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Europeanisation within Austria's Healthcare System: Path-dependent Usages of Europe in Border Regions

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During the last couple of years, sociological approaches in European studies have gained increasing attention from scholars. The "usages of Europe" approach looks at the opportunities and resources that the EU provides for national actors to advance their interests, from a bottom-up perspective. As European rules on cross-border healthcare have been threatening the principle of the territoriality of healthcare services, the article analyses two cross-border healthcare projects in Austrian border regions to determine if and how actors' strategies have been Europeanised, and whether their actions could destructure national welfare boundaries. In order to explain how these regional actors incorporate European resources into their strategies a combination of the "usages of Europe" approach with Historical Institutionalism is suggested.

Europäisierung im österreichischen Gesundheitssystem: Pfadabhängige Usages of Europe in Grenzregionen

Schlüsselwörter: Usages of Europe, Gesundheitsdienstleistungen, Europäische Union, Österreich, Tschechische Republik, Deutschland

Soziologische Ansätze erfahren in der europäischen Integrationsforschung steigende Aufmerksamkeit. Der „usages of Europe“-Ansatz untersucht aus einer Bottom-up-Perspektive die Handlungsmöglichkeiten und Ressourcen, welche die EU nationalen Akteuren zur Verfügung stellt, um ihre Interessen durchzusetzen. Da die europäischen Regelungen für grenzüberschreitende Gesundheitsdienstleistungen das für Gesundheitsdienstleistungen geltende Territorialitätsprinzip infrage gestellt haben, analysiert der Artikel zwei regionale Projekte zu grenzüberschreitenden Gesundheitsdienstleistungen in österreichischen Grenzregionen. Er geht der Frage nach, ob und wie die Strategien von Akteuren europäisiert worden sind und ob ihre Handlungen die nationalen Grenzen von Wohlfahrtsstaatlichkeit erodieren können. Um zu erklären wie regionale Akteure europäische Ressourcen in ihrem strategischen Vorgehen nutzen, wird vorgeschlagen, den „usages of Europe“-Ansatz für die Analyse mit dem Konzept der historisch-institutionalistischen Pfadabhängigkeit zu verbinden.

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Introduction

The EU is challenging the boundaries of national welfare states (Ferrera 2005): welfare states that were once created for the national population must allow benefits to be carried from one country to another. In the field of healthcare provision, the European Court of Justice has put the topic of cross-border healthcare on the Brussels political agenda. The rulings delivered by the Court have facilitated access to medical treatment for patients in other Member States. While the issue of cross-border healthcare has been defined in Brussels in terms of patients' rights, the Court's decisions are largely based on the principle of non-discrimination of national healthcare providers against healthcare providers from other EU countries (Greer 2009, 42). In order to see the extent to which national healthcare systems can be Europeanised due to such rules, a bottom-up approach is used. This contribution therefore examines whether the EU rules on cross-border healthcare provision change the politics in EU Member States and whether healthcare providers will strategically "use" Europe to advance their own interests, thus resulting in a possible "de-structuring of national welfare boundaries" (Ferrera 2005).

Using a bottom-up approach for the analysis of the EU's impact on national healthcare systems is a change of perspective in comparison to previous studies. These studies have mainly explained national governments' reactions to EU cross-border healthcare (Sindbjerg Martinse/Vrangbaek 2008) or the legal and administrative application of the Court's rulings (Obermaier 2009) from a top-down perspective. Hence the focus will be put here on the strategic dimension of European rules on cross-border healthcare and their "usability" for subnational actors. In many Member States the subnational level is responsible for the provision of healthcare. Through the EU's Regional Policy the subnational level can engage directly with other subnational authorities across their national border, which implies a potential threat to national boundaries (Ferrera 2005, 180–187), thus putting regions at the forefront for benefitting from EU rules on cross-border healthcare.

