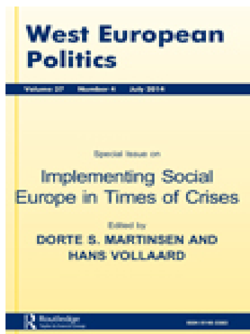

West European Politics

ISSN: 0140-2382 (Print) 1743-9655 (Online) Journal homepage: https://www.tandfonline.com/loi/fwep20

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To cite this article: Nikolay Vasev & Karsten Vrangbæk (2014) Transposition and National-Level Resources: Introducing the Cross-Border Healthcare Directive in Eastern Europe, West European Politics, 37:4, 693-710, DOI: 10.1080/01402382.2014.919776

To link to this article: https://doi.org/10.1080/01402382.2014.919776

Published online: 08 Jul 2014.

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West European Politics, 2014
Vol. 37, No. 4, 693–710, http://dx.doi.org/10.1080/01402382.2014.919776

Routledge
Taylor & Francis Group

Transposition and National-Level Resources: Introducing the Cross-Border Healthcare Directive in Eastern Europe

NIKOLAY VASEV and KARSTEN VRANGBÆK

The Cross-Border Patients' Rights Directive represents an attempt to resolve the unclear situation that had developed due to 'negative integration' within the field of healthcare. While the adoption of the directive ends the EU-level decision process, it represents the start of the implementation process, where national institutional structures and interests play a key role. This article investigates the role of resources as a key factor shaping transposition within the member states, with a focus on Poland and Bulgaria. The article shows that a multidimensional perspective of resources is important for understanding transposition of EU directives in member states. While previous research has tended to consider resources at the aggregate, national level, the present study shows that specific concerns about the 'adjustment costs' at the sector system level are of key importance.

The creation of 'social Europe', defined broadly as EU law that establishes supranational social policies as well as EU law affecting social rights and policies in the member states, has met considerable resistance in member states. Welfare policies have remained one of the policy areas where national governments have usually resisted integration, not least because of the electoral importance of most social programmes (Leibfried 2010). 'Positive integration' has thus encountered many obstacles (Martinsen and Falkner 2011), while the gradual evolvement of 'negative integration' has been more successful through combined pressure by individual member states, the European Commission and the Court of Justice of the European Union (CJEU). Within healthcare the process of negative integration led to a rather unclear situation where legal activism pushed the agenda of cross-border mobility, while member states were dragging their feet (Martinsen and Vrangbaek 2008). To resolve this situation, and to push the agenda further, the Commission took the initiative to formalise

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TABLE 1
STATE ADMINISTRATIVE AND HEALTH SECTOR RESOURCES

		Poland	**Bulgaria**	**Source**
State administrative resources	GDP per capita	$20,600 (2012 est.)	$14,100 (2012 est.)	CIA World fact book
	Government debt	48.3% of GDP (2012 est.)	16.3% of GDP (2012 est.)	
	Total general government expenditure	42.2% of GDP (2012 est.)	35.9% of GDP (2012 est.)	Eurostat
Health sector resources	Health expenditure per capita (current US$)	615 (2011 est.)	306.97 (2008 est.)	
	Health expenditure by hospitals (euro per inhabitant)	211.54 (2011 est.)	125.79 (2008 est.)	
	health expenditure by general hospitals (euro per inhabitant)	189.92 (2011 est.)	92.54 (2008 est.)	
	Current healthcare expenditure (millions of euro)	23,703.65 (2011 est.)	2,340.14 (2008 est.)	
	In-patient curative care (millions of euro)	7,317.42 (2011 est.)	931.80 (2008 est.)	
	Out-patient curative care (millions of euro)	4,939.84 (2011 est.)	287.75 (2008 est.)	
	Clinical laboratory (millions of euro)	66.11 (2011 est.)	22.80 (2008 est.)	
	Practising physicians per 100,000 inhabitants	217.9 (2010 est.)	371.1 (2010 est.)	
	Hospital beds per 100,000 inhabitants	658.5 (2010 est.)	661.6 (2009 est.)	

EU legislation about patient mobility. After a failed attempt within the 'Service Directive' in 2006, a new attempt was made in 2008, and finally adopted in 2011 as the 'Cross-Border Healthcare Directive' following a protracted negotiation process and several important modifications (Hatzopoulos and Hervey 2012).

