costs to the other sector. This administrative adaptation to the occurrence of cross-border healthcare is however not necessarily a sign of Europeanization, given that Austrian law already provided the same possibilities for reimbursement of treatment costs abroad before Austria's accession to the EU. Austria has thus been a much more open system than the healthcare systems of other Member States. Europeanization can be however seen in a limited way insofar as the system operates within the framework of the EU's coordination of Member States' social security system under Regulation 883/2004 (1408/71). Austrian public sickness funds can furthermore rely on the aggregate data of cross-border patient mobility and their experience of similar cases of cross-border healthcare that appear every year. The CJEU's rulings on cross-

[88] Interview 27, *loc. cit*.
[89] Interview 42, *loc. cit*.

border healthcare have not been unfolding any destabilizing effects on sickness funds capacity to control patient flows. Following their inherit interests as payers, sickness funds are sceptical about potential future developments of cross-border healthcare and have an interest in avoiding any destabilizing effects on themselves. Yet, despite the increase of administrative burden for prior authorization procedures due to the free movement of EU citizens, Austrian public payers of healthcare retain control over cross-border healthcare.

4.2.2 Payers' Usages of Europe

Limited Usages at National Level

The European rules on cross-border healthcare do not necessarily only mean an administrative burden or a modified room of manoeuvre regarding the control of patient fluxes for national sickness funds. They can also become an opportunity to use Europe for the own benefit. German sickness funds for example have been concluding contracts in border regions or holiday destinations with foreign doctors that sometimes offer lower prices for treatment, such as Polish providers (Kostera, 2008, p. 22). Even though such contracts could be used to control costs, and hence would correspond to payers' interest in cost efficiency, Austrian sickness funds have not been concluding contracts with foreign providers in general, even though the sickness fund in the Burgenland region (bordering on Hungary) has been considering such solutions, given the offer of Hungarian providers for cross-border dental care [90]. Agreements only exist with foreign sickness funds in border regions where medical treatment inside Austria would be difficult to provide due to geographic reasons. A more strategic usage of European market opportunities is thus not in the interest of sickness funds, despite a potential to save costs:

> "I will put it like this, similar to other Member States; the health sector is a sector in which we are forced to realize savings as the costs [of healthcare] are exploding. We have in the new Regulation [883/2004] improvements especially for cross-border commuters and cross-border commuters on pension benefits. And I have realized that our sickness funds already there were opposing themselves as they said it [the revision of the Regulation] would cost much more. That means that an expansion of benefits is seen [by sickness funds] very sceptically. On the other hand we see competition and liberalization of the [healthcare] market […]. Concerning the sickness funds… Let's say that the whole provision of [medical] services is always based on contracts between sickness funds and medical professions. They try to frame it [negotiations] in a possibly harmonious way. Therefore I don't believe that sickness funds would shoot forward and would massively try to push a liberalization and competition [in provision agreements]" [91].

As the citation shows, sickness funds are rather interested in preserving the status quo of paying for cross-border healthcare and are even opposed to any increase in payments under existing European Regulations. It is however not only this nationally defined interest of sickness funds which prevents them from developing contractual

[90] *Ibid*.

[91] Interview 10, *loc. cit*.

relationships with providers outside of national borders: from an institutional perspective two major aspects prevent a loss of national boundaries. The first aspect is the development of Austrian healthcare reforms itself. Unlike other Member States with Bismarckian healthcare systems such as Germany or the Netherlands, Austria has not introduced market competition mechanisms amongst sickness funds, but given the complex actor constellation in healthcare governance has opted for an approach of increased central planning. Especially the Social Partners oppose any competition mechanism. Any usage of Europe pushing competition would therefore conflict with sickness funds' own national stance on the issue. A strategic usage of Europe by contracting with foreign providers would thus provide a short term benefit, but would be harmful to the institutionalized equilibrium of interests between actors in Austrian healthcare governance and thus also to sickness funds' own interest. Secondly, such unilateral usage of Europe would put into question the institutionalized practice of consensually negotiating contracts with providers.

Yet, despite the existence of consensus-oriented negotiations a 'softer' usage of Europe is still not bereft of interest inside the Austrian healthcare system when it comes to negotiating prices with national providers. Not the EU rules on cross-border healthcare, but EU-wide price-setting become a point of reference in the framework on national negotiations with providers:

> "I would say that as far as the EU is concerned, we are very much interested how the tariffs and medical coverage look like in other Member States. You always try to keep an eye on the other countries. Is there something that we can emulate? We certainly try to adopt positive experiences that others have made […]. We closely look what is happening in other countries [and how much medical services cost there]…" [92].

Such reference to Europe corresponds to a cognitive usage of Europe. "Europe" becomes a more general resource in terms of a reference to what prices would be acceptable for sickness funds. However, such references are mainly made when sickness funds compare tariffs that are paid to providers in other Member States such as Germany, which does not only have a similar Bismarckian healthcare system, but where price and wage levels are comparable to those in Austria. And providers oftentimes use as a counter argument that Germany still has a larger market and a larger population, and that therefore price-setting in Austria, for example for hearing aids, would be different [93]. Certainly, such limited usage of Europe during negotiations is explainable by the consensus oriented style of negotiations between payers and providers in Austria. From a theoretical viewpoint however, it shows also that the more vaguely Europe is used as a resource, resulting in a mere cognitive usage of Europe by referring to 'European' price setting standards, the less effective such usage becomes.

Inside the Austrian healthcare system therefore, the impact of the CJEU's rulings on cross-border healthcare on Austrian payers seems rather limited to the extent that Austrian legislation has always granted some leeway for medical treatment abroad and thus incentives for making usages of Europe are rather weak. Actors such as

[92] Interview 42, *loc. cit*.

[93] *Ibid*.

sickness funds might consider using Europe to pursue their own goals inside Austrian healthcare governance, but their calculations with regard of that usage are based on national practices and institutional boundaries. What looks at first sight as a large congruence between the individual contracting logic of a Bismarckian healthcare system with EU rules, should however not deviate attention from the fact that sickness funds do control patient flows and hence control costs. While sickness funds face increasingly complex cases on which they have to decide if they grant authorization for medical treatment abroad, they do not use Europe to contract with foreign providers, but rather prefer the national status quo. While Regulation 883/2004 (1408/71) has been in place for several decades, and sickness funds show an administrative adaption to these rules, the effect of furthering European integration by the CJEU's ruling is thus at best indirect as institutionalized practices are not largely changed inside the national system. The EU provides nevertheless a limited resource for payers to follow their own interests. At the same time, however, payers make a usage of Europe through the Main Association of Austrian Social Security Institutions, which is a member of the European Social Insurance Platform.

Usages of Europe at European Level

When Austria acceded to the European Union in 1995, the Main Association of Austrian Social Insurance Institutions followed an invitation from the German Social Insurance Institutions to join their representation in Brussels. Together with French and Dutch Social Insurance, the Austrian Main Association and German Social Insurance Institutions formed the European Social Insurance Partners, which in the meantime has changed its name to "European Social Insurance Platform" [94]. The main motive for the creation of such an association of Bismarckian type Social Insurances in 1996 was "to optimize their involvement in European affairs through cooperation yet preserving the specific identity of each social insurance system" (Felix, 1996). While all involved social insurance institutions followed the common aim to coordinate their positions concerning any socio-economic questions dealt with in the Brussels arena, the Austrian Main Association of Social Insurance Institutions followed furthermore the aim to better observe European social policy developments, to evaluate these developments, and to furnish all branches of Austrian social security with the necessary information (*ibid*.). Over the years the membership of the European Social Insurance Platform has increased significantly. Now 34 insurance funds or national associations of insurance funds (health insurances, accident insurances, pension insurances) from 16 Member States are members, all cooperating in four standing committees that are organized according to the branches of social insurance, one of them being dedicated to health insurance (European Social Insurance Platform). The health committee of the European Social Insurance Platform started to work on cross-border healthcare and to coordinate members when the second major ruling of the CJEU on the *Smits-Peerbooms* case was issued. While the *Kohll-Decker* rulings were still perceived by some sickness funds in several Member States as a unique case, the subsequent rulings made clear that depending on the national legislation, some Member States

[94] See http://www.esip.org.

could face the obligation to change national rules [95]. Similar to many Member States' governments, sickness funds were skeptical about the CJEU's jurisdiction on cross-border healthcare and preferred the legislative status quo, given that the long-standing Regulation 883/2004 (1408/71) already provided sufficient regulation for cross-border healthcare in the EU. The members of the European Social Insurance Platform took the position that the CJEU's rulings were rather due to an incorrect application of the existing rules. Moreover, before the Directive 2011/24 came into force which codified these rulings, many Member States did not change their legislation and decided to "muddle through" [96].

Following the other rulings, the different social insurance institutions of Member States would thus rather have preferred to incorporate them when Regulation 1408/71 was revised and replaced by its successor Regulation 883/2004. Austrian officials would also have preferred to include the rulings in the revision of Regulation 1408/71. However, a number of Member States did not yet want to recognize the CJEU's rulings as the *Watts* ruling – which made clear that previous rulings were applicable to all kinds of healthcare systems run by Member States (see chapter 3) – had not yet been issued when the revision of Regulation 1408/71 started [97]. From an Austrian perspective, which was shared by other social insurance institutions, it would have been preferable not to have started a process of negotiating a new Directive which should codify the rulings instead of creating a second legal source regulating cross-border care. At the same time, many social insurance funds considered the CJEU's rulings less of a problem than Member States with national health systems, thus confirming that Bismarckian type healthcare systems show a better institutional fit with the rules set by the CJEU (see also chapter 3). From a European perspective, however, the economic disparities between Member States where still a concern for social insurance systems. As the previous sections have shown, Member States with a higher level income such as Austria were rather worried about the potential influx of patients, whereas the 'new' Member States were more concerned about which potentially more costly treatments in other Member States would be acceptable. While the contractual logic with foreign providers would thus not be a problem, national differences in cost-control by sickness funds posed a major problem. The sickness funds of Eastern European Member States would therefore have preferred to remain at the legal status quo of European regulation of cross-border healthcare [98]. The potential destructuring effects of European integration in cross-border healthcare are thus much less of a concern for Austrian sickness funds than for those of other Member States. Nevertheless, given sickness funds' role as payers of healthcare, all Member States' sickness funds had an interest in avoiding a loss of control over patient flows and stabilizing their position. This interest in stabilizing national boundaries in the wake of European integration was not only shared by Bismarckian type social insurance institutions but also by national health systems (Greer & Rauscher, 2011a). When the

[95] Interview 18, Coordinator for healthcare, standing committee on health, European Social Insurance Platform, Brussels, 15 November 2010.

[96] *Ibid*.

[97] Interview 10, *loc. cit*.

[98] Interview 18, *loc. cit*.

European Commission initiated its consultation procedure prior to drafting a proposal for a Directive codifying the CJEU's rulings, the Main Association of Austrian Social Insurance Institutions together with the other members of the European Social Insurance Platform made a strategic usage of Europe by issuing a common response to the Commission's consultation.

The position paper sent to the Commission by the European Social Insurance Platform echoed the interest of payers in fine-tuning Regulation 1408/71 and its successor Regulation 883/2004. The paper made clear that social insurance institutions did not think that any further legal regulation at European level would be necessary. The European Social Insurance Platform underlined that for decades existing European regulations would have provided successfully for necessary cross-border healthcare for European citizens and that it considered the rulings by the CJEU as a mere "supplement and not an alternative" to existing regulations. The Platform furthermore demanded to respect the principle of subsidiarity by citing the example of regions with a high number of tourists that need to be treated. In these cases European regulations would not be capable of solving local problems, and hence the management of cross-border healthcare in these areas should be left to the national level. At the same time, the Platform made clear that it would not oppose cross-border healthcare where European integration would prove to be an added value for patients and social security systems, such as border regions. The position paper states that in these cases though individual contractual agreements would regulate such cross-border healthcare, and that such cooperation would allow to offset price differences between cooperating partners as the cross-border projects could lead to savings. The Commission was asked to further support regional cross-border collaboration in healthcare through the instruments of European Regional Policy. The Platform asked the Commission to support Member States that would not have transposed the CJEU's rulings into national law, yet underlining that such transposition would be the responsibility of Member States (European Social Insurance Platform, 30 January 2007).

The European Social Insurance Platform's response to the Commission clearly relates to the interests of payers of medical care in cost-efficient treatment for their insured citizens. In their response the social insurance institutions sought to stabilize their national boundaries, pointing at the success of existing regulations. This strategic usage of Europe is thus aimed at defending the nationally defined roles of payers against aspects of European integration concerning the modalities of payment for medical treatment. More interesting, however, is the payers' position concerning cross-border collaboration in healthcare. Social insurance institutions do not oppose European integration per se, but where they perceive an added value of European integration which might match their interests, such as providing more efficient healthcare in border regions, they welcome European integration. Their strategic usage of Europe thus corresponds to that of the Austrian *Länder*, which on the one hand welcome cross-border collaboration and on the other hand refuse any reduction of national regulatory competences by European integration. The defensive yet active usage of Europe shows also – similar to the previously described example of Vienna's regional government – that even if some sickness funds would prefer to

follow 'ostrich policies', such strategic usage of Europe becomes necessary for social insurance institutions especially if aspects of European integration can contradict the values and interests of social insurance institutions:

> "We had a great common denominator on this issue [cross-border healthcare]. This is not always the case, now it was quite comfortable. In principle we are all *d'accord*, we focus on social security, on sustainable financing of social security systems against the risk of illness. This is what we are there for and this is what we advocate. We are not there for [other aspects of healthcare] which are often discussed in the EU under the label 'health economy' […]" [99].

