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European dimensions of Health Politics in Austria:

The Case of Cross-border Healthcare

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Abstract

During the last couple of years sociological approaches in Europeanization research have gained an increasing attention by scholars. This paper suggests a bottom-up approach in researching the EU's impact on Member States by using the "usages of Europe" concept (Jacquot&Woll 2008, 2010) in the field of healthcare. A series of European Court of Justice's landmark rulings on cross-border patient mobility made Member States fear that the boundaries of their healthcare systems could become dangerously porous. This paper therefore inquires if the EU rules on cross-border provision of healthcare change the politics in EU Member States and if healthcare providers will strategically "use" Europe to advance their own interests that would result in a possible "destructuring of national welfare boundaries" (Ferrera 2005). Since the "usages of Europe" concept does not specify the conditions for actors using Europe, the paper argues that path-dependent logics of action defined by the set-up of the national healthcare system determine actors' strategies of using Europe. Taking evidence from two Austrian cross-border healthcare projects, the paper argues further that providers can make use of Europe to their benefit, but do not "escape" from their national healthcare system and leave the national boundaries largely intact.

Introduction

The EU is challenging the boundaries of national welfare states (Ferrera 2005) in various ways: welfare states that have once been created for the national population must allow carrying benefits from one country to another. In the field of healthcare provision the European Court of Justice has put the topic of cross-border healthcare on Brussels' political agenda. The rulings delivered by the Court have facilitated the access to medical treatment for patients in other Member States. While the issue of cross-border healthcare has been framed in Brussels in terms of patient's rights, the Court's decisions are largely based on the principle of non-discrimination of national healthcare providers against healthcare providers from other EU countries (Greer, 2009, p. 42). In order to see how far national healthcare systems can be Europeanized due to such rules, a bottom-up approach is used. Previous studies (e.g. Sindbjerg Martinsen & Vrangbæk 2008; Obermaier 2009) have used a top-down approach, concentrating on governmental, judicial aspects and the transposition of EU rules, but have usually neglected actors' responses. The paper asks therefore if the EU rules on cross-border provision of healthcare change the politics in EU Member States and if healthcare providers will strategically "use" Europe to advance their own interests that would result in a possible "destructuring of national welfare boundaries" (Ferrera, 2005). To answer this question a sociological approach will be used. It looks at the "usages of Europe" that actors can make (Jacquot&Woll 2008, 2010). Yet, this approach does not imply a certain outcome of actors' usages. A combination of the "usages of Europe" approach with historical institutionalism and path dependence is suggested. The argument that is put forward here is that actors in a healthcare system such as healthcare providers will make use of Europe in order to pursue their own goals. Path-dependent logics of action will define however this usage of Europe and thus result in a strategy where providers can make use of Europe to their benefit, but do not "escape" from their national healthcare system and leave the national boundaries largely intact. This argument is tested on Austria which borders 'old' and 'new' Member States. The focus will be on two cross-border projects: the first one is situated between Upper Austria and Southern Bavaria and is hence a co-operation with an 'old' Member State. The project operates between two countries of the same language and with similar price-levels in healthcare provision. The second project is set up between the region of Lower Austria and the Czech region of Southern Bohemia and is thus a co-operation with a 'new' Member State. It operates between two countries with different languages and substantial differences in prices of healthcare services. For the comparison only Austrian actors' strategies and perceptions are considered. Since such co-operation is the most pronounced form cross-border co-operation of healthcare providers, possible effects on the national healthcare system should be visible.

The paper is structured in three parts. The first part describes the relationship between national healthcare systems and the EU, and summarizes the Court's rulings and the potential destructuring effects on national healthcare systems. The second part develops the analytical framework while the last part applies it to the above-mentioned case. The empirical section is based on secondary literature on the Austrian healthcare system, primary literature (such as reports by the analyzed cross-border projects, newspaper articles) and 30 semi-structured interviews carried out with relevant actors of the Austrian healthcare system (federal, regional and local level) from August 2009 till January 2011, while mostly interviews concerning the projects are used here. Interviews have been conducted and transcribed in German. The parts of interviews that are presented in the paper have been translated by the author.

Cross-border access to healthcare in the EU – a threat to national welfare state boundaries

Health policy as a part of the state's social policy is a core element of national welfare regimes (Steffen, Lamping & Lehto, 2005, p. 1). Healthcare systems do not only regulate the access to healthcare and its financing, but they also regulate major actors' interests such as physicians, patients, providers and the pharmaceutical industry (Freeman 2000, p. 8). It is thus not surprising that EU Member States consider healthcare policies as a genuinely national competence and have been reticent to transfer any competencies to the European level (Steffen, Lamping & Lehto, 2005, p. 3).

