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## **Bounded rationality in transposition processes: the case of the European patients' rights directive<sup>1</sup>**

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### *Abstract*

Studies explaining the timeliness and correctness of the transposition of EU directives into national legislation have provided rather inconclusive findings. Therefore, they do not offer a clear-cut prediction concerning the transposition of the patients' rights directive, which is one of the first that concerns the organisation and financing of national healthcare systems. This paper applies the perspective of bounded rationality to explain (irregularities in) the timely and correct transposition of EU directives. The cognitive and organisational constraints long posited by the bounded rationality perspective may affect the commonly employed explanatory factors of administrative capacities, misfit, and the heterogeneity of preferences among veto players. To prevent retrospective rationalisation of the transposition process, this paper traces this process as it unfolded in Denmark and the Netherlands. As

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bounded rationality is apparent in the transposition processes in these relatively well-organised countries, future transposition studies should devote greater consideration to the bounded rationality perspective.

## 1. Introduction

Many policy sectors in the member states of the European Union (EU) have been confronted with the transposition of EU directives into national legislation. The healthcare sector is a relative latecomer in this respect. Adopted in 2011, *Directive 2011/24/EU on the application of patients' rights in cross-border healthcare* (hereafter, the patients' rights directive) is one of the first concerning the organisation, financing and provision of diagnosis, care and cure to *ill* persons (to be distinguished from public health, which refers to policy measures to increase the physical and mental well-being of *all* persons). Little is known about implementation of EU law in the healthcare sector (Lamping 2013), but transposition studies of other policy sectors may indicate how it could unfold. The scholarly literature on the transposition of EU directives has grown substantially over the last two decades. A wide variety of factors have been indicated to explain the timeliness and correctness of transposition. However, the transposition literature does not provide unequivocal expectations for the timely and correct transposition of directives in a 'new' healthcare sector. Administrative capacity and domestic opposition seem to be influential factors, but transposition studies continue to struggle with "inconclusive", "contradictory", or "inconsistent" findings concerning the factors explaining timely and correct transposition (Steunenberg and Rhinard 2010; Toshkov 2010; Toshkov et al. 2010; Treib 2008).

This inconclusiveness could result from the particular countries and policy sectors studied or the imprecise measurements used (Toshkov 2010; Toshkov et al. 2010). Sensitivity to contextual specificities can provide firmer conclusions regarding timely and correct transposition (Steunenberg and Rhinard

2010). This article therefore explores the transposition process of the patients' rights directive in detail to determine the specific factors in the underexplored healthcare sector. It also delves into this process for theoretical reasons. Implementation processes (including transposition) are often as messy and conflictive as other policy processes (Barrett 2004; Püzl and Treib 2007). As theories on bounded rationality have long noted, preferences, problems, solutions, and decision-making processes can be fairly unclear to the actors involved, due to their cognitive constraints such as limited attention and organisational complexities such as the fluidity of participants or disjoint policy-circuits (Simon 1985; Cohen et al. 1972). This is of particular relevance in the complex decision-making machinery of the EU (Jones 2001: 196; Nowak 2010; Olsen 2001; Richardson 2005; Zahariadis 2007: 86) and even more so when a distracting economic crisis with ensuing budget cuts is taking place. The inconclusiveness in transposition studies could thus arise from the actors' varying cognitive and organisational possibilities to understand a directive and its (mis)fit with national legislation, develop clear preferences, or adopt proper strategies in a timely manner to support or oppose its transposition. The research question in this paper is therefore whether bounded rationality, in part, explains whether and how directives are timely and correctly transposed and how this is related to the commonly employed explanatory factors of administrative capacity, misfit and veto player preferences.

The only way to determine whether, when and how cognitive and organisational constraints interact with other potential explanatory factors and relate to the timeliness and correctness of transposition is to examine the transposition process *as it unfolds*. Process-tracing *during* the transposition of the patients' rights directive has been employed to avoid *post-hoc* rationalisations of strategies by the actors involved. Two cases of well-administered countries, Denmark and The Netherlands, are selected to examine whether bounded rationality is apparent even in these countries and thus may constitute a more general factor affecting transposition across member states.

This article proceeds as follows. After an evaluation of the transposition literature and the potential contribution of the bounded rationality perspective in section 2, the case selection, methods and empirical sources are discussed in section 3. The latter section also presents the origins and contents of the patients' rights directive. Following reports on the Danish and Dutch cases in sections 4 and 5, respectively, the final section presents conclusions regarding whether bounded rationality affects the transposition process and its outcomes. If so, bounded rationality should be emphatically considered in future transposition research.

## *2. Explaining the timely and correct transposition of EU directives: a matter of bounded rationality?*

Explaining the regularities and irregularities in the transposition of EU directives into the national legislation of EU member states has been an important subject in EU studies. Transposition studies reveal that the administrative capacities of member states and the heterogeneity of preferences among the relevant domestic actors seem to be the most influential factors explaining (un)timely and (in)correct transposition (for reviews of the transposition literature, see Toshkov 2010; Toshkov et al. 2010; Treib 2008). A lack of administrative capacities (financial, human and organisational resources such as staff expertise and coordination strength) could explain delayed and incorrect transposition (see also Vasev and Vrangbæk (2014), this volume, for the importance of sector-specific resources). If their preferences differ, veto players, such as the ministries and sub-national authorities involved in transposition, can delay transposition using their blocking power. Misfit between EU legislation and domestic policy legacies has often been examined as explanatory factor but rarely seems significant. In general, transposition studies have remained inconclusive regarding the factors explaining transposition.