The European Social Insurance Platform, in which the Main Association of Austrian Social Insurance Institution participates, not only reflects the interests of an association that represents amongst others the payers of healthcare, it also defends the principles of market regulation by corporate actors in healthcare. Like the regional government of Vienna has joined the European Social Dialogue, the Austrian Main Association has adapted its practices to multi-level politics by using the resources that Europe provides for influencing policy-making. While the aim of the described strategic usage of Europe concerning cross-border healthcare is nationally defined and shared across Member States' insurance institutions (despite economic differences), European representation of social insurance institutions is not necessarily the result of European integration in cross-border healthcare. Rather, it follows from positive European integration after the Maastricht Treaty came into force in the early 1990s, when a corporatist policy community was taking shape based on the already existing Social Dialogue between employers' associations and labor union associations. That development following the Maastricht Treaty has increased the significance of social policy in general and especially policies concerning labour regulation at European level: "EC social policy-making is not in principle different from corporatist policy styles prevailing in some Member States" (Falkner, 1998, p. 189). While the development of healthcare politics at European level has rather been driven by the CJEU, healthcare does not follow the same pattern of regulation as labour policies at European level. Social insurance institutions that also regulate pensions and accident insurance – and are therefore subject to European formulation of labour policies – had to follow up on other corporate actors by establishing their own representation in Brussels. This representation in Brussels and the subsequent strategic usage of Europe, such as the Austrian Main Association's membership in the European Social Insurance Platform, show however that the opportunity structure offered by Europe is not used to circumvent national boundaries. Rather, social insurances try within the framework of European integration to protect national boundaries as far as possible when a European removal of boundaries based on the principles of market-economy is not seen as legitimate. What results is, as could be observed in the case of the Austrian *Länder*, an interest representation in healthcare which co-exists with national systems of healthcare governance and where corporate actors' positions in Brussels mirror their national practices and institutionally shaped interests in a variable pattern

[99] *Ibid*.

of multi-level governance. The following sections will therefore analyze providers' potential usages of Europe.

4.2.3 Providers: the Medical Profession and Cross-border Healthcare

Physicians

The most important group of providers of medical care are physicians. Austrian Physicians are organized in the Austrian Physicians' Chamber (*Österreichische Ärztekammer*), additionally nine physicians' chambers exist in Austria's *Länder* for which the Austrian Physicians' Chamber is their umbrella organization. Membership is compulsory for Austrian doctors in order to open a practice. The main tasks that have been delegated to the medical profession in terms of auto-regulation include a large variety of competencies that cover not only professional regulation, but also traditional political lobbying activities (Gottweis & Braumandl, 2006): in terms of professional regulation, the Physicians' Chamber and its departments or agencies are responsible for carrying out doctors' examinations, the licensure of doctors as self-employed or employed physicians, life-long learning of physicians, decisions on quality standards and quality management. Moreover the Austrian Physicians' Chamber also has the right to decree professional codes of conduct, guidelines for advertisements, as well as guidelines on tariffs. In terms of healthcare governance, the Chamber agrees with the Main Association of Austrian Social Insurance Institutions on contracts regulating the remuneration for medical treatment, it develops prevention guidelines and measures for improving patient safety. In terms of political representation, the Physicians' Chamber aims at "preserving reasonable working conditions" for doctors, and develops "concepts, programmes, reports and proposals on the Austrian healthcare system" (Österreichische Ärztekammer, 2013).

In its general political guidelines for health policy, the interests of the medical profession are clearly set out: the Physicians' Chamber mainly advocates for a strengthening of the outpatient sector by reducing sickness funds' debts and thus reducing pressure on sickness funds to save costs. It is mainly the federal government which is asked to insure that sickness funds would have sufficient funding. At the same time, doctors ask for an increased transfer of patients from hospitals' walk-in-clinics to the outpatient sector, including a better remuneration for treating patients after usual office hours. By the same token, doctors are opposing an increased role of the *Länder* in delivering outpatient care and plead for keeping the dual system of financing of inpatient and outpatient care, as any state financed healthcare system would be for them a "nationalization of medicine". Following their interest in a free patient choice of providers, the guidelines also call for increasing patient choice when treated by in-network physician by allowing insurants to choose between the current benefits-in-kind system or a system of reimbursement with fixed rates, which insurants with a higher income could supplement with private health insurance. Such a system would thus allow employees with higher incomes to purchase supplementary medical services. Competition by other actors should be however avoided, according to the Physicians' Chamber. Walk-in-clinics operated by sickness funds in larger cities should be abolished, and in rural areas doctors should be allowed to more easily combine work in hospitals with work in their private practices. Other points of doctors'

demands include the reduction of administrative tasks for hospital doctors and fixing more clearly a maximum of working hours. While these demands correspond to doctors' interest in facilitating access to medical providers (while services are covered by sickness funds), the Physicians' Chamber also has an interest in raising the quality of healthcare by measures of life-long learning and leaving the competency to take measures to improve quality within the limits of their professional auto-regulation (Österreichische Ärztekammer, November 2008).

The general political guidelines of the Austrian Physicians' Chamber do not only cover their goals of free access to their services, including a comprehensive coverage of these services by sickness funds. Their political demands also oppose further state intervention in healthcare, and thus a shift of power in healthcare governance to the *Länder*. While doctors do not oppose state regulation in general, they ask for regulation which respects profession self-regulation and guaranteed payment of services by sickness funds at the same time. More importantly, the guidelines underline that each of the doctors' political claims in the guidelines are beneficial from patients' perspective. From a political perspective the Physicians' Chamber's demands correspond to the classical interests of a medical association in a Bismarckian healthcare system, namely a "trade union to defend the self-interest of its members" (Moran & Wood, 1993, p. 3). As in similar healthcare systems like France or Germany, the aim of the Physicians' Chamber is thus to defend their professional autonomy, and most importantly doctors' material interests vis-à-vis the sickness funds (Hassenteufel, 1997, p. 80). Even if doctors demand a better funding of sickness funds' budget to reduce the pressure on them concerning potential savings – which would in turn ease pressure on providers – providers' interests are opposed to those of payers that have an interest in cost-efficiency and control of services. From a payers' point of view, the interest of doctors could be summarized as that of an unregulated "freelancer who would like to have the benefits of a state official through irredeemable contracts" [100]. Such a view does of course not take into account the important societal role which doctors play in delivering healthcare, nor does it include doctors' interest in improving quality of healthcare. It highlights however the politically opposed interests between the two main groups of actors responsible for the delivery of outpatient care in Austria. Given doctors' role as medical providers with an interest to free access of citizens to medical care (Blank & Burau, 2010, p. 246), the perception of European integration in cross-border healthcare and of that of the CJEU's rulings would differ from sickness funds' perception as much as their interests differ at national level. The CJEU rulings have indeed been met by the Austrian Physicians' Chamber, which claims to have principally a very liberal position [101]. Following this liberal attitude, the CJEU's rulings have not been of any concern for the Physicians' Chamber, also because the long-lasting practice of sending Austrian patients in border regions abroad are not seen as problematic. More generally, physicians' representatives do not think that patient flows across borders would increase dramatically and that the

[100] Interview 39, *loc. cit*.

[101] Interview 16, Director international office, *Österreichische Ärztekammer*, Vienna, 4 November 2010.

relatively low incidence of current cross-border healthcare would threaten national healthcare systems. Austrian doctors have been informed by the Chamber through the Austrian Physicians' Journal (*Österreichische Ärztezeitung*) about the rules that the CJEU had set for cross-border healthcare beyond the possibilities of Regulation 883/2004, but it was not seen to be a necessity to provide further information, nor has the Physicians' Chamber received any requests from doctors [102]. While European integration in cross-border healthcare has not been seen by the Physicians' Chamber as a problem, potential advantages for providers have been recognized, but possibly might only be realized for individual renowned specialists who might attract foreign patients [103]. Concerning the possibility of attracting foreign patients, the Physicians' Chamber comes to a similar conclusion [104].

The institutional incentives set at national level are thus seen as an obstacle to potentially using European regulations as a chance for offering redundant hospital beds. It is insofar a criticism of the *Länder* providing too many acute care hospital beds from doctors' points of view and refers back to Austrian reforms of the hospital sector. And a boundary removal by European integration concerning cross-border healthcare might have ambiguous effects on Austrian doctors. While European integration could provide for the chance of attracting foreign patients, an increased outflow of Austrian patients to healthcare providers in other Member States might be a disadvantage, even though the Physicians' Chamber does not estimate that patient flows will dramatically increase. These considerations thus explain that the CJEU's rules on cross-border healthcare have neither been immediately perceived as a threat nor as an explicit opportunity. While chances of increasing revenue thanks to the CJEU's rulings on cross-border healthcare are limited by national institutional incentive structures, already existing European regulations have obliged doctors in their daily routines to adapt administrative procedures to the requirements of Regulation 883/2004 when it comes to treating patients from other EU Member States in the outpatient sector:

> "The [foreign] patient has to identify himself and doctors are obliged [to treat them], which has not been perceived by everyone with joy since the tariffs paid by sickness funds are significantly lower than what a private patient would have to pay. But that's it […]. If a European foreigner comes with his electronic card [European Health Insurance Card], he has the same right to a benefits-in-kind [medical] service as an Austrian" [105].

Thus existing European regulation under the long-standing rules for emergency treatment in the outpatient sector already prevent providers from increasing their income when treating EU nationals, given that these patients can use their European Health Insurance Card and providers in Austria are then paid by national sickness funds. While administrative practices of accepting the European Health Insurance card have been Europeanized, the system of coordination of social security systems under Regulation 883/2004 has not provided for possibilities of using Europe to the benefit

[102] *Ibid*.
[103] *Ibid*.
[104] *Ibid*.
[105] *Ibid*.

of providers beyond what national remuneration schemes allow. Additional rules that allow European patients to more easily access medical treatment in the outpatient sector in other Member States have not been seen as problematic by physicians, also because physicians do not expect an increase in patient flows. Given Austria's proximity to Hungary however, physicians are not the only group of providers that might be concerned by the CJEU's rulings on cross-border healthcare. The long-lasting habit of Austrians receiving dental treatment in Hungary (see chapter 3) might have an influence on how Austrian dentists perceive European integration concerning cross-border healthcare.

Dentists

Austrian dentists and orthodontists are organized in the Austrian Dentists' Chamber (*Zahnärztekammer*), which was created in 2006 by federal legislation. Until that year, these specialists were also represented by the Physicians' Chamber. The organization of the Dentists' Chamber follows the same model of organization as the Physicians' Chamber, with the Dentists' Chamber at federal level and nine regional Chambers. Regional Chambers have a significant autonomy in terms of administration and concerning the competence to negotiate contracts with regional sickness funds. The tasks of the Dentists' Chamber are the same as those of the Physicians' Chamber, namely to represent all "professional, social and economic interests" of Austrian dentists and orthodontists. Also similar to the Physicians' Chamber, the Dentists' Chamber is competent in all matters falling under professional self-regulation such as issuing binding regulations on tariffs (concerning contracts with sickness funds), on publicity and advertisements, as well as on radiation protection, etc. (Österreichische Zahnärztekammer, 2013). The Dentists' Chamber's role is thus generally similar in healthcare governance to that of the Austrian Physicians' Chamber; only that it is competent for providers of dental medical care. While negotiations with sickness funds on tariffs follow the same consensus-oriented style of negotiations with physicians, the main difference between both provider groups is the number of treatments covered by sickness funds. While generally all medically necessary treatments are covered by sickness funds for general practitioners and other specialists, dental treatments are only covered by sickness funds in principle. This means that while dental treatments such as extractions etc. are covered by sickness funds, more expensive fixed dental prostheses are only covered under exceptional circumstances. This applies also to other dental treatments such as dental crowns or inlays made from certain expensive materials. Similar to dental treatments, sickness funds might only grant partial subsidies for fixed dental braces. Given the expensiveness of some dental treatments which might only be covered partially or not at all by sickness funds, an important number of Austrians are seeking dental treatment in Hungary (Hofmarcher, 2013, p. 225) (see also chapter 3).

While no exact figures exist on how many Austrian patients actually seek dental care in Hungary, estimations vary between roughly 70,000 and 160,000 patients a year. While the same rules of an 80% reimbursement of what sickness funds would have paid for treatment in Austria applies also to dental treatment abroad, the lack of existing statistics can be explained by the fact that most treatments are completely paid

for by patients themselves. The main reason for Austrians seeking dental treatment in Hungary is the considerable price difference, as for example dental implants cost around half of the price which would be charged by Austrian dentists: "with rising patient mobility to Hungary, Austrian dentists increasingly face competition on services and prices offered in Hungary and which are openly advertised in Austrian newspapers and websites" (Winkelmann *et al.*, 2013, p. 27). Given that Austrian sickness funds only partly cover dental treatment, they exercise only limited control of the dental medical market:

> "Coverage of dental prostheses is legally only a partial service of social insurance institutions and thus also left to the free market. And of course, it plays a role which prices consumers are facing. And he [the consumer] goes where it [dental treatment] is offered at lower prices, yet he won't be able to check the quality [of dental treatment abroad]. These are areas where social insurance does not take, is not allowed to take or cannot take precautionary measures and where such a health market is developing freely. And this [dental treatment] is compared by consumers according to the amount [price]. Well, you don't make that effort because of smaller treatments. But [the question] whether I can afford a dental prosthesis for 15,000 € plays a role for consumers" [106].

