

**Europeanising Healthcare:
The Effects of European Integration on Domestic Systems**

A thesis submitted for the degree of Doctor of Philosophy

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Declaration

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Summary

A large range of literature is pertinent to understanding and conceptualising the influence of the European Union (EU) on domestic and healthcare system changes. Scholars have explored the influence of European integration on domestic systems and on specific subsets of social policy, including EU health policy. Many analyses have focused explicitly on a specific type of policy, the field of policy, or country, with regard to this Europeanisation process. Others have explored and worked to contextualise EU health policy, which covers a large range of topics, and its implications for domestic healthcare systems.

Building on the extant of literature that examines the role of EU, this thesis examines how Europeanisation impacts domestic healthcare systems through a qualitative case study analysis. It offers an in-depth, systematic study of how European integration affects domestic healthcare systems and actor behaviour across MSs, through integration of EU health policy and other EU policies applicable to health. The thesis seeks to outline a model that illustrates both the generalisable and differential effects of Europeanisation on welfare states, specifically on healthcare systems, by creating a theoretical framework that devises a structured explanation of the influence of the EU on healthcare systems, incorporating varied domestic institutional arrangements into its design.

The thesis outlines a theoretical model of Europeanisation on domestic healthcare systems, which is disaggregated into four component arguments. The findings show that there are two main types of EU policy pertinent to healthcare systems: health policies and non-health policies. These policies are either binding or non-binding in their compliance level. EU policies result in either major or minor impacts on the domestic healthcare systems. The most

significant impacts of EU policy on the domestic level stems from non-health policies applicable to healthcare systems. Moreover, the Working Time Directive (WTD) serves as a critical juncture with significant influence on MSs. With regard to EU policies, some effects are visible across MSs, notably from major policies that influence key components of healthcare systems, such as financing and personnel. However, there is variation across countries about the domestic interaction with, and effects of, the EU. This variation stems from the different institutional arrangements of the healthcare systems, which structure European integration. As a result of the influence of Europeanisation, a feedback mechanism of domestic actors inputting into EU policymaking develops, influencing the future process.

Case study analysis of three cases—Germany, Ireland, and Spain—are conducted to test the explanatory power of the theoretical model. The explanatory framework is largely supported by the qualitative analyses. Case study analysis comprises of high-ranking key healthcare actor interviews as well as supporting secondary analysis. The methodology includes original interview analysis conducted as part of the thesis. The interviews serve as a base for structuring the focus of the resulting case study analysis. As a result, the three cases contribute to the development of the Europeanisation and health literature by exploring institutional and actor trends and developments in detail. The evidence supports many aspects of the model. Unexpected findings from the analysis are also highlighted and discussed.

In summary, the thesis illustrates that there are trends visible across domestic healthcare systems with regard to the effects of European integration through qualitative analyses. Institutional arrangements also structure the Europeanisation effects, so they must be incorporated into explanatory models. The findings illustrate that external pressure, such as EU policy, can improve the understanding of the influences on, and evolution of, healthcare systems.

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Chapter 1

Introduction

Overview

The introductory chapter establishes the problem that guides this thesis—understanding the impact of the European Union (EU) on domestic healthcare systems. Firstly, this chapter outlines the main research question: to what degree and how does European integration affect domestic healthcare systems with varied institutional arrangements? This question and those deriving from it instruct this thesis.

Second, the variation to be explained by this study is examined. The thesis explores changes to domestic healthcare systems, with particular attention devoted to policy discussed by key actors interviewed during the study, and the relation of these changes to the influence of the EU.

Third, the main contributions of the thesis are outlined. This thesis serves to test concepts developed in the existing literature and in the developed theoretical model through the application of qualitative cases study analysis. The thesis strives to help to contribute to explanations of the Europeanisation of healthcare by contributing new data and insights, including the addition of data from interviews. It seeks to build on the understanding of the consistent influences as well as the differentiated impact of the pressures of European integration on domestic healthcare systems. A common effect from Europeanisation is apparent across member states (MSs), but there are also differential impacts on MSs dependent on its domestic institutional arrangements, which are developed in the theoretical model. The thesis explores

the role that national factors play in the Europeanisation systems' process of healthcare.

Finally, the chapter concludes with the plan of attack, which lays out the structure of the thesis. The thesis examines the existing literature, devises a theoretical model based on its insights, and tests the model through case study analysis. The thesis concludes by critically assessing its design, contribution, and findings. I now explore the central research questions that are at the heart of this thesis.

Research Question

Over recent decades, the structure and role of the European Union have developed and evolved. Many scholars have shown that EU authority and policy has expanded in many areas, such as agriculture, monetary and competition policy, moving from the domestic level to the supranational, the EU level. As such, debate has emerged between the intergovernmentalism and neo-functionalism of the nature of this European change (Moravcsik, 1998; Majone, 1997; Pierson, 1996a; and Pierson and Leibfried, 1995). Alongside this trend, concurrent changes are occurring to both domestic welfare states and healthcare systems as new pressures and challenges emerge (Pestiea and Lefebvre, 2018; Vanhercke, Natali, and Bouget, D., 2017; and Taylor-Gooby, 2004).

Consequently, as policy jurisdiction moves from the domestic sphere to the supranational one, the volume and scope of EU policy increases. In the literature, this trend of increased supranational policymaking power is referred to as a “deepening” of European integration, whereas the addition of MSs is called a “widening” of European integration (Chari and Kritzing, 2006; Jachtenfuchs, 2005; Molle, 2006). Policy areas in which the EU has a strong mandate, those that are a priority at supranational level, are considered “first-order policies.” First-order policies are predominantly economic, and policy development is driven mainly through binding regulation (Chari and Kritzing, 2006, pp.2-5).

In contrast to many areas of first-order policy, the EU does not have a legal mandate, including in healthcare service and delivery; MSs retain primary responsibility with regard to the structure and financing of their healthcare

systems. Over the years, healthcare policy has remained under the purview of the individual MSs despite increased Europeanisation of an increasing number of policy areas (Greer, 2006; Hervey and Vanhercke, 2010; Lamping and Steffen, 2009). EU health policy “serves to complement national policies” (European Commission, 2019a).

However, academics must consider supranational developments, specifically the role of European institutions, not solely relying on domestic-level influences (Marks, 1993; Pierson, 1996a; Pierson and Leibfried, 1995). A substantial and growing literature explores how EU affects health policy and healthcare systems (such as De Ruitjer, 2019; Greer, et. al, 2019; Hervey, Young and Bishop, 2017; Martinsen, 2015; Greer, 2014; and Hervey and Vanhercke, 2010). As such, many types of EU policy impact health. These can broadly be classed into broad categorisations of public health, internal market, and fiscal governance (Greer, et al, 2019; Greer, 2014).

As a result, this thesis seeks to contribute to the understanding of the development of healthcare systems and the role that the EU plays. It seeks to help answer the question: to what degree does European integration affect domestic healthcare systems? How and when do pressures created by the EU alter domestic healthcare systems? What is the nature of such change—is it uniform, varied, or differential across Member States? Do these impacts vary by EU policy type? How do domestic institutions and actors influence this process of Europeanisation across varied healthcare system arrangements? What insights does the interaction of EU policy and domestic systems provide to us about the Europeanisation process and healthcare institutional change over time? How have recent developments affected the Europeanisation process?

Some scholars have referred to effect of the EU on healthcare systems as “chaordic” in character, reflecting both chaos and order (Lamping and Steffen, 2009). Given the lack of an overarching healthcare policy, the nature of supranational developments in healthcare is complex, occurring over a range of policy topics (Greer, et. al 2019; Lamping and Steffen, 2009). How can the European integration of domestic healthcare systems best be conceptualised over time, across different institutional arrangements and across varied policy areas? Which EU policies are most pertinent to the development of domestic

healthcare systems? This thesis seeks to understand the extent of the impact of the EU on domestic healthcare systems in a systematic manner that generalises across MSs while accounting for institutional variation.

Variation to be Explained

In the 1960s, health comprised a small component of national economies throughout the advanced industrialised world. The absolute and relative size of the healthcare sector drastically increased over the next forty years throughout the Organisation for Economic Co-operation and Development (OECD). Health expenditure growth rates were nearly double the overall economic growth rates during this period of time (Hagist and Kolikoff, 2006). Healthcare system rapid growth continued in Europe through the periods of general welfare state retrenchment in the 1980s and 1990s.

Beginning in the 1990s, Europe witnessed a string of healthcare reforms as domestic governments strove to reduce spending (or at least, curb its growth) after a prolonged period of stagflation during the economic crisis of the 1970s. European healthcare systems underwent many reforms and changes throughout the 1980s and 1990s as countries faced new challenges (Ritsatakis, et al, 2000; Saltman, Figueras, and Sakellarides, 1998). Then, the economic and financial crisis beginning in 2008 had large implications for the financing and structure of domestic healthcare systems (Maresso, et al, 2015). Much variation, therefore, persists across countries, which warrants investigation to understand changes at local and domestic levels.

In conclusion, understanding the variation cross-nationally and temporally is important when developing explanations of institutional system development and policy change. This thesis examines European healthcare system change over recent decades. As healthcare systems are large, institutional arrangements with many differences across countries, a comprehensive approach must be utilised to best explore and conceptualise changes stemming from Europeanisation.

Contribution of the Thesis

The thesis provides an overview of the literatures relevant to understanding the impact of the EU on domestic healthcare systems, including the current state of play. It strives to help to contribute to explanations of the Europeanisation of healthcare by contributing new data and insights, including the addition of data from interviews. It seeks to build on the understanding of the consistent influences as well as the differentiated impact of the pressures of European integration on domestic healthcare systems. A common effect from Europeanisation is apparent across member states (MSs), but there are also differential impacts on MSs dependent on its domestic institutional arrangements, which are developed in the theoretical model. The thesis explores the role that national factors play in the Europeanisation systems' process of healthcare.

There are three main contributions of this thesis. The *first contribution of this study* is to provide an overview of and contribute to the literature, which is presented in detail in Chapter 2. This thesis thus draws on insights from these four literatures—the welfare state, health, Europeanisation and EU health policy literatures—which is necessary to understand healthcare system development across Europe. These extensive literatures offer a lot of insights relevant to the Europeanisation of healthcare systems. This thesis serves to test concepts developed in the existing literature by exploring three systems in detail.