Given this inconclusiveness, transposition studies could benefit from theories on *domestic* policy-making, rather than EU-specific ones (Treib 2008: 19). The bounded rationality perspective is well-

situated in this respect. Due to its complexity, the EU is a “solid candidate” to qualify as a so-called organised anarchy (Zahariadis 2007: 86). In an organised anarchy, preferences, problems, and decision-making processes are rather ambiguous and unclear among the manifold actors, whose involvement is often fluid (Cohen et al. 1972: 1). In particular, in these complex contexts, rife with uncertainty, actors have limited opportunities to take well-informed, rational decisions, instead tending to act under ‘bounded rationality’ (Simon 1985). Devoting attention to actors’ cognitive constraints and the organisational complexities in which they operate might offer a better understanding of the inconsistencies in the explanations of transposition.

Rational choice theories suppose that actors have sufficient resources and information to conduct a comprehensive analysis of the transposition alternatives and their effects to adopt a strategy to maximise the net value of expected returns for themselves. They thus assume that the preferences of these actors are fixed, rank-ordered and unambiguous and decision-making procedures are clear. However, organisation theory and behavioural decision theory have long highlighted the limitations of these rational choice assumptions as descriptive and predictive models of human behaviour (Jones 1999). Actors rather act under bounded rationality, which is “...behavior that is adaptive within the constraints imposed both by the external situation and by the capacities of the decision maker” (Simon 1985: 294). Bounded rationality does not assume that actors are irrational. Individuals generally have reasons for what they do (Simon 1985: 297). However, due to the complexity of political life and actors’ cognitive limitations, policy choices are not made according to rational procedures. Instead of surveying the overall situation and weighing different alternatives against one another, actors have limited attention spans. Actors behave according to habituation and routine, opting for a satisfactory, instead of the optimal, solution. When confronted with major policy changes, they tend to mobilise their serial processing capacity instead of acting in a utility-maximising manner (Jones 1999: 303). A limited attention span implies that actors do not consider all implications of a decision but make what they can

of the situation, thus only examining the most relevant aspects. As Simon noted, “[p]eople are, at best, rational in terms of what they are aware of, and they can be aware of only tiny, disjointed facets of reality” (Simon 1985: 302). In other words, actors’ information processing is often not optimal, and even if information is available, it is often ignored (Jones 1999: 310).

Information could enhance rational decision-making. The more and the longer actors have been involved in policy processes, the better they may analyse policy alternatives and their consequences and act accordingly in a strategic manner. However, more and better information does not necessarily limit differences in views, perspectives and priorities among the actors involved (Zahariadis 2007: 66). Decision-making is not only a matter of uncertainty (actors lacking information) but also of ambiguity (actors’ diverse understandings of information). Ambiguity complicates the rational pursuit of preferences by an organisation, as the ultimate goals are unclear to the actors involved (Jones 1999: 308). Certain organisations are more prone to ambiguity and uncertainty than others. This notion is central to the garbage can theory developed by Cohen, March, and Olsen (1972) and the policy streams model advanced by Kingdon (1984). Due to the complex and fragmented nature of an organisation, such as a national government or a university, actors are unable to completely grasp the decision-making process. Given the fluidity of participants and variety of disjoint policy-circuits in the decision-making process, attention can only be selective. This allows strategic actors (policy-entrepreneurs) to manipulate the content and timing of information to link a (self-perceived) problem to their favoured (pre-existing) solution. Policy choices thus rather emerge from the organised anarchy than result from a well-considered selection of alternatives for a given problem.

Studies of bounded rationality have largely focused on the choices made in the agenda-setting parts of policy processes. Nevertheless, there is no reason that this perspective may not be fruitfully applied to choices made in other parts of policy processes, such as implementation (Zahariadis 2007: 80, 86). For a

variety of reasons, the implementation of EU law would be a prime subject for the study of bounded rationality. First, shared preferences among the manifold actors in the complex, multi-level, sectorally divided EU is rather unlikely. EU legislation reflects the compromises of 28 member states, the European Commission and the European Parliament. As a consequence, it often contains fuzzy, ambiguous aims. The discretion to select the means by which the policy goals established in EU directives are to be met increases uncertainty and ambiguity, particularly if the directives concerned do not neatly fit domestic policies. Indeed, new, complex directives offering substantial policy discretion are more likely to suffer from delayed and incorrect transposition (*cf.* Kaeding 2006; Steunenberg and Toshkov 2009). Furthermore, within the complex EU, actors at the national level may be unaware of evolutions at the EU level. The development of preferences among actors during the negotiation phase of EU directives could therefore coincide with a lack of preferences regarding (aspects of) the EU legislation among implementation actors. Additionally, the rationale behind the numerous compromises established during Council negotiations may be long forgotten when these compromises are to be implemented domestically. Further, even if manifold implementing actors are aware of the basic rationale, they could be overly absorbed by other domestic issues to thoroughly consider their preferences, problem analyses and strategies. Preferences and strategies would thus be rather developed during the implementation process, which would lead to actors retrospectively justify their policy choices. A change in participants and distractions from other policy issues, which are rather likely in massive organisational complexes such as the EU and the healthcare sector, could contribute to the confusion regarding strategies, preferences and problem analyses concerning the transposition of a directive.

The bounded rationality perspective could thus explain why the scholarly literature is inconclusive concerning the factors determining the timely and correct transposition of EU directives. First, veto player explanations assume actors to be rational. Such an assumption is debatable. Preferences might not be given and fixed, while cognitive and organisational constraints hamper actors' understandings of



the problem (*i.e.*, the directive to be transposed), the (mis)fit between the directive and national policies, the available decision-making strategies and possible solutions. Due to organisational and cognitive constraints, the transposition process could eventually result in a quasi-accidental connection of a problem and policy solution on the part of a policy-entrepreneur. Three explanatory factors commonly considered in transposition studies would thus be clearly affected by bounded rationality. The following section explains how this paper will assess the impact of bounded rationality on the transposition process.