Co-ordination mechanisms of social security systems covering also healthcare, have nonetheless been in place at the EU level for several decades. The main legislation relevant to the topic is the recently amended Regulation 1408/71 EC. The Regulation ensures that EU citizens staying in another Member State have access to the other Member State's healthcare systems for emergency medical treatment. The Regulation also permits medical treatment in another Member State if the national healthcare system cannot provide a specific treatment. For such a treatment prior authorization of the national health authorities or the relevant sickness funds is necessary (Hervey & McHale, 2004, p. 115). But patients also might want to seek planned non-emergency medical treatment in other Member States for various reasons. With regard to these patients the European Court of Justice has issued several rulings starting 1998 that have put "patient mobility law" on the EU's agenda (Greer & Rauscher, 2011, p.4). These landmark rulings have started to challenge the boundaries of the Member States' national healthcare systems.

The first two Kohll and Decker cases that were referred to the European Court of Justice (ECJ) in 1998 by national courts for preliminary rulings concerned Luxembourg's citizens (European Court of Justice, 28.04.1998b; European Court of Justice, 28.04.1998a). The ECJ ruled that healthcare services are no exception to the Treaty regulations on services in general and that patients could get ambulatory care without prior authorization in other Member States than their home Member States (European Court of Justice, 28.04.1998b). In subsequent rulings the ECJ "fine-tuned" its legal position (Obermaier 2009, p. 191) considering that prior authorization will be still necessary for hospital care (Harvey & McHale, 2004, p. 132). In the last ruling of 2006 on the Watts case, the ECJ decided that the prior rulings would apply to all Member States (European Court of Justice, 16.05.2006). This prevents Member States from obliging patients to use national healthcare providers, i.e. Member States cannot "discriminate" in favor of their own providers against providers in other countries" (Greer & Rauscher, 2011, p.4).

The rulings on patient mobility can thus be interpreted as a "dramatic case of neo-functionalist spillover dynamics" (Greer, 2006, p. 142) of the EU's internal market. Member States' obligation to reimburse patients without prior authorization for medical treatment of a physician in another Member State jeopardizes for example a conception of healthcare services that is linked to national

territory (Lamping, 2005, p. 31). Member States had quite diverging views on the ECJ's rulings and several Member States found that the "case-law is formulated too much in favor of the internal market" (Sindbjerg Martinsen, 2007, p. 38). This development has consequently triggered a process of political discussion and bargaining between Member States, the Commission and the European Parliament to codify the Court's rulings in a Directive. This process has lasted over ten years in which the issue of cross-border healthcare has been politically framed in terms of patient's rights, even though the Court's decisions are largely based on the principle of non-discrimination of national healthcare providers against healthcare providers from other EU countries (Greer 2009, p. 42). A first Commission's proposal for a Directive (Commission of the European Communities, 02.07.2008) trying to create a bridge between legal requirements and political controversy (Sindbjerg Martinsen, March 2009, pp. 14f), failed to get a final agreement by Member States. Only in March 2011 an agreement could be reached on the Directive 2011/24 "on the application of patients' rights in cross-border healthcare" which still has to be transposed into national law by Member States.

While some Member States had already transposed the rulings into national law, others wanted to wait for a Directive. In Luxemburg the rulings have even led to a confrontation between the national medical association and sickness funds regarding treatment rates (Baeten, Coucheir & Vanhercke, 2009, pp. 6–8). The different views of Member States on implementation have further implications than just complying with European law. The long process of political bargaining points at the complex structures of national healthcare systems that are influenced by the 'EU variable' and national actors such as providers can now try to gain legitimacy for their demands from the new European patients' rights (ibid.). According to Ferrera (2005, p. 219ff) these new options for action can lead to a situation in which the national boundaries of welfare states are even further challenged: "a novel opportunity structure gradually emerges, prompting actors to reconsider their spatial positioning, their confrontational strategies, and their traditional loyalties [...] the internal order of the pre-existing bounded space is subject to increasing challenges and is gradually destabilized" (ibid.). Using the concept of Europeanization, it will be thus inquired what kind of "usage" actors will make of the European options for action in healthcare.

Europeanization and the "usages of Europe"

According to Radaelli (2000, p.1) "Europeanization refers to: Processes of (a) construction (b) diffusion and (c) institutionalization of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and shared beliefs and norms which are first defined and consolidated in the making of EU decisions and then incorporated in the logic of domestic discourse, identities, political structures and public policies". The advantage of this rather broad definition is that it leaves the choice of the analytical tools to be used to the researcher but alerts us that 'ways of doing things' is a concept of great subtlety (Ladrech 2010, p. 15). This definition aims at taking account of the complex relationship between the EU and the Member States. Instead of having a unidirectional conception of the EU's impact on Member States (top-down perspective), it allows to consider Member States' reactions and what they try to upload to the European level (bottom-up perspective). We can thus think of different institutions, actors and levels of action that might change at the same time. Insofar Europeanization is not a simple linear process of adaptation, but rather a circular process in which Europeanized Member States upload their interests. This process has an impact on European integration which in turn will again lead to an impact on the national level, influencing once more the European level (Saurugger 2010, p. 259).