A sociological approach will be used in order to answer the research question of this article. The approach looks at the "usages of Europe" that may be made by actors (Jacquot/Woll 2008, 2010). However, this approach does not imply a certain outcome of actors' usages, but it allows scrutinizing how regional actors incorporate "Europe" in their practices. However, simply looking for these usages of Europe that regional actors make in cross-border healthcare would be overestimating the EU's impact on healthcare systems: the empirical research carried out so far, shows a large variety of existing forms that regional cross-border cooperation in healthcare can take across Europe. These projects often face considerable national institutional challenges (Rosenmöller/McKee/Baeten 2006) and are thus not necessarily able to "use" Europe as they see fit. In order to take the national set-up into account when it comes to actors' usages of Europe, a combination of this approach with historical institutionalism and path dependence is suggested. The argument that is put forward here is that actors in a healthcare system such as healthcare providers will make use of Europe in order to pursue their own goals. However, nationally defined path-dependent logics of action will define this usage of Europe, thus resulting in a strategy whereby providers can make use of Europe to their benefit, but do not "escape" their national healthcare system and leave the national boundaries largely intact. Given the institutional differences between Member States' healthcare systems and the large variety of regional cross-border projects in healthcare, an in-depth case study of one country is suggested in order to scrutinize closely what exactly determines actors' usages of Europe and if this leads to a threat to national boundaries. The results of such a case-study approach only permit contingent generalizations

(George/Bennett 2005), i.e. the findings might not be easily applicable to all regional cross-border healthcare projects. Yet, it allows us to identify processes in a complex institutional environment that might define the forms and aims of actors' usages of Europe, thus enabling us to draw conclusions on the "usages of Europe" approach itself.

The main argument of this article is tested on Austria, which borders "old" and "new" Member States. The Austrian healthcare system is part of a "prototypical Bismarckian welfare state" organized in a federal state (Obinger/Tálos 2010, 101ff.). It has been argued from an institutionalist perspective that Bismarckian healthcare systems would be rather compatible with European rules on cross-border healthcare as they already allow a free choice of treatment on the national level and an individual insurance coverage of patients (Sindbjerg Martinsen 2005, 1033). The assertion that Bismarckian healthcare systems should be more easily adaptable to European rules is at least to a certain extent in contradiction with the common reputation that Bismarckian welfare states have, namely that they show an averseness to change in general (Palier 2010). A Bismarckian healthcare system should hence provide a fertile research ground to scrutinize what and how actors make use of Europe. The focus will be on two cross-border projects: the first one is situated between Upper Austria and Southern Bavaria and is hence a cooperation with an "old" Member State. The project operates between two countries with the same language and similar price levels in healthcare provision. The second project is set up between the region of Lower Austria and the Czech region of Southern Bohemia and is thus a cooperation with a "new" Member State. It operates between two countries with different languages and substantial differences in the cost of healthcare services. For the comparison, only Austrian actors' strategies and perceptions are considered, which allows comparing possible strategic varieties between projects, even though both of them operate in the same national institutional environment. Since such cooperation is the most pronounced form of cross-border cooperation of healthcare providers, possible effects on the national healthcare system should be visible.

This article is structured in six parts. After this introduction the following second part describes the relationship between national healthcare systems and the EU, and summarises the Court's rulings and the potential destructuring effects on national healthcare systems. The third part develops the analytical framework, while the fourth part provides the institutional setting of the Austrian healthcare system. The fifth part then applies the theoretical framework to the above-mentioned cases and discusses the empirical findings and possible implications for the conceptual development of the "usages of Europe" approach. The last part is formed by the conclusion. The empirical section of this article is based on secondary literature on the Austrian healthcare system, primary literature (such as reports on the analysed cross-border projects, newspaper articles etc.) and semi-structured interviews carried out with relevant actors.¹ The interviews were conducted and transcribed in German. The parts of interviews that are presented in the article have been translated by the author.

Cross-border access to healthcare in the EU

National healthcare systems do not only regulate the access to healthcare and its financing, but they also regulate the interests of major actors such as physicians, patients, providers and the pharmaceutical industry (Freeman 2000, 8). EU Member States therefore consider healthcare policies to be a genuine national competence and have had reservations about transferring any competencies to European level (Steffen et al. 2005, 3).

The European Court of Justice (ECJ) put “patient mobility law” on the EU agenda starting in 1998 (Greer/Rauscher 2011, 4), allowing patients to access medical treatment more easily in other Member States. These landmark rulings have the potential to challenge the boundaries of the national healthcare systems of Member States.

In the first two Kohll (C-158/96) and Decker (C-120/95) cases, the ECJ ruled that healthcare services are no exception to the Treaty regulations on services in general and that patients could get ambulatory care without prior authorisation in Member States other than their home Member State. In subsequent rulings, the ECJ “fine-tuned” its legal position (Obermaier 2009, 191), considering that a national procedure for prior authorisation would be necessary for hospital care (Harvey/McHale 2004, 132). In the last relevant ruling of 2006 on the Watts case (C-372/04), the ECJ decided that the prior rulings would apply to all Member States. This prevents Member States from obliging patients to use national healthcare providers, i.e. Member States cannot “discriminate” in favour of their own providers against providers in other countries” (Greer/Rauscher 2011, 4).