While the adoption of the directive ends the EU-level decision process, it represents the start of the implementation process, where regulation meets the (national) boundaries of welfare and social Europe and stands as its ultimate test. The overall perspective of this special issue is that implementation of social Europe is likely to be hampered in the context of economic and legitimacy crises (Martinsen and Vollaard 2014). At the same time, these crises test the durability of cross-border social sharing in the EU. This paper aims to investigate the role of resources as a key factor for shaping transposition within the member states. We will investigate this by looking at healthcare, a core welfare sector, and two Eastern European countries, where resources are likely to be particularly important, and we will develop a theoretical framework for the study which builds on previous considerations of state administrative

capacity and sector organisation. The specific question to be addressed is: how have state administrative and health sector resources influenced transposition in Poland and Bulgaria?

Transposition and Resources

Several recent review articles have summarised the current status within EU implementation research (e.g. Toshkov 2008; Treib 2008). Early studies emphasised administrative and procedural capacity within national political/administrative systems. Then followed a series of studies using institutional or legal 'misfit', 'veto players' or domestic policy preferences as the primary explanatory variables. More recent studies have aimed to broaden the scope of theoretical contributions and develop more nuanced models encompassing multiple explanatory variables while taking national or content-related factors into account (Steunenberg 2006).

One of the most important insights from recent transposition studies is that no single factor seems able to explain all cases. Both structural and agency-related dimensions must be taken into account (Treib 2008: 17) and there appears to be a need for more detailed studies that can account for different types of directives, different sectors and different regions within the EU. We agree that there is a need to develop multidimensional models, and suggest that the issue of resources should have a prominent role as an explanatory factor in such models. We will explain why in the following.

Based on Steunenberg (2006), it is likely that actors' interests in the domestic policy world are important in the transposition process, particularly in accession countries that are typically not characterised by a 'culture of compliance' (Falkner *et al*. 2005: 319). Taking the lead of Dimitrova (2010) and Steunenberg (2006), we suggest that sector-specific configurations are very important for the political implementation game of 'bargaining, persuasion and manoeuvring under conditions of uncertainty' (Bardach 1977: 56). The importance of sector configuration is further underpinned by the observation that the Commission's scoreboards show considerable variation across sectors in the transposition records of Central and Eastern European countries (CEEs) (see also Toshkov 2009). Both Dimitrova and Steunenberg emphasise the role of veto players within the sectoral configuration. These veto players 'are politicians and members of the administration. In the weak state environment, another group, namely non-state actors, linked to government through informal networks, may also be expected to play an important role' (Dimitrova 2010: 145). We agree that politicians and administrators are important, but found no empirical evidence of strong veto-players outside these groups when considering the transposition of the Cross-Border Healthcare Directive in Poland and Bulgaria. The interest and knowledge level among civil society actors was limited, decentralised authorities were weak, and even within parliaments there was limited activity related to the directive. This means that government administrations are key actors, and that their rationality, focus and capacity are

key issues for transposition. Based on a review of literature, we found that government actors are likely to consider the 'adjustment costs' that international rules impose on national governments, either directly or indirectly (Sedelmeier 2009: 6). This perspective is rooted in the 'management' approach to compliance studies (Börzel, Hofmann *et al*. 2010; Fearon 1998; Tallberg 2002).

While these and several other studies emphasise the role of resources at the national level (Börzel, Fernandez *et al*. 2010; Falkner *et al*. 2004, 2008; Zubek and Staronova 2010), they fail to identify sector-specific resources as critical to understanding transposition in specific cases. Sector-specific financial and operational resources, infrastructure, personnel and skills are important for setting the economic and policy framework within which health policy actors must operate (Tallberg 2002: 613), and they are important because they determine the ability to deliver services at the level expected by the voting population.

In contrast to the lack of emphasis on sector-level resources, there have been a number of studies looking at state *administrative capacity* as an explanatory variable in EU implementation (Hille and Knill 2006; Krizsan 2009; Steunenberg and Toshkov 2009). Following Hille and Knill (2006), we argue that resources are an important determinant of administrative capacity. The underlying causal mechanism is relatively straightforward: 'resources allow for a more prompt, comprehensive and sophisticated implementation of policies because civil servants, their training, their computers, their offices and their cars cost money' (Hille and Knill 2006: 539). Moreover, resources can buy the infrastructure that enables the flow of information that is essential for in-depth analysis of options and consequences of transposition choices. State-level administrative resources may thus facilitate the analysis of transposition options and consequences for sector-specific resources, which we expect to be the dominant factor in determining transposition outcomes.

