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Introduction

More than 30 years ago, the social security systems of OECD states were diagnosed to be in crisis. This crisis heralded in the end of the "Golden Age" of the national welfare state. The European OECD states, which were also part of the European Community, all witnessed rising unemployment in the wake of the oil crises, and as a result of economic openness to world markets and rising competition of labor costs, Keynesian economic policies of deficit spending became unavailable as an option to revive the economy. Not only did external processes of globalization demand adaptations of the welfare states, but also internal factors such as the rising age of populations and the change of family patterns questioned whether European welfare states were still capable of delivering for national populations, and how classical branches of the welfare state such as unemployment insurance, pension systems and healthcare systems should be adapted to meet these new challenges (Esping-Andersen, 1996). Along with this crisis diagnosis of the welfare state in general, healthcare systems have become the center of governments' attention since the 1980s, as spending on health policies has increased while the number people contributing to the social security schemes has decreased due to rising unemployment and slow economic growth. Insofar, healthcare mirrors the challenges that welfare states face in general. A "healthcare inflation" (Giaimo, 2002, p. 2) seems to be taking hold, caused by steadily ageing populations requiring technically more sophisticated and more expensive treatments, while the number of contributors is slowly declining. The fear of a race to the bottom has persisted among OECD states since the 1980s. As a consequence, most governments of OECD member states have been trying to reform their healthcare systems since the 1990s. After 20 years of reform efforts, the European welfare state has not vanished though, and a race to the bottom has not necessarily taken place. Nor is there a convergence to be found between different

types of welfare states (Starke, Obinger & Castles, 2008). However, with advancing European integration the welfare state faces additional challenges.

EU Member States are part of a political and economic system endowed with a single market, a common currency, and with a system of supra-national policy-making. While there is no sign of a convergence of Member States' welfare states towards a "unique European Welfare State" (Corrado *et al.*, 2003), especially labour market related issues such as parental leave are meanwhile negotiated in a corporatist pattern on the European level through collective agreements between labour unions and employer organizations (Falkner, 1998). This advancing European integration has potential impacts on the national level, especially for countries in Southern and Eastern Europe (Kvist & Saari, 2007). The introduction of the so-called new modes of governance such as the Open Method of Coordination (OMC), which stipulates peer-review and coordination of policy measures in the field of employment and labour policies between Member States, have triggered a "jump start to EU social policy" (*ibid.*, p. 2). These measures were introduced through the EU's Lisbon Agenda, which was aimed at reviving European economies in a globalized world. However, given the absence of a convergence of welfare states towards a single European model, we can witness a tension surrounding the issue of European integration in relation to the national welfare state. The accession of new Member States with lower household incomes, lower average salaries, and a different level of social protection have created new fears of a race to the bottom of social protection among possibly competing Member States (Guillén & Palier, 2004). Fears usually manifest themselves around politically salient pieces of European legislation like the famous Services Directive that aimed at facilitating the provision and consumption of services across the EU. These fears point "to a fundamental tension between the goals of creating a genuine single market among 27 plus countries with vast economic and social disparities" (Sapir, 2006, p. 388). This tension becomes more acute when the lacking competencies of the EU regarding redistributive policies are taken into account: the EU furthers economic integration while the welfare state remains mainly a national matter, thus potentially limiting national policy choices that impact on the economy and the welfare state alike. The problem "is the fact that the future viability of *national* welfare states is directly challenged by European *economic* integration which drastically reduces the effectiveness of democratic self-determination at the national level" (Scharpf, 1997, p. 23). Such a challenge is especially problematic when the fact is taken into account that the European nation state stays the main cognitive and normative reference for European citizens while the EU oftentimes lacks legitimacy (Foret, 2009). This challenge related to European Integration thus puts into question a purely national conception of social policies and points to a possible loss of institutional boundaries of the European welfare state. While the European welfare state has started to "leak", new spatial opportunities for actors are created and a restructuring of institutional rules at European level is the consequence (Ferrera, 2005).

Healthcare is a prime example of these dynamics of advancing European integration. For a long time it was considered a purely national competence. Now, however, it has been put on the EU's agenda by the Court of Justice of the European Union (CJEU) and it shows all the emblematic symptoms of the tension between

European economic integration and national conceptions of the welfare state. While different domains of Member States' healthcare systems had been an object of European integration and European legal regulation well before these rulings – such as areas of public health, the fight against communicable diseases, but also concerning rules of public procurement, mobility of the health work force and the mutual recognition of diplomas (Mossialos, McKee & Palm, 2004; McKee, 2003; Hatzopoulos, 2008, Hatzopoulos, 2003; Hervey & McHale, 2004) – the rulings of the CJEU have touched the core area of healthcare systems, namely the access to and delivery of healthcare for Member States' citizens. In a series of landmark rulings on patient mobility and cross-border healthcare, the Court has made clear that Member States' healthcare systems have to comply with the rules of the EU's Internal Market when it comes to individual patient rights and the non-discrimination of healthcare providers [1] (Greer, 2006). The rulings increased the possibilities for EU Member State citizens to get medical treatment in another Member State ("cross-border healthcare"), yet providing that under certain conditions the home Member State has to pay for these treatments in the other country. After a decade of negotiations, these rulings have been codified in a European Directive (Directive 2011/24 on the application of patients' rights in cross-border healthcare).

Following the landmark rulings of the CJEU, other studies have thus looked at institutional adjustments of healthcare policies or the legal impact on Member States from a top-down perspective, in order to determine whether healthcare systems have been Europeanized (Sindbjerg Martinsen, 2005; Sindbjerg Martinsen & Vrangbaek, 2008; Obermaier, 2009). While policy adjustments have been taking place, these studies usually do not focus on actors' responses to European integration in healthcare, even if it could be shown that the way governmental actors use Europe has largely contributed to Member States' stance towards European integration in healthcare (Davesne, 2011). The aim here however is to look beyond what has been called a "Europeanisation of Social Protection" (Kvist & Saari, 2007) in terms of policy-changes or to ask whether Europe has started to matter in national welfare policy-making. More recent research shows that Europe does indeed have a differential impact on national welfare states and that there is a Europeanization of welfare (Graziano, Jacquot & Palier, 2011b). However, not only institutional changes in the form of policy adaptations are important, as actor relations such as corporatist bargaining structures can also affect European integration (Falkner & Leiber, 2004). The more recent literature therefore calls for a closer look at how national actors adapt to, mediate or resist a Europeanization of welfare, and how this relates to institutional change at national level (Graziano, 2009).