Cross-border healthcare is thus not necessarily a welcome issue for Austrian dentists as they face increased market competition. European integration is however not the source of the occurring cross-border healthcare regarding dental treatments between Austria and Hungary. While the partial coverage of dental treatments by sickness funds is the main source for cross-border healthcare, historical ties between both countries play a much more important role as Austrian citizens could already travel without a visa to Hungary since the end of the 1970s [107].

Even though cross-border healthcare has been no novelty for Austrian dentists, the offer by Hungarian dentists has been increasing over the decades. Hungarian cities in the border region such as Sopron sometimes have around 100 practicing dentists, while their population size is rather small. On average, Austrian cities of similar sizes would have rather four to five practicing dentists. Hungarian dentists thus aim their offer mainly at foreign patients coming from Austria. Before Austria's accession to the EU, Austrian dentists would profit from national customs regulations. Dental treatments in Hungary were considered as declarable goods if the treatments involved replaceable dental parts, whereas fixed dental prostheses were considered as having 'melted' with the body of patient and thus were not declarable goods. As other parts could be taken out of the patients' mouths, these had to declare dental treatments in Hungary and had to pay customs duties [108]. Austria's and Hungary's accession to the EU have made such customs regulations impossible, European integration has hence contributed to the facilitation of cross-border healthcare for dental treatments.

Especially in larger cities in Eastern Austria such as Vienna, Hungarian dentists also actively offer additional services to dental treatments in Austrian newspapers. Such services include a free shuttle service to nearby Hungarian cities, quick appointments

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[106] Interview 27, *loc. cit*.

[107] Interview 22, Director, Austrian Dentists' Chamber, Vienna, 17 January 2011.

[108] *Ibid*.

and some walk-in dental clinics also have 'wellness' offers with massages, and free drinks. Furthermore, Hungarian dentists underline in their advertisements that they speak fluent German [109]. As Austrian national regulations limit the possibilities of Austrian dentists (and other providers of healthcare) to freely advertise their services, the Austrian Dentists' Chamber has documented the advertisements by Hungarian dentists in Austria. In several cases the Chamber has taken legal action as Austrian dentists would not be able to offer for example free shuttle services. Based on Austrian legislation and the corresponding regulations by the Dentists' Chamber, Hungarian dentists were sued in a civil case for unfair competition. The Dentists' Chamber has won many of these cases, but most of the time has aimed at a compromise agreement with foreign dentists where the latter had to pay the court fees and were obliged to publish the result of the agreement in Austrian newspapers [110].

As the Dentists' Chamber does not receive any further political or institutional support against (legal) competition, it has also started information campaigns for Austrian patients highlighting the disadvantages of cross-border treatment concerning for example the unknown quality of foreign providers or the problems of taking legal action abroad in case of liability issues when treatment errors might occur [111]. Over the past few decades, however, dental treatment in Hungary has reached similar quality levels as in Austria, as Hungarian dentists are trained at comparable levels and European quality standards set by dentists' associations usually provide for a similar level of quality of treatment in both countries (Winkelmann *et al.*, 2013, p. 27). Cross-border healthcare does not necessarily mean increased competition as European regulations on product liability have limited the possibilities of competing by using different (and potentially cheaper) material for dental treatment. Hence, costs for operation material are nearly the same for Austrian and Hungarian dentists, and the average increase of living costs in economic growth over recent decades has reduced somewhat the price gaps existing between dental treatment in Hungary and Austria [112]. European integration has thus on the one hand indirectly facilitated already existing patterns of cross-border healthcare between Austria and Hungary as protectionist customs regulations had to be abandoned. Yet, European regulations on product liability have also contributed to setting a level playing field between competing dentists. However, questions of liability and follow-up treatment remain a problem with cross-border healthcare as many patients who travel to Hungary for dental treatment are sometimes not aware of the necessity of follow-up treatments (*ibid*., p. 27).

Against this background of already existing cross-border patient mobility for dental treatment between Austria and Hungary, the CJEU's rulings on cross-border care did not bring about any change for Austrian dentists. And while cross-border healthcare per se is not necessarily always perceived as a positive phenomenon by Austrian dentists, it also offers chances for treatments of foreign patients. While dentists in Eastern Austria potentially 'lose' patients to foreign providers, dentists in Western

[109] Interview 1, *loc. cit*.
[110] Interview 22, *loc. cit*.
[111] Interview 1, *loc. cit*.
[112] Interview 22, *loc. cit*.

Austria have an increasing number of foreign patients who want to receive dental treatment. Most of those patients are coming from Switzerland, where price levels are higher than in Austria. Besides the already existing cross-border patient mobility, the Dentists' Chamber does not fear that patient flows might increase due to the CJEU's rulings as once they have built a relationship of trust with their dentist, patients do not necessarily try to receive dental treatment by foreign providers [113]. Compared to physicians, Austrian dentists are more opposed to cross-border healthcare in general, as they have been under pressure of competing healthcare markets. This is due to less regulation by sickness funds, given the only partial coverage of dental treatments by public health insurance. In terms of competition, European integration had indirect effects of removing boundaries between markets. At the same time European integration has not reduced national boundaries when it comes to the regulation of dental care. The rulings of the CJEU and increased access to cross-border healthcare did not therefore have the same effects as in more regulated areas of the healthcare system. Dentists have thus not perceived further European integration in healthcare as an additional threat. The next section will therefore analyse whether and if so how physicians use Europe to accord with their interests.

4.2.4 Providers' Usages of Europe at National and European Level

Abstaining from Usages of Europe at National Level

Providers have not (yet) made active usages of Europe in the negotiations with sickness funds when it comes to either determining the numbers of doctors under contract with sickness funds allocated to specific areas or to setting tariffs for medical treatments. This is due to the fact that foreign patients are mainly treated in the outpatient sector in touristic areas of Austria, which at the same time are usually rural areas (with the exception of Vienna). Rural areas, however, have a lower density of doctors who have contracts with the sickness funds (Hofmarcher & Rack, 2006, p. 86) and thus show a higher number of out-of network physicians for which patients would receive the usual reimbursement of 80% of what a treatment with a regular physician would have cost. Against the background of the relatively high number of available hospital beds for acute care, this means that from a public health perspective oversupply and undersupply potentially co-exist in the Austrian healthcare system. Public debates on potential undersupply are however kept at bay or are prevented, given the political salience of the issue. While health economists have criticized a potential undersupply, the executive would deny that undersupply could exist in the outpatient sector as corporate actors would effectively negotiate tariffs and numbers of local physicians with contracts with the sickness funds [114].

Yet, providers could potentially have an incentive to make usages of Europe in those rural areas; but the long-standing European Regulation 883/2004 (1408/71) regarding access to cross-border healthcare is somewhat of a double-edged sword for doctors. In touristic areas only few hospitals exist, leading to a situation where general practitioners have usually very well equipped practices, including possibilities for

[113] *Ibid*.

[114] Interview 48, *loc. cit*.

expensive treatments (such as x-rays or medical ultrasounds for ski accidents, for example). Foreign patients have usually been treated in these practices as private patients who pay higher fees. With the introduction of the European Health Insurance Card, however, EU patients have to be treated at the lower tariffs of sickness funds [115]:

> "Now everyone has this card [European Health Insurance Card] with him and it has become much easier for them. And that leads in these tourist areas […] to bigger problems, because this excellent supply [of medical services] which exists in these areas is put into question […]. This is exactly the problem […]. [Now] these are [negotiated] social tariffs [which doctors receive for treating European patients]; mind you, we always have financed this very high standard in tourist areas through higher tariffs for EU citizens" [116].

Insofar European regulations rather reinforce the problem of rural areas that have a low density of physicians who at the same time have to provide a wider range of services than in urban areas. Higher numbers of out-of-network physicians who do not have to accept the European Health Insurance Card and who can charge higher tariffs would be at the same time a significant problem for the local population. Theoretically this would be fertile ground for providers to make a usage of Europe, claiming higher tariffs from the sickness funds:

> "I mean this is a general problem in the healthcare system, that we do not calculate real prices. It is […] for inpatient care a result of negotiations. For outpatient care it is nothing different. The tariffs of social insurance institutions are not real prices, but they are negotiated tariffs […]. They are historically grown tariffs […]. One would have to evaluate the whole thing economically and to calculate it. But social insurance is worried that everything would become even more expensive" [117].

Including Europe into these negotiations would however contradict the usual practices: conflicts over tariffs usually arise between sickness funds and physicians when contracts come to an end and have to be renegotiated. These conflicts are usually settled in a consensual way, and sometimes negotiations are informal between the heads of each institution involved. The procedure to determine the supply of network doctors in a given area has to respect furthermore a complex set of legal requirements [118]. Institutionalized consociational negotiations thus act like an institutional brake to potential usages of Europe, just as they do for sickness funds. Under the climate of ongoing reforms to reduce costs, an outright demand to increase tariffs using European regulations as an argument would not be in the long-term interest of physicians, especially when the fact that tariffs have to be negotiated consensually in different regions of Austria is taken into account:

> "[…] If you break out of the system, you would break your neck […] If I'd use [in negotiations] whatever EU Directive, then I would be facing a front of opposition

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[115] Interview 26, legal desk officer, regional Physicians' Chamber Vorarlberg, Dornbirn, 20 January 2011.

[116] *Ibid*.

[117] *Ibid*.

[118] See for an elaborate discussion of the legal aspects of determining the places available for network doctors Mosler, 2003 (in German).

> […]. There wouldn't be this [healthcare] system, if not all players would profit from it to some degree […]. This [healthcare system] – as much as the system of Social Partnership – has sometimes led to reform gridlocks. And then there are sometimes rules where you ask yourself is this really necessary… these informal agreements. But it [the system] generates a great stability. And in Austria there is a great stability concerning delivery of healthcare. Every Austrian knows I will get what I need" [119].

While greater access to healthcare through EU regulations might suit physicians' interest somewhat better than those of sickness funds that fear to lose control over costs, this European resource is not necessarily translated into usages. On the one hand it seems that the CJEU rulings per se already support doctors' interests, making no further usage necessary as doctors already are in a 'comfortable' situation, especially where out-of-network doctors are concerned. On the other hand, an upfront strategic usage of Europe that would contradict existing informal negotiation practices would rather backfire and is thus not of interest for providers. The consensual and informal character of negotiations also explains why sickness funds might use tariffs in other EU Member States only as a more general cognitive argument and not refer to the EU rules on cross-border healthcare, as has been mentioned in previous sections. Like providers, payers do not make an upfront usage of Europe regarding EU rules on cross-border healthcare. While Europe has the potential to reinforce existing tensions concerning provision of medical care in rural areas, such tensions are not necessarily found in other regions of the country and do not constitute a 'critical mass' that would set incentives for actors to use Europe strategically. The strategic usefulness of usages of Europe at national level is thus limited to general comparisons with tariffs of other European states, as the section on usages by sickness funds has shown. The CJEU's rules on cross-border healthcare as such have therefore not led to any significant change of negotiation strategies, even though Europe is present. While providers abstain from making usages of Europe at national level, they do show usages of Europe at European level.

Usages of Europe at European Level

Physicians

Like the *Länder* governments of Lower Austria, the Austrian Physicians' Chamber made a strategic usage of Europe by responding to consultation procedure initiated by the European Commission in 2006 concerning possible measures of codifying the CJEU's rulings on cross-border healthcare. The Chamber underlined in its response to the Commission the distinct character of health services from a legal and political point of view in comparison to services in general. The response agreed to Community action only if Member States responsibility for organising their healthcare systems would be respected and if European involvement in healthcare would mean an added value in terms of improving quality of healthcare in the EU. The response underlined further that the principle of subsidiarity should be respected and pointed at the historically grown different healthcare systems of EU Member States. The Physicians' Chamber considered that no sufficient data would be available to

[119] Interview 19, *loc. cit*.

evaluate concretely how many European patients would actually be involved in cross-border healthcare and that patients usually would prefer to be treated at home, with the exception of border regions where bilateral agreements between Member States would provide for cross-border healthcare. Like social insurance institutions, physicians underlined that additional legislation at European level would not necessarily be wanted as in their opinion problems in cross-border healthcare would rather arise for patients from non-compliance of existing legislation, i.e. Regulation 883/2004 (1408/71) instead of from a lack of legislation. The Physicians' Chamber also pleaded to leave the responsibility for settling potential liability disputes in the Member State where cross-border healthcare would be provided and that patients should receive clear and comprehensible information about applicable regulations. Austrian physicians opposed any initiative that would establish a "blame and shame system" of European providers to enhance patient safety, instead systematic errors of healthcare systems should be identified (Österreichische Ärztekammer, 31 January 2007). More importantly, the response to the Commission contained two crucial demands by the Austrian Physicians' Chamber: the first concerned the definition of outpatient and inpatient care. Given that the CJEU made a distinction between the requirements for prior authorization for cross-border healthcare between inpatient and outpatient care, the question arises as to whether all Member States have the same definition. The Chamber asked for a clear definition between both types of medical treatment, but demanded a possibly narrow definition for what medical treatment would be considered as inpatient treatment, while outpatient treatment should be defined as broadly as possible. The second demand was in respect of keeping two different sets of rules for cross-border healthcare, i.e. keeping the rules under Regulation 883/2004 apart from those rules established by the CJEU's rulings (*ibid.*).