When it comes to the Europeanization of national policies, the most prominent concept used to describe the mechanism that 'triggers' domestic change is the 'goodness of fit' concept. It assumes that the pressure that is exerted on the national level depends on the "fit" or "misfit" between domestic policies or institutions with EU requirements. The lower the compatibility between these

two variables, the higher will be the pressure on the Member State to adapt and to change its policy or institutions (Ladrech 2010: 32). So far, several studies have been carried out on the impact of the ECJ's rulings on cross-border healthcare on Member States' systems using the misfit concept and/or looking at factors that determine the change that occurs on Member State level (Sindbjerg Martinsen, 2005; Sindbjerg Martinsen and Vrangbæk, 2008; Obermaier, 2009). What these previous studies all have in common is that they take a top-down approach of Europeanization as their analytical point of departure and mostly focus on administrative or legal and institutional factors, even if they consider certain political preferences. Furthermore the classical goodness of fit concept is applied to explain at least partially domestic change. However, with regard to the complexity of Europeanization processes there seems to be a 'blind spot' in these studies, given that not only institutional factors are important, but that national actors also play a crucial role. As Radaelli points out:

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

Consequently, I want to suggest an analytical framework that combines both a sociological approach focusing on actors with a historical institutionalist approach respecting the institutional legacy of healthcare systems in order to complement institutionalist accounts of Europeanization. This is based on the assumption that "institutional approaches to the EU would greatly benefit from a dose of sociological thinking" (Jenson & Mérand 2010, p. 74). Sociological approaches to study the EU are very heterogeneous and a common research-agenda is lacking, these approaches are based upon a common research standard. According to Saurugger (2009, p 936) sociological approaches stand out due to two factors: first, they focus on the interaction of individuals or smaller groups, concentrating on dynamics of European integration may they be institutional, cognitive, political or sociohistoric. Second, when it comes to European integration, the focus of research is on "the complex processes which can be found in the heart of integration" (ibid., p. 937). This research agenda requires a bottom-up design which "starts from actors, problems, resources... at the domestic level. ... A bottom-up approach checks if, when, and how the EU provides a change in any of the main components of the system of interaction" (Radaelli 2004, p. 4).

One of these sociological bottom-up approaches concerns the 'usages of Europe' developed by Jacquot and Woll (2003, 2004, 2008, 2010). Their approach tries to go beyond the goodness of fit approach and the pure study of institutional constraints in Europeanization research. They argue that policy change on the national level can occur without any adaptive pressures from the EU level since "the European Union can become a vector of change by providing new resources ... which policy actors use strategically" (Woll & Jacquot, 2010, p. 113). In this perspective national actors are considered as the mediators of European requirements since they have the capability of filtering and using them as a resource to follow their own agenda on the domestic level (Jacquot, 2008, p. 21). The focus is hence on the strategic interactions of individuals and on the resulting strategic and cognitive dynamics of Europeanization. Yet actors will not have an automatic response to a given EU input into the national system. They are able to learn and to use this learning process for their advantage. Actors can chose to interpret, engage with or even ignore European integration. The concept of the 'usage of Europe' is therefore defined as "social practices that seize the European Union as a set of opportunities, be they institutional, ideological, political or organizational" (Woll & Jacquot, 2010, p. 116). This definition implies that the resources and constraints that are supplied by the EU for individual action are not sufficient for strategic action. An actor will intentionally have to make use of these resources. This voluntary action might however not lead automatically to the strategic goal set by the actor since the effects of an individual action are difficult to predict. An actor thus will in turn have to adapt to his environment which influences their behavior on the long run (ibidem.).

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

Will healthcare providers in cross-border projects make a use of Europe in such a way that national welfare boundaries can further challenged? Or put differently: "what do they perceive to be the right and the wrong way of pursuing their goals (strategy) in a given social interaction. In other words, which ideas do they hold about what their interests are?" (Jenson & Mérand, 2010, p. 85). This focus on actors alone however does not imply a certain outcome and would underestimate the institutional framework which surrounds actors. It would not do justice to national healthcare systems that are "built on strong historical and institutional legacies" (Sindbjerg Martinsen, 2005, p. 1031). I therefore suggest combining "usages of Europe" approach of with a historical institutionalist approach, especially since both approaches are complementary to each other: "Contemporary sociological approaches may in fact have more to do with institutionalism than with constructivism. Here, we are talking about two kinds of institutionalism in particular: historical and organizational institutionalism" (Saurugger & Mérand, 2010, p. 6). The historical legacy of a healthcare system will thus also influence actors' strategies: once a welfare state with a healthcare system has been installed it sets incentives for a certain way of action for social and political actors. All actors involved will invest in the existing structure of interest mediation of a welfare state. Because of these investments the decisions of the past that have set up these distinct welfare state structures are difficult to reverse and causing institutional inertia (Pierson, 1993, pp. 608/609). Insofar a healthcare system sets also the rules of the game for actors and determines the costs of alternative strategies that actors could pursue (ibid., p. 596):

"[...] welfare institutions structure debates, political preferences and policy choices. They affect the positions of various actors and groups involved in reform processes. They frame the kind of interests and resources that actors can mobilize [...]" (Palier, 2010, p. 27).