Assuming that European integration has an impact on national welfare states and taking the example of European rules on access to cross-border healthcare, this book suggests a change of perspective by analyzing the domestic impact of European integration in terms of Europeanization within the context of the interplay between actors' interests and practices on the one hand, and institutional effects on the other.

[1] Starting in 1998 with the *Kohll-Decker* ruling of the CJEU (cases C-158/96 and C-120/95).

European cross-border healthcare in forms of regional projects and privately or publicly organized healthcare arrangements has already become a reality in many European countries, especially in border regions. While available literature has addressed these projects mainly from the perspective of public health studies, and economic or legal perspectives (Rosenmöller, Baeten & McKee, 2006; Wismar, 2011; Odendahl, Tschudi & Faller, 2010; Zimmermann, 2008), oftentimes the political implications are only marginally addressed. The topic will be addressed by two theoretical assumptions, which will serve as an analytical framework, to be developed in the following sections of this chapter.

The first assumption concerns the national institutional environment of actors, and is based on Historical Institutionalism: national institutions that define what is possible and impossible for an actor are liable to path-dependence, and are hence difficult to change, a fact which in the field of welfare state reforms can be witnessed by incremental policy change and slow – if at all existing – adaptations to new policy challenges (Pierson, 1993, Pierson, 1996). While Historical Institutionalism has been criticized for putting too much weight on policy inertia (Pollack, 2009), more recent accounts of historical institutionalist policy analyses have been theorizing the role that actors play in institutional change. Actors have different strategies available that they can use to circumvent institutional rules and which may change these very institutions over time (Streeck & Thelen, 2005a; Mahoney & Thelen, 2010). Thus, while actors might be constrained by national institutions, they are also able to deviate from institutional rules. In the case of European integration in healthcare, Europe offers new avenues for actors to do so.

The second assumption is thus derived from Comparative Federalism, and concerns the opportunity structure that Europe offers to national actors that could chose to "break out" of their national institutional set-up. The development of a patchy, yet existent health policy at European level (Greer, 2008) provides in fact a new layer of supranational governance beyond the regional and national level to which healthcare actors can have access. The European rules on cross-border healthcare can in fact provide a sort of "bypass" to Europe reminiscent of the development of welfare states in federal polities (Obinger, Leibfried & Castles, 2005a; Obinger, Leibfried & Castles, 2005b). In order to provide a theoretical approach to analyse how actors might seize (or not) the opportunities that Europe offers them, two notions stemming from Political Sociology will be borrowed in order to supplement the chosen historical institutionalist approach: the concepts of *practices* and *usages*. Here, mainly the usages of Europe by national actors will be considered and how they are incorporated into their routines. The concept of 'usages of Europe' developed by Jacquot and Woll is 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). In this bottom-up perspective, national actors are considered as mediators of European rules since they have the capability of filtering them and using them as a resource to pursue their own agenda on the domestic level (Jacquot & Woll, 2008, p. 21). Following the above developed theoretical assumptions, and given that European integration in healthcare delivery is a rather "recent" phenomenon, and based on the assumption that actors' strategies change more easily than national institutions, the following

hypotheses can be formulated: (1) *Even if national healthcare actors use Europe, their interests remain largely determined by the national institutional set-up of the healthcare system. (2) The institutional boundaries of the national healthcare system may have become porous, but they remain intact.* The hypotheses are tested in a single-case study on Austria. The book will then be analyzing the responses to European integration of the different kinds of actors that are responsible for the delivery of healthcare in the Austrian healthcare system. As key groups of national healthcare governance tend to follow different goals in health politics (Blank & Burau, 2010), it is assumed that their usages of Europe should differ accordingly.

1.1 Case Selection and Structure of the Book

Case Selection

Austria has been chosen, as it is a *crucial case* to test the hypotheses, with a crucial case being "one in which a theory that passes empirical testing is strongly supported and one that fails is strongly impugned" (George & Bennett, 2005, p. 9). Austria being a crucial case for hypothesis testing is due to two puzzles, one of a theoretical nature, the other being empirical: from a theoretical point of view, the Austrian welfare state and its healthcare system belong to the Bismarckian type of welfare states (Esping-Andersen, 1998), and Austria has been classified as a typical consociational democracy (Lijphart, 1999). It has been argued from the perspective of Europeanization studies that Bismarckian healthcare states show a relatively high compatibility with European rules on cross-border healthcare (Sindbjerg Martinsen, 2005). We could therefore expect that actors would not find significant obstacles in adapting their interests and strategies to European integration in healthcare, even in a shorter time period. Potential effects of changing the dynamics between agency and institutions should hence be clearly visible. At the same time, this theoretical argument is in contradiction with the existing literature on public policy analysis which claims that institutional *and* policy changes in Bismarckian welfare states tend to be extremely slow, and in many aspects Bismarckian types of welfare states have been showing institutional inertia when it comes to analysing potential institutional change (Esping-Andersen, 1996; Palier, 2008 ; Palier, 2010a). These findings have also been found in the Bismarckian type of healthcare systems (Hassenteufel & Palier, 2008). This theoretical puzzle is corroborated by an empirical puzzle: on the one hand, Austria has been the only Member State where national legislation did not need to be changed due to the CJEU's rulings on cross-border healthcare, as Austria already permitted the reimbursement of elective cross-border healthcare before the rulings were issued, and even before Austria's accession to the European Union (Obermaier, 2009, p. 79). Yet, Austria was one of the few Member States that have been voting against the European Directive which codified the CJEU's rulings, thus opposing European integration at least symbolically, i.e. while policy change was not necessary, institutionally shaped interests might lead to resistance. Both puzzles point at inner-Austrian dynamics which have to be thoroughly scrutinized. Austria should therefore be a fertile research ground to determine whether public policy assumptions about institutional change in Bismarckian welfare states can be corroborated or whether Europe can effectively overcome national institutional inertia. Austria is furthermore

an interesting case study from the perspective of Comparative Federalism. Even if Austria has been considered to be a "federation without federalism" because of its societal homogeneity and a lack of distinctiveness between subnational territories (Erk, 2004), its polity clearly is a federal state with important competencies for the subnational level with regard to the regulation, financing and provision of healthcare. As European integration in healthcare can be conceived as offering national actors an additional quasi-federal layer of governance beyond the national boundaries (see chapter 3), this book can contribute to more recent research concerning the effects of federalism on healthcare (Costa-Font & Greer, 2013).