This strategic usage of Europe by the Austrian Physicians' Chamber follows its nationally defined liberal stance on the regulation of medical markets: the demand to keep European rules for cross-border healthcare separate under Regulation 883/2004 and under the CJEU's rulings corresponds to the existing Austrian dual system of outpatient care, namely doctors with contracts with sickness funds and out-of-network doctors. Hence, keeping the two sets of European rules on cross-border healthcare would mean a high institutional fit between national and European rules. As the CJEU had ruled that patients can freely consult doctors across border in outpatient care, keeping a separate system would potentially benefit the growing number of Austrian out-of-network physicians. Advocating keeping two different sets of European rules for cross-border healthcare corresponds also to physicians' interest in maximizing patient choice of providers in outpatient care. The Chamber's demand to define outpatient care broadly and inpatient care narrowly at European level mirrors the national system of healthcare delivery:

> "We clearly can see specialist treatment [in Austria] in the outpatient sector, while in most other countries – and that is not the difference between Beveridge and Bismarck [systems], even in the Netherlands it is like this – specialist treatment is carried out in hospitals, even though [physicians practice] independently but are using hospitals' resources. But this area of specialist treatment in the outpatient sector is

> quite typical [for Austria] and doctors think of course a little bit about additionally gaining something from [foreign] clients […]" [120].

Physicians' usage of Europe does however not only aim at defending national structures of healthcare delivery – which favours free practice of medical care in comparison to other countries where dependency of the medical profession on hospitals is more important – it also is in line with their national interest of avoiding increase regulation of medical markets. The Chambers' demand not to codify the CJEU's rulings in a separate Directive illustrates this interest. At the same time, Austrian doctors underline quality, given that a European integration in healthcare could also lead to an increased competition of providers across Member States. Thus highlighting quality of treatment reflects on the one hand the nationally defined tasks of the Austrian Physicians' Chamber to defend the reputation of the profession. The usage of Europe aims on the other hand at protecting the national members of the Chamber against providers from other EU Member States who might offer treatments at lower prices by also using lower treatments standards.

While the Austrian Physicians' Chamber made an independent strategic usage of Europe by responding to the Commission's consultation, a further strategic usage of Europe was made through the European representation of physicians, the Standing Committee of European Doctors (also named *Comité permanent des Médecins européens*, abbreviated CPME) [121]. Given doctors' interest in regulation of the healthcare market, the CPME was already founded in Amsterdam in 1959. Like the other representations of corporate actors, with the Treaty of Maastricht coming into force which foresaw a competency for the European Commission to act in the area of public health the CPME opened its own office in 1992 in Brussels. Long before Austria's accession, the Austrian Physicians' Chamber had already had an observer status since the creation of the CPME (Comité Permanent des Médecins, 2013).

For CPME members, the issue of European integration in cross-border healthcare was not a controversial one and doctors were much less sceptical than payers of healthcare or Member States' governments. Following their shared interests in facilitating access to healthcare, the CPME also cooperated with different user associations in developing its position on European regulation of cross-border healthcare [122]. The CPME followed the negotiations of the Directive codifying the CJEU's rulings on cross-border healthcare and communicated early on its position in a common response to the Commission's consultation, as did the European Social Insurance Platform. Like the Austrian Physicians' Chamber's response, this response to the Commission underlined the special character of health services and agreed that these services need "stricter controls and regulation than most other services" by Member States: "It is essential that Member States take responsibility for guaranteeing the quality and equal availability of healthcare for their citizens in all circumstances" (Comité Permanent des Médecins, 31 January 2007). Like the reponse of the Austrian

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[120] *Ibid*.

[121] See : http://www.cpme.eu.

[122] Interview 30, Policy officer, Comité Permanent des Médecins, Brussels, 30 September 2011.

Physicians' Chamber, the CPME's position paper asked for a clear definition of inpatient and outpatient, with a narrow definition for inpatient care and an as wide as possible definition of outpatient care. As under the CJEU's rulings outpatient care in another Member State would not require prior authorization by national sickness funds, this demand corresponds to doctors' interest in facilitating further access to health services. Concerning the question of what an "undue delay" could mean for a patient waiting in their home countries who could thus ask for an authorization to receive medical treatment abroad, the CPME suggested an individual case-by-case evaluation of the waiting patient's medical condition. Contrary to the Austrian Physicians' Chamber's position, the CPME demanded that the rules for cross-border healthcare set by the CJEU should be codified in a separate legal text which should also clarify that Member States should be calculating the costs of inpatient care clearly in order to provide full reimbursement of these costs when patients go abroad (*ibid*.). The difference between the CPME's position and the position of the Austrian Physicians' Chamber regarding the necessity of codification of the rulings can be explained by the necessity of coordinating different healthcare systems' cost calculations for inpatient care. Given the differences in allocating financial subsidies to the inpatient sector between Member States, it is in the interest of doctors to have clear European rules on cost calculations in order to receive sufficient payment of medical services by other Member States.

Whereas economic differences played a major role in building a common position at European level for payers of healthcare, financing structures of healthcare (and especially inpatient care) make European regulation necessary for doctors, despite their relatively liberal stance on regulating the healthcare market. Surprisingly, the distinction between General Practitioners and specialists did not play a role in determining the CPME's position. This is due to the fact that in some Member States even general practitioners are considered specialists, whereas in other Member States General Practitioners are not [123]. While the CPME considered that a Directive regulating cross-border healthcare according to the CJEU's rulings would be necessary, it had doubts concerning the implementation of such a Directive: as the tariffs for medical care differ significantly between Member States, patients coming from countries with lower tariffs and who have not received prior authorization would have to pay significantly more when going to a Member State with higher tariffs. However, doctors would also see opportunities in attracting foreign patients from different Member States, especially in countries with tourist destinations, leading to a specialization of local doctors in treating foreign patients, even if the potential numbers of incoming foreign patients are limited [124].

In comparison to payers of healthcare, doctors therefore also see advantages of potentially increasing competition between providers as market mechanisms could also help to drive quality of healthcare upwards. This view is hence not only in line with the liberal stance of the medical profession, but following their logic of competition would also serve their interest in enhancing the quality of healthcare.

[123] *Ibid*.
[124] *Ibid*.

The CPME did however not expect any major changes for European doctors due to a codification of the CJEU's rulings on cross-border healthcare in the coming years. Rather doctors saw the rulings and European integration in cross-border healthcare as a greater challenge for payers of healthcare and Member State governments alike [125]. European doctors' general position in favour of European integration concerning cross-border healthcare and their positive attitude towards potential impacts of European regulation of cross-border healthcare is however limited in its scope by nationally defined interests of individual member organisations. The demand of the Austrian Physicians' Chamber and the CPME that Member States' capacity to regulate healthcare should be respected illustrates this argument. The position of the medical profession is therefore somewhat ambiguous.

This ambiguity is due to the fact that the medical profession's representation at European level is divided between member organisations that defend the role of doctors as a liberal profession whereas other member organisations are more closely tied to the state depending on how healthcare is regulated in respective Member States. In 2008 for example the Italian, Spanish and French member organizations left the CPME as they felt outvoted by the other members from Northern European member organizations. At the same time provider representatives from German-speaking countries such as Austria and Germany as well as from Britain and Scandinavia are more present in Brussels than those from Southern Europe (Greer, 2009, pp. 75-76). Nationally shaped interests and individual relationships between national organizations of the medical profession with respective Member State governments therefore influence the strategic usage of Europe by doctors. Like other actors of the Austrian healthcare system, even before Austrian EU-membership Austrian physicians had adapted their practices to patterns of multi-level-governance. Involvement at European level and European integration are much more compatible with doctors' interests as a 'liberal profession'. The strategic usages of Europe by the Physicians' Chamber, either individually or through their European representation, correspond to their nationally defined interests of increasing patients' choice of treatment, full coverage by payers of their services, and a minimum of requirements that demand prior authorization at national level for patients to receive cross-border healthcare. This liberal stance is at the same time somewhat thwarted by other nationally shaped interests, namely that of increasing quality of healthcare and that of the benefits of national regulation of the medical profession. Arguments concerning the quality of healthcare can be put forward in favour of increased competition due to European regulation of cross-border healthcare, as the CPME's response has shown. At the same time, national provider associations from countries with higher tariffs for medical care might use the argument of quality of healthcare against a too lax regulation of cross-border healthcare as competitors from Member States with lower tariffs are not necessarily welcome. More important, however, is the CPME's and the Austrian Physicians' Chamber's demand of respecting national competencies in regulating healthcare. In the end, national regulations define how far professional autonomy is granted, and the respective healthcare systems of Member States define which competencies are

[125] *Ibid*.

delegated to doctors in healthcare governance. Europe is thus not seen as being more legitimate in regulating healthcare than national governments. The aim of physicians' usages of Europe can therefore be described as one of maximizing the benefits for the medical profession through the facilitation of patients' access to healthcare in Europe, yet without putting into question the national institutional set-up of healthcare systems. However, physicians are not the only providers of medical care, and other providers such as dentists might not share the liberal stance of physicians.

Dentists

Contrary to the Physicians' Chamber, the Austrian Chamber of Dentists has not made a strategic usage of Europe by uploading its own policy preferences to the European level in an individual response to the European Commissions' consultation procedure on cross-border healthcare. The Austrian Chamber of Dentists is though a member of the Council of European Dentists (CED) which represents Member States dental associations as well as three organizations from Norway, Iceland and Switzerland who have observer status [126]. Like the CPME, the CED was founded soon after the creation of the European Communities in 1961. Its aims are similar to that of the CPME, i.e. to promote the interests of the dental profession at European level, to promote quality standards of dental care, and to lobby European institutions when it comes to legislative processes concerning the dental profession and consumer protection (Council of European Dentists) [127].

Similar to the CPME, members are not equally active regarding their participation in the CED's meetings. Again, one of the most active national associations is one from the "Northern" Member States, namely the German dental association, which also has an own office in Brussels. National difference in the funding of dentists' associations, size and the number of associations representing dentists at national level also play an important role for the activities at European level. Oftentimes, individual heads of associations determine how far national dental associations become involved at European level [128].

The CJEU's rulings on cross-border healthcare have been discussed in the CED's task force on the EU's Internal Market since the beginning, and subsequent rulings have been exchanged between the CED's member organisations. Similar to the other European representations of corporate actors at European level it followed the development of the Directive on cross-border healthcare intensely and, amongst other means of lobbying, communicated its position to the European Commission when responding to the consultation procedure. Like the CPME, dentists underlined the importance of leaving the responsibility of healthcare services at Member State level and that the rules set out by the CJEU's rulings should be codified in a Directive. The CED, though, took a much more critical stance towards European integration with regard to cross-border healthcare than physicians. The first demand of the CED was that cross-border patient mobility should not actively be promoted (Council of

[126] See http://www.eudental.eu/

[127] Interview 37, Head of office, Council of European Dentists, Brussels, 6 December 2011.

[128] *Ibid*.

European Dentists, 31 January 2007). The main motivation for the CED to favour a more restrictive approach is based upon providers' interests for the quality of care, which from the dentists' position seems more important than potential financial gains:

> "The point was that while we were in favour of directly providing information to patients, we are still not in favour of actively encouraging patient mobility. And this is because we think that for dentistry the situation is quite distinctive and special. Because we think that patient mobility is mainly motivated by financial concerns, which is of course the prerogative of every individual. But we are concerned because we think that especially when it comes to dental tourism very often the safety and the quality are not really preserved, because treatments are done in a very short period of time, there is not enough time for treatment afterwards or follow-up" [129].

The individual relationship between providers and users therefore conflicts with a liberal stance on healthcare market regulation. The strategic usage of Europe by the Austrian and other dental associations consequently defends national boundaries when it comes to dental treatment of patients. More noticeably, this position has been agreed unanimously, even though for example Hungarian dentists have a financial benefit from Austrian patients travelling to Hungary. From an overall national perspective, however, this benefit is limited as patient streams to Romania seem to be developing in Hungarian border regions as dental treatment is cheaper in Romania than in Hungary [130]. Risking the removal of national institutional boundaries by encouraging patients to receive cross-border healthcare might therefore be detrimental to national dentists' financial interests in the long run. The CED thus highlighted in its response to the Commission that the continuity of care is essential and that quality of care must be ensured. Nevertheless, comprehensive information for patients about the reimbursement procedures and how to carefully plan cross-border dental care should be provided according to the CED (Council of European Dentists, 31 January 2007). This demand and the CED's demand to codify clearly the CJEU's rulings in a Directive also relate to individual dentists' experience with existing cross-border dental care: many dentists have reported confusion about how to deal with patients coming from abroad to the CED. Especially the fact that dentists might have to issue more detailed invoices to payers of healthcare from other Member States has caused concern as this would change nationally institutionalised practices. These experiences result in the CED's demand for proper information also for dentists. At the same time, however, the CED opposed any potential "ranking" of dentists in different Member States and demanded that information should be limited to the necessary aspects of planning cross-border care [131]. The CED's position therefore aims at defending the collective reputation of its member organisations. And more generally the CED opposes any further European integration in standard setting for the quality of dental beyond the exchange of best practices and setting commonly agreed guidelines.