While path dependence is a useful explanatory variable for inertia it lacks however analytical strength in explaining why some change can occur nonetheless (Hassenteufel, 2008, p. 244). This is where actors' usage of Europe comes in. European requirements come from the outside of the national system and actors will be able to make use of them as described above. They will have to weigh their strategic options that the EU provides against the position and resources their national system has allocated them, but also against the interests of other actors in the respective healthcare system. Thus providers in a national healthcare system might want to use the Europe for their own benefit, but this usage will be determined by a path-dependent logic of action preventing an "escape" from the national healthcare system. The following chapters will briefly explain the Austrian healthcare system and test this argument on two cross-border healthcare projects.

The Austrian healthcare system

The Austrian welfare state is a "prototypical Bismarckian welfare state" (Obinger & Tálos 2010: 101): and the healthcare system is mainly funded by payroll contributions on a pay-as-you-go basis. The organizational principle is based on the principle of self-administration: board members of the social insurance branches are usually nominated by the Austrian Trade Union Federation (chambers of

labor) and the employers' counterpart (chambers of economy). These chambers are statutory organizations representing capital and labor (ibid. 102 ff).

The healthcare system is the second biggest branch of the Austrian welfare state with around 30% of welfare expenditure being spent on the healthcare system. Most citizens are insured by compulsory health insurance (98% of the population). Sickness funds are funded with payroll contributions by employers and employees. A significant part of the healthcare expenditure is also funded by the state's general tax income. This money is mostly used to finance the hospital infrastructure (Heitzmann & Österle 2008, p. 53ff).

The structure of the Austrian healthcare system is quite complex due to the corporatist self-administration of the social insurance system and the federalist structure of the Austrian polity. While the federal government can only enact general or basic legislation regarding the hospital sector, Austria's nine states (*Länder*) regulate the more precise implementation and enforcement of laws regarding the hospital sector and own most hospitals. On the other hand, ambulatory treatments in the outpatient sector are regulated by negotiation between the chambers of physicians (Medical Association) and 21 health insurance funds and the Federation of Austrian Insurance Institutions (Hofmarcher & Rack 2006, p. xviii). The healthcare system is thus marked by an organizational separation between the outpatient sector and the inpatient sector (Theurl 1999, p. 334). Most *Länder* with the exception of Vienna have re-organized their hospital sector during the last years. Hospitals have been privatized in forms of organizational privatization: an operating company runs the hospitals while the *Länder* as owners of these companies act as guarantors through 'health funds' (*Gesundheitsfonds*) (Hofmarcher & Rack 2006, p. xviii).

The ageing of Austrian society, technological advancement of treatment methods have led to a steady increase of healthcare expenditure since the 1970s. In order to limit healthcare expenditure, state control was reinforced over the fragmented healthcare system and the latest healthcare reforms have aimed at reorganizing the organization and financing of the hospital sector (Obinger & Tálos 2010, p. 111). This gave also rise to a discussion on the number of hospitals operated by the *Länder*. Recently the Austrian Court of Auditors (*Rechnungshof*) has published a report that illustrates the political debate: a study on administrative reforms shows that hospitals with less than 300 beds show a lack of cost-efficiency. However, 60% of Austrian hospitals have less than 300 beds for medical treatment. For acute treatment the number of hospital beds per 1000 inhabitants is 70% higher than the EU-15 average (Rechnungshof 31.05.2010, p. 12).

Guarantees by *Länder* governments that local hospitals will not have to close are said to prevent saving effects and the tabloid press used this allegation to call small and less efficient "political hospitals" (Kronenzeitung 08.06.2010). A suggestion by a federal secretary of state to think about the closure of smaller hospitals was immediately refuted by several *Land* prime-ministers (Tiroler Tageszeitung, 10.05.2010). Besides these internal factors Austria's geographical position plays a role for Austria's healthcare system. With the last EU enlargement, the last remaining barriers for cross-border healthcare have been removed between Austria and its Northern, Eastern and Southern neighbors. EU enlargement has thus increased opportunities for cross-border healthcare in Austrian border regions, especially given that treatments are available at lower costs in Austria's neighboring Eastern countries (Österle 2007, p. 113). This creates several opportunities:

"[...] individuals travelling to other countries searching for better and/or cheaper care will induce reactions by (potential) providers. Developments may also be driven [...] by single providers or small communities. [...] This includes cross-border cooperation initiated by national or subnational actors such as hospitals or single insurance funds [...]" (Österle 2007, p. 122).

The Austrian health insurance is furthermore in line with EU rulings on patient mobility. The General Social Security Act states that a patient, who receives ambulatory care or inpatient treatment with providers that are not affiliated to sickness funds, will receive reimbursement for the medical

treatment: the reimbursement is fixed at 80 percent of the amount the sickness fund would have paid for the treatment to a contracted provider. The reduction of 20 percent is justified by additional administrative costs for the sickness funds. The Austrian healthcare system therefore offers already the possibilities granted by the ECJ besides the possibilities of Regulation 1408/71 (Obermaier 2009, p. 79/80). Given these circumstances, what use do regional actors make of Europe?