Structure of the Book

The aim of the following sections of chapter 1 is to provide an analytical framework. Following the chosen bottom-up approach, the next sections first theorizes the national institutional *regime* that welfare states and healthcare systems represent for shaping actors' competencies and interests. It discusses the notion of institutions and their relationship to agency from a historical-institutionalist perspective, then it presents the typical characteristics of a Bismarckian welfare state and the most common goal orientations on the part of actors in Bismarckian type healthcare systems. The chapter is concluded by presenting the 'usages of Europe' approach that will be used for the analysis in chapter 4.

Mirroring the theoretical bottom-up approach, chapter 2 starts at national level and briefly retraces the historical development of the Austrian welfare state as well as the development of the Austrian healthcare system starting with the final decades of the Austrian-Hungarian Empire. It describes how certain institutional characteristics of the Austrian welfare state, namely a strong role of corporate actors, political parties and regional governments in welfare – and even to a larger extent in healthcare – have been built up, developed further, and have been carried over from the Empire to today's Second Austrian Republic, despite several political regime changes over the past 170 years. After having developed the historical background of the case study, the chapter addresses the dynamics between institutions and actors inside the Austrian healthcare system by looking at the more recent developments of governance, financing and provision of healthcare. While consociational politics, a strong implication of political parties and federalism mark the healthcare system from the outside, the Austrian healthcare system shows further institutional features that make it one of the most complex healthcare systems of the OECD. The chapter also develops the role that each group of actors (the state – i.e. executives and the legislative, corporate actors such as social insurance institutions and providers) plays in healthcare governance and then addresses how these actors through more recent reforms have been positioning themselves vis-à-vis the institutional split between inpatient care and outpatient care in the healthcare system. The chapter looks furthermore at the practices of healthcare governance which include consensual and informal negotiations as well as political bargaining between corporate actors and the state as well as between the federal level and the regional level.

Chapter 3 then describes the rulings of the Court of Justice of the European Union concerning cross-border healthcare and their potential to remove national institutional

boundaries, and how European integration in healthcare provides for a quasi-federal opportunity structure for national actors to potentially "escape" their national system or to make use of European resources for their own benefit. The chapter furthermore provides data on the rules governing the provision of cross-border healthcare services in Austria.

Chapter 4 then analyses the usages of Europe due to European integration in cross-border healthcare by the four most important actor groups responsible for the delivery of healthcare in Austria, i.e. the Austrian *Länder*, payers (social insurance institutions/sickness funds), and providers (physicians and dentists). The chapter starts with the lower level of governance, namely local and regional providers of healthcare that operate cross-border hospital projects and analyses how the *Länder* in their role as providers, regulators and payers of inpatient care use Europe. The following sections analyse how corporate actors on the one hand deal with European rules on cross-border healthcare in their roles as payers and providers at national level and whether they make use of Europe at national level. Furthermore, it is analysed how these actors have used Europe at European level to influence decision-making on the Directive codifying the European rulings on cross-border healthcare. The subsequent section then looks at the possibilities for patient representatives to use Europe. Chapter 5 forms the conclusion verifying the hypotheses. It also discusses the empirical findings as well as the theoretical implications of these findings for further research on European integration in healthcare.

1.2 Institutional Regimes and Agency in a Bismarckian Healthcare System

1.2.1 Building Welfare Institutions and Healthcare Systems

One of the main assumptions of this study is that European integration, very much like globalisation, does not operate in an "institutional void", given that national welfare states have a strong historical institutional legacy. According to Ferrera (Ferrera, 2005), nation building in Europe is intimately linked to the development of welfare states as the European nation state has become "socially structured" by stabilizing patterns of interaction and organizational forms through coalition building among different actors along national cleavages. As chapter 2 will show, the strongest cleavages during the Austro-Hungarian Empire were for example between the right and left political spectrum, between various nationalities, and between the center and the periphery. The Austro-Hungarian Empire tried therefore to create welfare institutions that would hold the Empire together in a politically instable environment. For such a process of structuring to take place, boundaries were necessary. They denote "any kind of marker of a distinctive condition relevant to the life chances of a territorial collectivity and perceived as such by the collectivity itself" (*ibid.*, p. 19), i.e. in geographic terms it means the demarcation of a territory through borders that separate national communities from one another. But these boundaries do not only have a physical function. In their symbolic significance they represent the constitutive power for group or more precisely national identities (*ibid.*, p. 19f): "It was through boundary-setting that European states and nations were built. Boundaries 'caged' [preexisting structures and] actors into the national terrain and prompted their

politicization" (*ibid.*, p. 20). At the same time, institutions were shaped that stabilized the system of the state creating domestic loyalty. This finally initiated a process of 'system building' in the given territorial space (*ibid*., p. 21). The European welfare state that had been created along the borders of nation states has led to systems in which national "territories carried social rights […] that could not be severed from them" (*ibid*., p. 59). These social rights are based on national solidarity as welfare states pool citizens' resources in order to protect them from old-age poverty, the consequences of sickness and unemployment. Welfare states are therefore a highly institutionalized form of solidarity trying to be efficient and serving social justice at the same time. As described in chapter 2, this process of institutionalizing solidarity to stabilize the state did not succeed in the Austro-Hungarian Empire, rather the welfare state was built along national and ethnic lines *inside* the Empire. However, the welfare state institutions that had been built during the times of the Empire continued to exist after the Empire's demise and were carried over to the First Austrian Republic.