The *second main contribution of this study* is a qualitative addition to the existing literature. Forty key actors in healthcare systems were interviewed about the impact of the EU on their domestic systems. These interviews provided insight and data into the Europeanisation of healthcare. These findings are central to highlighting key policies and developments that are explored through the comprehensive case study analysis.

The *third contribution of this study* is that it devises and tests a theoretical framework to summarise the impact of European integration over time across numerous countries. This explanation does not focus on a sole MS or on one specific EU policy. The framework attempts to employ a holistic approach to understanding the impact of the EU on healthcare systems. As a result, the model can be applied to other domestic healthcare systems beyond the three examined

in the qualitative analysis. The framework can also be adjusted and adapted to other areas of social policy. The explanation presents the generalisable effects of the EU across domestic healthcare systems while incorporating the strengths and weaknesses of the various institutional arrangements to account for differentiated regime effects of European integration. The model helps to conceptualise the “chaotic” dynamics of the Europeanisation of healthcare systems. The model is dynamic and includes a feedback mechanism in line with the existing literature. This framework is tested on three significant EU MSs in the empirical chapters with some surprising findings. The robustness of the theoretical model is therefore assessed. Thus, the thesis seeks to use a qualitative approach to tackle a difficult question in a systematic manner.

Research on the development of domestic healthcare systems is ever changing and developing as healthcare systems themselves alter and reform. This thesis explores and tests how European integration affects healthcare systems. Findings pertaining to the effects of external pressure—such as the EU—can improve the understanding of the influences on, and evolution of domestic healthcare systems. The insights can be applied to practice in order to improve the efficiency and effectiveness of future reform efforts. Analysis of domestic change stemming European integration can help to build on current models of healthcare system development. This thesis shows that the EU has both consistent as well as differentiated impacts across MSs, which has implications for future research.

Thesis Outline

The thesis begins with a discussion of the explanatory variable and an outline of the theoretical framework. Chapter 2 offers an in-depth examination of the existing literature relevant to the research question. Four main bodies of literature are detailed. As discussed above, the first explores the welfare state broadly from a comparative perspective across advanced industrialized economies. The second examines healthcare systems as unique in comparison to other areas of domestic policy. This literature seeks to categorise healthcare systems and explain the factors. The third literature explores the direct and indirect influences of Europeanisation on domestic systems, policy, and polity.

The final literature summaries the work pertaining to the impact of the EU on healthcare systems. The studies are explored, and the gaps are discussed. The thesis seeks to expand on the literature. As such, it outlines and tests a model on the varied effects of the EU on domestic healthcare systems examining institutional differences and actor behaviour in diverse healthcare system arrangements.

Building on the literature review, Chapter 3 outlines the theoretical framework that guides the rest of the study. The broad effects of the EU on domestic healthcare systems are explored in this model, which comprises of four central dimensions. The justification for the model is summarised. The remainder of Chapter 3 explores the research design of the thesis. The explanatory variables are outlined. Then, the central hypotheses of the thesis are laid out, and the expectations are detailed. The qualitative analysis explores the extent of and the mechanisms behind EU influence on domestic healthcare systems devoting particular attention to interview analysis. This structure is justified, and the design is outlined. The case study selection is also explained. As such, the cross-country analysis and research design set the basis for the qualitative case study analysis of the three MSs in Chapters 4, 5 and 6.

Chapters 4, 5 and 6 comprise the case study analyses on Germany, Ireland and Spain, respectively. The arrangement and evolution of each regime are discussed. The expectations for the EU impact on each healthcare arrangement are presented. Finally, the findings from the case study analysis, incorporating and structured around the elite actor interviews, are outlined.

Summarising the main findings of the first empirical investigation, Chapter 4 presents Germany; this evidence supports many of the central tenants of the model. As expected, the primary supranational influence evident is through non-health EU policies in outside areas, such as employment, that spill over. The Working Time Directive plays a critical role in Europeanisation. Societal actors are strongly mobilised due in keeping with the strong corporatist foundations of the system. The chapter shows that various German healthcare system actors are highly aware of the role that the EU and work to develop the capacity to impact the system. The level of misfit of EU policies with the German

arrangement appears to be generally low, which minimises its adaptational costs.

Ireland is discussed in Chapter 5. In Ireland, the EU has had an impact on domestic healthcare system, which is particularly influential on the bureaucracy and administration of services. In Ireland, the impact of the Working Time Directive is also evident. The impacts primarily influence aspects of the healthcare system where it has historically struggled, such as around financing and health professional rights. There is some mobilisation of national officials at EU level, but the societal actors are not as strong and organised as in Germany. Ireland generally complies with European legislation, but is limited in its ability to shape it due to finite national resources and organisational constraints, which appears to correlate with its domestic healthcare system characteristics.

Chapter 6 explores the impact of the EU on the Spanish healthcare system, the final case. In Spain, the impact of the EU is perceived at domestic level to be the lowest of the three case studies. Like the other two cases, the Working Time Directive plays a key role in the Europeanisation process. The nature of Spain's healthcare system as relatively recently developed and federalised affects this Europeanisation process at domestic level. However, the decentralised nature of the system seems to impact the ability of local and domestic actors to mobilise and actively shape European policy that impacts healthcare.

The final chapter, Chapter 7, concludes by summarising the thesis' central findings. Then, the overall conclusions and their implications are outlined. The limitations of the thesis are briefly outlined. The contributions of the thesis and the potential for future research are detailed.

Chapter 2

Literature Review: Existing Explanations

Introduction

This chapter reviews the existing explanations in the literature relevant to answering the question guiding the thesis: to what extent and in what manner does European integration affect varied domestic healthcare systems? Four sets of literature relating to this question are summarised and assessed in this chapter. These works of literature are (I) comparative politics explanations of political economy and the welfare state; (II) healthcare explanations, including modelling and healthcare categorisations; (III) Europeanisation explanations relating to domestic policy; and (IV) Europeanisation of healthcare policy explanations. Each subfield contains important insights pertinent to the development and evolution of the welfare state and healthcare systems specifically.

However, the potential exists to further connect, build on, update, and add insight through theoretical model development and in-depth qualitative study. This thesis contributes to the field by systematically examining healthcare system change across varied institutional structures stemming from influences of the EU. Specifically, how can this research build off the existing literature and help contribute to these explanations through further analysis? Moreover, how can insights from these four bodies of work be combined to conceptualise the influence of the EU on domestic healthcare systems' institutions and actors?

The *first* literature (I) examines *comparative political explanations of political economy and the welfare state*. This extensive literature explores the

welfare state and social policy in a cross-national context due to its drastic expansion over the twentieth century (most notably Esping-Anderson, 1990, and Hall and Soskice, 2001). The determinants of and influences on welfare states are summarised. This field has primarily considered specific policy areas, like employment protection and skills development, in which the economy and government are closely linked. These typologies are criticised as static in nature minimally and partially applied to the analysis of healthcare policy (Alber, 1995; Bambra, 2005a; Bambra, 2005b; Wendt, 2009).

Consequently, the *second* reviewed literature (II) comprises of *healthcare system explanations*. This field is divided into two classes of explanations. Some accounts utilise demographic and economic variables to explain variation in healthcare systems, mainly focusing on spending and largely ignoring political and institutional influences (such as Hitris, 1997; Huber and Orosz, 2003; McCoskey and Selden, 1998; O'Connell, 1996; Potrafke, 2010). Other studies apply comparative political analysis to broadly explain differences in policy and institutional arrangements cross-nationally (such as Anderson, 1963; Field, 1973; Freeman, 1998; Moran, 1999; Moran, 2000; OECD, 1987; Wendt, Frisina and Rothgang, 2009; Dixon and Poteliakhoff, 2012). Overall, these studies are mainly descriptive categorisations. The models do not sufficiently explain reform, especially deviation from path dependency. Many forces, like globalisation and Europeanisation, inevitably influence healthcare systems as significant components of both the welfare state and the economic system (Bambra, 2005b; Figueras, 2011). However, many of these accounts do not adequately incorporate broader political-economic forces, such as Europeanisation, into systematic explanations of system change. When these studies explore changing dynamics, they primarily focus on individual case studies and national influences.

Due to the static nature of welfare, political-economic, and healthcare regime explanations, the *third* literature (III) discussed includes the *Europeanisation explanations and domestic policy*. The field of study examining European integration is briefly outlined. Then, scholar's work about Europeanisation is reviewed, particularly literature exploring its effects on domestic, polity, policy, and systems (such as Geyer, 2000; Dyson, 2007;

Faulkner, 2007; Featherstone, 2003; Haverland, 2001; Radaelli and Pasquier, 2007; Liebfried, 2010; Natali and Vanhercke, 2015; and Kilpatrick, 2018). Literature on Europeanisation is devoted to understanding the actual and potential impact of the emerging EU on domestic level policies, with some studies analysing social policy (notably Faulkner, 1998). Nevertheless, the welfare state literature and Europeanisation literature connection offer the potential for future insights and updating in light of developments, particularly regarding healthcare and in the case studies included in this thesis.

The final and *fourth* literature (IV) explored is the field devoted to the *explanation of the Europeanisation of healthcare*. This thesis is most firmly rooted in the insights from this literature and seeks to add to the development of this discipline. This last section is subdivided into four parts. The first part summarises health and healthcare policy definitions (such as Greer et al., 2014). The second subsection outlines the literature on the types of EU health policy (including Hervey, 2007; Greer, 2009; Baeten, Vankercke, and Coucheir, 2010; Baeten and Thomson, 2011; Greer, 2014; Greer et al., 2014; and de Ruijter, 2019). The third portion is an overview of the literature on the key actors and institutions in the Europeanisation of healthcare (including Hervey and McHale, 2004; Martinsen and Vranbaek, 2007; Brooks, 2012; and Martinsen, 2012). The final subset looks at the factors and changes of the Europeanisation process itself (such as Krajewski et al., 2009; Martinsen, 2011; Vollaard, von de Bovenkamp & Martinsen, 2016; Purnhagen et al., 2020; and Greer, 2021). There is extensive literature on the EU and healthcare. This thesis employs this literature, combining it with institutional models, to develop a model of the national varieties of the Europeanisation of healthcare, which Chapter 3 outlines.