To conclude on providers' usages of Europe at European level, we can say that providers' interests are not very coherent. While physicians do show a much more

[129] *Ibid*.
[130] Interview 22, *loc. cit*.
[131] Interview 37, *loc. cit*.

liberal stance towards European integration in cross-border healthcare, dentists rather oppose further European integration. The structural reason might also be that national dentists' associations represent a "liberal profession", but at the same time have members who work in much smaller practices, and therefore the potential increase in administrative workload for providing the necessary paperwork for patients and potentially increased competition is not welcome. Physicians on the other hand could see different opportunities for attracting patients depending on whether they work in hospitals or specialized walk-in-clinics in tourist regions. What the strategic usages of Europe of dentists and physicians at European level have in common, however, is that national competencies of regulating healthcare should not be seriously put into question by European integration. This stance relates to providers preferring nationally institutionalized definitions of professional autonomy over removing boundaries to make it easier for patients receiving cross-border healthcare. Furthermore, the self-conception of the medical profession as healers plays an important role which opposes any potential commercialization of medicine through European integration. These considerations lead dentists to define the limits of how far European integration in healthcare should go: "Well I mean it's all healthcare, that's the responsibility of Member States. That's not even a question; it's pretty clearly defined in the [EU] Treaty. At the EU level what you might have is of course coordination; you might have cooperation as you have on rare diseases. You might have exchanges of best practices. That's pretty much where it stops" [132].

The analysis of corporate actors' usages of Europe so far has shown that national practices of consensual negotiations prevent actors from making usages of Europe at national level; at best they show a rather soft cognitive usage of Europe as the section on payers' usages has shown. At European level, all corporate actors make a strategic usage of Europe – individually and collectively through European associations alike. These strategic usages mostly mirror nationally defined interests and reproduce at European level national stances on European regulation of cross-border healthcare: while payers are more sceptical and opposed to any potential loss of control over patient fluxes, providers do see some chances of generating benefits from increased access to cross-border healthcare. This more positive view is however mitigated by a more sceptical perception of potential impacts of European rules on cross-border healthcare concerning increased competition, reliable financing of healthcare services by providers, potential inequalities, and detrimental effects on the quality of care.

4.2.5 Discussion: Usages of Europe by Corporate Actors

Usages of Europe at National Level

The CJEU's rulings and the following policy process on developing Directive 2011/24 EU codifying these rulings have not led to specific usages of Europe at national level by corporate actors. Nevertheless, sickness funds make a more general reference to Europe – and therefore a weak cognitive usage of Europe – when it comes to negotiating tariffs with providers. This weak usage is based on an increasingly important role of Europe as such for healthcare systems, but is not directly linked to

[132] *Ibid*.

cross-border healthcare. The absence of usages of Europe in negotiations between payers and providers corresponds largely to their nationally shaped interests and to their evaluation of European opportunity structures against their practices in national healthcare governance: consensual negotiations and informal settling of disagreements prevent each actor from using Europe during negotiations on tariffs in the outpatient sector. While Europe is present in these negotiations it does not change actors' strategies. Besides these consensus-oriented negotiation strategies, national reforms play a role in preventing payers from using Europe to their benefit. Since the Social Partners have preferred increased planning capacities over increasing competition among payers of healthcare, sickness funds have no interest in using potential opportunities to close contracts with foreign providers, even though patients are frequently treated at lower rates by Hungarian dentists. Contracting with foreign providers would save costs for payers but would at the same time increase competition amongst providers and would contradict national reforms of concerted planning between corporate actors in the outpatient sector. Sickness funds' perception of European regulation of cross-border healthcare is furthermore rather sceptical: European rules on cross-border healthcare increase the administrative burden on sickness funds and even long-standing rules of reimbursement between Member States under Regulation 883/2004 (1408/71) have proven to be sometimes difficult. Payers therefore share similar perceptions with the *Länder* when it comes to administrative practices of reimbursing cross-border healthcare (see also chapter 4.1.5).

Table 10. Usages of Europe by Payers and Providers

Actors	*European opportunities*	*Institutional constraints*	*Usages of Europe*
Payers	Possibility of contracting with foreign providers Potential loss of control over patient flows European representation (European Social Insurance Platform)	National practices of consensual and informal negotiations on tariffs National reforms on planning of healthcare	Cognitive (at national level) Strategic (at European level)
Providers	Increased access to EU wide healthcare European Health Insurance Card prevents additional income Increased competition European representation in Brussels (CPME, CED)		None (at national level) Strategic (at European level)

Providers also abstain from making usages of Europe at national level, even though potential under-provision of outpatient care in rural areas would provide a

fertile ground to use Europe in order for sickness funds to claim higher payments for their services. Yet, again, such usage would be contradictory to institutionalized practices of consensually negotiating tariffs. Moreover, even if the CJEU's rulings on cross-border healthcare facilitate access to healthcare – which could mean an increase of revenue for providers in the outpatient sector – the existing European Health Insurance Card under Regulation 883/2004 prevents such increase in revenue as providers will receive national tariffs for treating European patients in their practice. At national level, European rules on cross-border healthcare are therefore of an ambiguous nature for providers: on the one hand, foreign patients could contribute to financing high quality outpatient care in rural areas when paying themselves, on the other hand the European Health Insurance Card prevents such effect. Moreover, providers do not constitute a homogenous group of actors. While physicians who are out-of-network doctors could ask patients for direct payments and thus increase their revenues, Austrian dentists face the competition of Hungarian dentists who offer treatment at lower prices. Especially the latter oppose any detrimental effect on national regulation of healthcare by European integration. While competitive pressure on Austrian dentists might be declining as prices for dental treatment in Hungary might be rising in the long run, dentists show a less optimistic appreciation of European integration in healthcare than physicians, despite their common interest in limiting state regulation of the healthcare sector as a "liberal profession" with institutionally enshrined competencies of professional self-regulation. Moreover, providers' interest in the quality of healthcare and in a stable provider-patient relationship makes potential market opportunities through European integration somewhat less attractive for providers.

Usages of Europe at European Level

Payers and providers alike make a strategic usage of Europe firstly by uploading their policy preferences to the European level, for example by responding to the consultation of the European Commission. More importantly, both groups of actors have the administrative resources to actively engage in European policy making through their membership in their respective associations in Brussels. This Europeanization of strategies started with the Treaty of Maastricht, when Social Policy became part of the European policy agenda. As could be observed with the Austrian *Länder* (see section 4.1.5), corporate actors engage in multi-level governance which co-exists with their competencies in national hierarchical governance of outpatient care. Austrian corporate actors in healthcare have hence become members of the corporatist policy community at European level. As expected, payers' and providers' positions and the goals of their strategic usages differ according to their nationally shaped interests. Payers of healthcare, despite being in a relatively comfortable position given that national legislation does not show any misfit with the CJEU's rulings on cross-border healthcare, aim at stabilizing national control mechanisms over patient flows and costs of medical treatment of insurants in other EU Member States. Nationally compensation mechanisms between sickness funds and the *Länder* have been created in order to avoid any potential shift of costs to sickness funds by cross-border healthcare. Yet, this mechanism was created well before European

integration advanced into the area of cross-border healthcare. As a consequence, the Austrian social insurance institutions' usage of Europe aimed at preserving the legislative status quo when it comes to regulating cross-border healthcare at European level. For them, the CJEU's rulings granting further access to cross-border healthcare were rather a result of incorrect application of Regulation 883/2004 (1408/71) than reflecting the necessity of extending patients' rights to cross-border healthcare.

Providers' – and especially physicians' – strategic usage of Europe reflects their nationally defined interest of a "liberal profession": doctors demanded at European level a restrictive definition of inpatient care (for which a prior authorization by sickness funds is required) and an as wide as possible definition of outpatient care (for which no prior authorization is required). This would largely facilitate patients' access to foreign providers, and especially to specialists who practice in Austria in the outpatient sector and whose treatments might be more expensive than those of general practitioners. Austrian doctors also did not see the necessity of further European regulation beyond existing legislative acts. At the same time, quality of healthcare is used as an argument to prevent unfair competition among doctors from different Member States. Surprisingly, providers of healthcare do not show a coherent position at European level, like dentists who have been subject to competition between Member States used Europe to oppose any further increase of competition between healthcare providers, highlighting again potential negative effects on the quality of healthcare and the necessity for patients to receive follow-up medical care by the same provider instead of going to another Member State for a one-time dental treatment. Providers have therefore a much more ambiguous position vis-à-vis European integration concerning cross-border healthcare than payers. In the end, providers' attitude is not as "liberal" concerning the regulation of healthcare markets as they might claim in the beginning. This is also related to national regulation of the medical profession. In each Member State the medical profession has nationally defined rights of self-regulation, and this national regulation should not be impacted by European integration. Consequently providers' and payers' usages of Europe might differ concerning their goals of either keeping the status quo or facilitating the access to cross-border healthcare, but both actor groups defend the principle of Member States' competence to regulate healthcare. As has been argued in section 4.1.5, European multi-level governance of healthcare therefore rather co-exists with national structures of healthcare governance. Based on their nationally defined interests, corporate actors try to influence European policy-making through strategic usages of Europe to their own benefit, but at the same time try to avoid that the institutional balance of national healthcare governance is affected.

Europeanization is thus mainly limited to strategies and practices, but does not impact on institutional structures of healthcare delivery. From a bottom-up perspective, the usages of Europe mirror much more coherently their nationally shaped interests than the usages of Europe made by the Austrian *Länder*. From a European perspective however, payers and providers of different Member States are not always coherent in their interests and resulting positions vis-à-vis European integration in healthcare. As the analysis of payers' usages of Europe has shown, economic differences between Member States play an important role when it comes to regulating the details of cross-

border healthcare: while all payers agree on stabilizing national control over patient flows, their interpretation about what is medically necessary (and payable) is not the same. The variety of providers' strategies and positions reveal a difference between those doctors having a higher affinity to state regulation and those who defend the position of a "liberal profession". A second difference exists between the position of providers who are more attached to quality of care and long-term relationship with patients and those who prefer facilitated access to healthcare, even though the quality of healthcare and the reputation of the own profession also plays an important role for them.

As could be observed with the usages of Europe on the part of the Austrian *Länder*, corporate actors' usages of Europe are first and foremost strategic. The impact of these usages is oftentimes conditioned by the administrative and political resources made available at national level. And with the exception of a weak cognitive usage of Europe during negotiations of tariffs, other forms than strategic usages of Europe are absent. This is mainly due to the absence of the public when it comes to European policy-making, and hence corporate actors do not see a necessity of legitimizing their positions by using Europe. Considering the nationally shaped strategies of corporate actors, it can be argued again (see also section 4.1.5) that usages of Europe by these actors do not necessarily threaten the boundaries of healthcare systems. The necessity for actors to engage in European multi-level governance of healthcare shows that boundaries of healthcare systems have become more porous because of European integration, but actors in the end do not put national regulation of healthcare into question. Furthermore, Austrian legislation and practices of cross-border healthcare regulation already before joining the EU show that healthcare systems, especially those of smaller or medium-sized Member States where not every specialized medical treatment might be readily available for less frequent illnesses, have not been such closed systems as one might have expected. Cross-border healthcare either planned by authorities or organized individually has always been a reality in border regions concerning the transfer of patients to Germany for specialized treatment or concerning dental treatment in Hungary. None of this cross-border healthcare that has been happening for a long time has put the Austrian healthcare system at risk. European integration in cross-border healthcare therefore offers only marginally more opportunities than those already existing.

4.3 Interim Conclusion: Usages of Europe and National Boundaries

The Austrian healthcare system – as those of other Member States – has been clearly Europeanized as it is subject to a variety of European regulations concerning competition law, rules on professional regulations, and the rules on services of general interest (see also the introduction to chapter 1). Long-standing European regulation of cross-border healthcare, such as the rules set out in Regulation 883/2004 (1408/71), have also contributed to the Europeanization of healthcare delivery. While these rules – emergency cross-border healthcare with the European Health Insurance Card and inpatient care in another EU Member State after prior authorization – have not touched Member States' national boundaries (Ferrera, 2005), administrative procedures such as reimbursement mechanisms and practices of treating an important number of foreign

patients especially in tourist regions have been adapted to European requirements. At the same time, the Austrian healthcare system was never a completely closed system as the history of welfare state building drawn by Ferrera (*ibid*.) would suggest (see chapter 3). The CJEU's rulings on cross-border healthcare have facilitated access to cross-border outpatient care and have also set out rules for the reimbursement of cross-border inpatient care received in EU Member States. These rulings created therefore destabilization rights:

> "Simply put, the creation and extension of new European rights, such as the right to have non-emergency medical treatment in a different country without pre-authorization, can have legal effects far beyond the number of patients who use their new rights. Refashioning a financial mechanism that depends on equalization within a state, or cross-subsidies within parts of a single public hospital, so that they do not violate EU internal market law can be a practical challenge and a problem for solidarity" (Greer & Rauscher, 2011a, p. 222).

This leap forward in European integration in the form of destabilization rights with regard to the delivery of healthcare within a given national territory has provided national actors that govern this system of healthcare delivery with new spatial opportunities. By putting the delivery of healthcare on Brussels' political agenda, national actors received the possibility to use Europe internally for their own benefit as well as the possibility of "bypassing" the national level of governance by accessing the European tier of governance, also in healthcare. Healthcare potentially would be part of a quasi-federal system of governance. Such bypassing of the national level to directly access the European level of health policy-making bears strong resemblances to the history of national welfare state development (Obinger, Leibfried & Castles, 2005). However, how does Europeanization proceed once European integration concerning the delivery of healthcare has made such leap forward? What are the goals of national actors responsible for healthcare delivery when using European opportunity structures? Do all actors in national healthcare governance react the same way, and do their usages of Europe threaten national boundaries or aim at circumventing or changing national institutional rules?