### 3. *Studying a process as it unfolds*

Qualitative case studies are best suited to examining how bounded rationality affect the transposition process *as it unfolds* (*cf.* Gerring 2007). Therefore, the collection of legislative documentation, reports from the ministries on transposition, parliamentary debates, policy papers composed by the wide variety of health actors and interviews with key players and experts were completed *during* the transposition process to determine how preferences, strategies, and problem analyses evolved during the transposition period. The cases selected are Denmark and the Netherlands. If bounded rationality had an impact, even in these two relatively well-organised countries, future transposition studies should consider this factor more emphatically.

The phenomenon to be explained is the timeliness and correctness of the transposition of the patients' rights directive into national legislation. The directive will be considered timely and correctly transposed if no strong criticism is raised by well-informed and independent legal experts on the implementation of key articles. These key articles are presented in table 1 below. The directive has a long history, riddled with controversies. Based on Regulation 883/2004 on the coordination of social security systems (and its predecessors since 1958), most EU citizens could only be granted the privilege of receiving

reimbursement for planned healthcare obtained elsewhere in the EU. In a series of verdicts since 1998, the CJEU (Court of Justice of the European Union) declared cross-border healthcare to be subject to the free movement of goods and services in all EU healthcare systems. In principle, EU citizens therefore have the right to access to cross-border healthcare and its reimbursement. However, the CJEU identified exemptions to free movement, such as a system of prior authorisation for hospital treatment, justifiable for reasons of financial sustainability for national healthcare systems or the maintenance of public health. Many member states opposed interference by the CJEU or other EU institutions in the organisation and financing of their healthcare systems. The European Commission nevertheless pursued various means to regulate cross-border patient healthcare. After it failed to consolidate CJEU case law on healthcare in the “Bolkestein directive” on services in the internal market in 2004, the European Commission promulgated a directive specifically addressing cross-border healthcare in July 2008. The issue of prior authorisation of cross-border healthcare was one of the most controversial issues. The political agreement that the European Parliament and the Council eventually reached in the second reading was established by means of numerous compromises, as reflected by the directive’s 64, often lengthy, recitals. The eventual agreement departed from the European norm of consensus politics. Austria, Poland, Portugal and Romania voted against the final compromise in the Council, whereas Slovakia abstained from voting. After its official publication on March 9<sup>th</sup>, 2011, member states had two-and-a-half years to transpose the directive, until October 25<sup>th</sup>, 2013. The directive covers healthcare generally, regardless of how it is organised, delivered or financed, except for long-term care, vaccination programmes or organ transplantation. The directive obliges the member states to reform existing information on patients’ rights to facilitate (not stimulate) cross-border healthcare (for further details, see table 1).

Articles to be transposed	Most important aspects to be implemented
4	<p>A member state providing treatment is obliged to ensure:</p> <ul style="list-style-type: none"> <li>• national contact points providing information on (the supervision of) healthcare standards</li> <li>• healthcare providers provide information on treatment options, availability, quality and safety, and prices</li> <li>• transparent complaint procedures if patients suffer harm</li> <li>• access to the patient’s medical record</li> <li>• non-discrimination in access and pricing</li> </ul>
5	The member state of affiliation (in terms of health insurance) is obliged to inform patients of their cross-border rights and entitlements and related appeal and redress procedures
6	Member states should establish one or more national contact points
7	Member states are obliged to have transparent mechanisms for the calculation of treatment costs; member states should report to the Commission on all refusals of prior authorisation and the reasons thereof
8	<p>If prior authorisation (PA) is introduced, it is only justified for hospital care and highly specialised and cost-intensive care</p> <ul style="list-style-type: none"> <li>• PA has to be issued if treatment cannot be granted within a medically justifiable timeframe</li> <li>• Member states of affiliation shall make information publicly available regarding what healthcare services and goods are subject to PA</li> </ul>
11 (plus implementing directive 2012/52/EU)	Mutual recognition of prescriptions

**Table 1: key articles of the patients’ rights directive to be transposed by October 25<sup>th</sup>, 2013**

The directive contains a high level of discretion, as numerous clauses state that Member states “may” engage in certain actions. For instance, member states “may” deliver information on cross-border healthcare in other than its official language(s) and “may” cover additional costs related to cross-border healthcare other than those indicated in the directive. The directive also contains several articles concerning voluntary cooperation on issues such as health technology assessment, e-health and the creation of reference networks of highly specialised healthcare providers. Voluntary cooperation is not

examined here, as it does not have to be transposed into national legislation. Table 1 only presents articles that must be transposed.

The case studies examine the transposition processes to determine the impact of bounded rationality and three commonly employed explanatory factors: administrative capacities, the policy (mis)fit between the directive and national rules and the preference heterogeneity among veto players. Table 2 details the potential indicators of these three factors. It also indicates how the impact of bounded rationality could be identified.

Factor	Potential indicators
Factor 1: Administrative capacities	<ul style="list-style-type: none"> <li>• experts on cross-border healthcare or general civil servants</li> <li>• many/ few staff available for transposition</li> <li>• transposition plan: yes/no</li> <li>• clear division of responsibilities for transposition: yes/no</li> <li>• information sharing among implementing actors: yes/no</li> </ul>
<i>Impact of bounded rationality on factor1 if:</i>	<ul style="list-style-type: none"> <li>• <i>fluidity of implementing actors</i></li> <li>• <i>disjoint policy-circuits</i></li> <li>• <i>not the primary but a secondary responsibility for actors</i></li> <li>• <i>distraction by other issues such as the economic crisis and budget cuts</i></li> <li>• <i>limited understanding of the transposition procedure among implementing actors</i></li> <li>• <i>adoption of satisfactory, routine solutions instead of selecting alternatives</i></li> </ul>
Factor 2: Policy fit	<ul style="list-style-type: none"> <li>• substantial or little patient choice and prizing information in the healthcare system</li> <li>• relevant CJEU case law (not) implemented</li> <li>• (not) accustomed to cross-border healthcare</li> </ul>
<i>Impact of bounded rationality on factor 2 if:</i>	<ul style="list-style-type: none"> <li>• <i>limited institutional memory and experience concerning cross-border healthcare policies</i></li> <li>• <i>confusion among actors concerning the extent of misfit</i></li> <li>• <i>confusion among actors concerning what timely and correct transposition means</i></li> </ul>
Factor 3: Heterogeneity of preferences among veto players	<ul style="list-style-type: none"> <li>• veto players: sub-national authorities, parliament and ministries involved: yes/no</li> <li>• diverging preferences concerning the directive among (informal) veto players</li> </ul>