Austria has developed a Bismarckian type of welfare state which is a specialized form of compulsory social insurance against old-age poverty, sickness and unemployment, amongst other social risks, which were chosen to make social rights 'function' by nationalizing redistribution amongst the citizens of these states (*ibid.*, pp. 44-49). This development also concerns Bismarckian type healthcare systems that constitute one of the core parts of the welfare state. Hence, Freeman points out "the health system is coterminous with public (state) intervention: health policy problems are problems of and for the state" (Freeman, 2000, p. 8). Health systems do not only regulate the access to healthcare and its financing, but they also regulate the interests of the pharmaceutical industry, the development of medical technologies, and at the same time they regulate struggles between different interest groups such as physicians' associations, patients' associations, and the pharmaceutical industry's associations (*ibid*., p. 8).

During the 'Golden Age' of the welfare state, i.e. the three decades after the Second World War, the national welfare state had reached a climax in its institutional and political development. In all European countries the coverage of the population had reached (nearly) a hundred percent. Healthcare systems had shifted in this time from the provision of cash benefits to systems of benefits in kind, i.e. the free-of-charge delivery of hospital and physician's treatments as well as pharmaceuticals. This shift made the welfare state's provision of healthcare even more complex since more regulation among service providers, patients and the pharmaceutical industry was needed (Ferrera, 2005, p. 75). By 1970, every European state disposed of distinct insurance space with much reduced exit options for its insured members. This meant that obtaining an exemption from the compulsory insurance scheme was very restricted and entry options for foreigners were very limited (*ibid.*, pp. 49, 75). This process of consolidation and expansion can be exemplified by the codification of legal regulations of the Austrian welfare state in the General Social Security Act during the 1950s. Social insurance coverage in healthcare for example was then extended to cover most parts of the Austrian population during this period (see chapter 2).

From the 1970s onwards, after the first two oil price shocks, many European economies slid into a phase of recession, and welfare state reforms were enacted.

Many feared a race to the bottom in social policies. However, the historically grown welfare states have proven to be quite resilient in their institutional structures vis-à-vis the forces of globalization. From a theoretical point of view, historical institutionalist scholars have therefore been pointing out the inertia of these institutional arrangements and their role in shaping actors' interests.

1.2.2 Welfare States as Institutional Regimes

As has been noticed by historical institutional scholars working on the effects globalization has on welfare states, welfare state institutions have proven to be much more resilient to bow to external pressures than one might expect, and national institutions once created show some important 'stickiness': "Both the popularity of the welfare state and the prevalence of 'stickiness' must be at the centre of an investigation of restructuring. The essential point is that welfare states face severe strains and they retain deep reservoirs of political support" (Pierson, 2001, p. 416). Historical Institutionalists are interested in how institutional choices exert long-term effects on the political decisions of their creators. Once an institution is created for a certain policy, actors will adapt to these institutions. In their view, organizational or policy designs are reinforced over time once they have been created and initiate the development of political, economic and social networks. These networks will then show resilience to alternatives to the existing organizational set-up in place as actors have invested energy, time and money in the creation and running of these networks. Hence, national welfare states with their historically grown form have more than a simple tendency to discourage exit from the national system. The organizational form of welfare states and the networks that actors engage in, set more generally 'the rules of the game' and they determine the costs of alternative strategies that actors can pursue (Pierson, 1993, p. 596).

Institutions as "building blocks of social order" have an *obligatory* character. This means that actors are usually expected to comply with institutionally prescribed behaviour and can "call upon a third party" (Streeck & Thelen, 2005b, pp. 10-11) to impose compliance on an actor that might not want to comply with the behavioural regime imposed by institutions. Welfare policies, for example, are institutions to the extent that they provide actors with certain responsibilities and create expectations in the society about the way in which these policies are implemented: "[…] they constitute rules that can and need to be implemented and that are legitimate in that they will if necessary be enforced by agents acting on behalf of the society as a whole" (*ibid.*, p. 12). *Legitimacy* of national welfare institutions results therefore from an enactment of these behavioural rules by actors. Complex systems of institutions such as welfare states and their related healthcare systems are hence *regimes* which can be defined as "a set of rules stipulating expected behaviour and 'ruling out' behaviour deemed to be undesirable" (*ibid*.). Seeing institutions as behavioural regimes according to Streeck and Thelen means therefore to be able to analyse "relations between identifiable social actors" (*ibid*., p.13). Actors in a welfare state and their healthcare systems are thus part of a complex regime of interactions. So even if the EU offers opportunities beyond this regime, it seems questionable that actors can exit from it that easily as their core functions and competencies have been defined by

the national institutional *regime*. In Austria, for example, the welfare state forms an institutional *regime* that has grown since its inception during the Austro-Hungarian Empire and which has been carried over to the First and then to the Second Austrian Republic. While the Austrian state's executive functions as the main regulator of the welfare state and the healthcare system, various corporate and regional actors to whom tasks of delivering healthcare have been delegated, have legally and sometimes even constitutionally defined competencies relating to the governance, financing and provision of healthcare. Already inside the national system, changes that could lead to reconfigurations of competency arrangements are difficult to bring about. Such a phenomenon is called path-dependence. National healthcare reforms in different states have been analyzed from this angle, aiming at explaining why healthcare systems are difficult to reform 'in a big way' (Wilsford, 1994). As chapter 2 will show, the Austrian healthcare system shows many signs of a path-dependent policy development. However, careful analysis must take into account that national welfare institutions are not completely unchangeable objects.