In the edited volume by Tanja Börzel, *Coping with Accession to the European Union*, researchers emphasise the linkage between state administrative resources and private actors' participation as both a proxy for the lack of the former and a utilisation of the latter for the amelioration of the situation (Börzel 2009). This indicates another link to sector resources since the institutional structure of the health sector and the level of financial and other resources within this sector is likely to influence the strength of non-state actors, and thus their ability to participate in policy networks, which in turn may support state administrative capacity in the analysis of transposition options and consequences. Traditional measures of state administrative capacity such as the World Bank's index of Governance Indicators (Kaufmann *et al*. 2005) fail to capture such qualitative dimensions related to the character (supportive or conflicting) and strength (professionalisation and knowledge) of the policy networks that may strengthen public sector capacity (Börzel and Heard-Lauréote 2009) particularly in countries characterised by a 'culture of compliance' as typically found in Northern Europe (Falkner and Treib 2008).

In terms of the dependent variable, we suggest that it is important to move beyond simple measures of timeliness and formal compliance. Such measures are important, but they do not capture more qualitative dimensions of transposition, such as the level of detail in specifying administrative procedures, the degree to which consequences have been assessed and documented, and the plans for dealing with substantial, process and practical issues as highlighted in the implementation literature (Pressman and Wildavsky 1984; Winter 2003).

Summing up, our theoretical understanding consists of the directive as the impulse, health sector and state administrative resources as independent variables influencing key actors and ultimately the transposition, our dependent variable, which should be considered in terms of substance as well as timeliness. Our interpretation of resources is a dichotomous one. We take into consideration not only the general macro-level factors, which we frame as state administrative-level resources, but also specific health sector resources. This leads to the following expectations.

First, that policy-makers are likely to be concerned with the direct or indirect 'adjustment costs' that international rules impose on national governments in the healthcare sector (Sedelmeier 2009; Tallberg 2002). More specifically, they are prone to be concerned with the issue of whether particular transposition choices are likely to strengthen or weaken the ability to deliver services at a desired level, and whether the transposition endangers the control of resource allocation and planning in the health sector. Second, we expect that if policy-makers have strong concerns about the impact of a directive, they are likely to choose minimalistic or protectionist transposition outcomes with as many safeguards and barriers as possible. Third, we expect state administrative resources to matter, but to be an insufficient explanatory factor in themselves. It is the interrelationship between sector resources and state administrative resources that determine the substance, timeliness and quality of transposition.

Design, Operationalisation and Methodology

To investigate our propositions, we have chosen an empirical design focusing on a directive with a potentially high impact on system resources and several ambiguous components, the Cross-Border Healthcare Directive. Healthcare expenditure accounts for more than 7 per cent of GDP in the EU countries, and is the second largest expenditure type after social care (Freysson and Wahrig 2013: 1). We have further chosen to focus on two Eastern European countries, Bulgaria and Poland, where limited resources within their public healthcare systems are an important concern. The empirical contribution of the paper is thus to add to the accumulation of case-based analyses of transposition practices by investigating a new policy field, healthcare, and two Eastern European countries that have received limited attention in previous studies. The overall approach is a comparative qualitative case study of transposition. Focusing on just two cases means that we are unable to verify our claims in statistical terms. Instead, we provide detailed qualitative information that can

illustrate the feasibility of our proposition and serve as a platform for generating further hypotheses. Qualitative case studies are well suited for this purpose (Baxter and Jack 2008: 544).

Both Poland and Bulgaria operate social health insurance systems with mandatory enrolment in national public insurance institutions. They also both rely mostly on public delivery organisations for contracting health services. Both countries have a regionalised structure for ownership and management of the delivery organisations. In addition, as both systems are in Eastern Europe, they are characterised by comparatively lower resource availability than their Western European counterparts, increasing the likelihood that resource constraints play a role in the transposition of the directive. There are thus a number of similarities, but also important differences in terms of resource availability, as we will illustrate below.

We cannot fully investigate the issue of compliance in implementation, since the Cross-Border Healthcare Directive is only in the transposition phase and data collection ended in November 2013, before a final transposition proposal had been presented in the Polish and Bulgarian parliaments.

Our analysis is based on scrutiny of written materials, including official transposition documents and public communications by the relevant ministries in Poland and Bulgaria, expert/consultancy reports related to the directive and summaries of stakeholder responses to official hearings. In addition we have conducted interviews with government officials and independent experts. We also conducted interviews with stakeholders outside government in Bulgaria, while we chose to rely on responses to official hearings and analysis of media coverage to obtain a similar picture of voices outside of government in Poland. We further investigated the parliamentary activity by collecting the (very few) formal questions asked about the directive and its transposition.