The rulings on patient mobility can thus be interpreted as a “dramatic case of neo-functionalist spillover dynamics” (Greer 2006, 142) of the EU’s internal market. The obligation of Member States to reimburse patients without prior authorisation for medical treatment by a physician in another Member State jeopardises, for example, a conception of healthcare services that is linked to national territory (Lamping 2005, 31). Member States had quite diverging views on the ECJ’s rulings, and several Member States found that the “case-law is formulated too much in favour of the internal market” (Sindbjerg Martinsen 2007, 38). This development has consequently triggered a process of political discussion and bargaining between Member States, the Commission and the European Parliament to codify the Court’s rulings in a directive. This process has lasted over ten years, and the issue of cross-border healthcare has been defined politically in terms of patients’ rights, even though the Court’s decisions are largely based on the principle of non-discrimination of national healthcare providers towards healthcare providers from other EU countries (Greer 2009, 42). An agreement was reached on Directive 2011/24 only in March 2011, “on the application of patients’ rights in cross-border healthcare”, and still has to be transposed into national law by Member States.

While some Member States had already transposed the rulings into national law, others wanted to wait for a directive. In Luxemburg, the rulings have even led to a confrontation between the national medical association and sickness funds regarding treatment rates (Baeten et. al. 2009, 6–8). The different views of Member States on implementation have further implications than just complying with European law. The long process of political bargaining points at the complex structures of national healthcare systems that are influenced by the “EU variable”, and national actors such as providers can now try to gain legitimacy for their demands from the new European patients’ rights (ibid.). According to Ferrera (2005, 219ff.), these new options for action can lead to a situation in which the national boundaries of welfare states are even further challenged:

a novel opportunity structure gradually emerges, prompting actors to reconsider their spatial positioning, their confrontational strategies, and their traditional loyalties [...and] the internal order of the pre-existing bounded space is subject to increasing challenges and is gradually destabilised.

These new spatial opportunities are especially important for regional authorities in Member States’ border regions, as the EU provides opportunities to engage in cross-border healthcare

projects with the support of its Regional Policy. During the last two decades a large variety of cross-border cooperation mainly in the field of hospital care has been developing across Europe reaching from projects between Finland and the Baltic States in the North to projects between Slovenia and Italy in the South (Rosenmöller et al. 2006). The projects often face national institutional barriers (Glinos 2011) and “can also entail *risks* for health care systems, especially if the process is not managed effectively and if authorities in both countries are insufficiently involved” (Rosenmöller et al. 2006, 185). It is therefore important to examine the kinds of “usages” actors will make of the European options for action in cross-border healthcare in order to analyse the EU's domestic impact in terms of Europeanisation.

Europeanisation and the “usages of Europe”

According to Radaelli (2000, 1)

Europeanisation refers to: processes of (a) construction (b) diffusion and (c) institutionalisation 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.

This definition takes the complex relationship between the EU and the Member States into account. Instead of having a unidirectional conception of the EU's impact on Member States (top-down perspective), it considers the reactions of Member States 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, as Europeanisation is not a simple linear process of adaptation, but rather a circular process in which Europeanised Member States upload their interests (Saurugger 2010, 259).

When it comes to the Europeanisation of national policies, the most prominent concept used to describe the mechanism that “triggers” domestic change is the “goodness of fit” concept. It assumes that the pressure exerted on the national level depends on the “fit” or “misfit” between domestic policies or institutions with EU requirements (Ladrech 2010, 32). However, with regard to the complexity of Europeanisation processes, there seems to be a “blind spot”, given that institutional factors are important and that national actors also play a crucial role. As Radaelli points out:

The idea of impact is somewhat static and mechanistic, whilst real-world processes of Europeanisation provide considerable opportunities for creative usages of Europe. Domestic actors can use Europe in many discretionary ways [...] They may draw on Europe as a resource without specific pressure from Brussels. (Radaelli 2004, 4)

Consequently, I would like to suggest an analytical framework that combines both a sociological approach focusing on actors with a historical institutionalist approach that respects the institutional legacy of healthcare systems in order to complement institutionalist accounts of Europeanisation. This is based on the assumption that “institutional approaches to the EU would greatly benefit from a dose of sociological thinking” (Jenson/Mérand 2010, 74). According to

Saurugger (2009, 936), sociological approaches stand out due to two factors: first, they focus on the interaction between individuals or smaller groups, concentrating on the dynamics of European integration, be they institutional, cognitive, political or sociohistoric. Secondly, when it comes to European integration, the focus of research is on “the complex processes which can be found in the heart of integration” (ibid., 937). This research agenda requires a bottom-up design which “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, 4).

