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INSTITUTIONAL ADAPTATION TO CROSS-BORDER HEALTH CARE IN THE GERMAN-POLISH BORDERLAND

1. The concepts of border and borderland

Border studies have experienced a renaissance of interest (Newman/Paasi 1998, Paasi 2000, Newman 2002) and are contemporary the object of research within many academic fields, e. g. sociology, human geography, history, and psychology – to mention only a few of them. Talking about boundaries, borders and borderland makes it necessary to define these terms. Many useful definitions have already been given by a lot of scientists though there is still a lack of a common interdisciplinary theory (Newman 2006). Different disciplines use different approaches to define terms in an appropriate manner (Wilson/Donnan 2000, Agnew 2001, Prescott 2008) and therefore often the same terms are not used in the same way or different terms are used as synonyms (Donnan/Wilson 2001). This article considers a boundary an abstract line, very often not even recognized by people since it only represents an artificial construct created for reasons of policy. A boundary only becomes a dividing demarcation after it has been manifested by putting up border fences and guard posts and by employing guards for controlling the cross border traffic and so on. The most interesting feature of borders can be seen in their *dual character* (Tägli 1983, Häkli/Kaplan 2002). On the one hand, borders *separate* countries and consequently cultures or economic areas thus causing distinctions between "us" vs. "them", "inside" vs. "outside" etc. In addition, borders do not only cause differences *between* countries but also *within* one state by creating socio-economic disadvantages for the inhabitants residing in the

periphery in comparison to those living in the core (House 1980). In effect, people of the borderlands considered as the relatively near border situated territory on both sides of the border are often forced to turn the obstacle into a chance by instrumentalizing the border for own purposes of earning or saving money. This can either happen in a legal way by e.g. crossing the border for buying food and clothes or in an illegal way by smuggling goods etc. (Zhurzhenko 2006). Therefore, a second, at the first glance contradictory feature of borders can be mentioned: They do not only separate, but also provide opportunities of intensified contacts and an exchange between the individual actors living in the borderland area. This assumption is the basis for this article since it postulates that a border and the corresponding borderland do not only restrict people's everyday life but that they can also be regarded as chances. In particular, the foundation of the European Union and the establishment of the Schengen Area play an important role in shedding light on borders as chances. Since border controls have been omitted within the Schengen area border traffic has been simplified enormously which in turn provided the opportunity of commuting between countries, of crossing borders only for refuelling etc.

2. The German-Polish borderland

The arguments stated above are also true for the German-Polish border since it can be considered a separating as well as a connecting line. The separating aspect results from the dynamically historical development of the German-Polish border. After the end of World War II Polish territory experienced a westward shift and the Oder-Neisse Line was defined as the new border. Silesia and parts of Pomerania and East Prussia were annexed to Poland, something that led to a cut of existing interpersonal relationships between people living on both sides of the river. On the Eastern bank of the river a resettlement caused a complete exchange of the population. Consequently, the Oder-Neisse region respectively the contemporary German-Polish borderland does not represent a territory where cultures and traditions could have developed over centuries as it was for instance the case in the German-French borderland. On the contrary, the radical change in the German-Polish border led to a deep cultural and linguistic gap and consequently alienation was dominating (Bernhardt 2006). The isolation policy pursued by the German Democratic Republic did not only further deepen the cultural gap but also cut economic cooperation and infrastructure.

However, Poland's joining of the European Union on 1st May 2004 as well as of the Schengen area on 21st December 2007 provided the basis for the mutual approach of both countries. In that respect, in particular the latter event is of importance since it represented the precondition for the cessation of border controls at the German-Polish border which in turn resulted in an intensification of border crossing respectively an increased exchange on the individual or micro level. Thus, the border's significance as a divider declined as the opportunities for exchange increased. Due to the significant price differential between Poland and Germany German citizens very often have been crossing the border in order to refuel, to go to the hairdresser, to buy clothes or food. It can also be observed that they order artificial limbs, dental implements or glasses because in Poland these products can be offered for much lower prices than in Germany.