Thus, various bodies of literature are relevant to the thesis that are complex and evolving in nature. Consequently, I conclude the existing literature section by discussing the applicability of the four bodies of literature to answering the research question. The room for development in the current studies is explored. These critiques set the context for this thesis and the contribution that the thesis makes. The final section outlines that as effects of European integration on healthcare systems remain, the potential exists to systematically examine how international forces influence healthcare systems

through detailed qualitative analysis. This study strives to build on this literature and add further insight to existing explanations to understand better how domestic healthcare systems evolve in an increasingly international world.

I. Comparative Politics Explanations

A substantive literature categorises social policy—government policies that impact citizen welfare—after benefit provisions drastically expanded in the 1960s and 1970s. Historically, scholars have focused on issues such as pensions and disability benefits. Health comprises the most significant proportion of social spending in advanced industrialised economies, yet broad categorisations do not often include healthcare.

Countries are clustered into “like” groups with similar structures regarding economic and government interaction. These regimes are grouped by methods of benefits provision across various social policy areas. A lock-in effect—difficulty changing existing institutions—can perpetuate these practices once implemented. This literature provides some of the foundation for this thesis, which strives to create an explanatory framework that generalises across countries over time. The section disaggregates this literature into three subsets: a) economic-political relations, b) welfare state regimes, and c) pressures on the welfare state.

Economic-Political Relations

The link between politics and economics is a cornerstone of the advanced industrialised economies literature. They are interconnected, so changes to one have knock-on effects that impact the other. As health is a large part of national economies, this field is essential to understanding and exploring the evolution of the healthcare system in its broad economic context.

Initially, scholars (notably Lindblom, 1980) argued that as governments give businesses a privileged position, public policy decisions are highly influenced by industry. Companies receive benefits like tax breaks and tariffs benefits. This situation occurs because governments often feel they need business more than workers. Companies can choose to take capital elsewhere. Industry does depend on the government for outputs like infrastructure, and the

bureaucracy can monitor some business activities (Lindblom, 1980). Nevertheless, this argument focuses mainly on how business affects government, not on how government impacts business.

Over time, scholars like Block (1994) contested the traditional paradigm that a divide exists between what the government provides and what is available through free markets, proposing instead that states play a significant role in structuring and influencing the economy. States, in general, provide a legal framework for recurring relations between various economic actors, monetary, and credit systems, for means of payment for transactions, and the management of territories and regulations. Levels of government regulation vary cross-nationally (Block, 1994). This explanation focus is unidimensional and descriptive, providing limited predictive value. It offers insight by proposing a bi-directional relationship between the economy and politics.

Scholars, such as Hall and Soskice (2001), developed a description of political-economic interaction, dividing political economies into two varieties of capitalism—liberal market economies (LMEs) and coordinated market economies (CMEs)—with institutional constraints differing across systems and structuring the relations and strategic interactions amongst system actors. In LMEs, few state regulations exist. Industry is highly competitive and focused on the short-term stock market. Unions are weak, and employment protections are low. In contrast, CMEs are highly regulated. Cooperation occurs across industries. Unions are strong, and employment protections are high. Investment focuses on long-term economic success rather than short-term investment gain (Hall and Soskice, 2001).

According to this explanation, political economies react characteristically when issues arise, applying standard solutions to new challenges, so lock-in effects result from past practices. The various components of the economy are interconnected, so reform of one aspect leads to changes in the others. This property generally prevents economies from adopting uncharacteristic solutions (Hall and Soskice, 2001). The argument does not illustrate how the rules, such as levels of coordination among business and government, influence how actors interact, nor does it have much consideration for the role of workers (Martin and Thelen, 2007). The classification does not sufficiently account for

cross-national variation within the two systems. It does not explore nuanced policy areas, such as healthcare, that historically are not directly tied to employment policy.

The varieties of capitalism (VoC) position is a central foundation in the literature (Blyth, 2003). The VoC literature (Hall and Soskice, 2001; Streeck and Yamamura, 2001; Schmidt, 2003; Amable, 2003; Morgan, Whitley, and Moen, 2006) has been criticised as static, not accounting for changes derived from pressures like globalisation. Other factors, like internationalisation, class, and historical legacies not included in the literature are essential too (Howell, 2003). Scholars then explored whether or not globalisation leads to convergence or continued divergence amongst systems. Although the two varieties face similar pressures, they have different stakes and government systems. LMEs as shareholding systems focus on profitability; the market regulates between companies and constituents. On the other hand, CMEs are stakeholder arrangements, so concepts like employment security are priorities for society; non-market mechanisms are used to regulate interactions between companies and constituents. Therefore, different rules and regulations prevent globalisation from eradicating differences between the systems (Hall and Thelen, 2009; Peck and Theodore, 2007; Vitols, 2001; Hay, 2000; Kitschelt et al. 2000). Furthermore, evidence indicates that how the varieties change under pressure itself varies, and countries in the same class have followed the different paths, depending on factors like politics and coalitions (Thelen, 2012).

Furthermore, critiques of the literature caution on over employing VoC literature. Countries do not necessarily belong to one given variety only (Becker, 2007). Elements of mixing the types are found cross-nationally beyond the original LME/CME dichotomy (Witt and Jackson, 2016). Moreover, the VoC model is not well suited for times of crisis. Although the VoC argument has become relatively standard in the literature, scholars need to differentiate between theory and practice (Hay, 2020; Hodgson 2016; Streek, 2010; Howell, 2003). The model helps to simplify a complicated world. The model has been employed and developed to apply to industrialising economies (such as Nölke, et al. 2019).

However, critiques argue that capitalism itself varies rather than capitalism coming in distinct types. Instead, approaches should be rethought to “the dynamic patterned of diversity” in capitalism (Hay, 2020, p.303). Thus, institutions, interests, and ideas within economic types are influenced by external pressures like economic crisis, Brexit, and European integration as the way capitalism and democracies’ interaction evolves (Hall, 2014; Streek, 2014). The construct helps to identify biases and patterns, particularly in a post-financial crisis world (Hay, 2020). Criticism points to the theory needing updating to be able to account for macroeconomic and political instabilities (Schwartz and Tranøy, 2019). Moreover, the interaction of other considerations, such as informal networks and trust within economies, must be factored in to models (Weiss, 2021).

In summary, this literature describes the connection between the economy and government, which shapes political system development. The theories broadly discuss differences across countries by general structure and across some policy areas. The VoC literature offers essential insights into how economies behave and a framework to group them for understanding, though weaknesses are evident over time in the face of new challenges. Categorisations and explanations of various social policies are underdeveloped. Other scholars have explored variation across domestic policies and disaggregated countries into different regimes, to which I now turn.

Welfare States Regimes

All advanced industrialised economies have some form of a welfare state, including pension policy and a healthcare system. However, much cross-national variation exists in welfare states’ spending, structure, and beneficiaries cross-nationally. Most notably, Esping-Anderson (1990) classifies welfare states into three regimes. Liberal systems, like the UK, have low-public spending on welfare. The limited programmes that exist are means-tested and not universal. Christian Democratic systems, like Germany, have high quasi-public spending. Most programmes are connected to employment through social insurance schemes. Social Democratic systems, seen in Scandinavia, are citizenship-based, general-tax programmes. Decommodification—the ability for the worker to

leave the workforce—is highest in Social Democratic systems and lowest in Liberal systems (Esping-Anderson, 1990). The welfare state regime literature is often critiqued for its negative focus on its goal and its static nature.

Others, including Estevez-Abe, Iversen, and Soskice (2001), argue that the welfare state is structured to support skills development rather than merely allowing workers to exit and re-enter the workforce. The types of skills needed vary with the three production market strategies of economies. Workers are rational and calculate the costs and benefits of skills. General skill systems, including the US, do not need to offer many benefits, and protection is low. Industry-specific systems, like Denmark, have low employment protection, but high unemployment protection to support high skills development. Firm-specific countries, such as Japan, have low unemployment protection, but high employment protection to retain workers. Countries like Germany, with a mix of firm- and industry-specific skills, have high protection to keep workers in the industry (Estevez-Abe, Iversen, and Soskice, 2001). These models are based on manufacturing, not the rising service industry, which explains class development.

The welfare state classifications primarily explore either the quantity provided by the welfare state or the aim of welfare state provisions, but often do not examine both together. Bonoli (1997) proposes an alternative, a multi-dimensional approach to welfare state classification. One dimension disaggregates between occupation-based Bismarkian systems, such as Germany, and universal Beveridge systems, including the US and Scandinavia. The second-dimension divides systems based on high and low spending (Bonoli, 1997). Quality of social provisions and how money is spent, not solely the total amount, are absent from these arguments. Differentiating how money is spent is essential when analysing social policy developments.

Goodin and Rein (2001) further examine the pillars of the welfare state: who pays and provides welfare services. They argue that four pillars should be included in regime studies: the state provides benefits from tax revenue through public agencies; the market offers labour and capital assets; the family provides nuclear support; and the community provide benefits through non-state organisations. Different pillars are utilised more frequently by certain regimes.

Liberal systems often employ the state and market. Corporatist arrangements rely heavily on the market and family. Social Democratic systems mainly use state supports. Pillar-focus can change over time across countries (Goodin and Rein, 2001). Domestic policy distinctiveness and lock-in effects occur from past policy (Herwartz and Theilen, 2003). This analysis is primarily descriptive rather than prescriptive, but offers an angle from which regimes should be viewed.