Forms of Usages of Europe

The preceding sections have shown that the groups of actors responsible for the delivery of healthcare in Austria use Europe to their benefit in various ways. At the lowest level of governance, we can find cognitive and strategic usages of Europe by individual hospital providers and by the Austrian *Länder* to set up and carry out projects of cross-border hospital collaboration, especially in those border areas where inpatient care is provided at a small distance from the border. At European level, the Austrian *Länder* use Europe strategically to influence European policy-making to exchange best practices with other regions of EU Member States, and to generate financial subsidies through the European Regional Policy for their healthcare projects. Payers, in form of sickness funds make a weak cognitive usage of Europe when it comes to the negotiation of national tariffs with providers, while providers virtually abstain from making usages of Europe. Both groups of corporate actors – payers and providers – use Europe strategically at European level to upload their political

preferences to the European policy-making process. They do so individually and through membership in European associations of payers and providers.

These usages of Europe are a form of *bricolage* of actors' practices (see chapter 1): In addition to their practices of governing the national healthcare system, Austrian actors adapt existing practices and develop new practices by their usages of Europe to benefit from European integration. Getting involved with "Europe" has become for many of these actors a part of their routine in healthcare governance. Adding Historical Institutionalism to this analysis of usages of Europe provides insight into the institutionally shaped interests of actors that influence which forms of usages of Europe are made, why actors might abstain from usages of Europe, and to which end exactly these usages of Europe are made. Each group of actors, sickness funds/social insurance institutions, physicians and dentists, the *Länder* have specific interests which have been shaped by the development of a Bismarckian type of welfare state. And the very complex structure of the Austrian healthcare system lends itself to path-dependent policy developments. This institutional structure has created practices of party politics and conflicts between the centre and the periphery, influencing the building of hospitals, consensual and informal negotiations between payers and providers in the outpatient sector, and resulting in complex financial negotiations along the organizational separation between inpatient and outpatient sector. All these institutionalized practices correspond to "a set of rules stipulating expected behaviour and 'ruling out' behaviour deemed to be undesirable" (Streeck & Thelen, 2005b), i.e. actors who do not conform to these rules are usually sanctioned (see chapter 1). Physicians' opposition to consensually negotiated healthcare reforms or to the introduction of the electronic health file described in the introduction to section 4.1 illustrates this argument. The abstention from usages of Europe by providers or the very weak usages of Europe by payers at national level can therefore be explained by the traditional consensual form of negotiations of tariffs. Even if both actor groups potentially could make a usage of Europe during these negotiations, such outright usage would contradict existing practices. Using Europe in a confrontational way could provide benefits for either of these actors, but could risk 'backfiring' in the long run. Actors are therefore cautious when it comes to using Europe at national level.

Goals and Effects of Usages of Europe

Historical Institutionalism also helps to explain which goal orientations the different actor groups follow. Payers seek an increase in cost efficiency of healthcare and try to exert control over costs; providers prefer a facilitated access to healthcare and want to increase the quality of care (see also chapter 1). The usages of Europe of the analysed actor groups at European level mirror the goal orientations they have developed at national level: the *Länder* make usages of Europe 'à la carte', they use Europe strategically to gain support and funds for cross-border projects in their role as providers, but as regulators of healthcare they also make a strategic usage of Europe to defend the national institutional set up of their healthcare system. Providers use Europe strategically to facilitate access to healthcare and to highlight the necessity of a high quality of healthcare, whereas payers of healthcare also use Europe strategically to avoid any erosion of their competency to control patient flows and resulting costs

of medical treatment. Moreover, adding an institutionalist perspective provides an explanation why some actors can make usages of Europe and others cannot or do not succeed. The termination of the Austrian-German cross-border collaboration illustrates this argument: the initiators of the cross-border collaboration have made strategic usages of Europe at national level and attempted to make strategic usages at European level. Given their limited political, administrative and financial resources at national level, their attempt to make usages of Europe at European level failed and in the end their room of manoeuvre was circumscribed by other more powerful actors' interests. And when in the eyes of regional authorities the project expanded too far it was simply terminated. The Austrian-Czech cross-border collaboration on the other hand has the support of regional authorities and has been more successful in using Europe strategically to generate European co-funding. At the same time the involvement of regional authorities on both sides of the border results in a much more complex and slower project development.

The different usages of Europe of the quasi-federal opportunity structure that the EU is offering actors do not result in a replacement of national healthcare governance, but rather lead to a co-existence of patterns of multi-level governance at European level and traditional hierarchical patterns of governance at national level. That these two different forms of governance are more parallel than exchangeable becomes clear when looking at the motivations and positions of the analysed actors. While all analysed actor groups pursue different goal orientations when making usages of Europe, none of these actors puts the national system of healthcare governance into question. Even those actors who might profit from removing regulatory boundaries, like providers, underline the competency of Member States to regulate healthcare. This is due to two aspects: namely that first, no actor only perceives advantages of European integration in healthcare and second, actors are well aware that their own competencies and their political, financial and administrative resources are defined at national level. Making usages of Europe at European level therefore does not equal furthering erosion of national control over the healthcare system beyond existing European integration. The resources that the EU provides for actors can also be used to defend the national system. This relates to actors' perceptions of legitimacy. Even if the EU provides opportunities for multi-level games or new quasi-federal opportunities in terms of access to healthcare, it does not provide a viable alternative to the national healthcare system: "There is no such thing as a European healthcare system, and as long as decisions on financing, organization and service delivery are taken at a national level, there is little chance of one existing" (Steffen, Lamping & Lehto, 2005, p. 3).

What contributes furthermore to the sceptical perception of European integration in cross-border healthcare, is actors' experiences with the administrative mechanisms under Regulation 883/2004 (1408/71). Too often have Austrian payers waited a considerable amount of time for reimbursement of costs of cross-border healthcare by other Member States. In the end, these problems had to be solved by intergovernmental negotiations to settle the question of more efficient reimbursement procedures. The probability that a majority of actors would consequently perceive the EU as more legitimate than the national system of healthcare governance is therefore extremely

low. Yet, European integration has advanced in cross-border healthcare due to the CJEU's rulings. And while possibilities exist for actors of using Europe to their own benefit, many (but not all) of the analyzed actors also perceive a necessity or 'duty' of using Europe and becoming involved in patterns of corporatist policy-making at European level. Especially regional authorities who pay and regulate healthcare as well as payers of healthcare make strategic usages of Europe to circumscribe potential destructuring effects of European integration on the national healthcare system. The strategic usages of Vienna's Hospital Corporation or those of the Main Association of Austrian Social Insurance Institutions illustrate this argument. Actors who do not use Europe to defend their own interests at European level " […] might find themselves bypassed in Brussels, due to their own 'obstinacy' in using their old member-state channels when they should be plunging into EU health politics" (Greer, 2009, p. 75). These actors' motivation is therefore not to actively bypass the national level, but rather to prevent European integration from further eroding national competencies. This does not contradict the assertion that European integration has a detrimental effect on national welfare sovereignty (Ferrera, 2005; Leibfried & Pierson, 1995), especially since actors want and have to get involved in European policy-making once European integration has made a leap forward. But analysis of actors' usages of Europe shows that the national institutional set up of healthcare governance retains significant power to channel actors' interests and strategies. Boundaries of national welfare states have become porous, but they are largely left intact. And institutionally shaped interests explain to a large extent the motives for, the forms of, and the goals of actors' usages of Europe.

Asymmetrical Europeanization

The above findings need however to be qualified from a theoretical perspective: adding Historical Institutionalism to the analysis of actors' usages of Europe runs the risk of over-determining actors' decisions on making or not making usages of Europe. Political entrepreneurship, such as the case of Lower Austrian involvement in cross-border healthcare collaboration or in the network of European Regional and Local Health Authorities, also plays an important role when it comes to actors' decisions to make usages of Europe. Nevertheless, when looking at who of the analyzed actors makes usages of Europe and who does not or cannot make usages of Europe, it becomes clear that actors who have significant political, financial and administrative resources at national level are also more likely to successfully use Europe to their own benefit. These national institutional resources also explain why bureaucratic or corporate actors who have limited access to the public do not show any legitimating usage of Europe. In the policy processes at national and European level they simply do not need to use Europe to justify their positions. And not all strategic usages of Europe are a viable option for each type of actor. Strategic usages of Europe such as proceedings in front of the CJEU or lobbying activities at European level require significant national resources before an actor can have access to European opportunities. As the case of the project on Austrian-German hospital collaboration has shown, actors scan for European resources and might try to use Europe. National institutions and institutionalized practices however set the limit of what is possible.

The result is that while actors' strategies are Europeanized, institutional structures do not show any significant change.

The institutional complexity of governance structures of Bismarckian type healthcare systems such as the Austrian one also provides an explanation why usages of Europe inside the system occur much less frequently than at European level. The Austrian system disperses power among various actors but at the same time requires a large amount of coordination and consensus building. The latter institutional requirement explains why from a public policy perspective Bismarckian welfare states and healthcare systems are prone to incremental policy change (see chapter 1). The same requirement sets incentives for actors to abstain from usages of Europe in order not to put consensus building at risk when it comes to governing the national healthcare system. How far Europeanization occurs is therefore also determined by the type of welfare state analyzed. This argument can be corroborated by other research which has found that usages of Europe and changes of welfare state policies due to European integration are rather limited in Bismarckian welfare states (Graziano, Jacquot & Palier, 2011c, p. 317). The fact that Austria was already in line with the CJEU's rulings on cross-border healthcare from a legal perspective hence plays a subordinate role from a theoretical perspective. It is not the fit or misfit (see chapter 1) that determines effects of Europeanization, but rather institutional regimes as well as actors (bounded) rationality, their perceptions and entrepreneurship are decisive.

The result is an asymmetrical Europeanization: it is asymmetrical between structure (institutions do not change or change slowly) and agency (strategies and administrative practices change), between actors (those who have access to European resources and those who have not), and sometimes also inside the same group of actors. The last point refers to the involvement of actors at European level: "[…] the EU health policy community is still very much changing and developing; even by the fluid standards of EU interest representation […], EU health policy is exceptionally viscous. Different interest groups in different countries are taking an interest in different aspects of the EU at different speeds. The result is a wide spread of tactics, goals and investments, with Member State groups' relations with the EU ranging from a total lack of interest, to participation in EU associations, to opening their own Brussels offices and hiring their own lobbyists" (Greer, 2008, p. 7). Various examples from the analysis in this chapter corroborate this finding. For example, some Austrian *Länder* actively engage at European level in the European Regional and Local Health Authorities network, but other Austrian *Länder* are completely absent. The same holds true for the regions of other Member States, where again those regions with significant competencies for healthcare are more likely to be active than those without such competencies. And actors' attitudes vis-à-vis European integration in cross-border healthcare vary depending on which aspect of European integration is analysed. Not even the same group of actors necessarily shows similar attitudes, as the example of Physicians' liberal attitudes in comparison to the resistance by dentists shows. From a European perspective this picture becomes even more complex when for example taking into account that payers from 'old' Member States feel less pressure due to European integration regarding cross-border healthcare than those from 'new' Member States, given the economic differences between them. In the end,

this asymmetrical Europeanization results in strategies that range between 'cherry-picking' of European resources and resistance against European integration at the same time.

Rejection of the Directive on Cross-border Healthcare by Austria

A telling example of resistance against European integration is Austria's rejection of Directive 2011/24 EU which has codified the CJEU's rulings on cross-border healthcare (Kostera, 2013a). Despite Austria being in line from a judicial perspective with the CJEU's rulings and despite the active usages of Europe by the Austrian *Länder* in cross-border collaboration, the latter largely contributed to Austria's rejection of the Directive. While the federal government was less skeptical about the Directive, the *Länders'* opposition against the Directive seems to have been a reflection of internal reform discussions about the influence of the federal level in healthcare and represents attempts by the *Länder* and the federal level respectively to assert a maximum of influence. The ultimate rejection of the Directive due to the *Länders'* intervention permits to draw some conclusions on the significance of the *Länders'* usages of Europe in cross-border healthcare collaboration: as providers of healthcare the *Länder* have shown some important usages of Europe to their benefit, especially in border regions. They are furthermore active at European level, where they use Europe to exchange best practices and to increase their influence on European initiatives regarding healthcare. Yet, when it comes to the question of financing and regulating healthcare, the *Länder* do not act differently in comparison to single Member States that regulate inpatient care. If Europe potentially threatens the competencies of regulating healthcare, the *Länder* will strictly oppose European regulation. The complex institutional system of financing healthcare (see chapter 2) was in the end the decisive factor that explains this opposition, and it also explains the fact that usages of Europe are only made in parallel to existing structures of national healthcare governance, but not to contradict those structures. Most noticeably the federal level, which does not have to directly pay inpatient care, was much less worried about European integration with regard to cross-border healthcare than those actors who directly pay it, even though all actors agreed that national control over patient flows should not be reduced by European regulation (*ibid*.). Austria's rejection of of Directive 2011/24 EU however did not prevent it from coming into force and was more of a symbolic act to accommodate the interests of the *Länder* following a pattern of cooperative federalism (*ibid*.).Nem nonemquunt explit ipid et unt que es min restest, est dent, nest, sum sinvel eossimint voluptur seque exerspe rendignia dolorer spelit esto dolenda pa eosa vit fugiat ut autem voluptae nossime re pa volupta tempern atinven daeped es et molorib usdae. Mincidel modit eosa dolorrum harciandis molor acerror ruptusam ut aut aut voluptur sum quae voluptatum facerore voluptat.