Streeck and Thelen (2005a) have tackled this issue by reconsidering the role of incremental change (Streeck & Thelen, 2005b, p. 1). Accounting thus for resistance to change by various actors on the one hand, as well as accounting for gradual changes over time that could lead nevertheless to a transformation of existing institutional set-ups on the other, means that the enactment of institutions needs to be considered. There needs to be a distinction between the rule itself and the *implementation* by actors. If an actor does not fully comply with the role he is expected to fulfil, the opportunities that the actor has for strategic action can become an object of analysis, and we can thus focus on processes that allow for gradual change. Opportunities for action (and hence for change) manifest themselves through different factors. To illustrate this aspect, Streeck and Thelen provide as an example tax lawyers who try to find loopholes in the tax law for their clients (*ibid.*, p. 15). Finally, social control is not omnipotent. This leads to the conclusion that the interactions between those who create the rules and those who execute them specify what an institution is in practice. Institutions can thus gradually change despite their disposition for inertia. An example for such gradual change can be found in the governance reforms of the Austrian healthcare system described in section 2.2. Several consecutive federal governments have been striving for increased coordination amongst the various actors responsible for healthcare delivery. To this purpose, new institutions – a Federal Health Agency and a Federal Health Commission – have been created inside the existing healthcare system to serve as platforms for coordination between actors. Over time, such new institution's competencies are then usually increased while the other institutional competencies of actors are kept at their status quo. This strategy is called institutional layering: it works by *differential growth* of institutions, i.e. the new ones are expanded at the edge of old ones. The long-term aim of the creation of those new institutions is then to slowly overcome older institutional arrangements (*ibid.*). This reform strategy and the necessity of coordination amongst actors responsible for healthcare governance in the Austrian healthcare system illustrate an important feature of the Bismarckian type of welfare state, namely the high dispersion of power among different actors that will be addressed by the next section.

1.2.3 Bismarckian Welfare Regimes and Healthcare Systems

Bismarckian welfare states and their healthcare systems show a high dispersion of power between the state and corporatist actors concerning the regulation and delivery of healthcare. This dispersion of power means on the one hand that actors have to fulfil different roles in regulation and will pursue a variety of goals in a healthcare system; it means on the other hand, that their relationship and attitudes towards European integration in healthcare should not be uniform. Different bigger and smaller current EU Member States can be classified as having a Bismarckian type of welfare state. These states include Austria, Germany, France, Italy, Belgium, the Netherlands, Spain, and also Hungary, Poland and Slovakia (Palier, 2010b). The classification of these welfare states as a Bismarckian type go back to Gøsta Esping-Andersen's (1998) work "The Three Worlds of Welfare Capitalism" which has become the central point of reference for welfare state research and still inspires today's research (Schubert, Hegelich & Bazant, 2008, p. 15).

Esping-Andersen (1998) distinguishes three types of institutional *welfare regimes* that have developed in Europe – the liberal, the social-democratic and the conservative-corporatist (or Bismarckian) welfare *regimes*: "To talk of a regime is to denote the fact that in the relation between state and economy a complex of legal and organizational features are systematically interwoven" (Esping-Andersen, 1998, p. 2). The general aim of the Bismarckian type of welfare state in comparison to other types of welfare states is to safeguard the social status of the citizens. The state thus only intervenes if a family is not capable of guaranteeing a socially acceptable life-standard. These states tend to perpetuate the traditional family model, meaning that the wife and children of the insured worker are not usually insured autonomously but depend on the 'bread-winner's' affiliation to the system (Esping-Andersen, 1998, pp. 21ff). Bismarckian welfare states usually share several institutional key variables: The financing mechanism of the welfare state is mainly based on social contributions ('payroll taxes'). These contributions are used to fund para-public administrations or social insurance funds. These funds can be pension funds, sickness funds etc. As a rule the corporatist Social Partners are involved in the management of these funds, which means that the state's bureaucracy plays a more limited role. When it comes to entitlements for social benefits, citizens will generally be entitled to benefits if they have paid their contributions, thus linking the benefit structure to their employment status. The benefits that the insured receive are most often also related to their earnings, and thus to their monetary degree of contributions into the system (Palier, 2010a, p. 24). These principles are valid in many aspects of the welfare state of the Second Austrian Republic, even though some Austrian reforms – especially from the 1970s onwards – have introduced tax-financed benefits which are usually not to be found in Bismarckian welfare states (see chapter 2).

Despite some methodological criticism about the difficulties of creating ideal types of welfare state or lacking consideration for the role women in the welfare state (Schubert, Hegelich & Bazant, 2008, p. 16), Esping-Andersen's typology remains the most prominent and useful one to analyze the welfare state. The criticism reminds us however that careful bottom-up analysis must take into account a high degree of institutional complexity: "it should be emphasized and acknowledged that no real

welfare system is ever pure and always represents a complex mix of policy goals and institutions" (Palier, 2010a, p. 25). One can argue that this holds even truer for healthcare systems. The institutional regimes of healthcare systems of EU Member States depend in their set-up on the type of welfare state they are part of. Social-democratic welfare states such as Sweden, Denmark and Norway as well as liberal welfare states such as the United Kingdom have created *National Health Systems* that are funded by taxes with strong state control over expenses and governance. Conservative-corporatist welfare states like Germany, Austria and the Benelux countries as well as France operate *social insurance systems* that are funded by payroll contributions. These features have several structural implications for the delivery of healthcare and actors' interests:

> "Tax-based finance tends to imply universal coverage, the public ownership of healthcare facilities and a salaried medical profession. Insurance contributions, meanwhile, are paid into funds organized by occupation or region. Funds contract with what is usually a greater mixture of public and private providers of inpatient care, and with independent physicians paid according to the service they provide" (Freeman, 2000, p. 5).

This citation points at different important institutional features of Bismarckian healthcare systems that influence not only the delivery of healthcare, but also how politics are made in healthcare systems, how the system is regulated, and which actors can be expected to follow which goals. Four institutional key variables can be identified that influence actors' power and interests in healthcare systems: (1) Policy-making and the political system, (2) funding, (3) provision, and (4) governance.

The Political system of a country that operates a social insurance based healthcare system sets the larger institutional context of healthcare politics. Political systems which concentrate the authority for policy-making at the central level, i.e. unitary systems, show a higher capability of making policy changes. In contrast, federal systems like Austria which divide political authority between the central government and sub-national governments often show a lower capacity for making comprehensive policy changes, and have a higher tendency to show incremental healthcare policy change. This is the case in federal systems where most often powers regarding healthcare are attributed at least partly to the sub-national level. However, the distribution of power between concentration and fragmentation does not only concern different levels of government (federal, regional, local), but also the number of actors involved. Bismarckian healthcare systems disperse decision-making powers between different non-state actors such as corporatist provider organizations, sickness funds, and the state itself. In such systems the influence of the government on healthcare policy change can be limited (Blank & Burau, 2010, pp. 35-41). The Austrian healthcare system is a prime example of such dispersion of power among different actors (see chapter 2).