There is a noted overreliance on the welfare state typologies in the literature, particularly concerning health and delivery of services, not just benefits and social transfers (Bambra, 2007; Kautto, 2002). The typologies are criticised for not considering factors like gender, race, class, and population subgroups (Bambra, 2007; Herd, 2005; Bambra, 2004; Sainsbury, 1999; and Orloff, 1996). Thus, the welfare state conceptualisation warrants more development. Scholars have shown that much of the typology continues to be valid as an ideal type, although it may present as a continuum rather than groupings in actuality (Ferragina and Seeleib-Kaiser, 2011). The literature has been critiqued as weak in particular areas like caregiving, education, and healthcare (Lewis, 1992; Bambra, 2005; Wendt, 2009; Busemeyer and Nikolai, 2010; and Reibling, 2010). It also does not systematically consider regional differences in welfare regimes within a national system, which can be significant in federal systems (Daigneault et. al, 2021).

The welfare state is much broader than often presented. There are significant differences between countries based on service provision, poverty relief and social services (Garrett, 2016). Thus, system classifications exist to disaggregate countries by broad general welfare policy regimes. The structure, the level and types of benefits, and the funding scheme of the systems are explored in the various approaches. There is no consensus on which one classification best captures variation and generalisations across regimes. The theories, on the whole, classify current systems and base predictions on dependency.

Welfare state provisions have survived waves of globalisation, privatisation, and other neoliberal welfare reform that affected service provision—pressures of cost containment and new challenges in the post-

industrial era. The categorisations and their effectiveness vary, but all modern advanced industrialised economies have some form of a welfare state (Garrett, 2016, p. 133). Welfare production and consumption—whether from the markets, family, or government—remain at the heart of welfare regimes (Esping-Anderson and Myles, 2018).

Yet, these explanations do not examine specific regimes in great detail and often do not fully account for changes to and the evolution of institutions. Most literature conceptualises the welfare state as a path-dependent institution that largely does not change (Pierson, 2000). Evidence supports that the welfare state faces challenges, changes, and provides policy feedback (Jensen et al, 2019; Béland and Schlager, 2019). Other studies have looked at multiple influences and determinants of welfare regimes, which is considered next.

Pressures on the Welfare State

The welfare state did not develop in isolation; instead, it was shaped by political forces. The aims of social provision and economic policy often are at odds with each other (Garrow and Hasenfeld, 2014). In a similar vein, its perpetuation, adaption and evolution are subject to political and institutional impacts. Comparativists have used four main influences to explain variation in social systems and policies: the role of institutional characteristics, the influence of interest groups, the importance of ideology, and new challenges for the welfare state. It is important to note that Europeanisation as a new challenge is discussed in detail in the last two sections of the literature review and not included comprehensively in this section to prevent duplication.

Institutional Characteristics' Impact

Welfare states derive from social policy. Social policies are generated by decisions made by the government. Consequently, the “rules of the game” and the key actors in the policymaking process influence the creation and development of the welfare state. The first primary influence discusses how institutional characteristics—notably the importance of electoral system design, political party dynamics and veto points— impact the outcomes of the social policymaking process, and, consequently, the welfare state.

Firstly, electoral system design impacts redistributive policies. Iverson and Soskice (2006) apply median voter theory to understanding policy outcomes and welfare regimes. They propose that in first-past-the-post systems in which the candidate who receives the plurality of the votes wins the election, the median voters align with the upper class. This phenomenon occurs because the middle class does not want to pay elevated tax levels that are redistributed to the lower socioeconomic classes, so it, enticed by low tax rates, sides with the upper class. In contrast, proportional representation systems result in coalition governments with relatively stable policy positions over time. The middle class aligns to the left to redistribute from the upper class, both groups knowing they will benefit from their alliance (Iverson and Soskice, 2006). Others have further expanded on the argument, exploring how the structure of inequality affects redistribution (McCarty and Pontusson, 2011; Lupu and Pontusson, 2011). Therefore, electoral systems predispose countries to develop disparate levels of social spending, impacting long-term trends.

Secondly, party dynamics also influence both tax and government spending policy. Party incentives are essential to understanding policy outcomes. In majoritarian two-party systems, such as in the US, moderate electoral stability leads to short-term, particularistic demand focus resulting in relatively low taxation rates and limited state benefit provision. Shifting coalitions, in countries like Italy, have unstable elections; as a result, parties engage in short-term negotiations. Finally, in dominant coalition systems, like Sweden, with stable elections, long-term negotiations result in high taxes and large government programmes (Steinmo and Tolbert, 1998). Others, examining niche parties, find that parties are also strategic, co-opting specific issues when third parties threaten their electoral gains. Therefore, policy developments can emerge as a result of strategic calculations (Meguid, 2008). Welfare state structures, including healthcare systems specifically, are found to correlate with public opinion and support (Jordan, 2010). Some scholars incorporated dynamics like decade trends and changes in government power to explain changes like healthcare reform (Toth, 2010).

Finally, veto points influence actor involvement in policymaking (Popic, 2021; Estevez-Abe, 2008). Estevez-Abe (2008) combines this finding with the

previous insights on electoral systems and party dynamics to create a structural logic model to explain welfare state development. She contends that government type matters—the more veto points in a system, the easier it is for opposition to kill legislation during the policymaking process. As policy is easier to stop, countries with more veto points have less redistribution than countries with fewer points. District magnitude is important in determining whether or not candidates and parties tailor campaigns and policy to specific groups or the general population. The importance of the personal vote in the electoral system impacts candidate voting; behaviour is based on whether one can vote on beliefs or must follow their party. Estevez-Abe argues that all of these factors are important to the creation and evolution of policy regimes (Estevez-Abe, 2008). Scholars like Popic (2021) have extended this analysis to the area of health policy reform. Others show how decentralisation too plays an important role in the welfare state development (Greer, 2010c).

In conclusion, the rules of the game impact the development of the welfare state. Veto point opportunities affect provisions. Coalitional arrangements have more negotiation outside legislative channels, whereas majoritarian systems more easily pass legislation without bargaining. Parliamentary systems have fewer veto points, so much negotiation is achieved informally through the party. Presidential systems rely heavily on individuals rather than the party, so the party has less negotiation power; individuals are often able to veto legislation effectively. Federalism is an additional source of veto points. Overall, veto points reduce social spending and the overall welfare state size (Huber, Ragin, and Stephens, 1993). Party composition of the government as well as access points for relatively small groups in policymaking is shown in later studies to also impact benefits (Huber and Stephens, 2018).

Recent scholarship explores the nuanced dynamics of electoral and partisan impacts on the welfare state. The strategic timing of cuts in the electoral cycle is another factor that can affect the welfare state (MacKuen, et. al, 1992; Zohlnhöfer, 2007; Hübscher and Sattler 2017; Königand Wenzelburger, 2017). Evidence supports blame avoidance in social policy developments in some scenarios but not in others; not all types of parties are punished by the retrenchment of spending (Vis, 2016). Power-sharing, for example, amongst

parties also has implications for the welfare state trajectory (Thomson, et al. 2017).

Therefore, institutional arrangements—including the constitutional structure, access points, and party dynamics, impact policy and welfare regimes. Many scholars argue that further integrating insights from electoral and party dynamics will improve welfare state studies (including Manow et. al, 2018; Häusermann, et. al, 2013). Despite the strengths of these arguments, other scholars argue that interest group dynamics must also be examined to understand policy regimes and policy developments to which I now turn.

Interest Group Influence

The second main factor established in the literature that shapes the welfare state pertains to interest group influence. Workers lie at the core of the welfare state. Worker power thus affects the distribution of resources. There are various ways for the working class to organise thereby impacting distribution. The distributive process can be broken into stages (from least to most progressive): mean-tested, social insurance, general transfer programmes, equality of income, and equality of wages. The working class strives for the most distributive policy outcomes. According to this field of scholars, levels of unionisation determine overall redistribution rates (Korpi, 1980).

However, the working class is not one unified group: the subset controlling the debate and influencing policy matters. The exposed sector comprises workers impacted by international trade, focusing policy efforts on increasing productivity and constraining wages. Contrastingly, the protected sector—the government—does not worry about productivity and wage growth when advocating policy (Crouch, 1990). Moreover, the types of policy—whether solidaristic (benefiting all residents in a system) or dualist (benefitting workers in the labour market)—that emerge also depend on which types of workers dominate political debate. Workers vary not only by economic exposure and vulnerability, but also by their skill type (Martin and Thelen, 2007; Martin and Swank, 2004). The traditional arguments for redistributive policies and welfare state development focus on worker organisation.

In addition, understanding the interaction of worker organisations with business that structures worker benefits must be considered when understanding welfare regimes. There are three labour governance systems. Firstly, in cartel systems, such as Germany, businesses compete globally rather than locally or nationally. As a result, industries work to keep new firms out of the market by providing high wages and benefits to minimise worker poaching. In the second labour governance system, segmentalism, which is characteristic of the US, firms compete and do not collaborate as an industry. As a result, benefits are provided to attract skilled workers, often poaching workers from rivals. Finally, solidaristic systems, like Sweden, centralise pay setting and wage depression in order to increase employment, so the welfare state is provided to prevent union-employer conflict (Swenson, 2002).

Generally, interest groups impact public policy by influencing elected officials who pass policy (Hansen, 1991). Government officials want information and resources relevant to their constituencies, which interest groups can provide (Burstein and Linton, 2003; Hansen, 1991; Lohmann, 1993; Wright, 1996). Scholars have found that institutional arrangement is important; interest groups are more likely to be successful in expanding the welfare state in countries with more open, democratic political systems (Amenta and Poulsen, 1996; Fording, 1997). The role of interest groups in welfare state expansion and retrenchment differs drastically; interest group support is critical to implementing cutbacks (Pierson, 1996b). Interest groups arguably impact the welfare state and cannot be excluded from analyses. The direction is not unidirectional; businesses also respond to political challenges, which leads to variation in business support for the welfare state across countries (Paster, 2018; Paster, 2013). Organised interests and public opinion both influence changes to the welfare state (Ebbinghaus and Naumann, 2017).

Employing the worker perspective, voters should not largely support reducing benefits or retrenchment policies (Boeri, et. al, 2001; Taylor-Goodby, 2001). Factors like crises influence welfare state support (Margalit, 2013). However, recent trends challenge traditional working-class assumptions like increasing right-wing and decreasing social democratic support from the middle-class have implications for the welfare state (such as Loxbo, et. al, 2021;

Manow, et. al, 2018; and Gingrich and Häusermann, 2015). These changes highlight the importance of the next factor to the development and evolution of the welfare state and healthcare systems: the role of ideological factors.