<i>Impact of bounded rationality on factor 3 if:</i>	<ul style="list-style-type: none"> <li>• <i>actors have non-existing, partial or changing preferences</i></li> <li>• <i>limited understanding of consequences of non-compliance</i></li> <li>• <i>policy-entrepreneur uses the directive for different purposes</i></li> </ul>
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**Table 2: potential indicators of the three explanatory factors and bounded rationality's impact on transposition**

Whereas Denmark and the Netherlands are often considered to be member states with relatively strong administrative capacities, they differ on policy fit and veto actors. Denmark is expected to face greater difficulty in transposing the directive than the Netherlands. As will be explained in detail below, the Netherlands has had more experience with cross-border healthcare. It also implemented the relevant CJEU case law before the directive was proposed, while Denmark has been reluctant to do so. The Dutch system of regulatory competition among health providers and health insurance companies also seems to better fit the directive's emphasis on free choice than the public planning underlying the Danish national health service system. In addition, regions may act as veto players in the decentralised Danish healthcare system. On first sight, Denmark would thus face greater challenges in transposing the directive timely and correctly than the Netherlands.

#### *4. The Danish transposition of patients' rights in cross-border healthcare*

Danish healthcare is provided by means of a national health service (NHS) system, which offers healthcare as benefits-in-kind, tax-financed, largely free of charge and publicly supplied. The system can be characterised as a decentralised, public, integrated healthcare system in which the responsibility for organising and delivering services is placed in the hands of the five Danish regions (Martinsen and Vrangbæk 2008). Primary care services are provided by private practitioners, *i.e.*, general practitioners (GPs), but are publicly funded and firmly integrated into regional planning. General practitioners serve

as important gatekeepers in the system, referring patients to specialised care and hospital care. Treatment is largely provided free of charge, but co-payments exist, primarily for medicine, dentistry and physiotherapy.

Territoriality is a deeply entrenched principle in the Danish healthcare system. Danish prior authorisation for healthcare treatment in other member states has been very limited. In the Danish legal proposal to implement the patients' rights directive, the Danish government estimated that the regions in total receive approximately 60 applications for prior authorisation annually, of which approximately 10 are granted (Interviews, November 2012; August 2013).<sup>2</sup> In addition, regarding the inflow of foreign patients, Denmark has traditionally refused access for planned treatment. The Danish Ministry of Health has, as of July 2008, informed the regions that public hospitals cannot charge foreign patients for care provided, meaning that a foreign patient cannot receive planned treatment at a Danish public hospital, if not authorised by means of Regulation 883/2004.<sup>3</sup> An EU citizen can access public healthcare in Denmark only by means of the EU health insurance card, if residing in Denmark or if authorised to receive planned treatment under Regulation 883/2004 but not directly on private initiative. Thus the boundaries of Danish healthcare are quite tight, with limited, firm, publicly controlled access and exit possibilities.

#### *4.1. The process of transposition in Denmark*

The Danish position on EU regulation of the healthcare sector has been rather reluctant. The Danish implementation of CJEU case law can be characterised as defensive and minimal, mirroring the country's highly sceptical position concerning the application of internal market principles in healthcare

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<sup>2</sup> See L 33 "Forslag til lov om ændring af sundhedsloven og lov om klage- og erstatningsadgang inden for sundhedsvæsenet", p.20; presented October, 3d 2013.

<sup>3</sup> Ministerial note, July, 8th 2008, J.no. 2008-1200-122; Politiken, "Sundhed: Vi kan tjene på udenlandske patienter", December, 21st 2012

(Martinsen and Vrangbæk 2008). The Danish Ministry of Health long only allowed cross-border healthcare for health services for which the patient paid part of the cost him/herself. Following fierce critiques from the Danish ombudsman and the Danish Social Appeals Board, this was extended to also cover cross-border specialist treatment (Martinsen 2013). Thus Denmark entered Council negotiations on the Patients' Rights directive and its subsequent transposition with a limited national tradition in cross-border healthcare. The boundaries of the Danish healthcare system largely remained intact despite an internal healthcare market that was announced long ago by the CJEU. Furthermore, the policy fit between the European notion of free movement in healthcare and the Danish healthcare policy was poor. After initial opposition, the Danish government voted in favour of the directive. In this way, it accepted that doctors from other member states can refer patients for further treatment in Denmark, despite that the government and regions (the other veto player in the transposition phase) strongly preferred to maintain the exclusive gatekeeper role of Danish GPs.

The transposition process began in summer 2011 with the Ministry of Health as the responsible unit. For the first two year, transposition was a rather secluded process, in reality only involving few – but new - civil servants in the Ministry. Cross-border healthcare had long been administered by the same two senior civil servants in the Ministry, who had become key experts on the relevant regulatory framework, with established and regular contacts with the Danish regions. The Ministry of Health had, however, experienced major reorganisations, including budget cuts entailing substantial redundancies. One of the civil servants in charge had been fired and the other reassigned to other functions outside the department. The senior civil servant who had also played a key role in Council negotiations initiated the transposition process. When that person was fired from the Ministry, transposition was *de facto* placed on hold for approximately one year (Interview, July 2013). The new civil servant assigned the responsibility had no previous experience with the issue of cross-border healthcare and also was responsible for performing other departmental tasks. In reality, few and inconsistent resources were

devoted to transposition, making the specific sectoral administrative capacity low. The initial phase was marked by a considerable loss of institutional memory.