Operationalisation of Resources as a Key Variable for Transposition

Our operationalisation of state administrative resources is comprised of the financial, human and process-related resources within the government/administrative system in charge of transposing a given directive. It is a question of both manpower and expertise, and of the ability to hire external consultancies to aid in the analyses for the transposition. This is where we draw the division between health sector and state administrative resources. Whilst the latter are solely dedicated to the transposition of the directive, we consider the former to pertain to the functioning of the health system, at both the private and public levels. We look for available hard data on state administrative capacity and supplement this with impressions and statements from our interviews. An indication of the state administrative capacity can be found in international indicators for ‘Good Governance’. We follow the practice of Steunenberg and Toshkov (2009) in relying on the World Bank indicators to supplement our assessment of administrative capacity. The OECD ‘Governance at a Glance’ (2011) and the Bertelsmann Foundation’s ‘Sustainable Governance Indicators’

would have provided more in-depth data for our purpose, but unfortunately neither includes Bulgaria.

Health sector resources, on the other hand, include financial and operational resources, infrastructure, personnel and skills. Sector financial resources concern the sources of financing for healthcare and the level of spending for different parts of the healthcare system. Since such sector-specific measures depend upon the general economic environment, it is also useful to report general measures of GDP per capita, government spending and government debt. The next dimension is infrastructure and personnel. Our operationalisation of these resources includes any and all resources endemic to the health system. This includes both state and private infrastructure, providers and professionals. These are captured by general statistics about the number of hospital beds and staff, and the availability of various types of medical technology.

Transposition outcome can be characterised along two dimensions. First, a simple assessment of timeliness, and second, an interpretation of whether the transposition is protectionist, neutral or progressive in terms of its compliance with the directive based on detailed analysis of the substance of the transposition. Finally, we will include assessments of how comprehensive the analysis of transposition options and consequences has been, and the extent to which the transposition includes details about the state administrative and operational procedures to be implemented based on the legislation.

Our analysis proceeds in four steps. First, we will describe the genesis of the directive as a background for the specific transposition analysis. Second, we will present an analysis of state administrative and health sector resources. Third, we will use our interview material and supplementary written data sources to investigate the importance of resource dimensions for the transposition. Finally, we will compare the transposition outcomes in the two countries and relate this back to the resource variables for each country, thus forming an independent assessment of the importance of resources for the transposition outcome.

The Introduction of the Directive

The adoption of the directive has been a long and onerous endeavour, but the development of the rights codified in it began much earlier than the preparation of it. In lieu of member state initiative, the primary drive behind the extension of patients' rights has been CJEU activism (Martinsen 2011; Wasserfallen 2010). In fact, it is one of the stated purposes of the directive to codify and clarify the multiple decisions of the Court and to establish a more effective application of the principles advanced by the CJEU.

Although the literature frequently describes CJEU intervention in cross-border healthcare issues from the *Kohll* and *Decker* cases (Baeten 2012; Mossialos and Palm 2003; Obermaier 2008; Palm and Glinos 2010), the jurisprudence in this field began much earlier, in the late 1970s, with the *Pierik* cases (C-177/77 and C-182/78) from 1978 and 1979, and continued in the

early 1980s with the joined cases of *Luisi* and *Carbone* (Joined Cases 286/82 and 26/83). The latter two decisions pertain to Italian citizens who violated national legislation by exporting excess sums in foreign currencies for medical services and tourism expenses. The Court ruled that because of the freedom of provision of services, the recipients of services have the right to go to another member state in order to receive a service there. In this context national restrictions applicable to payments are invalid (Mossialos and Palm 2003: 13). Subsequent decisions expanding patients' rights – e.g. *Kohll* and *Decker* (C-158/96 and C-120/95), *Smits-Peerbooms* (C-157/99), *Vanbraekel* (C-368/98) – can be seen as corollary to the *Pierik* and *Luisi* and *Carbone* decisions.

Although efforts to introduce a directive on patients' rights started in 2004, due to strong member state resistance it was not until 2011 that the directive was successfully adopted.

One reason for the changes in attitude was a reduction in the economic risks due to a modification of the rules on reimbursement levels. Article 7, paragraph 4 dealing with reimbursement of costs now states clearly that '[t]he costs of cross-border healthcare shall be reimbursed … by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation' (Directive 2011/24/EU, 2011). In addition, the directive leaves the immediate payment to the patient, in that it only provides rules for reimbursement.