Ideological Factors

Much focus on the creation and development of welfare state regimes, and political science generally focus on the economy—how benefits are provided for economic use. The literature’s third pressure to the welfare state goes beyond the economy, exploring how ideology and values influence policy. Abramson and Inglehart (1995) argue that a shift from materialism to post-materialist values occurred beginning in the 1970s due to the spread of democracy and public economic security. As a result, the welfare state expanded with the rise of post-material values (Abramson and Inglehart, 1995). Ideological values must also be included in analyses.

Despite the changes in preferences of policymakers and citizens, modifying existing systems can be difficult due to institutional lock-in effects. As a result, the rate and scope of change stemming from shifts in preferences and ideology vary. Normal policymaking involves minor changes in policy techniques/instruments or instrument settings. Paradigm shifts involve not just bureaucrats, but also media and politicians. Paradigm shifts that change the underlying goals of policy infrequently occur. These shifts happen when significant ideological changes are coupled with the reform efforts of bureaucrats, media, and politicians (Hall, 1993).

Policy systems and efforts to reform these systems are not void of political opportunism. Issue framing and political dialogue construction led to divergent welfare state reform efforts. For example, the framing and priming of political officials enabled the Netherlands to diverge from its traditional path response to follow more Social Democratic solutions (Cox, 2001). Institutions evolve: they can be layered, adding to existing institutions; be converted, using existing institutions for a new reason; and drift, using existing institutions for different purposes than for what they were initially created. People, therefore, utilise institutions for their own political purposes (Thelen, 2004).

Ideological changes have occurred over time. The role of women has changed, which has led to changes in ideology (Dale and Foster, 2012; Wilson 2002; Piven, 1985). Large ideological shifts have also occurred. There has been increased support for social investment from broad coalitions of higher education and various socio-economic backgrounds with left-leaning views; workfare support has increased through a partnership of people with conservative and traditional views (Garritzmann, et. al., 2018). As a result, theories examining welfare state systems must consider ideological influences, in addition to institutional and economic explanations. These ideological influences can be challenging to measure and can complicate the analysis. New pressures have emerged like changing work and family life dynamics and globalisation that have consequences for the welfare state, which I now discuss.

New Challenges to the Welfare State

As the three previous influences illustrate, domestic-level influences are generally examined by welfare state studies. Institutional structure, interest group influence, and ideological trends account for much of the variation, but they do not account for all differences.

With the advent of a global economy, the “golden age” of the welfare state expansion drew to a close (Esping-Andersen, 1996). New challenges—like changing work-life balance and female workforce participation—put pressure on the welfare state to shift priorities (Taylor-Goodby, 2004). Europeanisation, is an additional supranational development with implications for the welfare state and healthcare that is explored extensively in the final two sections of the existing literature in greater detail.¹

With increasing pressures from globalisation and austerity, a string of welfare reforms, including in the healthcare field, occurred throughout Europe in the 1990s. Consequently, health expenditure growth rates slowed, and

¹ Globalisation and Europeanisation are different phenomena; processes for globalisation must be global in character as opposed to solely inter-regional results of European integration (Hay, 2006). The effects of supranational factors, notably the EU, need to be considered (Pierson, 1996a) in conjunction with established local and national-level explanations of domestic-level developments.

domestic system arrangements underwent much policy change, driving concerns of welfare retrenchment. High unemployment and other pressures lead to a reworking of the welfare state by parties and institutions (Korpi, 2003). Various scholars explored the changes to and future of the welfare state, including retrenchment pressures (Esping-Andersen, 1996; Pierson, 1996; Garrett and Mitchell, 2001; Swank, 2002; Korpi and Palme, 2003; Scheve and Slaughter, 2006; Starke, 2008; Potrafke, 2015; Martens et al, 2015; Potrafke, 2019). At the same time, there was a changing role of care in the welfare system as work-family dynamics altered and welfare systems developed (Daly and Lewis, 2018).

Globalisation is often presented as a threat to the welfare state. The convergence model predicts that a liberal decline of the welfare state will occur across the board due to an increasingly international and competitive economy. The national varieties theory argues that countries differ in traditions and arrangements; lock-in effects will prevent liberal convergence. Others still contend that a dynamic legacies approach looks at individual corporations and industries to determine country-by-country outcomes (Berger, 2005).

Some scholars (such as Iversen, 2005) present a national varieties response to globalisation. Retrenchment will occur to some degree across all systems, but particular changes vary by system. During the industrial period, welfare states could effectively balance fiscal constraint, equality, and employment due to increased productivity. However, systems now must determine which goals to support at the cost of others. Social Democratic systems aim for equality and employment at the expense of fiscal constraints. Liberal systems sacrifice equality, and Christian Democratic systems suffer employment losses (Iversen, 2005).

Others (including Garrett, 1998) believe that government intervention does not always result in decreased economic performance. Government has valuable outputs, such as providing infrastructure and security (Garrett, 1998). Nevertheless, scholars generally agree that trends, such as globalisation, impact the welfare state. The degree to which the systems are affected remains contested, and systematic analysis could be better developed. Some argue that

fears of globalisation impact have not been supported by the evidence (Rothstein and Steinmo, 2002).

One of the seminal arguments is Pierson's work on the topic of welfare state resilience rather than retrenchment as systems renegotiate, restructure and modernise in the face of globalisation and other pressures (2001, 1996a, 1996b, 1994). Welfare states have been able to restructure (Pierson, 2001) and shift policy (Streek and Thelen, 2005). Institutions are vital to welfare state development (Huber, Ragin and Stephens, 1993; Thelen, 2004). According to this argument, the institutional structure and the interest in the system should shape the response to pressures from internationalisation (Swank, 2002, p. 3). Pierson's argument (1996b) is that interest group structures and the welfare state are changing within the institutional constraints in which they operate. As such, the role of unions in redistribution social policies is being diminished with time. Welfare states have proven to be resilient.

New challenges have and continue to arise that have implications for the welfare state. The Eurozone financial crisis in 2008 proved a new challenge to the welfare state, shedding light on the issues that can arise within the market. Crises have had significant impacts on welfare states with diversity in how different types respond. Crisis and change are thus strongly linked, with support for many provisions increasing during these times. The financial crisis also put the welfare states across Europe under enormous social pressure from austerity and labour insecurity. Countries struggle with the aftermath in the post-crisis era (Schmidt, 2010; Considine and Dukelow, 2012; Blekesaune, 2013; Starke et al, 2013; Hemerijck, 2016; Mertens, 2017; Petmesidou and Guillén, 2017; Gerhards, et. al, 2019; Ducklow, 2021). The role of the EU in the welfare state through fiscal policy and other policies also increased as a result of the crisis, which is explored more in the sections on Europeanisation (Heins and de la Porte, 2015; de la Porte, and Heins, 2017; Gerhards, et. al, 2019). Debate exists if these new challenges are an increasing risk to the power of labour, which is central in classic decommodification arguments, through a "recommodification" process post-crisis, particularly in European countries hit hardest by the 2008 financial crisis (Ducklow, 2021).

The current coronavirus pandemic presents new challenges to the welfare state and healthcare systems in particular. The pandemic has exposed the weaknesses of current healthcare systems (Navarro, 2020). Some propose that the pandemic also highlighted risk perceptions amongst the public with regard to health and the economy, particularly when government response was slow (Breznau, 2021). Debate surrounds if the pandemic has altered public support for the welfare state based on the evidence as it accumulates (Busemeyer, 2021). Significant variations in national responses to the pandemic appear to reflect national legacies, particularly in the initial response to the crisis, largely rooted in Keynesian principles of preserving the economy (Béland, et. al 2021). The literature on the pandemic pressure on the welfare state is unfolding at present and will develop both in breadth and scope over the coming years.

Overall, many studies have found the arguments of Pierson (2001, 1994) and others resilient over recent decades as the welfare state adapts to new challenges (Starke, 2020). Electoral punishment, interest group mobilisation, and blame avoidance have influenced the politics of welfare state retrenchment (Starke, 2020). Recent data analysis explores welfare state reform in a comparative context the validity of welfare retrenchment claims, particularly with regard to electoral accountability. Temporal, cross-national analysis of unemployment policies shows that cutbacks and expansions over time are marked by stability with radical change as opposed to path dependency. Governments also use different instruments strategically for blame avoidance and credit claiming. Yet, partisan differences do not seem evident in policy tools or types of reform. Other tools are employed for expansion than retrenchment (Jensen and Wenzelburger, 2020; Jensen et al., 2018). The analytical findings question some traditional assumptions, including the role of political parties in welfare state development. However, there are also limitations to these statistical models and their ability to capture dynamic changes in policy and institutions.

Due to its size and scope, one would expect broader explanations of the welfare state and its development to devote much attention to healthcare policy specifically. However, healthcare systems are often not included in these

categorisations and analyses, although this literature is developing with time. Historically, healthcare systems are isolated, restricted by country borders, and lack patient movement. Subsequently, each country's developments and arrangements follow a unique trajectory, which does not lend itself to generalisation. Therefore, the next set of literature which I discuss, tangentially developed, specifically examines healthcare systems in industrialised countries as distinct from other aspects of the welfare state.

II. Healthcare System Explanations

The comparative politics literature is critical to understanding the development of the welfare state. However, overall regime classifications often do not incorporate healthcare systems. Typically, countries within a particular welfare state categorisation exhibit specific characteristics across policy areas. However, healthcare systems significantly vary cross-nationally and often are not structured like other social policy areas. Worker-focused explanations do not account for recent changes in health policy. As a result, tangential literature separate from the welfare state has developed exploring healthcare systems dominated by two subsets. The first is rooted in economics, explaining quantifiable variations. The second stems from the comparative literature classifying into regimes that only apply to healthcare rather than welfare states broadly (such as Field, 1973; and Esping-Andersen, 1990).