One of these sociological bottom-up approaches concerns the “usages of Europe” developed by Jacquot and Woll (2003; 2004; 2008; 2010). Their approach tries to go beyond the “goodness of fit” assumption and the pure study of institutional constraints in Europeanisation research. They argue that policy change at national level can occur without any adaptive pressures from EU level since “the European Union can become a vector of change by providing new resources [...] which policy actors use strategically” (Woll/Jacquot 2010, 113). In this perspective, national actors are considered as the mediators of European requirements, since they have the capability to filter them and use them as a resource to follow their own agenda at domestic level (Jacquot 2008, 21). The focus is hence on the strategic interactions of individuals and on the resulting strategic dynamics of Europeanisation. Yet actors will not have an automatic response to a given EU input into the national system. They are able to use this learning process to their advantage. 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, be they institutional, ideological, political or organisational” (Woll/Jacquot 2010, 116). This definition implies that an actor will intentionally have to make use of these resources. Such voluntary action, however, might not lead automatically to the strategic goal set by the actor, since the effects of an individual action are difficult to predict. An actor will therefore have to adapt to his environment, which influences their behaviour in the long run (ibid.).

Jacquot and Woll distinguish three types of usage: a cognitive usage, which refers to the interpretation of a political topic and mechanisms of persuasion; the legitimating usage, which refers to the public justification of political decisions; a strategic usage, which refers to an actor’s strategy in pursuing defined goals in order to influence the political process, build coalitions with other actors or simply increase their own room for manoeuvre. The last type is the most common and occurs mostly when most of the actors’ stakes have become clear. Most of the time, bureaucratic actors and decision-makers will use institutions and legal, budgetary and political resources for a strategic usage of European integration (ibid., 117). As this contribution focuses on regional healthcare providers, we can expect a strategic usage of Europe.

Will healthcare providers in cross-border projects make use of Europe in such a way that national welfare boundaries can be further challenged? The focus on actors alone would underestimate the institutional framework which surrounds them. It would not do justice to national healthcare systems that are “built on strong historical and institutional legacies” (Sindbjerg Martinsen 2005, 1031). I therefore suggest combining the “usages of Europe” approach with a historical institutionalist approach: “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 organisational institutionalism” (Saurugger/Mérand 2010, 6). The historical legacy of a healthcare system will therefore also influence actors’ strategies: actors involved in the healthcare system invest in the existing structure of interest mediation of a welfare state. Because of these investments, the decisions of the past that have set up

these distinct welfare state structures are difficult to reverse and cause institutional inertia (Pierson 1993, 608f.), as a healthcare system also sets the rules of the game for actors and determines the costs of alternative strategies that they can pursue (ibid., 596).

While path dependence is a useful explanatory variable for inertia, it lacks analytical strength to explain why some change can occur nonetheless (Hassenteufel 2008, 244). This is where actors' usage of Europe comes in. Looking for usages of Europe as such would lead to an overestimation of the impact on national healthcare systems. Regional actors are most likely to show a usage of Europe in cross-border projects, but only a combination with a historical institutionalist approach can show if these usages are also influenced by national institutional structures. European requirements come from outside the national system but actors will have to weigh the strategic options provided by the EU against the position and resources that their national system has allocated, as well as against the interests of other stakeholders in the respective healthcare system. Thus, regional providers in a national healthcare system might want to use Europe to their own benefit, yet this usage will be determined by a path-dependent logic of action preventing an "escape" from the national healthcare system.

The Austrian Healthcare System

Austria's healthcare system is the second biggest branch of the welfare state, with around 30% of welfare expenditure being spent on the healthcare system. Sickness funds are funded by payroll contributions from employers and employees. A significant part of the healthcare expenditure is, however, also funded by the state's general tax income. This money is mostly used to finance the hospital infrastructure (Heitzmann/Österle 2008, 53ff.).