3. Cross-border health care in the German-Polish borderland

However, a border crossing exchange cannot only be observed in the commercial area of consumer goods and products but also in the domain of cross border health care defined as the "healthcare a patient receives in a Member State different from the Member State in which he or she is insured" or "healthcare a health professional provides in a Member State different from the Member State in which he or she normally resides to work" (European Commission 2.07.2008). This articles, however, exclusively deals with the first aspect of the definition.

According to a survey conducted 2007 by the Gallup Organization in charge of the Health and Consumer Protection Directorate – General (DG SANCO) in the scope of the Flash Eurobarometer (European Commission & Gallup Organization 2007), 4% of all citizens of the European Union have already utilized cross border health care. These data correspond with the results found in a survey that was carried out within the scope of a project called EU-MED-EAST (State Capital Dresden 2004). Here, 4% of the German subjects contested that they have already used health care services in Poland. In addition, the European Commission pointed out, that 1% of the health expenditure is spent for cross border health care. These are approximately 10 billion Euros (European Commission 19.01.2011; MEMO/11/32). It has to be mentioned that this amount also includes the costs spent for non planned emergency cross border health care. As a result, the sum for planned cross border health care comes to less than 1% of this sort of health expenditure. Although at this point scepticism about the actual relevance of the

usage of cross-border health care still remains, the reader should be aware of the height of the absolute amount of money spent for cross-border healthcare.

The issue, however, this article deals with is the usage of cross border health care in the domain of out-patient treatment. In particular, it focuses on Polish spa resorts which have been treating German patients, insured at German statutory health insurances. They are allowed to use such a treatment abroad and to obtain reimbursement for a part of the costs. Nevertheless, they still have to finance a certain part of the treatment on their own. Consequently, they are interested in keeping their own proportion of costs rather low which often leads to the decision of using a treatment in Poland since there health care offers are much cheaper than in Germany. The legal basis for that was given after Poland had become a member state of the European Union in 2004 because in that moment the EU regulation No. 1408/71 came into force and entitled German customers to use Polish health care offers and receive reimbursements (see the judgment by the European Court of Justice in the cases Kohll [Case C-155/96; ECR 1998: I-1931] and Decker [Case 120/95; ECR 1998: I-1831] in 1998). Despite regulation No. 1408/71 and adjudication of the European Court of Justice there was still a lot of insecurity that determined people's decision not to make use of cross border health care.

In the aftermath of the recognized insecurity but at the same time increasing interest in cross border health care the Council of the European Union asked the European Commission to develop a proposal for clarifying issues related to cross border health care. This new *Directive of the European Parliament and of the Council on the application of patients' rights in cross-border health care* was presented on 2nd July 2008 by the Commission and finally accepted by the Council on 8 June 2010. It represents a supplement to the EU regulation No. 1408/71 but does not replace it. Moreover, it provides clear information on reimbursement and other important aspects of cross border health care and thus intends to reduce inequality and injustice concerning usage and access to high quality health care. It also aims to further the cooperation between the member states in order to enable the establishment and maintenance of a high quality health care within the European Union.

The new directive emphasizes that citizens of the European Union are entitled to use cross border health care and to obtain reimbursement. According to the guideline (EU) No. 883/2004 (European Parliament & European Council 29.04.2004) they have to apply for the treatment in advance. The approval can be rejected when the treatment in the chosen establishment would be a risk for the

patient's health or when the same treatment could also be provided in the state of residence within an appropriate time. Notwithstanding, the client always has the possibility of insisting on an examination of the rejection. Once accepted by the health insurance, the doctor treating the patient has to choose an appropriate accommodation in the respective country and the patient can travel to the chosen establishment. However, patients are only entitled to receive reimbursement for services abroad when the same service would be financed in the state of residence. In order to ensure that all interested patients have access to necessary information every member state is obliged to establish at least one information point within its country. This is anticipated to reduce the patient's insecurity regarding all issues related to cross border health care. The regulation No. 1408/71 and the new directive provide the basis for an increasing usage of cross border health care.