Cross-National Health Modelling

The first body of literature explores factors that influence healthcare expenditure. Data on national expenditure is readily available both over time and across countries. The dominant explanations of national health spending stress economic influences and demographic factors. Gross domestic product per capita (GDPpc) is one of the strongest predictors of overall expenditure across studies (Hitiris, 1997; McCoskey and Selden, 1998; Huber and Orosz, 2003). Additionally, the population's age distribution has been shown to influence spending (O'Connell, 1996). Inflation, unemployment, and rates of population growth impact over time (Hitiris, 1997; O'Connell, 1996; Potrafke, 2010). Changing economic influences are included in some analyses; economic

globalisation impacts the composition of government budgets, including health, although the effect is relatively small (Dreher, Sturm, and Ursprung, 2008).

Recently, healthcare state variables have been incorporated into explanatory models of cross-national, temporal spending. Some countries have unique trajectories (Huber and Orosz, 2003). Health expenditure variation has persisted due to distinctiveness in domestic policy and lock-in effects from past policy experiences (Herwartz and Theilen, 2003). Differences in healthcare system type (Barros, 1998), the existence of gatekeepers for access to services (Barros, 1998), and the strength of the primary care system (Starfield and Shi, 2002) are institutional aspects that arguably lead to cross-national variation. Moreover, decade-wide trends—including political efforts in the 1980s to control expenditures—influence health spending (Barros, 1998). Other additional demographic and non-demographic variables, such as insurance cover, administration costs, and rise of costly disease treatment have been added to these analyses (Medeiro and Schwierz, 2013; Hartwig and Sturm, 2014; Jakovljevic, et. al, 2019).

In addition to demographic and economic controls, political variable influences on health expenditure have been examined to a limited extent. These variables are established fully in the comparative politics literature discussed in the first section. This connection illustrates that health policy is influenced by many of the same forces that impact social policy broadly. Nonetheless, debate exists over the relative importance of these political factors compared to economic and demographic factors. In the long run, some scholars argue that political instability and volatility variables do not affect healthcare expenditures, although party portfolio instability has some short-term influence (Huber 1998). Others show that political ideology impacts healthcare, with left-leaning parties introducing measures that increase service provision at a subsequent cost of the system (DeDonder and Hindriks, 2007). Additionally, incumbent politicians arguably alter spending for electoral gain; election years increase health expenditure (Portrafke, 2010). Studies indicate that political variables like ideology do affect expenditure (Herwartzand Theilen, 2014).

The central weakness in this literature is that studies that specifically examine health expenditure focus on fundamental economic and demographic

determinants. Political variables are explored, but their inclusion remains limited to a few, broad variables. The models are becoming more dynamic with time and improved data. Models still do not explain sizeable temporal and cross-national variation, accounting for less than thirty per cent of spending changes, and fail to address other differences in healthcare systems beyond expenditure, such as the source of financing. Recent studies have increasingly worked to include concepts like globalisation in their models (Potrafke, 2019; van Vliet et al., 2021). Trends in European healthcare spending are continually being analysed for trends and patterns (see Mossialos, et al., 2019). The rising impact of the supranational factors, like the European Union on social system spending, is increasingly being analysed (Dudzevičiūtė, et al., 2018). More recent political and economic developments, such as increasing regionalism through European integration, have not been fully explored or systematically integrated into this field of study from a quantitative perspective.

Healthcare System Categorisations

The second broad literature involves the categorisation of healthcare policy specifically. As discussed in the earlier section, comparativists explore political and institutional explanations in more detail. Traditional welfare state models do not fully account for change over time and do not encompass complex healthcare systems. Literature on the welfare state and political economies rarely discusses healthcare policy.

As a result, categorisations emerged specifically for healthcare. Anderson first compared healthcare types cross-nationally based on dimensions: live coverage, public provisions, service range, insurance, and funding (1963). The father of healthcare categorisations, Field, has conceptualised and categorised health systems into four groupings— pluralistic, insurance, health service, and socialised (1973). Initial typologies placed systems on a spectrum based on funding sources. Funding results from general taxation revenues; from social insurance with employer and worker contributions; or from private insurance funded by individuals. These vary in equity and individual sovereignty outcomes. Three types of healthcare systems result. The first is national health service systems, as seen in the UK, which is publicly provided based on

citizenship and funded through general tax revenue. The second is social insurance systems, like those in Germany, funded by employer and worker contributions through employment. The final is private insurance, such as the US, which is funded by private contributions (Freeman, 1998, pp.396-397; OECD, 1987).

The categorisation developed by the OECD, focused primarily on coverage and ownership, provides the foundation of most healthcare system comparative research. The description, however, is simple and does not account for much variation, particularly variation within system types, such as different levels of spending and the types of services available. Additionally, actors and other influential political institutions are not included in the analysis. Nevertheless, most studies in the field cite and, are based on this unidimensional classification.

Many health-specific policy models focus on historical and institutional roots distinct to most countries, and explanations specific to healthcare. These studies often look at the uniqueness of individual domestic systems through case studies (Burau and Blank, 2006, p.74). This research provides an in-depth examination of specific country arrangements. However, the findings are descriptive and do not contribute to broader theoretical development by generalising across countries.

These initial typologies (Freeman, 1998; OECD, 1987) primarily focus on the funding source and ownership and remain the dominant explanation, particularly in economic analyses. Multidimensional classifications have also emerged, exploring different aspects of these healthcare systems. Three subsets of this healthcare categorisation literature are summarised: families of healthcare states, healthcare clusters, and healthcare decommodification.

Families of Healthcare States

Moran (2000) is the first attributed with combining the various dimensions explored in studies of healthcare into one typology incorporating consumption, provision and production. His multidimensional classification serves as the basis for other typologies (Wendt, Frisina, and Rothgang, 2009, p.75). Consumption includes patient access to care and system resource allocation;

provision includes control of hospitals and doctors; and production regulates medical innovation (Moran, 2000; Moran, 1999). Moran stresses the importance of state regulation in these aspects, because healthcare is a highly labour-intensive and technologically advanced service that is provided, not consumed, and thus is highly influenced by state decisions; the regulation of doctors, hospitals, and technology are critical to the typology (2000, pp.143-147).

Four families of the healthcare state result from how the state intervenes on each of the three interconnected dimensions of consumption, provision and production (Moran, 2000, p.155). The first is the *entrenched command-and-control family*, where the government dominates all three components and includes Scandinavia and the UK. The second is the supply-side, where there are many providers of services and technology innovators and encompasses countries like the US. The third is *corporatist healthcare state* and is found in countries such as Germany. In this family, public law organisations control consumption—the state does not fund the system, but regulates it through laws. Public law associations dominate the health professional field. Little technology exists in this system. The last family is *insecure command-and-control* and includes recently developed healthcare systems, like Greece and Portugal. This categorisation has public healthcare systems, but also have sizeable private sectors (Moran, 2000, pp.147-155).

Each of the four types of families has strengths and weaknesses, according to Moran (2000). When healthcare system governance is examined, the connection between healthcare and welfare families more broadly becomes apparent. The entrenched command-and-control systems cope well with managing scarce resources and equitably distributing resources but do not respond well to social and consumer demand; they are “particularly vulnerable to market experimentation” (Moran, 2000, p.157). Supply-side systems are technologically innovative, but they have difficulty controlling spending and ensuring equity. Corporatist systems generate high-quality services, but they are rigid. Subsequently, they do not cope well with social or economic change. Insecure command-and-control, although often created during periods of austerity, struggles with resources, particularly when developing efficient, equitable systems (Moran, 2000, pp.154-158). Therefore, the various types

respond differently to similar pressures; each has situations where it is more likely to succeed or to fail than are others. Moran's work attempts to reconcile traditional economic arguments with comparative regimes. The scope of Moran's categorisation is limited, pertaining only to which actor has control in three aspects—missing components include but are not limited to the source of funding, terms of eligibility for care, cost of care, and types of services accessible.

Building on typologies raised by Moran, classifications have expanded to include aspects beyond the source of coverage. Some include coordination mechanisms of healthcare delivery (Freeman, 2000). For example, Wendt, Frisina, and Rothgang (2009), employ an actor-focused approach to classify healthcare systems on three dimensions: the financing, the provision, and regulation (governance) of healthcare services. Each dimension is controlled by one of three actors: the market, the state and actors from outside of the government sector. Twenty-seven classifications result—some are ideological, and others match real-world cases. Three ideal types, each dominated entirely by one of the principal actors, emerge: the state healthcare, the societal healthcare, and the private healthcare systems (Wendt et al. 2009, pp.71-81).

Wendt et al. (2009) claim that system typologies can be utilised to assess the strength and direction of system change. System change occurs when one system alters all three dimensions, a rare occurrence. Internal system changes result from moving from one category to another in one dimension. A shift that does not result in categorical change, but involves some change within a dimension is classified as an internal level change. Reform efforts can be categorised into three types of change (2009, pp.81-85).

While useful, this classification scheme developed by Wendt et al. (2009) is complicated and is too large for the small number of countries typically compared in studies. Little generalisation across systems can occur with such a large number of potential arrangements. Some critical system components, such as expenditure level, are missing from their typology. Notably, a few scholars who discuss system change do not systematically incorporate it into their model. Nonetheless, the mention of systems as able to evolve is void from most healthcare studies, making the work of Wendt et al. (2009) important. The

classifications change with time and have been updated to incorporate new considerations like doctor payment methods (Wendt, 2014).

Healthcare Clusters

Expanding on the research of Moran (2000) and Wendt et al. (2009), Wendt (2009) captures healthcare systems using four indicators: healthcare expenditure, healthcare financing, healthcare provision, and institutional characteristics. Expenditure can be measured per capita or as a per cent of GDP. Financing consists of who pays for the system, measured by the share of public and private funding as a percentage of total health financing. Provision is often not included in typologies and comprises of two healthcare provider indices to determine if systems rely more on inpatient care (number of specialists and hospital nurses) or on outpatient care (the number of practitioners and pharmacists). Institutional characteristics are regulations that influence access. These characteristics include the mode of entitlement; the manner doctors are paid, the regulation of patient access, as well as the choice for selecting doctors (Wendt, 2009, pp.434-436).