In the initial phase of transposition, the Ministry organised a reference group in which the regions, relevant agencies and the municipalities represented by Local Government Denmark participated with the Ministry of Health. However, the regions and municipalities found that the reference group primarily served to allow the Ministry to present its considerations but did not grant them influence on transposition (Interview, November 2012). Moreover, the patient organisations felt that they were excluded, finding transposition to be a very closed process involving a few civil servants in the Ministry;

*“It is like they fear losing their grip. Therefore it just becomes more meetings where we are briefed. It’s one-way communication. (..) there is no invitation to establish a dialogue” (Interview, November 2012).*

For the first two years, the Ministry of Health was largely the only actor involved. However, its preparatory work was marked by unsettled consideration in the hands of new civil servants who had inherited a dossier that they had not negotiated and for which they had no relevant experience. Rather than strategies and clear preferences, main actors were unsure of how to cope with ‘very difficult rules’ (Interview, August 2012). Furthermore, the aims, principles and the basic logic of this task were found to challenge the Danish healthcare legacy, ‘forcing us to think along more market-based logics’ (Interview, July 2013). This clearly influenced their capacity and attention span. Key actors found themselves ‘operating in a sort of knowledge gap’, ‘trying to look to what the others (other member states) do’ (Interview, August 2012).

The regions expected that they would play an influential role in transposition but found themselves excluded (interviews, August 2012, November 2012, August 2013). As the governance level responsible for delivering healthcare and the practical application of the directive, there were numerous concerns and frustrations. The regions raised concerns regarding how to address patients’ demands for cross-



border healthcare, expecting them to only grow in the future. They thus expected the transposition process to also account for practical application, address alternative solutions and foresee their effects. According to the regions, it was highly important that the functions and resources of the contact point would match citizens' demands. It did not find the Ministry's solution of relying on existing 'patient supervisors' in the regions to be adequate. Existing institutions were not considered sufficient solutions. In addition, the regions found the fact that foreign patients could now access planned healthcare in Denmark a particular challenge. While the Ministry highlighted Diagnosis Related Group (DRG) prices as the natural level of price setting, again echoing existing solutions, the regions noted that the DRG is a rather abstract means of price setting, which fails to disaggregate the various components of a healthcare service or specify when a healthcare treatment begins and ends (interviews, August 2012, November 2012, August 2013). DRG prices might be effective in interactions between regions and national healthcare providers having learned to trust this price mechanism, but in an internal market, they hardly constitute transparent or full prices. Furthermore, as public hospitals had not been allowed to charge foreign patients for healthcare provided, there was no experience to draw upon. In summary, whereas the Ministry seemed to prefer to address contact points and price-setting through existing structures, i.e., 'business as usual', habituation and routine, the regions found this solution inadequate and considered it insufficient for practical application. The regions found that the Ministry did not sufficiently consider issues of practical application or the full effects of the directive;

*"This is a big change. Potentially it can affect many. The whole system is in play. (...) This is not just a question of some patient supervisors having to do something more. It's a question of gearing the whole system. This is about all the doctors and nurses out there, who also have to be able to handle the situation when a foreign patient comes in. Advise and guide them. We need to set up a system that can issue invoices and send payment reminders. We are not exactly used to this" (Interview, August 2013).*

The Danish law to transpose the Directive was initially expected in December 2012, then January 2013, and subsequently in April 2013. The lack of resources and experience in the Ministry and the degree of

legal uncertainty regarded the Directive were noted as the primary explanations for the delay (interviews, June 2013, August 2013). On the June 28<sup>th</sup>, 2013 the proposed law was finally presented to the Danish parliament on October 3<sup>d</sup>, 2013. The proposal consists of one law and five ministerial orders.

Denmark did not meet the transposition deadline. According to the relevant law adopted in December 2013 (in force from January 2014), authorisation has to be issued for hospital care and 'highly specialised and high cost care' not requiring hospitalisation.<sup>4</sup> The law obliges the Danish Health and Medicines Authority to issue a list indicating which treatments require prior authorisation, which are all treatments requiring at least one night of hospitalisation plus all treatments listed in the 'plan for specialisation' (*specialeplanen*). This plan comprises specialised treatments that can only be provided at hospitals authorised by the Danish Health and Medicine Authority. The list simply links to the website of the 'plan for specialisation', where a somewhat overwhelming range of treatments appear, including several requiring minor specialisations. There is no further justification for why this whole range of treatments requires authorisation and no governmental willingness to issue a list of which treatments can be accessed directly without prior certification from the Danish health authorities.<sup>5</sup> Furthermore, it remains unclear when the Danish authorities are obliged to issue authorisation. Applications will be made to one of the regional councils (democratically elected bodies in each region), which may have an interest in restricting the outflow of patients. A patient refusing to go abroad can complain, but to the National Agency for Patients' Rights and Complaints, which is also the institution responsible for supervising the work of the contact points. This institutional proximity is likely to condition its ability to conduct its tasks as an institution of appeal and redress objectively and in a non-discriminatory manner, as set out in article 9 of the directive. Finally, the resources allocated to implementation are considered inadequate. No new institutions will be established as 'contact points'. Instead, the existing 'patient

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<sup>4</sup> Danish law proposal, L33, as adopted December, 20th 2013; § 89

<sup>5</sup> See the Minister of Health's response to question 27, additional report from the Health Committee of the Danish Parliament, December, 18<sup>th</sup> 2013.

supervisors' in the regions will serve as contact points, with the National Agency for Patients' Rights and Complaints serving a coordinating function for the regional contact points.<sup>6</sup> Overall, the changes to national legislation are not assumed to result in additional costs for the Danish healthcare budget or its administration.<sup>7</sup> The regions consider this to be unrealistic and not in keeping with practical implications of the Directive, and hence they demand compensation from the state to fund and administer the additional costs that they foresee (Interview, August 2013; see also the hearings submitted by the regions).