Issues of reimbursement for German insurants are also regularized in the German Social Welfare Code called *Fünftes Sozialgesetzbuch* (SGB V; § 13 Abs. 4–6 SGB V, Becker 2010). Before Poland joined the EU the only regulation regarding insurants between Poland and Germany was a social security agreement. According to §140e SGB V German statutory health insurances are entitled to conclude contracts with Polish providers. In the field of spa business the heath insurances usually renounce this right.

4. Changing institutions as a consequence of cross-border healthcare

4.1. Defining institutions

The inclining numbers of German patients using spa business in Poland resulted in a completely new situation for Polish spa hotels. Those establishments which are located in the Polish borderland faced a challenge in that they had to adjust their services and treatments to German customers´ demands and expectations. This required a modification and an adaptation of those structures and processes which had been taken for granted all the time. Those relatively fixed scripts and schemata of behaviour and non-challenged entities are called *institutions* (Scott 1995, 2008; Jepperson 1991). At this point it should be recognized that institutions and organizations are completely different entities though these terms are often intermingled. Whereas an organization characterizes an enterprise which tries to transform an input via a throughput into an output, thus establishing a value creation (Porter 1985), an institution is a relatively fixed pattern

of behaviour or an entity that is more or less taken for granted and not challenged anymore. Very often individuals internalize them during their socialization and act according to them without thinking about them anymore. Other institutions which are only valid in certain organizations have to be recognized and internalized during the engagement within that establishment (Weber 1972). Nevertheless, once accepted and routinized, they are perceived as external and independent from the individual and are therefore regarded as unchangeable (Durkheim 1908).

4.2. Old vs. new institutionalism

An appropriate theoretical approach portraying the just described thoughts is the *Neoinstitutionalism* (Zucker 1977, Meyer/Rowan 1977, DiMaggio/Powell 1983) which is contemporarily considered the most influential theory of organizational sociology. This approach is a further development of the old or classical institutionalism represented by Weber (1972), Etzioni (1961a, b) Selznick (1948, 1949, 1957) and other authors. They stressed the internal organizational structures and processes of an establishment, i. e. they concentrated on the self-contained organization and the institutions that enable it to produce efficiently and effectively. By focusing on internal processes and structures they neglected the influence of the society or environment. However, representatives of the new institutionalism are aware of the fact that organizations and economic action are embedded in society (Granovetter 1985, Zukin/DiMaggio 1990) and vice versa constitute them. Institutions diffuse all kinds of interactions of society and thus organizations (as constituting elements of society) are also expected to act according to certain institutions as well. Consequently, organizations pursue for double legitimacy: on the one hand they try to gain legitimacy by taking into consideration the expectations of the *institutional environment* (Meyer/Rowan 1977, DiMaggio/Powell 1983). On the other hand, they have to make sure that they act in accordance with their employees' ideas in order to legitimate organizational action *within* the establishment. For the discussed topic of Polish spa resorts adjusting to German customers' demands and thus pursuing for legitimacy it means twofold: Firstly, the establishments have to take into consideration the expectations of their patients of all nationalities as well as the national and EU-laws affecting spa business. Secondly, they have to ensure their employees' goodwill and support. In other words, it has to seek for external and internal legitimacy.