Wendt et al. (2009) employ four indicators to group countries into three types in Europe. The first is *health service provision-oriented type*, such as Germany. This category has high total expenditures with a large share from public funding and a moderate share of private financing. It has moderate inpatient care and high outpatient care with much doctor autonomy and patient choice. The second is *universal coverage-controlled access type* and comprises of countries including Denmark and the UK. These countries have moderate levels of total expenditure with high public funding and moderate private funding. It has moderate levels of inpatient care and low levels of outpatient care. There are many regulations controlling access to and the practice of doctors. The last category is *low budget-restricted access type* and consists of states like Spain. This type had low total spending with high levels of private expenditure. Patient access to doctors is highly controlled, and doctors are generally salaried. Inpatient care levels are low, and outpatient care levels are moderate (Wendt, 2009, pp.438-442).

The classifications of clustering of health systems continued to grow and evolve. Some presented six types of groups based on market mechanisms, regulations of supply and demand, equity in coverage, and public spending controls (Joumard, et. al, 2010). Others examined control over the provision, financing and regulation of healthcare resulting in six classifications— etatist social health insurance, national health service, national health insurance, private health system, social-based mixed type, and social health insurance (Böhm, et. al, 2013). Performance measures are being added in some typologies (Kotzian, 2008; Yu, 2014).

Thus, classifying complex health systems in concise, accurate, and comparable manners is difficult. Categorising is problematic (Freeman and Frisina, 2010; Burau, et. al, 2015). In Europe, Eastern and Central European healthcare systems also follow a different trajectory with unique characteristics from other healthcare systems (Marrée and Groenewegen, 1997; Recheland and McKee, 2009; Romaniuk and Szromek, 2016; Wendt and Bramba, 2020). The literature remains lacking in developing countries like Latin America and Africa (Wendt and Bramba, 2020). The clustering of healthcare states offers the benefits of previous work in the field by constructing a limited number of ideal types while including many facets of healthcare systems in clustering. Nevertheless, Wendt's classification is largely static, not including forces that lead to system evolution, and does not incorporate broader frameworks developed in welfare state research.

Healthcare Decommodification

Bambra (2005a) offers the final framework by employing the concept of decommodification, the ability of workers to leave the workforce, an essential tenant in Esping-Anderson's welfare regimes (1990). This study works to connect to broader concepts from welfare state literature to healthcare explanations. Bambra applies this concept to healthcare policy by quantitatively analysing healthcare decommodification based on two measures: cash benefits and healthcare service accessibility. Five clusters emerge based on healthcare decommodification. Finland, Norway, and Sweden have high cash benefits and healthcare service decommodification. Ireland, New Zealand, and the UK have

high service and low cash benefit decommodification. Germany, the Netherlands, and Switzerland have low service and high cash benefit decommodification. Austria, Belgium, Canada, Denmark, France, and Italy have moderate levels of service and cash benefit decommodification. Australia, Japan, and the US have low service and cash benefit decommodification (Bambra, 2005a).

Therefore, groups based on decommodification differ somewhat from Esping-Anderson's Christian Democratic, liberal, and Social Democratic clusters. Overall, five distinctive groups emerge rather than three. Bambra suggests that a conservative subgroup of Christian Democratic regimes exists. Similarly, a subset of liberal regimes emerges and has higher scores than expected. Social Democratic countries are the only family to score where predicted. The considerable variation in groupings illustrates that systems are affected by multiple factors that influence the policy output and lead to inconsistent policy development that varies more than anticipated by many welfare categorisations (Bambra, 2005a). The research does not explore the application of Esping-Anderson's typology (1990) to healthcare systems in-depth. Regardless, Bambra's piece is one of the few attempts to examine healthcare in a broader welfare context rather than as an exceptional policy. Decommodification does not receive as much attention in the literature as other topics even though combining welfare state explanations with health system classifications is useful to understanding rights, access, and equity (Wendt and Bramba, 2020).

As a result, categorisations of healthcare systems have evolved over time (Wendt and Bramba, 2020; Tavares, 2017; Wendt, 2014). Newer models have included considerations like resource level, care provision, public-private mix, and other concepts centred on both performance and resources (Reibling, et. al, 2019). Others have added the concept of segmentalism of services to categorisations to allow models to account for hybrids combining various packages and arrangements (Toth, 2016). They vary in the dimensions examined, the resulting categorisations, and the countries analysis. Certain dimensions like access to care, doctor autonomy, level state control, regulation, financing, and expenditure are common to many (Wendt and Bramba, 2020; Wendt, 2014). The classifications can be disaggregated into three categories:

actor-centred, institution-centred, and welfare-centred typologies (Wendt and Bramba, 2020).

Overall, a primary weakness of the healthcare categorisation literature is that it is largely descriptive, generally exploring differences between systems, but not systematically explaining and predicting institutional change over time. Generally, the models are largely static and do not sufficiently incorporate healthcare reform, especially when the reform deviates from path-dependent solutions. Moreover, most studies focus on the exceptionalism of healthcare policy and do not incorporate broader studies of the welfare state or political economies into the explanation, which scholars like Wendt and Bramba (2020) point to as an area for research growth. Much of the focus with regard to the welfare state has been on health inequities rather than health decommodification (Eikemo, et. al, 2008; Mackenbach, 2012; Wendt and Bramba, 2020).

Even among studies of healthcare systems, there is no consensus on the best categorisation. Although the dimensions vary, the clustering of countries seems to occur throughout many explanations. Yet, these works do not build off of one another systematically. However, the literature illustrates the importance of the interaction between certain actors, particularly the state, and the healthcare institutional arrangement in structuring system change. There is also the inconsistent and varied language used in the literature which needs to be corrected for the development of the field (Wendt and Bramba, 2020). Ideally, typologies as such do not emerge, but critical characteristics in grouping systems can be identified. The literature that explores how these domestic systems interreact with the phenomena of Europeanisation is now examined in the last two sections.

III. Europeanisation and Domestic Policy Explanations

European integration deepened and widened in the 1980s and 1990s. As a result, literature examining the impact of the EU on domestic politics and policies emerged beginning in the 1990s and evolved over time (such as Sedelmeir, 2012; Ladrech, 2012; Martinsen, 2011; Ladrech, 2010; Bulmer, 2008; Caporaso, 2008; Graziano and Vink, 2007; Radaelli and Pasquier, 2007; Featherstone and

Radaelli, 2003; Radaelli, 2003; Cowles, Caporaso, and Risse, 2001; Schneider and Aspinwall, 2001; Olsen, 2001; Featherstone and Kazamias, 2001; Ladrech, 1994). This field explored how the EU could influence and affect domestic-level policies and how this dynamic changed over time.

Defining and Measuring Europeanisation

The literature on Europeanisation explores the effects of economic and political integration on domestic politics. It is essential to note the lack of a consensus defining “Europeanisation,” which like the literature, has developed with time. Initial studies explored the EU as a regulatory state directly mandating domestic change (Levi-Faur, 2007). Some definitions are more expansive: viewing Europeanisation of not only EU policy and laws, but also as other influences that can affect domestic politics. Coordination and cooperation also impact policy (Radaelli and Pasquier, 2007).

There are two main effects of Europeanisation. The first is market integration, defined as “European-level trade, production, and finance” (Beyeler, 2003, p.161). The second is political integration, which comprises of “structures and governance of the European Union” (Beyeler, 2003, p.161). Europeanisation conceptualises the impact of the EU. It is a “research area” that still lacks a “shared definition,” although it generally surrounds domestic policy, politics, and polity (Sedelmeier, 2012, p825). Scholars, such as Featherstone (2003), have argued that incorporating Europeanisation into dependent and independent variables, employed in multiple regression analysis, is difficult due to definitional issues.

As a result, the research design of studies is key to determining the effects of Europeanisation (Radaelli and Pasquier, 2007; Bulmer, 2007; Haverland, 2007). Europeanisation studies have primarily focused on case study analysis rather than generalising across countries over time (Bulmer, 2007). Causal mechanisms for change are also often unclear. Therefore, Europeanisation studies primarily examine if the EU matters and to what extent; how the EU matters in the causal sense are often absent (Haverland, 2007). Europeanisation involves exploring polity, policy, and political pressure and misfit between Member States and the EU as well as distinguishing between hard and soft

policies (Ladrech, 2010). Others discuss the development of soft law over time in the Europeanisation process (Olsen, 2002). Some contend that hard law is more impactful than soft law on Europeanisation (Jacobson, 2001).

Once the type of analysis is selected, studies must distinguish between Europeanisation's effects and alternative explanations with similar outcomes. Globalisation and domestic-level politics, summarised earlier in this chapter, are two rival explanations to be differentiated. For example, Europeanisation outcomes present similar to the effects of globalisation, although at a more intense rate (Dyson, 2007; Ladrech, 2010). Designing studies to discern the results of one explanation from others is difficult, but is essential to understanding Europeanisation.

Europeanisation and Domestic Systems

Europeanisation is vital to understanding domestic changes that cannot be explained by pressures like globalisation on its own. It involves international markets, norms changes, and other considerations (Cowles, Caporaso, and Risse, 2001). Europeanisation can also have various effects on politics, policy, and polity (Ladrech, 2010). MSs can be influenced through positive integration, obligating change; negative integration, altering of the rules of the game that leads to changes; and socialisation, changing the belief and expectations of political actors (Featherstone, 2003). Political outcomes can take the form of policy absorption, accommodation, or transformation (Börzel and Risse, 2003). Policy changes resulting from Europeanisation are diverse in scope, ranging from prescribed changes to institutions due to integration to cognitive shifts and the changing strategic opportunities of various actors (Featherstone, 2003).

Europeanisation does not necessarily have one ubiquitous effect across all MSs—it affects the various national institutions differently (Radaelli and Pasquier, 2007; Mörth, 2003). There can be much variation regarding the implementation of EU policies across MSs; in some cases, domestic change stemming from Europeanisation does not always occur in a given MS (Börzel and Risse, 2003). Domestic institutional influences, actor preferences, culture, and tradition cross-nationally impact policy implementation (Sverdrup, 2007). Some countries cope with Europeanisation pressures more effectively than do

others. Fewer veto players lead, for instance, to faster adoption than systems with more players. Other factors include the length of EU membership, the number of parties, the level of consensual democracy, and the level of executive policy agenda control (Giuliani, 2003).

