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Subnational responsibilities for healthcare and Austria's rejection of the EU's patients' rights Directive

Thomas Kostera*

Centre d'Etude de la Vie Politique (CEVIPOL), Institut d'Etudes Européennes, Université libre de Bruxelles, Avenue Roosevelt 39, 1050 Bruxelles, Belgium

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ABSTRACT

In 2011, Member States and the European Parliament brought into force a Directive on the application of patients' rights in cross-border healthcare within the EU. Austria voted against this Directive even though its national legislation was already in line with the rulings of the European Court of Justice which had triggered the negotiations on the Directive. Why then, in the absence of any legal constraints on adapting to it, did Austria vote against the Directive? The article argues that it was the federal structure of financing hospital infrastructure and the subnational level's influence on national position building which led to the rejection of the Directive. The article retraces the process of position building by analyzing the interaction between the national and the subnational levels and concludes that Austria's position mirrors the national struggle between both levels of government over control of the hospital sector.

1. Introduction

A policy field of European Welfare States that has long been considered a predominantly national competence has recently been put on the European Union's (EU) agenda by the European Court of Justice (ECJ). In a series of landmark rulings on patient mobility and cross-border healthcare, the Court has made it clear that Member States' healthcare systems have to comply with the rules of the EU's Internal Market in matters of individual patient rights. In 2011, following more than ten years of political debate, a Directive was passed on this issue. The Court's rulings have allowed individual patients to carry their national rights to medical treatment to other Member States more easily. These rulings not only have political implications for government at national level, but also for the subnational level.

In most Member States the subnational level is responsible for certain Welfare policies such as the provision of healthcare, and the process of decentralizing competencies which took place in Europe after the economic crisis of the 1970s and 1980s has made the subnational level "much more sensitive and alert to their net financial balances vis-à-vis central governments, punctiliously comparing the revenues ... appropriated by the central state with the transfers received from the central state" [1]. The subnational level has furthermore gained institutional and financial rights that allow it to engage directly with the EU level. Institutionally the subnational level is not only represented through the Committee of the Regions but may also participate directly in the Council of Ministers through membership of the national delegations of some Member States.

Austria, together with Poland, Romania and Portugal, voted against the final draft of the Directive. This is rather surprising given that Austria's legislation was already in line with the rules laid down by the ECJ, and that Austria was in fact the only country in the EU that did not need to adapt its national legislation in order to comply with these

* Tel.: +32 02 650 45 48; fax: +32 02 650 30 68.
E-mail address: Thomas.Kostera@ulb.ac.be

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rules. Theoretically one would therefore have expected that in the absence of any lack of congruence between national and European legislation and of pressures to adapt [2], Austria would vote in favour of the Directive. The question that will guide this article is therefore why Austria voted against the Directive. The main argument put forward here is that it was not any legal fit or misfit that determined Austria's decision to reject the Directive, as Austria would initially have been in favour of codifying rules on EU cross-border healthcare. Instead, the federal funding structure and the influence of the Austrian regions (*Bundesländer*) at subnational level were the crucial factors in this decision. The process which led to the rejection of the Directive actually mirrors the struggle between the federal and the subnational level to decide who should have control over the provision of inpatient care.

1.1. Method and structure

In order to answer this article's research question, a qualitative case study approach was chosen. The Austrian position-building process on the Directive is retraced by this means. The advantage of this kind of case study is that it enables the researcher "to delve into the details and causal factors of a single unit" [3]. The disadvantage is that a case study only permits contingent generalizations [4], i.e. the findings are not easily applicable to the position-building processes of other Member States. The case study does however allow us to identify processes whereby subnational influence is brought to bear on national positions in the making of European healthcare policy. It also invites us to pay close attention to the tensions that can arise between subnational responsibilities for healthcare across the EU and the exclusion of subnational authorities from EU decision-making bodies. The method applied here in order to retrace these processes is mainly based on qualitative interviews. In total, 48 semi-structured interviews with relevant actors within the Austrian healthcare system (at federal, regional and local level) were carried out between August 2009 and July 2012 in the framework of research for a doctorate. For this article, the main source of data consisted of seven interviews with actors involved in the Austrian position-building process. These interviews were conducted and transcribed in German. The interview extracts presented in the paper were translated into English by the author.

This contribution is structured in five parts. The first section describes the most salient political issues at stake during negotiations over the Directive. The second section defines the federal imprint of Austrian policy-making in healthcare. The third section describes subnational influence on the formulation of EU policies in the Austrian context. The empirical section which follows, mainly based on semi-structured interviews with relevant national and regional bureaucratic actors, outlines the position-building process leading to the Austrian decision, including the development of the position at both levels of government. The final section of this contribution sets out our conclusions and answers the research question.

2. Cross-border healthcare and patient mobility on the European agenda

Before cross-border healthcare and patient mobility became politically salient at European level, access to medical treatment for European citizens in other Member States had been solely regulated by Regulation 1408/71, now amended by Regulation 883/2004. This legislation provides for the possibility of urgent medical treatment in another EU Member State. The Regulation also allows a second possibility: patients may receive medical treatment in a Member State other than the home country if a certain type of medical treatment is not available at home. In these cases prior authorization from the sickness funds in the home country would be needed before treatment in another Member State [5].

In a series of landmark rulings the ECJ has extended the rights of patients to receive medical treatment in other Member States beyond the provisions of Regulation 883/2004. Starting with the Kohll-Decker ruling in 1998 (cases C-158/96 and C-120/95) the Court ruled that if a national healthcare system allows patients to freely choose a physician for extramural care, this permission must be extended to any physician in the EU. Adjusting its position, the ECJ held in subsequent rulings that a procedure for prior authorization would still be necessary for hospital or intramural care, but that patients should be granted permission to leave for another country if an 'undue delay' occurred during waiting times for a necessary surgery [5,6]. In the final 2006 case concerning Yvonne Watts (case C-372/04) the ECJ ruled that the previous rulings were to be applied in all Member States. In other words, Member States would not be able to discriminate against foreign healthcare providers in favour of providers in their home countries [7]. Given the alleged potential of the rulings to jeopardize the conception of healthcare services that are essentially linked to national territory, a political discussion began between the Council, the Commission and the Parliament over the definition of clear rules on patients receiving elective medical treatment in other EU countries. Due to the conflicting views of Member States on the issue, it was only in 2011 that a Directive (2011/24) clarifying the rulings could be issued.

Two of the main issues that arose in the negotiation of Directive 2011/24 concerned control of patient migration and financial arrangements. The first issue concerns the residual national control of patient influxes from other Member States and outflows of national patients to other countries. The second issue relates to the financing of medical treatment. The Directive addresses these issues in various articles. Article 4 (3) allows a Member State to control access to its national healthcare facilities in order to ensure the system's financial stability and planning capacities. According to Article 7 (1) a patient must be reimbursed for costs incurred in another Member State at the level of the prices that would have been paid in the home country, though without exceeding the actual costs of medical treatment. This Article clearly aims at inhibiting any possible financial gains for an individual patient who obtains less expensive treatment in another Member State. These provisions therefore codify what the ECJ had already stipulated