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Conclusion

The main findings of this study can be summarized as follows: Austrian actors responsible for the delivery of healthcare actively integrate various usages of Europe into their existing practices of healthcare governance. These usages of Europe are more frequent at European level than at national level. Those actors who have important legal competencies, financial resources, and hence power in healthcare governance at national level, are also in a better position to use Europe effectively than those actors who lack such national resources. Limited usages of Europe at national level by corporate actors can best be accounted for by practices of consensually governing a typically Bismarckian healthcare system. None of the actors analysed, no matter how critical their stance vis-à-vis their own healthcare system might be, puts into question the legitimacy of the national healthcare system in the light of increased European competencies in regulating cross-border healthcare. Advancing European integration, mainly through the CJEU's rulings on cross-border healthcare, might have rendered national institutional boundaries porous, but national institutions retain their power of channelling actors' interests and of influencing corresponding practices of healthcare governance. These results invite us to further investigate which kind of healthcare governance structures are being developed at European level in parallel to those existing at national level, and to what extent Bismarckian welfare regimes might be showing resistance to institutional change induced by European integration.

Perceptions of Cross-border Healthcare

When European integration in cross-border healthcare made a leap forward due to the CJEU's rulings, it did not receive increased attention from many actors of the Austrian healthcare system. Even the payers of healthcare remained unperturbed: due to the existing relative openness of the Austrian healthcare system as result of

national legislation already being in line with the rulings. With the subsequent rulings on cross-border healthcare and the beginning of a political process on how to regulate cross-border healthcare at European level, existing projects of cross-border hospital collaboration at regional level started to show an interest in the potential effects of European integration. New initiatives for cross-border hospital collaboration were initiated; providers, payers, and the federal government began to evaluate European integration in cross-border healthcare. Actors' perceptions in terms of potential positive or negative consequences for the national healthcare system exhibit various differences, but also important commonalities. These variations can be best explained by the different actors' competencies and interests in Austrian healthcare governance. The Austrian *Länder* who act as regulators, payers and providers of healthcare have perceived European integration in cross-border healthcare as an opportunity to maintain and to receive additional European subsidies for hospital infrastructure even in remote border regions. Europe is also an opportunity to consolidate their own competencies with regard to inpatient care by providing means for cooperation in research, the exchange of best practices, and possibilities to directly influence European policy-making. At the same time, European integration has led to concerns about the reduction of control over patient flows, potentially increased costs, problems of reimbursement of costs of medical treatment between Member States, and potential abuse of European rules by foreign patients. This mixed perception correlates with the triple role of the *Länder* in providing inpatient care: as providers of healthcare they perceive European integration to be beneficial; in their role as regulators and payers of healthcare they tend to view European rules on cross-border healthcare with scepticism.

In the outpatient sector, payers of healthcare have seen opportunities of comparing tariffs with other European Member States which put them in a better position when it comes to negotiation with providers. But more importantly, and despite the practice of permitting patients already under national regulation to receive outpatient treatments abroad without intensive control, for payers European integration means an increase in the administrative workload, dealing sometimes with medically unjustified demands by patients for treatment abroad and the obligation to monitor and to avoid any potential increase of spending. Providers, on the other hand, show a much more ambiguous attitude vis-à-vis European cross-border healthcare. While they are generally in favour of a more liberal market approach and competition in the provision of healthcare, those providers who have been suffering from competition by providers from other Member States are much more in favour of limiting the impact of European integration on the provision of healthcare. The potential removal of boundaries that could open up a European market for the provision of healthcare is thus a double-edged sword for providers. On the one hand, cross-border healthcare could help to increase the revenue of some providers; on the other hand it might also lead to a loss of patients to providers from other countries who offer treatment at lower prices.

These different perceptions can be explained by payers' interests in the economically efficient financing of healthcare, by providers' interest in increasing the offer of high quality treatment (and hence also an increase in revenues) to patients,

as well as by user's interest in receiving timely and specialized healthcare. Despite these varying perceptions, two important commonalities can be observed: namely, that European regulation of cross-border healthcare can contribute to improving the treatment options available to patients and foster European cross-border collaboration to improve national healthcare, but that it must at the same time not endanger the national healthcare system. This perception is also shared by the federal level of government, by other corporate actors not directly responsible for the delivery of healthcare, and by Austrian Members of Parliament. Therefore, there is neither a uniform rejection of European integration in cross-border healthcare nor is there any 'carefree' acceptance of European integration. As much as the perceptions of European integration in cross-border healthcare may differ amongst actors, their usages of Europe vary to the same extent. And much like the perceptions of European integration, these usages are linked to each actor's role in national healthcare governance.

Variations of Usages of Europe

The Austrian *Länder* responsible for the delivery of inpatient care are the actors who most frequently use Europe to advance their own interests. These usages largely depend on three national institutional factors: the first is the traditional existence of smaller and hence relatively more expensive hospitals in border areas (see chapter 3). These hospitals have come under pressure due to national reform efforts to increase the economic efficiency of inpatient care and to centralize the planning of hospital infrastructure. Europe is used strategically for the development of cross-border hospital collaboration in border areas in order to come to the rescue of some of those hospitals. This relates also to the second institutional factor determining usages of Europe by the *Länder*, namely the institutionalized struggle between the federal and the national level about who should be responsible for the delivery of inpatient care. The *Länder* have an interest in keeping this competence, even though reform pressure has been increasing, and thus use Europe strategically also at European level to substantiate and to extend their own political room for manoeuvre in healthcare governance. The third institutional factor is the national system of financing healthcare. Europe is used to generate additional funds for healthcare projects as hospital infrastructure is dependent on negotiated subsidies at the federal level. Europe therefore also contributes to increasing the financial room for manoeuvre of the *Länder*, which would not be possible solely on the basis of national funding. Nevertheless, as regulators of healthcare the Austrian *Länder* also use Europe to defend the boundaries of the national healthcare system against aspects of European integration which could mean an erosion of their capacities to control patient flows or which would undermine their financial interests as payers of healthcare (see section 4.1).

As section 4.2 has shown, corporate actors such as payers and providers largely abstain from usages of Europe at national level, even though opportunities at national level for usages would exist such as the negotiations of tariffs for outpatient care in remote rural areas where foreign tourists frequently have to seek medical care. Apart from a weak cognitive usage of Europe by payers, corporate actors who regulate outpatient care do not make a forthright usage of Europe as this would contradict their practices of consensually negotiating tariffs. An actor who would use Europe

strategically in these negotiations would have a short term benefit, but would put into question the traditional system of negotiations in the long run. However, both payers and providers make strategic usages of Europe at European level to upload their respective policy preferences to European policy-making processes. Payers have tried to defend the status quo of regulating cross-border healthcare in order to avoid a loss of control over patient flows, while providers have been generally more positive towards a more market-oriented approach to healthcare which would be supported by European integration. However, providers' strategic usages of Europe reveal ambiguous goals when it comes to European integration: those providers who could potentially benefit prefer less regulation in order to increase competition, while those who have been suffering from increased competition defend the status quo of national regulation.

National Institutions and Usages of Europe: A 'Bismarckian' Resistance to Change

The various usages of Europe by actors responsible for the delivery of healthcare in Austria show that there is a *bricolage* of usages of Europe with their existing practices of governing healthcare. Their interests and strategies have been Europeanized. Yet, the goals of these usages are channelled and oftentimes limited by national institutions. From scrutinizing the interplay of national institutions and Europeanized agency we can conclude that the institutional *regime* of the Austrian healthcare system is still capable of "stipulating expected behaviour and 'ruling out' behaviour deemed to be undesirable" (Streeck & Thelen, 2005b, p. 12). These findings result from analysing the forms of usages of Europe that can be observed, the low degree of usages of Europe at national level, and the capacity of actors to derive an actual benefit from their usages of Europe. Adding Historical Institutionalism to the analysis of actors' usages of Europe – even though it might run the risk of over-determining actors' strategies from a theoretical perspective – helps therefore to gain insights into why some actors use Europe successfully, why others do not, and why others abstain completely from certain types of usages of Europe.

Concerning the forms of usages of Europe made by actors we can observe a heavy reliance upon strategic usages of Europe, some limited cognitive usages of Europe, and virtually no legitimating usages of Europe. This bias towards strategic usages of Europe is due to the selection of actors that have been analysed and to their role in national healthcare governance. The absence of legitimating usages shows that bureaucratic actors such as regional health authorities or hospital operators have a limited access to the public and thus mainly use Europe strategically instead of seeking public legitimation through European resources. Public legitimation of policy choices becomes relevant, though, when it comes to healthcare reforms in which also corporate actors are involved. Even though the economic crisis and the Maastricht criteria for the Euro currency have played an increasing role in Austrian politics since the crisis onset in 2008 and Europe can be used by the federal government to legitimize restrictive welfare state reforms, as already happened in the 1990s (see chapter 2), it does not play a role when actual measures of reforming the healthcare system are publicly discussed. These debates rather revolve around a national reform

path that is more than 20 years old and which mainly addresses the split between the outpatient sector and the inpatient sector, the federal system of financing healthcare, and the planning of infrastructure (see chapter 2). Europe might therefore be usable for justifying spending cuts, but such usage only has limited influence on the trajectories of healthcare reforms themselves.

Compared to legitimating usages of Europe, strategic usages are a much more promising option for agency. Many of these strategic usages on the part of actors responsible for healthcare yield either financial benefits (e.g. co-funding through the EU's regional policy) or direct access to European arenas of policy-making (e.g. representations in Brussels and uploading of policy preferences to the European level). However, as chapter 4 reveals, strategic usages of Europe are only fruitful if undertaken by actors that have significant legal competencies, administrative capacities, funding, and the necessary expertise. All of these institutional factors are determined at national level. Those actors who lack these resources, such as the Austrian-German project of cross-border hospital collaboration (section 4.1) are not necessarily able to derive a benefit from attempting to strategically use Europe. Access to European resources is therefore also dependent on the national institutional regime. And if actors' attempts to use Europe go too far in the eyes of other, more powerful actors, the former's effort can even be significantly thwarted by the latter. This is not to say that actors do not try to get a 'maximum' out of Europe: they scan for possibilities to actively use Europe, they learn how to access European resources for making usages, but they also learn where the national institutional limits are. In this sense, the self-limitation of payers to some weak cognitive usages of Europe during negotiations of tariffs not only shows that a consensual and informal style of negotiations prohibits any forthright strategic usages of Europe, it also shows that actors in these cases rely, if at all, on the usages of Europe with the weakest impact. Cognitive usages do not demand any more resources than making a reference to a vague notion of "Europe", i.e. a cognitive usage is much less costly than a strategic one, but its impact is also limited as any other actor can easily try to develop counter arguments and strategies. The combination of the usages of Europe approach with historical institutionalism thus provides a possibility to take into account national institutions, the resources and paths that bind actors when they decide on making use of Europe or not. The large variety of strategic usages of Europe observed by Austrian actors responsible for the delivery of healthcare also invites us to carefully define which resources are mobilized to make a strategic usage of Europe, as strategic usages based on financial considerations imply very different strategic calculations and potential outcomes in terms of Europeanization than those based on political resources to influence policy-making at European level, for example.

Another important aspect is actors' perception of European regulation of cross-border healthcare possibly competing with national regulatory capacity. Even those actors who could potentially benefit from an increased right to access to healthcare across Member States, like some of the providers but also those who might hope that European integration could improve transparency and economic efficiency of inpatient care at national level such as employers and industrial representatives, do not doubt that national regulatory competencies should not be reduced by European integration. The reason is that all actors are well aware of the fact that it is the national

institutional *regime* that grants and guarantees them their own competencies and resources. Providers' right to professional auto-regulation, for example, is defined at national level and varies across Member States. Unsurprisingly, providers might thus welcome European rules that facilitate access to healthcare, but oppose extended European intervention in standard setting or aspects touching upon other aspects falling under professional auto-regulation. And even the Austrian *Länder*, who make the most extensive usages of Europe at national and European level given their important administrative and political resources, have opposed aspects of European integration in cross-border healthcare which could potentially lead to financial losses. Therefore, national considerations concerning financing inpatient care and who should be responsible for the regulation of inpatient care – either the federal or the regional level – have led to Austria's rejection of the patients' rights Directive codifying the CJEU case law which triggered the leap forward of European integration in cross-border healthcare.

Even though a case study only permits contingent generalizations, the above findings suggest that the typical institutional traits of a Bismarckian healthcare system can be regarded here as the most important explanatory variable when it comes to determining the (limited) domestic impact of European integration on the Austrian healthcare system. Actors use Europe in a sort of flexible cherry picking strategy, and agency is hence Europeanized, but defend their own rather complex institutional regime which disperses competence of healthcare governance to a multitude of actors. Europeanization is thus limited in scope and incremental in pace. This argument can be corroborated by other research which has found that usages of Europe and changes of welfare state policies linked to European integration are rather limited in Bismarckian welfare states (Graziano, Jacquot & Palier, 2011c, p. 317). Change and resistance to change due to European integration therefore do not seem to depend on a potential misfit or fit between national legislation and European rules and regulations – Austria was the only Member State in line with the CJEU case law on cross-border healthcare from the outset but nonetheless voted against the Directive codifying the case law – but rather on the institutionalist argument that has been put forward by public policy analysis: institutional change in Bismarckian welfare states is rather incremental if not inert (Palier, 2008; Palier, 2010a). Bismarckian institutions therefore seem not only to be mere 'mediating factors' (Börzel, 2005; Börzel & Risse, 2007) that help to explain the scope of Europeanization, they are also outright structural brakes on Europeanization if actors perceive that welfare institutions themselves are potentially put into question by European integration.