The immediate consequences of these two features of the directive – i.e. the payment up to the level of coverage at the member state of affiliation and the upfront payment of costs by the patients – favour wealthier patients disproportionately. Since medical expenses can be considerable, patients treated under the provisions of the directive will need to be able to cover these personally prior to being reimbursed. In addition to that, they will also need to cover travel and possibly accommodation expenses. Thus, whilst the directive opens up national healthcare systems to foreign patients, it is naïve to expect that it offers foreign treatment on equal terms. By emphasising the financial aspects of treatment abroad, the directive exacerbates existing national divisions, and strengthens patients' rights predominantly for those who can already afford to enjoy them. In an international comparison, this means that the directive is likely to have greater impact in the older member states, while its effect in the new ones will be limited to the wealthiest patients.

State Administrative and Health Sector Resources in Poland and Bulgaria

An indication of the state administrative capacity can be found in the World Bank indicators for 'Good Governance'. These indicators include measures for 'government effectiveness', 'rule of law', 'control of corruption' and 'regulatory quality' (http://info.worldbank.org/governance/wgi/index.asp). The overall picture when using the World Bank Indicators is that they consistently rank Poland and Bulgaria in the lower end among European countries in 2011. In the case of Poland this corroborates the ranking in the OECD and Bertelsmann

indexes. The starting point is thus a relatively low level of 'state administrative resources' compared to older member states.

Comparing the two countries it stands out that Bulgaria fares worse than Poland on all parameters and ranks lowest among the EU countries on 'rule of law', 'control of corruption' and 'government effectiveness' and second lowest on 'regulatory quality'. Given the systematic differences in the international assessments of state administrative resources, we suggest that this can account for some of the differences in the strategic approaches and level of detail in the transposition strategies. We find evidence of this in the interview material, where the Bulgarian respondents in particular emphasise the limited capacity to undertake proper implementation of the directive. This is further illustrated by the fact that no official estimates of the costs and no detailed strategy document for the transposition have been put forward by the Bulgarian government. The Polish government has undertaken or commissioned more in-depth reports, but also remains restricted by the lack of data availability and human resources at the central level.

Information from the interviews in Poland and Bulgaria indicates that state administrative resources are rather limited in both countries (although admittedly better in Poland). Ministry officials point to limited capacity in the face of many other competing tasks and the general constraints on public administration in the two countries. This is further underlined by the relatively short membership in the EU combined with the limited exposure to EU legislative initiatives within healthcare. The process of transposition appears very centralised in both countries, involving a relatively limited number of civil servants at the state level. There are no ongoing consultations with other stakeholders, and regional/local authorities play a very limited role. The National Insurance Funds in Poland and Bulgaria provide some input, but overall we conclude that the two countries did not look for help from non-state actors.

Table 1 summarises relevant data on state administrative and health sector resources. The table compares the values for both of our cases. Although the two countries lag behind the older member states, the data shows unequivocally that the Polish system enjoys a much better material base, in terms of financial, material and human resources. This conclusion is also clear when comparing the detailed qualitative assessments in the so-called 'HiT reports' on Poland and Bulgaria from the European Observatory on Health Systems (Dimova *et al*. 2012 and Sagan *et al*. 2011, for Bulgaria and Poland respectively).

The Importance of Resource Dimensions for Transposition

A key document in the *Polish* preparation for transposition is a consultancy report commissioned by the National Ministry for Health in 2008 (Interview, Polish Ministry of Health). The report estimates the total costs for outpatient treatment (not subject to PA) to be 68 million PLN (over €16 million). This constitutes 0.22 per cent of the National Health Fund's budget for 2004. The figures are based on the number of treatments provided in the private sector in

Poland, assuming that the demand for such is largely driven by long waiting lists or doubts about the quality of treatment in the public sector. Yet the Polish authorities recognise that a lack of precise knowledge about the length of waiting lists and the price elasticity of the demand for cross-border healthcare render these estimates uncertain. Polish authorities assume that the price differences will deter most patients from travelling to Germany, whereas treatment in border regions with the Czech Republic, and to a lesser degree Slovakia and Lithuania, may also occur. The Polish authorities point to another potential contributor to raising the costs of implementing the directive, namely the potential for being forced to allow publicly funded access to private non-contracted providers within Poland. Referring to the consultancy report, they estimate that the additional cost to the Polish health service may be as high as 1.7 billion PLN (over €400 million), which is equivalent to 5.56 per cent of the National Health Fund's budget for the reference year 2004. This is based on the known demand for private services in Poland funded by out-of-pocket payments without reimbursement. In spite of uncertainties this figure is considerable and has drawn attention in the Polish policy debate. The prices of private providers in Poland are comparatively lower than their Western counterparts. This makes them particularly attractive to Polish patients seeking higher quality services at the expense of the public purse. Apart from the direct reimbursement costs, there might also be indirect costs for the Polish state due to weaker control over public health sector capacity and less efficient utilisation of infrastructure and human resources.