The structure of the healthcare system is quite complex due to the corporatist self-administration of the social insurance system and the federalist structure of the Austrian polity. The healthcare system is marked by an organisational separation between the outpatient sector and the inpatient sector (Theurl 1999, 334). While the federal government can only enact general or basic legislation regarding the hospital sector, Austria's nine states (*Länder*) regulate and own most hospitals. Most *Länder* have re-organised their hospital sector in recent years. Hospitals have been formally privatised: an operating company runs the hospitals while the *Länder* – as owners of these companies – act as guarantors through "health funds" (*Gesundheitsfonds*) (Hofmarcher/Rack 2006, 18).

The ageing Austrian society and technological advancement of treatment methods have led to a steady increase in healthcare expenditure since the 1970s. In order to limit healthcare expenditure, state control over the fragmented healthcare system was reinforced, and the latest healthcare reforms have been aimed at reorganising the organisation and financing of the hospital sector (Obinger/Tálos 2010, 111). This also gave rise to a discussion on the number of hospitals operated by the *Länder*. Recently, the Austrian Court of Auditors (*Rechnungshof*) published a report that illustrates the political debate: a study reveals 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. For acute treatment, the number of hospital beds per 1000 inhabitants is 70% higher than the EU-15 average (Rechnungshof 2010, 12).

Guarantees by *Länder* governments that local hospitals will not have to close are said to prevent saving effects, and the tabloid press used this allegation to call small and less efficient hospitals "political hospitals" (Kronenzeitung 08.06.2010). Besides these internal factors, Aus-

tria's geographical position plays a role in Austria's healthcare system. The last EU enlargement has increased opportunities for cross-border healthcare in Austrian border regions, especially given that treatments are available at lower costs in Austria's neighbouring Eastern countries. This creates opportunities for providers and subnational actors to initiate cross-border cooperation (Österle 2007, 113, 122).

Austria is furthermore in line with the EU rulings on patient mobility. The General Social Security Act states that a patient who receives ambulatory care or inpatient treatment with providers that are not affiliated to sickness funds will receive reimbursement for the medical treatment even outside Austria for 80 percent of the amount the sickness fund would have paid for the treatment to a contracted provider. The Austrian healthcare system therefore already offers the possibilities granted by the ECJ (Obermaier 2009, 79f.). Given these circumstances, what use do regional actors make of Europe?

Cross-border Healthcare Projects in Border Regions

Austrian-German cooperation

The Austrian *Land* of Upper Austria borders on the German *Land* of Bavaria. The two regions are separated by the river Inn. The town of Braunau is located on the Austrian side of the river, facing its "counterpart" – the German town of Simbach – on the other side of the river. Both towns operate hospitals. The Austrian hospital is co-financed through taxes by the Upper Austrian Health Fund. A cross-border project was begun in 1994 when the surgical department of the German hospital had to be closed, and a treaty was negotiated between German sickness funds and both hospitals. It was agreed that German patients could undergo surgical treatment in the Austrian hospital of Braunau. This agreement was later extended to other treatments. In 2004, a general renovation of the Austrian hospital was decided. In order to stay operational, two departments were transferred to the German hospital by a rental agreement. Meanwhile, around 2000 Austrian patients are being treated each year in the "Austrian" departments that are rented out by the German hospital (Krankenhaus St. Josef Braunau, 2011). As a result, it was the first EU project to treat two different "patient nationalities" in a common structure. In 2004, the EU could be used strategically as a financial resource: around 200.000 euros have been paid by the European Structural Fund for implementing barrier-free access to cross-border healthcare in both hospitals. While this money was used to implement the setting-up of treatment structures connecting both hospitals as well as for coordination, obstacles related to cross-border care soon appeared. They revealed that the territoriality principle goes far beyond patients' access to cross-border healthcare.

The first obstacle that appeared was that 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 Austrian hospital tried to transfer their physicians permanently to Germany under European regulations analogous to those regarding workers who are seconded to other EU countries for construction works. 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 authorisation was, however, refused by Upper Austrian authorities and obliged 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. When this attempt at the strategic use of European regulations had failed, the project partners

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 Kuranstalten, KaKuG*).² The federal minister at the time supported the bill,³ but during the parliamentary process and in informal talks with the minister, the Medical Association and the Association of Private Hospitals lobbied against the law. The Medical Association pointed out that if the law envisaged general solutions for 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, 2006). 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 are treated in the “Austrian” departments 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:

And this is when we had to recognise that it would have been better not to have this law, before we had the authorisation by Upper Austrian authorities. [...] But now there is this law that binds the state officials. [...] And then you notice how small you really are, when these big organisations start lobbying and tear the bill to shreds, and nothing comes out of it in the end for us to use.⁴

Other obstacles occurred, showing 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 percent of the treatment costs. When the rulings of the European Court of Justice 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 authorisation for hospital treatment continues to exist. The German sickness funds therefore have to continue to authorise treatment for German patients in the “Austrian” departments or in the Austrian hospital. The Austrian hospital then bills 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 is hence nearly twice as high as the bill for Austrian sickness funds. The German sickness funds reacted by granting authorisation with the remark that the bill must not exceed the price an Austrian sickness fund would have paid. Until now, however, the payments have not been cut without any explanation. Further problems also exist with 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 German and Austrian legal requirements had to be set up.⁵

Given these obstacles, the Austrian hospital operators tried to obtain the support of a Member of the European Parliament in order to present their concerns regarding the territorial conceptions of labour and medical law. This strategic usage of Europe also proved to be fruitless:

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.⁶

In order to solve the payment problem for German patients who require prior authorisation for medical treatment, informal agreements are applied on a case-by-case basis:

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.⁷

Out of 26,000 treatments each year, these cases amount to a maximum of approximately 500 patients, and this “informal” procedure cannot be used on a regular basis. The partners of the hospital project have thus thought about taking legal action and trying to get a clarification from the European Court of Justice. Using Europe the legal way has, however, not been integrated in their strategic actions, as a lawsuit would have to be set up against the German sickness funds, and this “would not be especially beneficial for the existing cooperation”.⁸

The officials of the Upper Austrian health fund responsible for financing the *Land* hospitals do not see a reason not to support the project, but do not have a solution to the general “clash” of Austrian and German legal requirements. However, if the number of German patients were to increase, they would see even more obstacles concerning the planning of hospital infrastructure.⁹

According to the Austrian healthcare provider, only a treaty between Upper Austria and Bavaria would provide legal clarity in the grey areas in the daily routines of this cross-border project. Yet the impression they get is that regional politicians do not see any possibility to obtain votes by supporting such a project and that structural reforms of the national hospital sector have a higher priority than a single cross-border project.¹⁰ Given the fruitlessness of national and European strategies, the project continues to arrange informal agreements according to each “everyday” problem. This example shows that the interests of the local providers have clearly been Europeanised, and that trying to use Europe strategically for cross-border healthcare is defined by the healthcare provider’s position in the national system; success is not guaranteed since other stakeholders inside and outside the national healthcare system do not necessarily share the same interests.

Austrian-Czech cooperation

One of Austria’s largest *Länder* is Lower Austria, which borders on the Czech Republic. Hospitals are operated through a “hospital holding” which is a merger with the Lower Austrian health fund. In Gmünd, some kilometres away from the Czech border, the holding operates one hospital of 180 beds, i.e. one of the rather small hospitals. The hospital is part of a cross-border healthcare project named “Healthacross”. The project is aimed at developing cross-border cooperation 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, and was begun in 2008. The Czech Republic’s adhesion to the EU in 2004 has been used as an incentive to cooperate more intensely. At the beginning of the project, stakeholders learned about the difficulties of the project between Austria and Germany. Nonetheless, the main goal of the project was to build a new hospital that caters for the medical needs of the Austrian as well as the Czech side of the border where a “twin” city to Gmünd is located. The project is supported

and partly financed by the European Regional Development Fund (Healthacross Report I 2010, 10–13), and initially, the project is not necessarily distinguishable from other infrastructural cross-border projects. Developments on cross-border healthcare have, however, played a role from the outset of the project, as one of the managers dealing with the implementation says:

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.¹¹

Such a strategic usage of Europe is necessary especially in the beginning in order to convince administrative employees and to get the necessary political support for starting a cross-border project: according to another manager, getting the initial support and raising awareness about the possible economic benefits of cross-border cooperation can be difficult since there is already quite some competition regarding the best medical care among the *Länder* within Austria.¹² While the European dimension is used to raise political awareness, a strong regional identity is put forward when the question of a possible coordination with the federal level arises: it is seen as a Lower Austrian lead project in regional 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. The ECJ's rulings nonetheless 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.¹³

The EU is also seen as a means to revive an economically detached region, starting with cross-border healthcare: "It's not about a single project that we create, it's about saying that we are a common region, and this is how we make it better and become more competitive."¹⁴