The second institutional feature is the funding of healthcare which is "concerned with raising resources and allocating monies to the provider" (*ibid.*, p. 69). Funding through social insurance institutions such as sickness funds is a hybrid form of financing between state funding and private insurance: while the funding as such is paid for by an independent insurance fund it has nonetheless a public mandate. Usually

the insured citizens will pay their contributions according to their salaries instead of their individual health risks, which means that the funding mechanism represents a form of social solidarity. In most social insurance systems the contributions are shared between employees and employers (*ibid.*, p. 75). This type of funding has however also implications for different actors in a healthcare system: "funding is about more than raising and allocating financial resources. How funds are raised and allocated is also a pointer to power. Different types of funding result in different types of control, and different types of control lead to different types of pressures for reform" (*ibid.*, p. 79). In Bismarckian type healthcare systems the degree of state control is therefore more limited than in healthcare systems that are financed directly through taxes. Oftentimes the state has problems to control the health care expenditure of social insurance bodies as they raise their contributions themselves. This argument can be illustrated by the complex system of healthcare financing in Austria: not only is outpatient care financed by payroll contributions and hence controlled to a large part by corporate actors. Inpatient care is mainly funded through taxes and the federal government has only limited competencies concerning how these tax subsidies are spent at regional level.

The third institutional feature concerns the provision of healthcare: "Healthcare services are first and foremost medical services, reflecting the prominence of doctors in the delivery of services and the allocation of healthcare resources" (*ibid.*, p. 83). Most often primary medical care is delivered in ambulatory setting by individual general practitioners (GPs), whereas acute medical care is most often delivered in hospitals. In most countries, hospital care represents the single largest share of healthcare expenditure. Furthermore, healthcare systems also determine how freely patients can choose medical treatment, such as the free choice of doctors and in which kind of hospital they want to be treated in. Healthcare systems also determine the exact rules of contracting between sickness funds and medical providers. Depending on the form that these rules take, actors will form their interests (*ibid.*, pp. 83-91). Healthcare delivery in Austria is for example based on patients' free choice of physicians. At the same time, the system shows an organizational split between inpatient and outpatient care, and hospital infrastructure is an important element of electoral competition at regional level.

The last institutional feature is the governance of healthcare. The form of funding through sickness funds and the way contracting between these funds and medical providers is organized influences also the governance of a Bismarckian healthcare system. Governance means here the coordination of the healthcare system and the actors in that system (*ibid*., p. 91). Bismarckian healthcare systems usually show a high institutional complexity of governance given the corporatist administration of sickness funds. Furthermore, corporatism can operate at different levels. In Bismarckian welfare states the central level sets the framework for contracting between funds and providers while the sickness funds, physicians and hospitals negotiate precise contracts at the sub-state or even local level (*ibid*.). Corporatist actors such as medical associations, sickness funds, and other provider organizations can raise their own financial resources and have also the right to determine the content of their contracts. If such a form of corporatism is combined with a federal political system, government

control is reduced and decision-making power is quite dispersed, which is the case for Austria. Moreover, different types of actors operate in the Austrian healthcare system. These actors generally show different interests and goal orientations.

1.2.4 Actors' Interests in a Bismarckian Healthcare Systems

A Bismarckian institutional regime sets the 'rules of the game' for regulation of a healthcare system that actors have to comply with. The actors develop their interests and goals according to their assigned institutional roles: broadly speaking, actors define their interests towards three main goals of health policy. The first two goals of health policy marked all types of healthcare systems in the Golden Age of the welfare state following World War II, namely the equity and *access* to healthcare as well as the *quality* of healthcare. Most healthcare systems follow the goal of equal access of citizens to medical treatment. And they try secondly to ensure the best possible quality of medical treatment for their citizens. Since the end of the Golden Age of the welfare state in the 1970s, however, healthcare systems have faced steadily rising costs and an increase of more complex technological but also more expensive medical treatments. Therefore a third goal of health policy developed: that of cost *containment or efficiency*. These goals are not necessarily complementary, but rather compete with each other (Blank & Burau, 2010, pp. 97-102), i.e. efforts to control costs can mean a decline in access or quality, or improving quality or access to healthcare can be detrimental for healthcare spending.

Four types of actors can be identified in a healthcare system: the state (national or regional government and agencies), providers (physicians, hospitals), payers (sickness funds) and users (patients or patient organizations). For example, sickness funds will be more concerned about cost control since they literally have to pay, whereas providers will emphasize the quality of healthcare services. Actors might however be pursuing several goals at a time, and hold different ideas about one and the same goal (*ibid.*, p. 246).

Diverse goal orientation of actors in a healthcare system implies also that these actors will not necessarily share the same views about European rules on access to cross-border healthcare services (see chapter 4). For example, during recent decades the federal government in Austria has put an emphasis on increasing the efficiency of the healthcare system by aiming at reforms of outpatient and inpatient care. Many of these reforms have met resistance because corporate actors such as physicians or sickness funds and regional governments feared a limitation of access to healthcare. At the same time, other reforms aiming at improving financial efficiency, such as the reduction of costs for medication and reforms of calculating reimbursement for inpatient care, have been enacted (see section 2.2). It is therefore necessary to see not only how each and every important actor positions himself towards national reforms, but also how these actors will perceive European rules on cross-border healthcare. And these actors do not necessarily hold the same ideas about taking up the opportunities offered by the European Union for going beyond the national borders or interacting with the European level. The following section will therefore present the resources that Europe can provide to these actors in order to follow their own interests.

1.3 National Actors' Usages of Europe

In order to theorize the strategies which are available for individual national healthcare actors facing European Integration in healthcare a more recent approach concerning "the usages of Europe" (Jacquot & Woll, 2003) will be used. It has been developed in the field of studies on Europeanization. While the suggested research could certainly have been constructed without even mentioning the concept of Europeanization, this would not do justice to the importance of the concept in the field of European Studies in Political Science. As the aim of this section is to provide an analytical concept to scrutinize the interaction between national healthcare regimes and actors' agency facing European integration, only the very basic features of Europeanization will be presented instead of providing an academic recount and discussion of the vast Europeanization literature[2], which has already been done several times and in a more detailed and complex manner than this present study would require.