However, this argument needs to be qualified by two aspects inherent to the design of this study. The first one relates to the size and strength of corporatism in the country studied: the findings indirectly correlate with Katzenstein's classic argument that small corporatist democracies such as Austria show a high degree of economic flexibility combined with important political stability in an era of economic vulnerability and open national markets (Katzenstein, 1985). Applied to European integration, it could be analogously argued that Austrian healthcare actors exhibit considerable strategic flexibility in adapting to European integration combined with significant national institutional robustness and resistance to change. As chapter 2 has

shown, the institutional core principles of the Austrian welfare state have prevailed over much more radical political regime changes than European integration could ever bring about. This result calls therefore for further investigation of how far Bismarckian welfare regimes, not only of smaller Member States, might be resistant to institutional change induced by European integration. The second qualification relates to the time frame of analysis. The leap forward of European integration touching upon the national systems of delivery of healthcare is less than two decades old and was initially met by all Member States with resistance. The step from negative integration through the CJEU's jurisprudence towards attempts of positive European integration in the Directive (Rothgang & Götze, 2009) alone has lasted over a decade, and the Directive on the application of patients' rights in cross-border healthcare leaves new room for judicial litigation and hence further European integration and Europeanization. This temporal aspect underlines however that European integration is a dynamic process which does not abruptly stop once for example the CJEU case law is codified in a Directive. And even though there is only little chance of a European healthcare system developing as long as governance and financing of healthcare remain at national level (Steffen, Lamping & Lehto, 2005), this study has revealed an increased engagement of national actors at European level, which invites us to further research the forms of healthcare governance that are developing at European level.

Quasi-federal, Multi-Level and Asymmetrical European Healthcare Governance

Chapter 4 has shown that various actors in the Austrian healthcare system use Europe to engage in policy-making processes at European level, that they have their own interest representations, and that they collaborate concerning the various aspects of healthcare delivery with actors from other Member States, reaching from the exchange of best practices, generating funds for cross-border projects, to participating in corporatist patterns of negotiating between public employers and employees. Many of the structures available to actors at European level, such as regional representations or European associations of payers and providers, date back to well before the rulings on cross-border healthcare had been issued by the CJEU. Many of these structures have been established over the past decades and some were set up even during the early stages of the then European Communities, such as the European association of physicians (CPME). For many groups of actors, though, the Treaty of Maastricht in 1993 seems to have been the starting point to actively become involved in policy-making at European level and to set up representations in Brussels, as social insurance institutions did by creating the European Social Insurance Platform. The inclusion of social policies in policy-making at European level has been much less a result of active social policy-making by Brussels than a result of spill-overs from the integration process of the EU's internal market (Falkner, 1998). Compared to other employment related policies, European integration concerning the delivery of healthcare is thus rather recent, even though the mechanism for coordinating Member States' social security systems has been in place since the 1970s. As argued in chapter 3 from a perspective of comparative federalism, national healthcare actors have thus gained access to the supranational layer of governance beyond the boundaries of their

welfare states. Even though Europeanization at national level remains rather limited, the involvement of national healthcare actors at European level shows that European integration has been reducing Member States' executives' room of manoeuvre to steer healthcare delivery as they see fit: even those actors like the Viennese regional authorities, who would have preferred the *status quo ante* of European integration in cross-border healthcare, meanwhile feel a duty to become involved in European policy-making. And like many of the healthcare actors analysed, they have been using the structures that have been previously created at European level since the 1990s. But actors such as the *Land* of Lower Austria also participate in creating new European structures like the European Regional and Local Health Authorities network, even though other Austrian *Länder* are absent in health policy at European level. The same finding applies to the regions of other Member States, where those regions with significant competencies for healthcare are more likely to be active than those without such competencies. We can therefore conclude that actors' European involvement does not constitute a coherent pattern of agency in the Brussels arena as not even the same group of actors necessarily shows similar attitudes, as shown by the examples of physicians' liberal attitudes in comparison to the resistance by dentists or the differing perceptions and interests between payers from various Member States.

European integration concerning healthcare has therefore led to a Europeanization of agency which is asymmetrical in many ways. While at national level it is asymmetrical between the institutional structure and agency as such and between actors, i.e. between those actors who have access to European resources and those who have not, it is also asymmetrical not only between actors from different Member States but also concerning their various interests and strategies at European level. Following Ferrera's (2005) argument that once European integration has destructuring effects on national boundaries, i.e. it renders these boundaries porous, restructuring of patterns of governance needs to take place at European level. The findings of this study suggest that this restructuring of governance patterns at European level does not result in a replacement of national healthcare governance structures, but rather leads to a co-existence of differential patterns of multi-level governance at European level and traditional hierarchical patterns of governance at national level. What then are the conclusions that can be drawn for the future development of European healthcare governance, even though it is still developing? Scholars of comparative federalism have argued that European integration provides bypasses to a 'Social Europe' in analogy to the development of welfare states in federal polities (Obinger, Leibfried & Castles, 2005; see also chapter 3). The major differences compared to federal states are however, that the EU has only very limited competencies with regard to the delivery of healthcare. This study shows further that the asymmetrical involvement of actors in patterns of multi-level healthcare governance is very different from that in federal polities, where governance structures attribute clear competencies and roles for individual actors in healthcare. Taking however into account that the EU is involved in various public health policies, the free movement of health professionals, and other aspects of healthcare, scholars have been calling the evolving European structures of healthcare governance a "European space of health" (Guigner, 2008). More recent research has also been arguing that we now see the making of a "European

healthcare union" which is "by and large of both a regulatory and voluntary nature" and is "a federative system combining self-rule (large part of healthcare still governed by Member States) and shared rule (mainly concerning collective coordination of cross-border healthcare, the market for health goods, services, persons and capital)" (Vollaard & van de Bovenkamp, 2014, p. 16).

Independent from the conceptual denomination that we might attribute to evolving European structures of healthcare governance, the tension between advancing European integration and national conceptions of welfare states persists. This can have important implications for healthcare policy-making: on the one hand, Member States' authority over healthcare systems is reduced by European integration, but on the other hand the European level of governance remains rather weak in health politics as "compared with other multi-tiered systems the EU's social policy-making apparatus is bottom-heavy" (Leibfried, 2010, p. 278). This combination of a weak European centre of policy-making, reducing at the same time Member States control over healthcare systems, can thus "restrict the room for innovative policy" (*ibid*.). European rules on cross-border healthcare illustrate this point insofar as the political process which led to a codification of the CJEU's case law in the Directive on the application of patients' rights in cross-border healthcare was mainly marked by a struggle between Member States, various healthcare actors and the European institutions about which level of governance should be responsible for the regulation of European cross-border healthcare. In terms of policy advancements, however, the Directive might bring about some facilitation for the access to cross-border healthcare. Yet, it seems questionable whether individual patients will profit from the Directive on any large scale in comparison to older arrangements of social security coordination between Member States, given the Directive's rules on prior authorization and payment of cross-border healthcare. And despite Member States' attempt to at least symbolically reassert control over cross-border healthcare through codification of European rules, there is still space for further European integration in healthcare when it comes to the actual implementation of the Directive. The results of this study invite therefore us to further investigate the development of European structures of healthcare governance and to analyse the interplay between European integration and Europeanization of healthcare, probably resulting in a weak form of a regulatory healthcare state.

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List of interviews

No.	*Date*	*Place*	*Institution*	*Function*
1	05/08/2009	Vienna	Gesundheitsmanagement (Consultancy)	Consultant
2	10/08/2009	Vienna	Gesundheitsmanagement (Consultancy)	Consultant
3	12/01/2010	Vienna	Federal Ministry of Health, EU Affairs Unit	Deputy Head of Unit, EU affairs
4	13/01/2010	St. Pölten	Lower Austrian Hospital Holding	Chief Medical Executive Officer
5	13/01/2010	St. Pölten	Lower Austrian Health Fund (NÖGUS)/ Lower Austrian Hospital Holding	Head of Unit, EU affairs
6	18/01/2010	Vienna	ÖBIG – Austrian Health Institute	Senior Policy Analyst Policy Analyst
7	21/01/2010	Vienna	Chamber of Labour	Desk Officer
8	25/01/2010	Vienna	Main Association of Social Insurance Institutions, Unit for Hospital Care	Head of Unit
9	25/01/2010	Vienna	Länder Liaison Office	Desk Officer
10	27/01/2010	Vienna	Federal Ministry of Labour and Social Protection	Head of Unit
11	08/07/2010	Vienna	Women's organization, Austrian People's Party (ÖVP)	Former Federal Minister of Health
12	13/07/2010	Vienna	Chamber of Economy (WKÖ), Department for Social Policy and Health	Senior Desk Officer Desk Officer
13	16/07/2010	Gmünd (NÖ)	Hospital Gmünd (Landeskrankenhaus)	Financial and Administrative Director
14	17/09/2010	Vienna	University of Vienna, Institute for Labour and Social Law	Professor of Social Law
15	29/10/2010	Linz	Upper Austrian Health Fund, Unit for inpatient care	Head of Unit, Desk officer, Desk officer (accountancy)
16	04/11/2010	Vienna	Federal Chamber of Physicians (Österreichische Ärztekammer)	Director International Office, Desk Officer International Office
17	04/11/2010	Vienna	Viennese Magistrate	Desk officer

No.	*Date*	*Place*	*Institution*	*Function*
18	15/11/2010	Brussels	European Social Insurance Platform	Coordinator Health
19	02/12/2010	Vienna	Institute for Advanced Studies	Senior Researcher (Public Health and Health Economics)
20	12/01/2011	Braunau/Inn	Hospital St. Josef Braunau	Financial and Administrative Director
21	17/01/2011	Vienna		Independent Healthcare Expert, Healthcare Columnist
22	17/01/2011	Vienna	Federal Chamber of Dentists	Director
23	18/01/2011	Feldkirch	Krankenhausbetriebsgesellschaft Vorarlberg (Hospital Operator)	Director
24	19/01/2011	Feldkirch	Patientenanwalt Vorarlberg (Patients‘ Advocate)	Patients‘ Advocate Vorarlberg
25	19/01/2011	Bregenz	Health Fund Vorarlberg	Senior Desk Officer, coordinator for patients‘ rights directive
26	20/01/2011	Dornbirn	Chamber of Physicians Vorarlberg	Desk Officer
27	20/01/2011	Dornbirn	Sickness Fund Vorarlberg (VGKK)	Head Contracting Department
28	09/03/2011	Vienna	Federal Ministry of Health, EU Affairs Unit	Deputy Head of Unit, EU affairs
29	10/03/2011	Vienna	Federal Ministry of Health, Directorate General 2: Legal affairs and health related consumer protection	Director General Legal affairs and health related consumer protection; Head of Unit Legal affairs of health and accident insurance; Desk officer, Unit for legisprudence of health insurance and accident insurance
30	30/09/2011	Brussels	Comité Permanent des Médecins (CPME)	Policy Officer

No.	*Date*	*Place*	*Institution*	*Function*
31	07/10/2011	Brussels	Committee of the Regions	Administrator
32	19/10/2011	Brussels	European Parliament	MEP
33	07/11/2011	Brussels	European Commission	Policy Officer
34	17/11/2011	Brussels	Representation of Lower Austria	Head of Representation and head of Euregha Network
35	18/11/2011	Brussels	Permanent Representation of Austria	Desk Officer, Federal Ministry of Health
36	24/11/2011	Vienna	Association of Austrian Industries	Desk Officer Social Protection
37	06/12/2011	Brussels	Council of European Dentists (EU Dental)	Head of Office
38	11/01/2012	Vienna	Green Party	Health Policy Spokesman, Member of Parliament
39	13/01/2012	Vienna	UNIQA Insurance Group	Member of Executive Board UNIQA Insurance, Responsible for healthcare
40	17/01/2012	Vienna	Der Standard Newspaper	Journalist (Health Politics, Federalism)
41	18/01/2012	Vienna	Patientenanwalt Wien (Patient Ombudsman)	Patient Ombudsman
42	18/01/2012	Vienna	Vienna Sickness Fund (WGKK)	Director, Medical Director
43	19/01/2012	Vienna	BZÖ Party	Health Policy Spokesman, Member of Parliament
44	20/01/2012	Vienna	ÖVP Party	Assistant of Health Policy Spokesman Dr. Rasinger (Member of Parliament)
45	24/01/2012	Vienna	FPÖ Party	Health Policy Spokeswoman, Member of Parliament
46	25/01/2012	Vienna	AUVA (Work Accidents Insurance Fund)	Head of Unit, Deputy Head of Unit
47	26/01/2012	Vienna	Vienna Hospital Corporation (KAV)	Desk Officers, Directorate General
48	30/07/2012	Vienna	European Centre for Social Welfare Policy and Research	Director Health and Care

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Diffusion/distribution : Interforum Benelux (Belgique, Pays-Bas et grand-duché de Luxembourg) ; SODIS/ToThèmes (France) ; Servidis (Suisse) ; Somabec (Canada).