The Ministry officials further emphasise the considerable costs associated with administering the system, and developing quality and waiting time information. Yet they also point out that the actual demands in the directive are somewhat unclear. Their interpretation is that one contact point in Warsaw will be enough, and that they are not obliged to provide information that is not already available.

Interviewees outside the Ministry point out that it is a clear strategy in Poland to make patients bear the burden of translating bills, prescriptions etc. The Polish authorities realise that this can involve a significant cost, and thereby constitutes an impediment for some patients. Interestingly, although the Polish authorities are concerned about the prospect of paying for their own citizens travelling abroad, they also tend to see the directive as a potential business opportunity for Polish service providers, particularly in the border regions. This has led the Polish government to sponsor campaigns, for example in Sweden, to attract foreign patients. A growing number of Danes and Germans already use Polish dental care facilities. Most of this traffic goes to private providers in Poland.

In *Bulgaria*, the approach to the preparation of the directive's transposition has been a lot less intensive than in Poland. This is due to the content of the directive and the perception among the political class about its impact in the Bulgarian system. In Bulgaria, it is largely acknowledged that the directive will have minimum to no impact for the majority of Bulgarian patients. Since the

directive requires only reimbursement to the level of coverage in the member state of affiliation, this puts Bulgarian patients at a serious disadvantage. Prices for medical treatments in Bulgaria are not determined according to market principles and are frequently undervalued. This means that the financial exposure to the Bulgarian healthcare system is minimal, whilst the price for treatment abroad will be shifted massively towards the patients. As a result, there has been virtually no political opposition to the directive.

This insouciance has also been reflected in the preparation of the transposition of the directive. In contrast to an in-depth analysis of the implications of the directive's transposition and implementation in Poland, the adoption of the directive in Bulgaria has remained an issue of fairly low salience. Here we must emphasise the other events in Bulgaria which have been taking place in the run-up to the deadline for transposition. Since February 2013 Bulgaria has experienced considerable political turbulence which has resulted in the removal of the incumbent government, the appointment of a provisional government and the subsequent election of a new government, which has since been accompanied by almost unceasing protests. This volatile political situation conflated with the low impact of the directive resulted in the extremely low salience. As a result the engagement of the Bulgarian government is not as high as that of Poland.

Another important factor, which distinguishes the situation in our two cases, is the underdevelopment of the Bulgarian non-contracted private healthcare service. The number of such facilities in Bulgaria is extremely low, and they mostly specialise in physiotherapeutic treatments, which are not covered by the National Health Insurance Fund (NHIF) anyway. Thus the domestic exposure that we see in Poland is simply not present in Bulgaria.

All of these reasons underline the lack of importance of the directive in the Bulgarian system, but they do not belittle the importance of the resource hypothesis in this case. On the contrary, they highlight how the limited financial impact designed into the directive conflates with the undervalued medical treatments in Bulgaria, resulting in a situation where the directive protects the financial stability of the Bulgarian healthcare system at the expense of the patient. The low salience and lack of political opposition to the directive result from its low impact, which contrasts with the situation in Poland. Whilst in Poland the presence of non-contracted providers and the possibility of Polish patients seeking treatment in neighbouring countries have heightened political attention at the government level, the absence of these factors in Bulgaria has resulted in the lack of tensions around the transposition.

Nevertheless, our interviews have identified cases in which resource concerns materialise as central in the preparation of the directive's transposition. A major concern here has been the question of the volumes, services and prices at which Bulgarian citizens will receive treatments abroad (Interview, Ministry of Health). The administration is concerned that Bulgarian citizens will use cheaper services abroad and that the directive will be conductive to medical tourism. This is why a special clause in the transposition texts will protect the

system from such cases. This clause will serve as 'the guarantee and the protection' (Interview, Ministry of Health).

Poland's minimalist approach to the interpretation of the directive in relation to the national contact point can also be seen in Bulgaria. There, the authorities have decided that a single national contact point will satisfy the needs of the population. Of course, the fact that the directive does not oblige the member states to provide information in foreign languages puts the ability of the contact point to answer foreign patients' questions in doubt. This also hints at the disadvantage that patients who only speak one language are likely to experience in acquiring information about treatments abroad.

An additional protection for the Bulgarian system will be the establishment of a positive list of treatments which require prior authorisation for reimbursement. This list is likely to include all of the treatments covered by the NHIF, which have good coverage. Whilst it is true that most of the treatments covered by the NHIF are underpriced and demand a co-payment by the patients, some of them offer better coverage than in Western Europe. This has to do with the pricing mechanism in Bulgaria, which is notoriously disproportionate and opaque and is also heavily influenced by lobby interests (Busse *et al.* 2011: xxv). Thus some treatments, most notably some cardio-surgical procedures, have extremely good coverage, and these are very likely to end up on the positive list.