The concept of Europeanization has become popular among political scientists since the middle of the 1990s. Europeanization moves the focus away from the integration process outcomes for the EU towards domestic changes that occur due to European integration (Börzel & Risse, 2007, pp. 483f). This analytical focus on the EU's impacts on Member States therefore means that scholars try to explain domestic processes and outcomes due to European integration rather than trying to categorize the EU itself (Featherstone & Radaelli, 2003, p. 4). The variety in approaches and study objects available has caused criticism, given the lack of a single definition of Europeanization. Therefore Radaelli (Radaelli, 2000, p. 1) has argued that the concept of Europeanization "runs the risk of conceptual stretching", i.e. that the term Europeanization needs external boundaries towards other analytical concepts and suggested the following definition that is used here: "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" (*ibid*.)

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 also to the fact that 'ways of doing things' is a concept of great subtlety (Ladrech, 2010, p. 15). The definition allows us furthermore to take 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 State 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

[2] To cite just some of the most acclaimed works: Cowles, Caporaso & Risse-Kappen, 2001; Featherstone & Radaelli, 2003; Graziano & Vink, 2007; Börzel & Risse, 2007; Ladrech, 2010; Saurugger, 2009b; Sanchez-Salgado, 2007; Palier & Surel, 2007 (in French).

their interests, which in turn 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, 2009b, p. 259).

Several studies have been carried out on the impact of the CJEU's rulings on cross-border patient mobility on Member States' healthcare systems using the misfit concept and/or looking at mediating factors that determine the change that occurs on Member State level: With regard to Denmark and Germany, Sindbjerg Martinsen (2005) has analyzed the role of the misfit of national institutions as well as the role of legal activism of national courts when it comes to the implementation of the CJEU's rulings. Furthermore, Sindbjerg Martinsen and Vrangbæk (2008) have analyzed how much institutional change occurs due to rulings in the Danish healthcare system, considering veto points and the institutional legacy of the Danish system as mediating factors. A major study by Obermaier (2009) has analyzed the implementation and compliance of the CJEU rulings on cross-border patient mobility in France, the United Kingdom and Germany. He finds that even a substantial legal and financial misfit can only partly explain the way these countries have chosen to implement the rulings, but that domestic policy preferences in healthcare, the activism of national courts acting as a 'sword of the CJEU', pressure of the European Commission as well as the CJEU's 'fine-tuning' of its own jurisprudence account for national patterns of implementation (*ibid.*, pp. 157-183). Yet, 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 of actors. These previously used approaches seem to underestimate the opportunities that the European Union offers even single actors in a healthcare system to pursue their own interests. Taking into account only institutional factors from a top-down perspective tends to reduce actors' role to those of simple 'rule takers', and in terms of outcomes only (visible) institutional changes could be taken into account. With regard to the complexity of Europeanization processes there thus seems to be a 'blind spot' in these studies, given that not only institutional factors are important, but that actors in the national healthcare system also play a crucial role (Radaelli, 2004, p. 4).

I therefore suggest using an analytical framework that combines both a sociological approach focusing on actors with a historical institutionalist approach in respect of the institutional legacy of welfare states and healthcare systems. 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 increased throughout the mid-1990s, but are very heterogeneous. Even though a common research-agenda is lacking, these approaches are based upon a common research standard. According to Saurugger (Saurugger, 2009a, p. 936), sociological approaches can be distinguished from other approaches in political science by two factors: first, they focus on the interaction of individuals or smaller groups, concentrating on the dynamics of European integration, be they institutional, cognitive, political or sociohistoric. Second, when it comes to European integration, the focus of research is thus not on the development of further EU competencies but on "the complex processes which can be found in the heart of integration" (*ibid.*, p. 937).

By taking sociological approaches and analyzing actors, a bottom-up research design is used. "Such a bottom-up research design "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 (Jacquot & Woll, 2003; Jacquot & Woll, 2004; Jacquot & Woll, 2008; Jacquot, 2008). 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). Whereas negative European integration might be putting constraints on actors in Member States with regard to their usual national resources of action, the EU offers different kinds of resources for actors. The latest research on usages of Europe and national welfare state reforms distinguishes five types of opportunities for resources:

Table 1. Resources for Usages of Europe [3]

Type	Possible resources
Legal	EU-legislation (primary & secondary) CJEU case law, etc.
Financial	Budgetary constraints Funding (e.g. funding from the structural funds, etc.)
Cognitive and Normative	Ideas, communications, references, etc.
Political	Multilevel games, blame avoidance mechanisms, argumentation
Institutional	Participation in agencies, committees, etc.

This large variety of resources does not lead to an automatic usage. Actors need to take these opportunities and transform them into resources that can be used at the national level (*ibid.*). In this perspective, national actors are not considered as intermediary variable, but as the mediators of European requirements since they have the capability of filtering these requirements and use them as a resource to follow their own agenda on the domestic level (Jacquot & Woll, 2008, p. 21). Their micro-sociological approach focuses hence on the strategic interactions of individuals, and resulting from these interactions the strategic and cognitive dynamics of Europeanization. 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. The behavior of actors is thus important for the manner in which a Member State is Europeanized, since actors can choose 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,

[3] Content of table taken from Graziano, Jacquot & Palier, 2011a, p. 10.

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 not however lead automatically to the strategic goal set by the actor since the effects of an individual action are difficult to predict. An actor will thus in turn have to adapt to his environment which influences his behaviour on the long run (*ibid.*). Therefore an actor will have the ability to use European resources on different levels of governance, i.e. actors can play "multi-level" or "two-level games" (Graziano, Jacquot & Palier, 2011a, p. 13). Jacquot and Woll distinguish three types of usages: a *cognitive usage* referring to the interpretation of a political topic and mechanisms of persuasion; 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 manoeuvre. This type of usage is the most common and occurs mostly when most of the actors' stakes have become clear. The last type of usage is the *legitimating usage* which refers to the public justification of political decisions (Woll & Jacquot, 2010, p. 117).