A second very important difference between old and new institutionalism is that the first ones believed in institutions defined by people in leading and managing positions which are exerted onto individual actors working on the operating basis. By behaving accordingly to them institutions are being established in *top down* processes. This has been taken into consideration by the neoinstitutionalists as well but in addition to that they became aware of the fact, that individual actors (in the organization the employees of the basis levels) play an important role in the establishment, reproduction and change of institutions. This was empirically proven by Zucker (1977) and further developed by Tolbert/Zucker (1996) in their diachronic schema demonstrating the habitualization, objectivation and sedimentation of institutions. In contrast to the old institutionalists they knew that institutions do not only dictate certain rules for behaviour but also provide a frame for interpretation and thus leave room for decision making and manoeuvre. They provide a frame within which members of society and of organizations have to move. By using this range of interpretation and thus slightly deviating from the mean, people are able to change institutions in the long term. In this way, the neoinstitutional approach also considers *bottom up* processes.

To put it in a nutshell, neoinstitutionalism takes over the idea of the old institutionalism that institutions formulated by leading persons are exerted onto employees and by constant obedience of them the expected behaviour becomes institutionalized and is not challenged anymore. In addition to that, neoinstitutionalists do not underestimate the importance of individual actors who are involved in the establishment and maintenance of institutions.

4.3. Modification of institutions

Applied onto the discussed problem of changing institutions in Polish spa resorts as an adaptation to the increasing number of German customers it can be claimed that medical personnel like physicians, nurses and physiotherapists actively and deliberately think about the new situation and try to find appropriate solutions. Sometimes they are able and allowed to implement them without approval by the manager or any other leading person but sometimes they can only think about new options and put forward their proposals. This active interpretation and cognitive analysis of the challenge and the according behaviour represent bottom up processes. Meanwhile, managers are also entitled to exert certain rules and norms and to expect their fulfilment. This is a top down proc-

ess. As can be recognized, the individual behaviour of those people acting on the basis (nurses, physicians, physiotherapists etc.) on the one hand and the individual decision making and leadership by people of higher positions lead to a constant interaction of bottom up and top down processes. Thus, the emergence of tension and conflicts are very likely. Nevertheless, all members enter a generative dialog with each other (Gergen/Gergen/Barrett 2004) and by theorizing the topic they come to compromises and often find the best solution for the discussed problem. This solution is being practiced and becomes institutionalized over time. In the case of adaptational processes within Polish spa resorts they could agree on the development of new scripts for admission and discharge as well as for different treatment forms, they could decide to introduce new multilingual labels and signposts for special premises. But not only spatial hints but also official announcement, treatment schedules, menus, but in particular invoices have to be printed in Polish and German which in turn requires the employment of German speaking staff. Moreover, with Poland's EU membership and the new possibilities for German customers to apply for reimbursement of part of their treatment expenses in Poland invoices have to fulfil the criteria of German health insurances. If they do not, they will not be accepted and reimbursement will be rejected. In order to satisfy their patients, spa hotels have to make an effort to be in accordance with these demands of the EU.

4.4. Index of successful adaptation

Institutions do not only constrain people's behaviour but also create self-confidence and stability (Scott 1995, Jepperson 1991) in that they provide certain cognitive schemata, scripts and normative elements leading people's behaviour thus making behaviour predictable. As long as the partner of interaction behaves according to the established institutions the acting person feels self-confident and knows how to react. Institutions, however, vary over different cultural communities, i.e. institutions which are established and accepted in a certain society are not necessarily familiar to people of another country. Applied onto the topic it means that institutions in Germany and Poland are not necessarily congruent. When the adjustment of institutions within Polish spa resorts has failed and the personnel behaves in a rather unfamiliar (still Polish) manner towards German customers, the latter ones do not know how to react and become irritated to a certain extend. Consequently, the success of institutional adaptation within the investigated or-

ganizations can be operationalized via an index of irritation: The more the Germans feel comfortable and self-confident about how to behave within a Polish spa resort, the more successful was the adjustment. In other words, the lower the index of irritation, the better the adjustment. This index can be considered a possibility of measuring the success of institutional adaptation empirically.

Final remark

Having outlined the situation of Polish spa resorts face as a consequence of increasing cross-border health care used by German insurants this article demonstrates a new topic onto which neoinstitutionalism can be applied and depicts an opportunity the success of institutional adaptation can be measured. The assumptions made in this article should be verified empirically in future research.