Cross-border healthcare projects in border regions

Austrian-German co-operation

The Austrian Land of Upper Austria borders with its northern part the southern region of the German Land of Bavaria. Both regions are separated by the river Inn, which is also the border between Germany and Austria. On the Austrian side of the river the town Braunau can be found. Right across the river the German town of Simbach faces its Austrian “counter-part”. Both towns are linked by a bridge and both operate hospitals. The Austrian hospital is operated by the catholic Order of the Sisters of Vöcklabruck, but co-financed through taxes by the Upper Austrian Health Fund. The project started in 1994 when the surgical department of the German hospital had to be closed and a treaty was negotiated between German sickness funds and both hospitals. It was agreed that German patients could undergo surgical treatment in the Austrian hospital of Braunau. This agreement was later extended to pediatric treatments, and from 1999 onwards Braunau used the CT scanner facilities of the German hospital for its patients. In 2004 a general renovation of the Austrian hospital was decided. In order to stay operational two departments with 30 beds out of a total of 140 beds have been transferred to the German hospital by a rental agreement. Meanwhile around 2000 Austrian patients are being treated each year in the ‘Austrian’ departments that are rented out by the German hospital (Krankenhaus St. Josef Braunau, 12 January 2011). As a result, the project was the first EU-wide project to treat two different ‘patient nationalities’ in a common structure. The EU could be used as a financial resource in 2004: around 200 000 Euros have been paid by the European Structural Fund for implementing a barrier-free access to cross-border healthcare in both hospitals. While this money was used to practically implement the setting up of treatment structures for the transport between both hospitals and for the medical coordination, other obstacles that are related to cross-border medical care appeared very soon in the project. These revealed that the territoriality principle goes far beyond patients’ access to cross-border healthcare.

The first obstacle that appeared was that Upper Austrian authorities insisted on the fact that Austrian patients, even if they are in a German hospital, should be treated by Austrian physicians. The Austrian hospital tried to second their physicians permanently to Germany under Regulation 1408/71 analogous to workers that are seconded to other EU countries for construction works. This would have been a possibility for the physicians to be insured by Austrian social security while working in the ‘Austrian’ departments in the German Simbach hospital. The authorization was however refused by Upper Austrian authorities and obliged the hospital to let physicians rotate between the Austrian and the German side to make sure that the Austrian physicians would not lose their Austrian pension and health insurance benefits. When this attempt of strategic use of European regulations had failed, the project partners contacted the Director General of the Legal Department in the Austrian Federal Ministry of Health. The Director General suggested to find a legal solution and supported the request by drafting a bill that would change the Austrian federal law regulating hospital operations (*Bundesgesetz über Krankenanstalten und Kuranstalten, KaKuG*)¹. The federal minister at the time supported the bill², but during the parliamentary process and in informal talks

¹ Interview Erwin Windischbauer, Financial and Administrative Director, Hospital St. Josef Braunau, 12 January 2011, Braunau.

² Interview Maria Rauch-Kallat, former Federal Minister of Health, 08 July 2010, Vienna

with the Minister the Medical Association and the Association of Private hospitals lobbied against the law. The Medical Association pointed out that if the law was envisaging general solutions for cross-border co-operation, this could incite future co-operations with new Member States where salaries are lower and hence lead to a situation where “cheaper” physicians could treat Austrian patients (Österreichische Ärztekammer, 15 February 2006). As a consequence the law was passed but provided that only Austrian patients could be treated by Austrian physicians in hospital departments in another country *close* to the border. There are however also German patients in the ‘Austrian’ departments in the German hospital to be treated. The ‘national’ strategy of improving the working conditions for the cross-border project had thus been unsuccessful vis-à-vis the interests and strategies of other actors in the healthcare system:

“And this is when we had to recognize that it would have been better not to have this law, before we had an authorization by Upper Austrian authorities [...] but now there is this law that binds the state officials. [...] And then you notice how small you really are, when these big organizations start lobbying and tear this bill to shreds where nothing comes out in the end that we could use”³.

Hence the project partners have decided to ignore the national law in their daily routines and to continue to also treat German patients without an official permission in departments where both nationalities are present.

Other obstacles occurred that showed the importance of national boundaries when it comes to financial aspects. The Austrian hospitals charge only the costs for medical treatment to Austrian sickness funds while the costs for investment and potential budget deficits are covered by taxes paid through the Upper Austrian health fund which amounts to circa 50 percent of the treatment costs. When the rulings of the European Court of Justice on cross-border healthcare were issued, Germany allowed its sickness funds to contract also foreign healthcare providers in the ambulatory sector. Yet the rule of prior authorization for hospital treatment continues to exist according to the rulings. The German sickness funds had thus to continue to authorize treatment for German patients in the ‘Austrian’ departments or in the Austrian hospital. The Austrian hospital then bills the German sickness funds for an official tariff for medical treatment that covered the medical treatment and the part of the cost that would have been covered in Austria by taxes. The bill for German sickness funds is hence nearly as twice as high as for Austrian sickness funds. The German sickness funds reacted by granting authorization with the remark that the bill must not exceed the price an Austrian sickness fund would have paid. Until now however the payments have not been cut without any explanation. Further problems also exist with the use of blood products, hygienic standards, and infections that are subject to report to medical authorities. For all these aspects double procedures had to be set up that satisfy German and Austrian legal requirements⁴.