Transposition Approaches

Whilst it is true that both countries have experienced delay in transposing the texts of the directive, it must be highlighted that this is linked to entirely different reasons. Whereas in Poland the potential impact of the directive has necessitated a careful approach and a detailed examination of the transposition texts, in Bulgaria the delay was purely technical and can be attributed to the limited work continuity between the governments that assumed and then left power in the months leading up to the transposition deadline. Nevertheless, the principal concerns in both countries have revolved around the directive's expected impact on state administrative and health sector resources. Thus the effective transposition we see is specifically designed to limit the financial exposure of both systems.

The fastidious transposition approach in Poland and the directive's insouciant reception in Bulgaria might suggest a lack of state administrative resources in the latter as compared to the former. This would also be suggested by the overall level of state administrative resources in the country, as described above. However, the differences in the perception of the directive and the respective state administrative resources dedicated to it are entirely derivative of health sector resources in both countries and how the directive threatens these.

In Poland we find a significantly better health sector resource base and this is in fact advantageous for cross-border patient movement. Not only does the

Polish system grant better coverage to its patients, but the private non-contracted providers in Poland offer treatments at acceptable prices within the country itself. Thus the health sector resource base in Poland is much more beneficial than the Bulgarian one. Consequently, this perception has resulted in much more exhaustive research on the implications of the directive on the side of the Polish state. In a sense, the higher health sector resources have triggered greater expenditure in state administrative resources, specifically in order to facilitate minimalist, but more importantly ‘protectionist’ transposition.

On the other side, in the Bulgarian case, the health sector resource base is comparatively scarce. It is perceived as rather prohibitive to patient mobility and has resulted in little attention from the state authorities. The limited requirements in the directive, and its watered down provisions, do not grant proper protection to impoverished patients. As previously stated, the directive is disproportionately beneficial to richer patients, leaving the poorer ones, like those in Bulgaria, with little chance of enjoying cross-border treatments. The few treatments which have good coverage in Bulgaria will most likely end up on a positive list, which shows that the Bulgarian government will protect the health sector resources it has, to the detriment of the patients.

Overall, the transposition outcome in Poland can be characterised as fairly detailed but relatively minimalistic/protectionist in content. This is based on significant concerns about sector resources. The transposition in Bulgaria can be characterised as fairly neutral, although with ‘protectionist’ elements in some areas as exemplified by the plans to enforce a ‘positive’ list. Neither of the two countries has been very active in soliciting input from external interest groups, and opposition parties have shown limited interest in the transposition of the directive. In conjunction with Börzel’s volume, this observation suggests that the state administration considered the advantages of such involvement to be less than the potential disadvantages from having to manage a process with multiple stakeholders in a resource-intensive sector. Once more, this emphasises the prevalent role of health sector over state administrative resources and the dedication of the latter to the protection of the former.

Conclusion and Discussion

We expected that policy-makers were likely to be concerned with the direct or indirect ‘adjustment costs’ that international rules impose on national governments in the healthcare sector (Sedelmeier 2009; Tallberg 2002). More specifically, we anticipated that they are prone to be concerned with the issue of whether particular transposition choices will strengthen or weaken the ability to deliver services and whether the transposition endangers the control of resource allocation and planning in the sector.

Our case analysis clearly illustrates that considerations for health sector resources play an important role in the two case countries. In both cases we see attempts to protect the control over health system resources by interpreting the articles of the directive in a rather protectionist fashion, which confirms our

first expectation. In both cases we have evidence from our interviews that the transposition strategies were informed by such resource concerns. Yet we also found differences between the two countries in the transposition strategies and in the comprehensiveness of analysis of economic and legal implications of transposing the directive into national law. These can be related to differences in the level of concern for the implications of the directive on planning capacity and sector resources. Poland appears to be most concerned about the costs of treatment abroad, and also has strong concerns about the potential of having to allow direct access to domestic, non-contracted private providers. Bulgaria, on the other hand, assumes that few patients are likely to use the directive to seek access to treatment abroad for the relatively low-priced majority of services. Yet Bulgarian policy-makers are concerned with the control over some highly priced treatments in the Bulgarian system. They therefore plan for a transposition which is neutral, but with some protectionist elements.