#### *4.2 On Limited Capacity, Habituation and Bounded Rationality*

The Danish transposition of the patient rights directive was not timely. Furthermore, Denmark has made extensive use of the prior authorisation procedure in its transposition, which is not considered to be in compliance with the directive according to legal experts (DR news, 24 October 2013). Finally, transposition is regarded as inadequate with respect to practical application.

The Danish transposition did not reflect strong administrative capacity. On the contrary, the organisational and cognitive constraints within an administration with limited resources were apparent. On the one hand, poor administrative capacity resulted in a limited attention span, in which little time was allocated to consider alternatives and their effects. Instead of considering a more complete set of alternatives, the administration's responses sought routine and habituation, opting to rely on pre-existing national solutions. Other actors, including the regions, found it difficult to influence the process. Instead of shared knowledge and dialogue, the process was found to be secluded, delayed and difficult to access. In such a situation, heterogeneity of preferences becomes rather irrelevant, as transposition is

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<sup>6</sup> L33, pp.22-23.

<sup>7</sup> Idem, pp.25-27.

*de facto* in the hands of the ministerial actors alone. In a transposition process characterised by limited capacity, the actors opted for what was manageable within the limited set of options that the disturbing principles of the directive allowed. The Danish government could not turn back the clock and preserve the Danish GPs' role as gatekeepers, deny foreign patients access to Danish healthcare or refuse to reimburse residents for medicine purchased in another member state. However, it was able to focus on prior authorisation, and so it did. Here, the government maximised its attention and extended the use of authorisation beyond what is considered correct.

##### *5. The transposition of the patients' rights directive in the Netherlands*

The Dutch healthcare system comprises a public framework in which mostly private actors provide, purchase and insure healthcare. It consists of three components. First, the National Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*) is a universal, obligatory, and income-dependent insurance scheme covering long-term and high-cost medical treatments since 1968. In practice, clients generally receive AWBZ care as benefits-in-kind from contracted providers. Second, the Health Insurance Act (*Zorgverzekeringswet, Zvw*) is a universal and compulsory insurance scheme for basic healthcare in place since 2006. According to the Zvw, private health insurers have to accept any client. Clients can change health insurers on an annual basis. Insurers can offer two policies through which they reimburse patients for healthcare obtained anywhere in the world (maximised by the average tariffs on the Dutch market) or selectively contract with healthcare providers (if necessary abroad) to provide healthcare to their clients (although clients can obtain healthcare from non-contracted providers and receive reimbursement up to a certain level). The Zvw is financed through premiums paid directly to the health insurers and income-dependent contributions and taxes. In both

Zvw and AWBZ, clients require a GP referral to access specialist care. Finally, the third component comprises complementary, voluntary health insurance.

Particularly since the early 1990s, patients' rights to informed consent, information, privacy, and quality of care, complaint procedures and choice have been extended. However, patient choice was not previously uncommon. The Zvw of 2006 replaced an obligatory and public form of health insurance and a voluntary and private one. Privately insured individuals (nearly one-third of the population) could freely select a health provider for treatment. Notwithstanding this tradition of patient choice, insurers' selective contracting with health providers has remained the basic organisational logic of the new Zvw, particularly for reasons of cost containment. To both facilitate patient choice and selective contracting by health insurers, increasing amounts of information on the quality and safety of care and pricing have been made available.

### *5.1 The process of transposition in the Netherlands*

The obligatory public health insurance scheme preceding the Zvw had a system of prior authorisation to obtain planned healthcare from (foreign) non-contracted providers. The AWBZ still operates such a system. Until the 1980s, cross-border care remained limited to occasional airlifts for heart surgery and an arrangement for clients from a relatively isolated border region who could more easily access Belgian hospital care. Growing awareness of a borderless Europe in the early 1990s led not only to greater territorial circumscription of AWBZ health consumption but also to studies and experiments regarding cross-border healthcare, particularly in the border province of Limburg (Vollaard 2004). Furthermore, the increasing salience of waiting lists in the late 1990s prompted health insurance funds to facilitate access to Belgian and German health providers. In 2002, Dutch health insurers had contracts with 21 hospitals and 136 other health providers abroad. Although many Dutch report that they are willing to

use cross-border care, in practice, cross-border patient mobility has remained limited (Van der Schee and Delnoij 2004). Dutch patients received approximately 28,000 treatments (excluding emergency and long-term care) annually in Belgium between 2007 and 2010 (Observatorium voor Patiëntenmobiliteit 2012). In the Netherlands, 10,536 hospitalisations involved foreigners, principally from Belgium, Luxembourg and Germany in 2007, which represents 0.60% of the total number of hospitalisations (Vandermeulen 2009).

The CJEU verdicts on cross-border healthcare raised considerable concerns in the Dutch healthcare sector concerning the sustainability of its system of (selective) contracting and GP referral in the face of the free movement of goods and services (Vollaard 2004). In its verdicts, also concerning Dutch cases, to the relief of the Dutch, the CJEU indicated that certain exemptions from free movement are justified. Notwithstanding these concerns, free patient choice in Europe also received sympathy from certain parliamentarians and even ministers of health. Ministers also perceived cross-border healthcare as a useful safety valve for the waiting lists and did not expect cross-border patient mobility to grow rapidly based on the experiments and studies mentioned above (Vollaard 2004). In response to CJEU case law, the Dutch government abolished the distinction between domestic and foreign non-contracted providers, allowed access to non-hospital care without prior authorisation, and replaced national with international medical standards to determine the medical necessity of receiving healthcare elsewhere. The new Zvw of 2006 abolished the system of prior authorisation for basic healthcare. Regarding CJEU case law, however, the Zvw's explanatory memorandum indicated that the level of reimbursement should not discourage clients from obtaining healthcare within the EU. Moreover, many health insurance policies still include a system of prior authorisation for cross-border healthcare (Van Roermund 2008).