Given these obstacles, the Austrian hospital operators tried to get support by a Member of the European Parliament in order to present their concerns over the territorial conceptions of labor and medical law. This European strategy also proved to be fruitless:

“I now get invitations for a reception in the evening in this and that Palais [...] You can go there a hundred times, this is such a different lobbyism there and we have tried it before in Austria [...] but no one sees it [cross-border co-operation] as a chance”⁵.

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

³ Interview Erwin Windischbauer, *ibid*.

⁴ *Ibidem*.

⁵ *Ibidem*

“For certain individual cases, when German patients would like to get treated in Austria, I call the German sickness fund and ask them what they would pay for the treatment and then I provide them with the tariff and then I give my ok or not. I must not do this as there is an official tariff regulation that determines the cost for foreign patients, but well, you sometimes bypass the regulations”⁶.

Out of 26000 treatments each year, these cases amount to circa 500 patients maximum and this ‘informal’ procedure cannot be used on a regular basis. The partners of the hospital project have thus thought about taking legal action and trying to get a clarification from the European Court of Justice. Using Europe the legal way has however not been integrated in their strategic actions as a legal procedure would take too much time. A lawsuit would have to be set up against the German sickness funds to get clear legal rules on the payment issue, but this “would not be especially beneficial for the existing co-operation”⁷.

The officials of the Upper Austrian health fund responsible for the financing of the *Land* hospitals do not see a reason not to support the project, but do not have a solution to the general ‘clash’ of Austrian and German legal requirements. But if the number of German patients was to increase however, they would see even more obstacles concerning the planning of hospital infrastructure⁸.

According to the Austrian healthcare provider only a treaty between Upper Austria and Bavaria would provide legal clarity in the grey areas in the daily routines of this cross-border project. Yet, the impression they get is that regional politicians do not see any possibility to get votes by supporting such a project and that structural reforms of the national hospital sector have a higher priority than a single cross-border project⁹. Given the fruitlessness of national and European strategies, the project continues to arrange informal agreements according to each ‘everyday’ problem. This example shows that the interests of the local providers haven been clearly Europeanized, but that trying to use Europe for cross-border healthcare is defined by the healthcare provider’s position in the national system and that success is not guaranteed since other actors inside and outside of the national healthcare system do not necessarily share the same interests. Will this be also the case for the project between Austria and the Czech Republic?

Austrian-Czech co-operation

One of Austria’s largest Länder is Lower Austria enclosing Vienna and bordering on the Czech Republic’s region of Southern Bohemia in its very northern part. In this region Lower Austria operates five hospitals via its Hospital Holding (Landeskliniken-Holding) that is merged with the Lower Austrian health fund. In Gmünd, some kilometers away from the Czech border, the holding operates one hospital of 180 beds, i.e. one of the rather small hospitals (cf. Landeskliniken-Holding, 09.07.2010). The hospital is part of a cross-border healthcare project named “healthacross”. The project aims at developing cross-border cooperation between the Lower Austrian Hospital Holding and the Czech hospital operator in South Bohemia in order to optimize the population’s access on both sides of the border to medical care and started in 2008. While limited local initiatives had been set-up beforehand, the Czech Republic’s accession to the EU in 2004 and to the Schengen Agreement in 2008 have been used as incentives to cooperate more intensely. The first phase of the project consisted in developing a report on economic and infrastructural key information and also comparing the project with similar cross-cooperation projects in Europe. In this process the project partners also learned about the difficulties of the project between Austria and Germany. Nonetheless, the main

⁶ Ibidem

⁷ Ibidem

⁸ Interview Stefan Potyka, Head of Unit, Unit for inpatient care, Upper Austrian health fund, 29 October 2010, Linz.

⁹ Interview Erwin Windischbauer, *ibid.*

goal of the project was to build a new hospital that caters for the medical needs of the Austrian and Czech side of the border where a “twin” city to Gmünd is located. The project is supported and partly financed by the European Regional development fund (Healthacross Report I, 2010, p. 10-13). Insofar the project might not be distinguishable initially from other infrastructural cross-border projects. Developments on cross-border healthcare have however played a role from the outset of the project, as one of the managers from the hired project office dealing with the implementation says:

“Yes [these judgments] have been very important. In the framework of the project they have been presented several times. [...] You can use them as a help for argumentation, ‘this is now a European judgment, you can’t close your eyes, and this will be everyday life in the future.’ [...] Now we can still construct something. One has to be well prepared regarding information [...]. One has to see how do I act, how do I get the best out of it, for my country, my system”¹⁰.