These observations also support our second expectation that policy-makers with strong concerns about the impact of a directive are likely to choose cautious or protectionist transposition outcomes with as many safeguards and barriers as possible. If, on the other hand, policy-makers expect that the implementation of a given directive will have limited impact on the consumption of services, planning capacity and resource control, they may be more prone to adapt the text of the directive without restrictions. Poland appears to fall into the first category, while Bulgaria, with some modifications as described above, comes closer to the latter.

In spite of the limitations of the case study approach and the inherent uncertainties in analysing an unfinished implementation process, we find that this paper can contribute several insights. First, it clarifies that a multidimensional perspective of resources is important for understanding transposition of EU directives in member states. Resources are an important variable for key policy actors when forming strategies and making transposition choices, particularly in resource-constrained settings. While previous research has tended to consider resources at the aggregate, national level (e.g. Börzel, Fernandez *et al.* 2010; Falkner *et al.* 2004, 2008; Zubek and Staronova 2010), our study shows that specific concerns about the 'adjustment costs' (Sedelmeier 2009: 6) at the sector system level are very important.

Second, the study also confirms that state administrative resources can play a role for transposition timeliness and quality. This has been shown before in some quantitative studies (Hille and Knill 2006), while other quantitative studies focusing on timeliness have failed to replicate the results (Steunenberg and Toshkov 2009).

However, our qualitative study shows that greater importance should be attributed to sector-specific resources. Their higher value in Poland has triggered more exhaustive exploration of the transposition outcomes and more protectionist approach, whereas their unavailability in Bulgaria has resulted in low salience of the directive, limited invocation of administrative resources and few cautionary measures. Our third hypothesis about complex interrelationships

between sector resources and administrative resources is thus confirmed. Administrative resources are an insufficient parameter on their own, while the combination of sector resources and administrative capacity can explain both substantive and quality/timeliness dimensions of transposition.

Thus, the findings here transform our understanding of the importance of resources in transposition. Whilst earlier studies have argued that resource limitations result in poorer transposition (Börzel, Hofmann *et al*. 2010; Falkner *et al*. 2004, 2008; Zubek and Staronova 2010), this study has shown that relatively greater sector resources can trigger purposefully protectionist transposition with intentionally limited implications. Once again, this stresses the importance of a multidimensional perspective of resources and the shift away from the singular focus on state administrative resources.

At a broader level the study illustrates some of the issues of implementing social Europe in the face of economic constraints. 'Social Europe' is defined broadly as EU law that establishes supranational social policies as well as EU law affecting social rights and policies in the member states (Martinsen and Vollaard 2014). While the stepwise legal activism of the CJEU aimed to push the boundaries of patients' rights, this met resistance from the member states. The final directive therefore ended up being less radical than the course of the CJEU rulings had suggested (Hatzopoulos and Hervey 2012). The CJEU has subsequently adjusted its practice accordingly in several of its latest rulings. It has stepped back from its radical interpretation of 'restrictions' and has extended the application of its interpretation of the 'objective public interest justifications' so that, for example, the use of PET and MRI scanners *outside* hospitals is now included (Hatzopoulos and Hervey 2012).

The final contents of the directive and the protectionist approach to its transposition documented here testify to the extension of the EU's soft power character in the emerging framework of social Europe. The further extension of this dimension of the European project is likely to continue facing strong opposition and limited or no ability to enforce stricter compliance with legislation. The true construction of a social level in the European Union is thus likely to follow further overall integration and complementary delegation of rights from the member state to the European level. In relation to this, Beramendi delivers some vital insights: 'the level of decentralization of redistributive policy is a function of the territorial structure of inequality. Herein lies an important key to understanding why some federations have more centralized welfare states than others' (Beramendi 2007: 784). Thus the limited architecture of social Europe demonstrated in the directive and the marginal extensions it introduces to patients' rights are corollary to the considerable socio-economic differences between the member states. In effect, the directive introduces an integrational asymmetry in the establishment of social Europe. This asymmetry is expressed in the disproportionately better conditions of the directive for old member state patients, and the marginal improvements for the majority of their newer counterparts. Essentially, the directive has a varied influence, depending

on the socio-economic contextualities of the system where it is being implemented.

Although both of our cases are from Eastern Europe, social disparities have implications even between them. Whilst in Poland the better health sector resource availability enables Polish patients to take advantage of the directive both at home and abroad, in Bulgaria the comparatively worse resource situation limits Bulgarian patients' chances to use it. Thus in between our cases we see that only those member states which can afford to will participate in an EU-wide social scheme. We also see that social Europe will not alleviate social disparities between the member states. In the case of the directive strong nationalist input from the member states has designed social Europe as a dimension that will only be accessible after a member state has attained a certain resource level. This is the case in Poland, but not yet in Bulgaria.

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