After the codification of CJEU case law, the health sector perceived any European legal initiative on cross-border healthcare as rather redundant. Partly reflecting the Eurosceptic mood following the referendum on the European Constitutional Treaty in 2005, the Dutch government responded very reluctantly to the draft directive in 2008 (interviews February 2012).<sup>8</sup> It eventually accepted the necessity of a directive for the member states that did not comply with CJEU case law, but stated, “our aim is that we don’t have to change anything in the Netherlands when we adopt that directive.”<sup>9</sup> The actively involved parliament initially regarded the draft directive as a violation of the principle of subsidiarity, as the organisation and financing of healthcare systems is primarily a national competence.<sup>10</sup> Parliament welcomed the final version of the directive, except for the left-populist SP, which perceived the directive as an instance of neo-liberal marketisation of health.

The government voted in favour of the directive, as it believed that the directive confirmed the Dutch interpretation of CJEU case law. The health minister consequently argued that with respect to the directive’s aim of codifying CJEU case law on reimbursement for cross-border healthcare, “[i]mplementation is in the case of the Netherlands not necessary, because the Netherlands already meets the requirements”.<sup>11</sup> The implementation plan adopted in November 2011 indicated that no legislative changes were necessary except for the establishment of a National Contact Point (NCP) and the mutual recognition of prescriptions. One of the Dutch negotiators of the directive coordinated the transposition process in the Ministry of Health. The ministry waited for further clarification on the NCP and prescriptions before taking further steps (Interview, February 2012).<sup>12</sup> The Ministry of Health did not consult the Dutch health sector (Interviews, February 2012; August 2013) but welcomed a visit by

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<sup>8</sup> cf. *Documents First Chamber 2007-2008*, 31.545F, letter of Minister of Health IZ-CB-U-2881572 (November, 3d 2008)

<sup>9</sup> *Documents Second Chamber*, 2009-2010, 21.501, no.228, Health Council (December, 15th 2010); cf. *Documents Second Chamber*, 2008-2009, 21.501-31, no.160, Health Council (December, 8th 2008); *Documents Second Chamber 2008-2009*, 21.501-31, no.174, Health Council (May, 29th 2009).

<sup>10</sup> *Documents First Chamber 2008-2009*, 31.545, no.5, Subsidiarity check directive (October, 2d 2008)

<sup>11</sup> *Documents Second Chamber*, 2010-2011, 21.501-31, no.235, Letter Minister of Health IZ3053582 (March, 4th 2011)

<sup>12</sup> See also *Proceedings Second Chamber*, 2011-2012, App.2664, Questions MP Voortman (April, 18th 2012)

DG SANCO officials in the autumn of 2012 and maintained contacts with fellow member states on the Committee of Cross-border Healthcare. Dutch representatives did not wish to play an active role in that Brussels committee for reasons of limited administrative capacity and the prevailing Eurosceptic political climate (interviews, February 2012; August 2013). Once a new transposition coordinator took office in the spring of 2012, concerns regarding timely transposition were growing in the health ministry. Confusion existed concerning the responsibilities of the directorates International Affairs, Pharmaceuticals, and Health Insurance (interview August 2013). The transposition also suffered from a lack of priority due to the impression that the Netherlands was already prepared and the change in personnel. However, the new civil servants could still rely on their predecessors and other experts to regarding all details of the cross-border healthcare dossier.

The ministry discussed several options for providing information to outgoing and incoming patients. Dutch health insurers could not serve as an independent source of information for their own clients, while they were not interested in offering information to clients from abroad (interviews, February 2012; August 2013). Contracting with a company to provide information to outgoing and incoming patients after a public tender procedure was eventually rejected as too inflexible and administratively time-consuming. In the winter of 2013, the ministry asked the Health Insurance Board (*College voor Zorgverzekeringen; CVZ*) to elaborate plans on a “slim version” of an NCP with a website and telephone service to inform patients about health quality policies and patients’ rights and refer them to individual health providers or health insurers for additional information (Interview, October 2013). The CVZ advises on the basic healthcare package, administers health insurance budgets, and manages the Social Security Coordination Regulation. Additionally, it was re-christened the Healthcare Institute in April 2014, also offering information on health quality, quality guidelines and the actual performance of health providers. The CVZ was considered the best candidate to be a NCP, and it expressed its willingness to be one. By early October 2013, the ministry of health officially designated the CVZ as the



Dutch NCP. It has yet to specify the new NCP tasks in law, as is required for all CVZ tasks according to the Zvw. For its part, CVZ “groped in the dark” concerning the requirements of an NCP (Interview, October 2013). The division of responsibilities regarding information sharing between member states, health providers and the NCP was unclear (Interview October 2013). The number and nature of contacts remained a “large uncertainty”. The CVZ largely relied on a report issued in December 2012 on behalf of the European Commission regarding establishing a website as centrepiece of the NCP. The Dutch website ([www.cbhc.nl](http://www.cbhc.nl)) with a contact form is planned to be operational in the summer of 2014. A direct telephone service will not be offered, as it is considered excessively expensive.