Especially in the beginning such a strategic usage of Europe is necessary to convince administrative employees and to get the necessary political support for starting a cross-border project: according to another manager getting the initial support and raising the awareness for possible economic benefits of cross-border cooperation can be difficult since there is already quite some competition over the best medical care among the *Länder* inside of Austria; getting attention for a cross-border initiative and ‘seeing beyond the borders’ is therefore rather difficult¹¹. While the European dimension is used to raise political awareness, a strong regional identity is put forward when the question of a possible coordination with the federal level arises – it is seen as a Lower Austrian lead project in regional co-operation and the *Land* should be responsible, co-operation with the federal level would neither be necessary nor really wanted. The responsible manager of the Hospital Holding also hopes that with a view to other Austrian *Länder*, Lower Austria would be cutting-edge in cross-border cooperation in healthcare. The ECJ’s rulings play nonetheless a role in defining the general interest of the regional actors even though Austrian citizens haven’t taken legal action: “I would say they [the rulings] help. One can see that there are needs of individuals. Otherwise these rulings would not exist. This means for us that there is a signal what citizens, what an individual wants. This is not something imposed by the government level”¹². The EU is also seen as a means to revive an economically separated region, starting with cross-border healthcare. Due to the times of the iron curtain economic and cultural ties have been cut and re-establishing these ties would be desirable: “It’s not about a single project that we create, it’s about saying that we are a common region and this is how we make it better and become more competitive”¹³.

While actors make strategic use of the EU to get the necessary political support and to define the overarching goals of the project, this usage stops once some more concrete aspects of cross-border cooperation are considered. The project aims at saving the small border hospital from closure since it offers 300 to 400 jobs in the city on the Austrian side. It should also provide quick medical access for Czech citizens who have to travel around 60km to the next hospital on the other side of the border. Since a renovation for the old hospital would be too expensive a new building could be used to treat Austrian and Czech patients¹⁴.

In order to put effective cross-border healthcare into practice, financing has to be assured. Hence, coordination with the sickness funds and the physician’s chamber is necessary: “We have both institutions represented in the project. This means that they can follow the project from the

¹⁰ Interview Martin Wieland, project manager, Healthacross Project, 05 August 2009, Vienna

¹¹ Interview Renate Burger, project manager, Healthacross Project, 10 August 2009, Vienna

¹² Interview Elke Ledl, Head of Unit, EU Affairs, Lower Austrian health fund, 13 January 2010, St. Pölten

¹³ Ibidem.

¹⁴ Interview Renate Burger, ibid.

beginning. We are happy about the interest of all institutions from the health sector. And of course, then there is always the question ‘who is going to finance this?’”¹⁵.

The building costs and the coverage of the treatment costs for Czech patients are the most obvious factor when Europe is not used, but when the own healthcare system plays the leading role in cross-border healthcare. Europe might even become something to worry about as the Director of the health fund puts it: “We observe the developments in Brussels very attentively, we also have some worries. How does this influence us? Certainly, Brussels is financially supporting the project and that helps us, but in general EU politics is not really transparent for a lot of people. [...] Our worries are quite simple: it is about the fact that money follows service. At whose prices will be paid? [...] I believe it can’t be other than that we bill the prices of the place where the treatment is provided. It is unthinkable, that treatments are provided in Austria at Czech rates because of the higher price levels [in Austria] and the higher material costs”¹⁶.

A survey had therefore to be carried out on the Czech side of the border to see if Czech patients were willing to pay an extra insurance that would cover the costs. It seems that they would be ready to do so, but a PR campaign is strongly recommended (healthcross Report I 2010, p. 83). While the financing is yet to be negotiated between project partners, a legitimizing usage of Europe would probably occur in such a campaign. This is however hypothetical.

The necessary administrative procedures for prior authorization for hospital treatment on both sides of the border to get the necessary approval bring “some administrative obstacles and uncertainty on the decision” (ibidem, p. 25) with them. Negotiations on bilateral agreements with all actors are therefore necessary (ibid.). Insofar actors are not even able to make a usage of Europe that threatens the national boundaries since the bilateral agreements will need to involve the providers and sickness funds of both sides of the border. There is thus no bypassing of the national set-up of the healthcare system. This means however that cross-border healthcare between the Czech Republic and Austria faces different obstacles, “differences in remuneration schemes, and the related question of financing and administrative hurdles, have so far hindered the development of formalized cooperation” (Österle 2007, p. 119). Having learned from the difficulties of the Austrian-German project, a feasibility study was commissioned addressing the legal and economic issues. The study came to the conclusion that a commonly operated hospital would not be possible, but that a new Austrian hospital on the border could offer rooms for a dispensary that Czech physicians could rent. This is due to the economic part of the feasibility study which pointed at the possible loss of revenue for existing Czech hospitals and which doubted that Czech sickness funds would cancel their long term contracts with Czech providers in order to set up new contracts with an Austrian-Czech hospital (healthcross Report II, 2011, p. 73). Given these results, the project partners would like to continue their co-operation but have not yet planned a follow-up project. The future of the project seems therefore uncertain.