While stakeholders make strategic use of the EU to get the necessary political support and to define the overarching goals of the project, this usage stops once some more concrete aspects of cross-border cooperation are considered. The project is aimed at saving the small border hospital from closure, as it offers 300 to 400 jobs in the city on the Austrian side. It also provides quick medical access for Czech citizens who have to travel around 60km to the nearest hospital on the other side of the border. Since the renovation of the old hospital would be too expensive, a new building could be used to treat Austrian and Czech patients.¹⁵

In order to put effective cross-border healthcare into practice, financing has to be assured: "And, of course, there is always the question as to who will finance this."¹⁶

The building costs and the coverage of the treatment costs for Czech patients are the most obvious factors when Europe is not used, and when the country's own healthcare system plays the leading role in cross-border healthcare. Europe might even become something to worry about, as expressed by a Medical Director:

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.¹⁷

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” (Healthacross Report I 2010, 25) with them. Negotiations on bilateral agreements with all stakeholders are therefore necessary (ibid.) so 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. This means, however, that cross-border healthcare between the Czech Republic and Austria faces different 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, 119). Having learned from the difficulties of the Austrian-German project, a feasibility study was commissioned to address the legal and economic issues. 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 with an Austrian-Czech hospital (Healthacross Report II, 2011, 73). Given these results, the project partners would like to continue their cooperation but have not yet planned a follow-up project. The future of the project therefore seems uncertain.

Discussion

Both projects are at different stages in their implementation and concern different countries, thus facing different challenges from the outset: the financing is the most acute problem for the second project, given the large differences between Czech and Austrian tariffs for treatment. The Austrian-German project does not have a problem with price differences, yet it is the financing structure – mixed financing by sickness funds and taxes in Austria and a sole financing by sickness funds in Germany – that puts constraints on the project. To overcome these obstacles, healthcare providers use different strategies: the first project tried to use national strategies and European strategies alike for its cross-border cooperation. The second project has had a more European strategy from the outset, and is also supported more actively at regional level.

Despite the differences regarding the challenges and forms of strategies that both projects face, strong commonalities can be observed from an empirical perspective with regard to their usages of Europe. In both cases, the interests of healthcare providers have clearly been Europeanised. The first common point refers to the *aim* of the usage that is 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. They do so by using Europe strategically, be it to generate political support or to receive funds for cross-

border cooperation. The limits of these strategic usages are to be found in the interests of other national actors. And these interests can contradict with cross-border cooperation, as is the case with the national bill on cross-border cooperation in the first project. The projects also prove that the new Directive and the rulings of the European Court of Justice on cross-border healthcare are not sufficient to overcome other 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.

Informal agreements and the bypassing of national law on a case-by-case basis are used, which would nonetheless not be possible on a larger scale and which are also not covered by European regulations. One may therefore say that actors try to make a strategic use of Europe and that there is a potential for destructuring effects, but that actors cannot “escape” their system – at least not in the short term. This reasoning refers to a complexity that is a barrier to negative European integration according to the rules of the EU’s internal market. Complex healthcare services can impede “attractive market opportunities” (Greer/Rauscher, 2011, 21). Similar experiences of national institutional obstacles to cross-border hospital cooperation can be found in other projects across Europe, too (Rosenmöller et al. 2006, 180–187).

The dominance of strategic usages of Europe in these projects and the mere absence of cognitive or legitimating usages of Europe are interesting from a theoretical perspective. The lack of other than strategic usages of Europe in the analysed projects underlines the necessity of not only looking at which resources the EU provides for potential usages, but of also taking into account which national institutional roles enable actors to access European resources. The absence of legitimating and cognitive 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. This empirical picture could change considerably if elected politicians such as governors or parliamentarians were to be included in an empirical study.

Several conclusions can be drawn from this reasoning: firstly, future research must carefully select which actors are to be analysed in order to cover a possibly wide range of usages of Europe. Secondly, the existing categories of the “usages of Europe” approach might need to be qualified according to the resources that actors use. The term “strategic usage” covers an impressive variety of actions (based on financial, political and legal resources) whereas the categories “cognitive usage” and “legitimating usage” seem to be more narrowly defined. Furthermore, it can be argued that also cognitive and legitimating usages are “strategic” in their character. Thirdly, a narrower qualification of categories of usages of Europe should also take national institutional resources into account that might influence an actor’s usage of Europe. An example from 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 administrative and financial capacities of an actor, not to mention the detrimental effect a lawsuit could have on the already existing cross-border cooperation. In comparison to such a strategic usage other forms of usages such as a cognitive usage are less costly, but as already mentioned, even the latter one is not necessarily a viable option for every type of actor. The combination of the usages of Europe approach with historical institutionalism provides hence a possibility to take into account national institutions, resources and paths that bind actors when they decide on making use of Europe. It also calls for in-depth case-studies as the strategies that are available for actors will differ considerably from one healthcare system to another.