REFERENCES CITED

Agnew, J. A. (2001): *Reinventing Geopolitics: Geographies of Modern Statehood*. Heidelberg: Department of Geography.

Becker, U. (2010): *SGB V: Gesetzliche Krankenversicherung. Kommentar* (2nd revised ed.), München: Beck.

Bernhardt, C. (2006): *Grenzregionen im Zeitalter des Kalten Krieges: Regionalentwicklung und Umweltpolitik an Rhein und Oder nach 1945*, in: S. Penth, M. Pitz, C. v. Hoof, R. Krautkrämer (eds.): *Europas Grenzen*, St. Ingbert: Röhrig Universitätsverlag, pp. 205–228.

Council of the European Communities (14.06.1971): Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31971R1408:EN:NOT (4.07.2011).

DiMaggio, P. J. / Powell, W. W. (1983): *The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields*, "American Sociological Review", 48 (2), pp. 147–160.

Donnan, H. / Wilson, T. M. (2001): *Borders: Frontiers of Identity, Nation and State*. Oxford: Berg.

Durkheim, É. (1908) : *Die Methode der Soziologie*, Leipzig: Klinhardt (original published 1895: *Les rčgles de la méthode sociologique*).

European Commission (2.06.2008): *Opening the door to better healthcare across Europe. Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border health care*, http://ec.europa.eu/health-eu/doc/crossborder_brochure_en.pdf (27.06.2011).

European Commission (19.01.2011; MEMO/11/32): *Q&A: Patients' rights in cross-border healthcare*, http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/11/32&format=HTML&aged=0&language=DE (4.07.2011).

European Commission & The Gallup Organization (2007): *Cross-border health services in the EU. Brussels*, http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (27.06.2011).

European Parliament & European Council (29.04.2004): *Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland)*, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32004R0883:EN:NOT (4.07.2011).

Etzioni, A. (1961a): *Complex Organizations. A Sociological Reader*, New York: Holt.

Etzioni, A. (1961b): *A Comparative Analysis of Complex Organizations*, New York: Free Press.

Gergen, K. J. / Gergen, M. M. / Barrett, F. J. (2004): *Dialogue: Life and Death of the Organization*, in: D. Grant, C. Hardy, C. Oswick, L. Putnam (eds.): *The Sage Handbook of Organizational Discourse*, London: Sage, pp. 39–59.

Granovetter, M. (1985): *Economic Action and Social Structure: The Problem of Embeddedness*, "American Journal of Sociology", 91 (2), pp. 481–510.

Häkli, J. / Kaplan, D. H. (eds.) (2002): *Boundaries and Place: European Borderlands in Geographical Context*, Lanham: Rowman & Littlefield.

House, J. (1980): *The Frontier Zone: A Conceptual Problem for Policy Makers*, "International Political Science Review", 1 (4), pp. 456–477.

Jepperson, R. L. (1991): *Institutions, Institutional Effects, and Institutionalism*, in: W. W. Powell, P. J. DiMaggio (eds.): *The New Institutionalism in Organizational Analysis*, Chicago: University of Chicago Press, pp. 143–163.

Meyer, J. W. / Rowan, B. (1977): *Formal Structure as Myth and Ceremony*, "American Journal of Sociology", 83 (2), pp. 340–363.

Newman, D. (2002): *Boundaries, Territory and Postmodernity*, London: Cass.

Newman, D. (2006): *The Lines that Continue to Separate Us: Borders in Our "Borderless" World*, "Progress in Human Geography", 30 (2), pp. 143–161.

Newman, D. / Paasi, A. (1998): *Fences and Boundaries in the Postmodern world: Boundary Narratives in Political Geography*, "Progress in Human Geography", 22 (2), pp. 186–207.

Paasi, A. (2000): *Territories, Boundaries and Consciousness*, New York: John Wiley & Sons.