Discussion

Both projects that have been presented are at different stages of their implementation and concern different countries. While the language does not play a role for the first project, the Austrian-Czech project has to cope with a possible bi-lingual structure. The financing is a more acute problem for the second project given the large price differences between Czech and Austrian tariffs for treatment. Whereas the Austrian-German project does not have problem with price differences, it is the financing structure – mixed financing by sickness funds and taxes in Austria and a sole financing by

¹⁵ Interview Elke Ledl, ibid.

¹⁶ Interview Robert Griessner, Director, Lower Austrian health fund, 13 January 2010, St. Pölten

sickness funds in Germany – that puts constraints on the project. To overcome these obstacles, healthcare providers use different strategies: the first project tried to use national strategies and European strategies alike for its cross-border co-operation. The second project has had a more European strategy from the outset, but also being supported more actively by the regional level. In both cases healthcare providers' interests have thus clearly been Europeanized. Given however their position on the 'lowest' level of the healthcare system, other national actors' involvement cannot be ignored. And these interests can contradict cross-border co-operation as the case on the national bill on cross-border co-operation of the first project has shown. The projects also prove that the new Directive and the European Court of Justice's rulings on cross-border healthcare are not sufficient to overcome other legal issues that are bound by the principle of territoriality such as labor law, hygienic standards and other aspects of medical law. Actors hence have to adapt their strategy according to their path-dependent position in the system. In the case of Lower Austria the hospital operator even tries to save the existing path of operating small hospitals through cross-border co-operation.

The EU has the potential of being a resource for actions that could lead to a further destructuring of national boundaries, e.g. in form of lawsuits. But as the first project has shown, the providers abstain from legal action in order not to endanger the existing co-operation. Here informal agreements and bypassing of national law on a case-by-case basis are used which would nonetheless not be possible on a larger scale and which are also not covered by European regulations. Even though the project partners of the second project have learned from the obstacles that the Austrian-German project had to cope with, it seems uncertain if this project will be continued. Hence one can say that actors try to make a strategic use of Europe, that there is a potential for destructuring effects, but that the usage of Europe is determined by path-dependent logics of actions and that actors cannot "escape" from their system, at least not on the short run. This reasoning refers to a complexity that is a barrier to negative European integration according to the rules of the EU's internal market as welfare services like healthcare can impede 'attractive market opportunities' (Greer & Rauscher, 2011, p.21). Nevertheless, time plays an important role: according to Ferrera (2005, p. 219) a possible destructuring due to European rules might incrementally unfold over a long time and that in the future "the Europolity can be seen as a widening and deepening bundle of 'member spaces' [...] constantly engaged in balancing acts between opening and closing, with a yet unknown destination in terms of the eventual 'structuring' pattern" (ibid, p. 220).

Conclusion

This paper tried to answer the question if a loss of national boundaries in the healthcare system could result from European rules on the access to cross-border healthcare. While the EU limits the territorial principle of healthcare insurance by providing emergency treatment and treatment after prior approval, the ECJ's rulings have extended these possibilities. This has worried Member States who did not share a common understanding how far patients' rights should go. Transposing the EU's rules on access to cross-border healthcare can have an impact on actors' interests in a Member State's healthcare system as the case of Luxemburg has shown. The paper therefore used a bottom-up approach in order to see if Europeanization of the healthcare system implies a loss of the national boundaries of the healthcare system. More concretely, does actors' usage of Europe lead to such a boundary loss? The main argument put forward here was that actors might very well use Europe to further their interest, but that path-dependent logics of action prevent actors from "escaping" their national healthcare system.

The analysis has shown that actors' strategies and interests have been Europeanized even at the lowest governance level of the healthcare system. In the analyzed cross-border projects the effects of a usage of Europe should have been the most pronounced. The paper finds that actors use indeed

Europe to set-up the project, to raise political awareness and to get support. But once actors face the hard facts of financing, they follow the 'rule of the game' of their own healthcare system and cooperate with the necessary actors. More interestingly, Europe serves here even to "save" a classical feature of the Austrian healthcare system, i.e. the existence of small regional hospitals that are economic focal points for certain Austrian districts. General economic differences in reimbursement rates and various administrative obstacles add further to a strategy that respects national boundaries. The European rules on access to healthcare also prove to be too tight for actors to circumvent necessary financing mechanisms of the national healthcare system. On a small scale they rather prefer to bypass national legislation on a small scale approach.

Due to the research design of the paper, it is of course difficult to generalize the results, also because further comparisons with other actors on Austrian soil have to be carried out. It seems however that the EU's rules on patient mobility and the access to cross-border healthcare are much less threatening than one could have thought at the time of delivery of the different rulings by the ECJ. Another limitation concerns the "usages of Europe" approach: actors might very well decide not to use Europe or to act against Europeanized interests in their system. This aspect needs to be integrated in further theoretical considerations.

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