Each of these types of usages is usually associated with typical elements that actors engage with in order to follow their goals. Furthermore, different actors will use Europe differently. As far as cognitive usage is concerned, ideas and expertise will serve actors such as public policy networks or political entrepreneurs in order to build and to frame a political problem. Also public policy networks are associated with a cognitive usage of Europe. With regard to the strategic usage of Europe, mostly bureaucratic or institutional actors will use European institutions, legal, budgetary and political resources for their political work. Legitimating usage is linked mostly to politicians who will use Europe for deliberation or to justify political decisions (Graziano, Jacquot & Palier, 2011a, p. 15).

If we take the example of welfare states and more precisely that of healthcare systems, the number of actors that have to be considered for potential usages of Europe should be enlarged. Previous works have mainly looked at national debates of employment-friendly welfare reforms in different segments of the welfare state (Graziano, Jacquot & Palier, 2011b), but were mostly limited to political actors or elites. As the case of the CJEU rulings on cross-border healthcare and patient mobility has shown, Europe even offers resources to an individual patient who then becomes an actor in the moment he or she uses a legal resource to enlarge the medical treatment options beyond the boundaries of the national healthcare system. Given the variety of actors that are responsible for healthcare delivery, such as politicians, corporate actors (medical associations, employers' associations, labor unions, sickness funds, etc.), bureaucratic actors such as federal and regional ministries, the scope of analysis has to be enlarged. If we want to analyze how these actors mediate Europe and what effect this mediation of Europe has, these actors have to be approached from a specific angle: "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, though, 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). It is therefore suggested to combine the sociological approach of "usages of Europe" with a historical institutionalist approach, especially since both approaches seem to be compatible: "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). Introducing Historical Institutionalism into the picture of analyzing actors' usages of Europe will help to better understand what was called "national games" of social interaction. If we take Streeck and Thelen's (2005a) definition seriously, that institutions are building blocks of social order and that institutionalized national welfare *regimes* define what is possible and impossible for national actors, we must take these national institutional opportunity structures and their goal orientations into account when trying to analyze actors' usages of Europe. Also the stickiness of institutional *regimes* has to be taken into account. Welfare states have not been swept away by globalization, even though they have undergone gradual change that has accumulated significant change over the last decades. Similarly, we can assume that Europe might cut into the boundaries of the national welfare states and offer new spatial opportunities, but change might come about in incremental steps and will be evaluated by actors against their national resources, not to mention that actors might very well try to resist to European Integration to preserve the national status quo. Consequently, combining Historical Institutionalism with the usages of Europe approach might also close some conceptual gaps that open up once the scope of potential actors to be analyzed is enlarged.

The 'institution-prone' reasoning developed above does not change the original aim of analyzing actors' usages of Europe: The aim of adding a historical institutionalist perspective is to scrutinize the national conditions and opportunities that set the framework for the role that actors can and cannot play. Taking the example of a Bismarckian healthcare system supposes that such a system and the way it interacts with national structures of policy-making frame and allow for much different practices of actors than in other types of welfare regimes. These practices can be defined as follows: "A practice is not what someone says s/he thinks or says s/he wants; it is what someone does" (Mérand, 2011, p. 182). Actors develop routines in their everyday work, they "accumulate a great deal of practical knowledge; that is, they develop a repertoire of social networks, behavioral attitudes, standard operating procedures, rules of thumb, tactics and strategies that help them cope with the practical problems they face every day" (*ibid.*). Adding historical institutionalism to this sociological definition of practices means that we have to scrutinize how actors enact national institutional rules and how they interpret them, both of these mechanisms allowing for a certain leeway for change (Streeck & Thelen, 2005b, p. 15). If actors start to use Europe regularly and incorporate this into their existing practices, this change in practices that can have an influence on the norms that surround actors has been called from a sociological point of view *bricolage*: "Bricolage is a sort of making do.

Each step is caused by the desire to solve a local problem […]. New problems arise in the process which are also addressed by whatever comes to hand […]. *Bricolage* is the art of invention (*ars vivendi*) within the 'reasonable' limits set by practical knowledge" (Mérand, 2011, p. 183). From a historical institutionalist perspective one might want to add that these practices are a sort of making do within the limits of the national institutional regime in which actors are confronted with European constraints and possible opportunities for action. Actors' *bricolage* of practices means therefore that they will try to accommodate the challenges and opportunities that Europe offers within their institutional role that they are used to. However, this does not imply that national regulation is dismantled, it rather becomes more complex.

We could expect that *payers* such as sickness funds have a critical stance towards European Integration, given that the increased options for patients to seek medical treatment in another country represent the risk of rising costs. *Providers* of medical care, on the other hand, might show the most ambiguous attitude towards European rules on cross-border healthcare: increased access to healthcare across Europe can potentially entail new sources of revenue through an increase of demand for medical care by foreigners. At the same time they might be subject to competition with providers from other countries that offer medical services at a lower price or a higher quality. The ambiguity that is to be expected calls for careful analysis of this group of actors' perception. *Subnational governments* that are also involved in the delivery of healthcare can be expected to have an equally ambiguous stance towards European Integration in healthcare. On one hand they should be worried that potential additional costs can arise from potential foreign patient fluxes, which would be problematic. Yet, the EU provides financial subsidies for cross-border cooperation through a variety of European funds. These funds and enhanced cross-border cooperation could set incentives for an increased involvement with the European level. Therefore the subnational or regional level has to be scrutinized thoroughly.

Following this reasoning, it is expected that national healthcare actors will start to use Europe, and hence their strategies will change. Their interests however remain largely determined by the national institutional set-up of the healthcare system. Europe might render the institutional boundaries of the national healthcare system porous, but they should remain intact. In chapter 4 these hypotheses will be tested on the main actor groups of the Austrian healthcare system responsible for the delivery of healthcare. In order to better understand the institutional environment in which Austrian healthcare actors operate, the following chapter 2 describes the historical development of the Austrian welfare state and its healthcare system and will then elaborate the dynamics between institutions and actors' practices in Austrian healthcare governance. Chapter 3 will describe the development of European Integration and cross-border healthcare before turning to analysis of actors' usages of Europe in chapter 4.