The implementing directive on the mutual recognition of prescriptions, published in December 2012, included specific rules on prescriptions to be incorporated in national legislation. One month too late, on November, 18th 2013, the Regulation Medicines Act was amended to this effect.<sup>13</sup> On December, 18th 2013, the Dutch government notified the European Commission of the transposition of both the patient’s rights and the implementing directives. From the perspective of the ministry, the transposition process was thus largely completed on schedule. Nevertheless, the Dutch transposition was subject to intense criticism from the outset. According to an independent legal expert, the government had much more “homework” to do (Van de Gronden 2011). First, the existing possibility to limit reimbursement of care received from non-contracted providers could discourage patients from using the generally non-contracted foreign providers, violating the principal of free access, particularly in extramural care. In addition, the choice between the directive and Social Security Coordination Regulation should be adopted in the Zvw. Furthermore, the incorporation of the right of cross-border healthcare and a system of prior authorisation into the Zvw would much more effectively guarantee patients’ rights vis-à-vis health insurers (Interview, October 2013). Ultimately, directives do not have direct force in the private-law relationships between patients and insurers

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<sup>13</sup> *Staatscourant* 2013 (November, 25th 2013), no. 33012

Criticism regarding incorrect transposition became more widespread when, in the autumn of 2011, the Ministry of Health expressed its desire to allow health insurers to fully refuse reimbursement for both extramural and intramural healthcare received from non-contracted providers (including foreign ones), as long as they indicate this refusal in health insurance policies in a timely and clear manner. The Ministry of Health reasoned that the patients' rights directive would allow it to do so, as it replaced the relevant CJEU case law. However, as Dutch health insurers have not many contracts with foreign health providers, the latter would be indirectly discriminated against while clients would be discouraged from seeking healthcare from foreign providers (Van de Gronden 2013; Van der Touw 2013). In addition, non-contracted care has not been acknowledged as an exemption to the free movement of health goods and services in EU law. The Dutch government argues that patients can still opt for a (more expensive) reimbursement policy with a free choice of health providers. However, while the aim of this directive is to codify relevant CJEU case law, the Dutch government has employed it to return patients' rights to the situation that existed before the CJEU case law developed since 1998, as the refusal to reimburse non-contracted providers even concerns extramural cross-border care. It is therefore unsurprising that the European Commission regarded the proposal as a violation of EU law.<sup>14</sup> The government's attempt to contain cross-border healthcare has been accompanied by a special inquiry into the rising costs of cross-border healthcare. The government seeks to maintain control of cross-border patient mobility, as it fears that increased use of healthcare abroad could reverse domestic efforts at health cost containment.<sup>15</sup>

## *5.2 Policy-entrepreneurs and institutional memory*

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<sup>14</sup> *Documents European Parliament*, E-004616/2013, Questions MEP Van Oomen and De Lange (April, 25th 2013)

<sup>15</sup> *Documents Second Chamber*, 2013-2014, 33.750, no.2, 37-38, State Budget (September, 17th 2013).

In contrast to all expectations, the directive was not transposed entirely on schedule in the Netherlands. The mutual recognition of prescriptions and the NCP tasks executed by the CVZ were not incorporated into national legislation before October, 25th 2013. More strikingly, the Dutch government attempted to make its health insurance legislation *less* in keeping with the directive. This demonstrates how a policy-entrepreneur can exploit a certain solution (the directive) to combat a different problem (cost containment) than planned (the codification of CJEU case law). More aspects of the Dutch transposition process reflected bounded rationality. The fluidity of personnel, the directive's limited priority and an unclear division of responsibilities led to delays in transposition. Nevertheless, the Ministry of Health considered various alternatives for establishing a NCP and selected the most rational option with respect to costs and benefits. Moreover, the change in personnel did not result in a loss of expertise. Nevertheless, as the proposal to limit reimbursements for non-contracted healthcare indicates, accurate information does not entail compliance with EU law. The emerging Dutch reservations concerning EU interference and cross-border healthcare have resulted in a growing divergence between the directive's goals and the preferences of the Dutch government and parliament. It is thus the heterogeneity of preferences between the national and EU levels rather than confusion regarding the contents of directive that explains the potential reversion of the Dutch compliance with EU legislation on cross-border healthcare.

## 6. *Conclusion*

The decision-making process of the patients' rights directive was marked by controversy. Has its transposition simply been a continuation of the conflicts by other means? In the cases of both Denmark and the Netherlands, continuing reluctance regarding EU interference in the organisation and financing of national healthcare is clearly present. Nevertheless, the delayed and incorrect transposition of the

patients' right directive is not simply a matter of antagonistic preferences. Moreover, it is also not possible that a simple misfit could explain the transposition processes in Denmark. Cognitive and organisational constraints such as the fluidity of participants, the loss of institutional memory, and a lack of priority certainly also had their effects, particularly in the Danish case. The scholarly literature has emphasised how organisational complexities such as the autonomy and multiplicity of actors and levels of government involved foster bounded rationality. The case studies above also emphasise the fragility of the limited number of staff members working on a certain decision. As the Danish case revealed, the dismissal and replacement of two experts reduced institutional expertise and memory. Transposition is likely highly conditional on the availability and consistency of expertise. This implies an organisational fragility, which may be a reason for the inconsistencies in the explanations of timely and correct transposition, as it requires not country-level or policy-specific but issue-specific knowledge on the part of the (few) civil servants involved.

The Dutch case also demonstrated how staff expertise is not necessarily lost after a change in personnel, as the predecessors and other experts remained available to the new staff. Cognitive and organisational constraints on (rational) decision-making may thus not be equally distributed across countries, policy sectors, or administrative units. Future research should therefore explore conditions under which EU legislation would be properly implemented from the perspective of bounded rationality. A lack of experience with transposition has already been identified as explanatory factor for delayed and incorrect transposition (Berglund et al. 2006; Steunenberg and Rhinard 2010). Mismatches between EU directives and national policies have also been identified as explanation (Steunenberg and Toshkov 2009). A larger misfit suggests greater uncertainty and ambiguity regarding how the directive should be transposed. This seems all the more likely when member states have to transpose new, complex directives offering substantial policy discretion in a relatively short time (*cf.* Kaeding 2006; Steunenberg and Toshkov 2009). The transposition process of new, complex directives are expected to entail greater

uncertainty and ambiguity concerning how they should be transposed among the actors in the policy sectors involved, whereas the time allotted to consider alternatives and their effects is rather limited. As the cases studies revealed, a bounded rationality perspective can thus be a fertile addition to the existing, yet inconclusive, explanations for timely and correctly transposition given the complexities of the multi-level European Union.

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