Conclusion

The empirical results of this study show that actors' strategies and interests have been Europeanised even at the lowest governance level of the healthcare system. In the presented cross-border projects, the effects of a usage of Europe should have been the most pronounced. Actors indeed use Europe strategically to set up their projects, to raise political awareness and to get European financial support. But once actors face the hard facts of financing healthcare, they follow the "rules of the game" of their own healthcare system. More importantly, Europe even "saves" a classical feature of the Austrian healthcare system, i.e. the existence of small regional hospitals. Nonetheless, European rules on access to healthcare prove to be too tight for actors to be able to circumvent the necessary financing mechanisms of the national healthcare system. A loss of national boundaries seems at least in the present case to be quite unlikely.

Due to the research design of this study a generalization of this result across all European cross-border healthcare projects is not possible, but national institutional limitations found in other European cross-border projects suggest that similar experiences are not unlikely. The results do not contradict Ferrera's (2005) assertion that European Integration has a detrimental effect on national welfare state boundaries in the long run, but they show that national institutional set-ups retain for the time being significant power to channel actors' interests and strategies. This applies also to a Bismarckian type of healthcare systems that shows a significant compatibility with European rules on cross-border healthcare, thus confirming the inherent adverseness to change of such a system.

The results highlight furthermore the importance of complementing the "usages of Europe" approach with historical institutionalism in order to explain why actors abstain from certain usages and prefer others. Not all categories of usages of Europe are a viable option for every type of actor. The choice of analysed actors will thus largely determine the usages of Europe that actors might show in a study. Looking at politicians will bias analytical results rather towards legitimating usages or cognitive usages if a certain politician plays the role of a political entrepreneur. If bureaucratic actors are considered for analysis, the result might lead to an over-representation of strategic usages. Even the category of strategic usages of Europe needs a qualification according to which European and national resources are used. This argument points at the effort a national actor might have to make to transform European resources into a strategy: using legal resources such as court proceedings needs expertise and funding. Not every actor might have the national resources to use Europe this way. Therefore, the category of strategic usages should be scrutinized in a more subtle way according to the resources that actors will use.

While using a bottom-up perspective to determine European integration's impact on national healthcare systems limits somewhat the possibility for generalization, it helps however to uncover processes that determine how actors adapt to the opportunities and tensions that exist between nationally defined healthcare systems and European perspectives.

NOTES

- 1 In the framework of my doctoral research, I carried out 48 semi-structured interviews with relevant actors of the Austrian healthcare system (federal, regional and local level) from August 2009 until July 2012. Interviews concerning the analysed cross-border projects are mainly used here.
- 2 Interview Financial and Administrative Director, Hospital St. Josef Braunau, 12 January 2011, Braunau.

- 3 Interview Maria Rauch-Kallat, former Federal Minister of Health, 08 July 2010, Vienna.
- 4 Interview Financial and Administrative Director, Hospital St. Josef Braunau, *ibid.*
- 5 *Ibid.*
- 6 *Ibid.*
- 7 *Ibid.*
- 8 *Ibid.*
- 9 Interview Head of Unit, Unit for inpatient care, Upper Austrian Health Fund, 29 October 2010, Linz.
- 10 Interview Financial and Administrative Director, Hospital St. Josef Braunau, *ibid.*
- 11 Interview Project Manager, Healthacross Project, 05 August 2009, Vienna.
- 12 Interview Project Manager, Healthacross Project, 10 August 2009, Vienna.
- 13 Interview Head of Unit, EU Affairs, Lower Austrian Health Fund, 13 January 2010, St. Pölten.
- 14 *Ibid.*
- 15 Interview Project Manager, Healthacross Project, 10 August 2009, *ibid.*
- 16 Interview Head of Unit, EU Affairs, Lower Austrian Health Fund, *ibid.*
- 17 Interview Medical Director, Lower Austrian Hospital Holding, 13 January 2010, St. Pölten.

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