Porter, M. T. (1985): *Competitive Advantage*, New York: Free Press.

Prescott, J. R. V. (2008): *International Frontiers and Boundaries*, Leiden: Martinus Nijhoff Publishers.

Scott, W. R. (1995): *Institutions and Organizations*, Thousand Oaks: Sage.

Scott, W. R. (2008). *Institutions and Organizations* (3th ed.), Los Angeles: Sage.

Selznick, P. (1948): *Foundations of the Theory of Organizations*, "American Sociological Review", 13 (1), pp. 25–35.

Selznick, P. (1949): *TVA and the Grass Roots*, Berkley: University of California Press.

Selznick, P. (1957): *Leadership in Administration*, New York: Harper & Row.

State Capital Dresden (2004): *Regionale grenzüberschreitende Netzwerkbildung im Gesundheits- und Sozialwesen*, http://www.healthregio.net/bilder/Sch%F6nePPT.pdf (18.08.2011).

Tägli, S. (1983): *The Question of Border Regions in Western Europe: A Historical Background*, in: M. Anderson (ed.), *Frontier Regions in Western Europe*, London: Cass, pp. 18–33.

Tolbert, P. S. / Zucker, L. G. (1996): *The Institutionalization of Institutional Theory*, in: R. S. Clegg, C. Hardy, W. R. Nord (eds.): *Handbook of Organization Studies*, London: Sage, pp. 175–190.

Weber, M. (1972): *Wirtschaft und Gesellschaft. Grundriss der verstehenden Soziologie* (posthumously created from his unfinished work of 1921/22), Tübingen: Mohr.

Wilson, T. M. / Donnan, H. (2000): *Border Identities: Nation and State at International Frontiers*, Cambridge: Cambridge University Press.

Zucker, L. G. (1977): *The Role of Institutionalization in Cultural Persistence*, "American Sociological Review", 42 (5), pp. 726–743.

Zukin, S. / DiMaggio, P. (1990): *Structures of Capital: The Social Organization of the Economy*, Cambridge, UK: Cambridge University Press.

Zhurzhenko, T. (2006): *The New Post-Soviet Borderlands: Nostalgia, Resistance to Changes, Adaptation. A Case Study of Three Near-Border Villages, Kharkiv Oblast, Ukraine*, in: M. Hurd (ed.): *Border Crossings: Territory, Memory and History in North and East Europe*, Eslöv: Gondolin, pp. 57–87.

DOSTOSOWANIE INSTYTUCJONALNE DO TRANSGRANICZNEJ OPIEKI MEDYCZNEJ NA NIEMIECKO-POLSKIM POGRANICZU

Streszczenie

Wstąpienie Polski do Unii Europejskiej 1 maja 2004 roku stworzyło prawne podstawy do korzystania przez Niemców z oferty polskiej opieki zdrowotnej oraz do zwrotu części poniesionych kosztów. Ponadto zniesienie kontroli granicznej na granicy niemiecko-polskiej 21 grudnia 2007 roku znacząco uprościło przekraczanie granicy. W rezultacie niemieccy pacjenci coraz częściej korzystają z terapii uzdrowiskowych w polskich kurortach ulokowanych blisko granicy. Z drugiej strony sytuacja ta wymusiła na polskich uzdrowiskach konieczność dostosowania się do wymagań niemieckich klientów. Dostosowanie to spowodowało modyfikację i powstanie standardowych jednostek oraz w miarę stałych sposobów postępowania, określanych mianem instytucji. Zarówno kadra kierownicza, jak i personel zatrudniony w uzdrowiskach muszą identyfikować te instytucje oraz modyfikować je i dostosowywać do nowej sytuacji, tzn. leczenia także niemieckich pacjentów. W artykule skupiono się na kwestiach instytucjonalnego dostosowania w Polskich uzdrowiskach i próbowano wskazać możliwości jego oceny.