Other academics, such as Goetz (2007), argue that regional clustering of Europeanisation effects exists based on countries' similarities in institutions and policies. Regions can be explored as families of states based on shared domestic variables, such as existing structures and their conditioned responses to problems. They can also be categorised based on geography, as the core and the periphery MSs (Goetz, 2007). Some also believe that Europeanisation effects vary across countries and families of states with similar characteristics and industrial sectors. Therefore, the sectoral level should be explored more in-depth (Dyson, 2007).

Europeanisation affects domestic environment, which has implications for parties (Graziano and Vink, 2007). EU developments can have implications at the domestic level within political parties and on electoral outcomes. For example, uncertainty from the EU developments can lead to defiant party behaviour at the domestic level. In addition, the spillover from the EU has implications for domestic politics (Ladrech, 2012). The EU has also been blamed by domestic actors by both opposition parties and government parties in the public discourse pertaining to unpopular policies (Heinkelmann-Wild, 2020)

Various scholars argue that the role of domestic actors, not just institutional and constitutional factors, need to be considered in the analyses of Europeanisation. Supranational institutions are important to the policymaking process. However, domestic level elites and actors need to be understood and examined to fully capture these Europeanisation effects (Chari and Kritzinger, 2006; Chari, 2001).

Interest groups also impact the extent of Europeanisation. Some interests are better represented than others. Some have insider status, organisational capacity, and financial resources. Europeanisation affects various business interests to differing degrees, with small businesses confronting particular obstacles (Coen and Dannreuthier, 2003). Thus, even for a group like the business community that can be seen as homogenous, Europeanisation has

varied effects. Multiple levels of governance may now exist, but domestic-level interest group activity has not disappeared (Grote and Lang, 2003). Social movements have had less success than interest groups at the EU-level, because they rely heavily on the media, which is primarily local or national. EU inside negotiations favours insiders in the policymaking process (Eisling, 2007).

The Process of Europeanisation

The application and direction of Europeanisation remains contested. Initial studies explored Europeanisation effects directly on MSs. However, some scholars stress that this change needs to be examined from the bottom (domestic level) to the top (the EU-level) in a methodology similar to comparative analysis (Dyson, 2007; Radaelli and Pasquier, 2007). Others argue that Europeanisation is a circular connection between the EU and MSs, with influence in both directions, requiring both forms of analysis (Radaelli, 2003). Over time, an interaction approach viewing Europeanisation as a two-way process has become prominent (Gúrkean and Tomini, 2021).

In addition, how domestic change occurs has been a subject of discussion. The concept of misfit and adaptational pressures between EU and domestic level is key to Europeanisation in many models through diffusion (Börzel and Risse, 2020; Börzel and Risse, 2012a; 2012b). Others highlight the limitations of this model in explaining change (Ladrech, 2010 and Caporaso, 2007). Domestic policies and beliefs are important when exploring compliance, so exploring domestic preferences at domestic levels are also important (Mastenbroek and Kaeding, 2006). Two camps discuss if Europeanisation adjustments of domestic actors' results from socialisation or rational choice (Sedelemeirer, 2011). Some discuss how domestic level actors have influenced the Europeanisation process itself, including the increased transfer of European policy from domestic to EU level thereby increasing the strength of the EU (Eigmüller, 2013).

As the literature has developed, it has become evident that Europeanisation is not just a matter of designation between a status of compliant or non-compliant by a particular Member State. The process of Europeanisation is more dynamic, incorporating three aspects: "goodness of fit, mediation, change" if countries decide to implement EU policy (Saurugger, 2014, p.191).

The manner in which the EU impacts the domestic level has been explored. A recent shift in the literature has occurred: from top-down Europeanisation to the strategic use of the EU by domestic actors across a range of policy sectors (Mastenbroek, 2018).

When turning specifically to social policy, much discussion surrounds the impact of Europeanisation (such as Geyer, 2000; Dyson, 2007; Faulkner, 2007; Featherstone, 2003; Haverland, 2001; Radaelli and Pasquier, 2007; Liebfried, 2010; Natali and Vanhercke, 2015; and Kilpatrick, 2018). Initially, the Europeanisation literature attempted to explore social policy with regard to the free movement of workers. With the change of the unanimity requirement, social policy directives emerged in the 1990s (Faulkner, 2007). Domestic policy expanded across Europe at the same time that the EU widened and deepened. However, EU social policy has not developed as much as other areas of policy at the European level due to a lack of funding and political ambition (Geyer, 2000). A social Europe as such does not appear to have developed. However, recent trends and pressures from developments like the refugee crisis and Brexit offer the potential for the EU to “reinvigorate the social policy agenda” through stronger EU policy (Vanhercke, Natali, and Bouget, 2017).

Challenges to Europeanisation

This literature struggles to address explaining developments in certain Member States, particularly and Central and Eastern Europe, as well as in candidate countries for entry in the EU. Some even posit if a process of de-Europeanisation is occurring in recent times (Gúrkean and Tomini, 2021; Kelemen, 2019; Sedelmeir, 2014). South Eastern Europe is now central to the EU’s promotion of Europeanisation and multi-level governance (Geddes, Lees and Taylor, 2013).

The dynamics following the economic crisis in the Eurozone has called into question the process of Europeanisation (Saurugger, 2014). Some believe that there has been a decline of social policy in Europe after the financial crisis. By exploring European elections and how social policy has been removed from the agenda, recent EU politics has demonstrated a lack of social policy response to crisis. Commission activities have instead focused on austerity and economics. Arguably, there is a declining social Europe despite increased citizen

support (Graziano and Hartlapp, 2019). It has led to questions in the literature of whether or not Europeanisation is a phenomenon that occurs during “good” times (Gúrkean and Tomini, 2021). Some contend that the EU, facing a string of crises since the financial crisis in 2008, including the recent pandemic, and is stuck in a “politics trap” of dysfunction at multiple levels, which has implications for the future of Europeanisation (Zeitlin, Nicoli, and Laffan, 2019). Others point to changes in solidaristic principles and potentially the future role of the EU in light of the coronavirus pandemic (Katsanidou, Reinl, and Eder, 2021).

There is a large and evolving body of work exploring Europeanisation and its impact on domestic systems. Subsets explore social policy development specifically. An extensive literature examines how the EU impacts healthcare policies and systems. The next section provides an overview of key scholars and their explanations pertaining to health.

IV. Europeanisation of Healthcare Policy Explanations

A substantial and diverse literature explores how the EU affects health policy and healthcare systems (such as De Ruitjer, 2019; Greer, et. al, 2019; Hervey, Young and Bishop, 2017; Martinsen, 2015; Greer, 2014; and Hervey and Vanhercke, 2010). This section summarises this literature related to the Europeanisation of healthcare policy specifically. There are two main types of healthcare system Europeanisation proposed by the literature: economic and political. At the EU level, a tension exists between promoting equality and efficiency in policy that consequently impacts policy development and change (Ferrera, Hemerijck, and Rhodes, 2001). First, the theory behind the economic integration of health is outlined. Then, the political impact as established in the literature is explored in more detail as it serves as the central mechanism examined by this thesis. The policy areas and key institutions are discussed. The section concludes with changes to the Europeanisation of health.

Economic Integration

The first dimension of Europeanisation is market integration. As detailed earlier, it is defined as “European-level trade, production, and finance” (Beyeler, 2003, p.161). In theory, economic integration on healthcare systems involves the

impact of anti-inflation policy and public deficit limits imposed by EMU. These requirements prevent countries from limitlessly increasing health spending through economic incentives. However, reform efforts illustrate the importance of these restrictions, particularly when countries have issues controlling spending (France and Taroni, 2005; Freeman, 2000, 34-49; Ferrera, 1995).

For instance, spending on the Italian National Health Service skyrocketed during the 1980s as local governments consistently outspent allotted funding. In order to join EMU, Italy reformed its healthcare service to contain its public sector deficit. This debt drastically expanded after the mid-1990s financial crisis, prompting reform and cutbacks despite Italy's relatively low health spending and low satisfaction levels (France and Taroni, 2005; Freeman 2000, pp.34-49; Ferrera, 1995). Regions continued to outspend their budget in the 1990s; consequently, the national government enacted legislation to meet budgetary restrictions (Tediosi, Gabriele, and Longo, 2009). Italy illustrates the historical importance of EMU on healthcare systems. Therefore, the EU can limit uncontrolled domestic health spending (Helderman, 2015). Many European health systems reduced their spending following the financial crisis (Renda and Castro, 2020). However, the enforcement power that the EU has to curb domestic overspends is limited.

Theoretically, the primary indirect impact of economic integration pertains to economic competitiveness. Both individuals and firms have increased mobility due to European integration. In countries with national health systems, individual tax contributions fund healthcare. Social insurance-based regimes primarily rely on employers to fund worker health plans. Healthcare for both systems is costly. Since economic integration creates mobility, firms are encouraged to reduce cost, increase competitiveness, and relocate if beneficial in the single market. European economic integration should encourage countries to reform their systems to reduce overall expenditure (Hitris, 1997). Moreover, countries should also alter their systems to prevent relocation to more efficient countries that provide quality care at a lower price. As a regional economy, these common pressures constrain welfare policy across EU MSs (Beckfield, 2006, p.969). Mobility is likely to increase in the future in

healthcare as integration deepens; topics like patient mobility are explored later in the chapter and in the thesis.²

There are two theoretical directions of the impact of economic competition stemming from increased European integration. The first direction, some scholars (such as Beckfield, 2006, p.969; France and Taroni, 2005; Freeman, 2000, 34-49; Ferrera, 1995; Hitris, 1997) predict a race to the bottom resulting in patient movement across borders to lower costs, so healthcare systems reduce expenditure to more effectively compete with other systems. However, the convergence and “race to the bottom” that this anticipates does not appear to have occurred in the decades of the increased development of the EU as it remains subject of academic debate and exploration.

The opposite, a rising tide impact, could occur as systems provide better quality or more efficient service, such as a shorter queues, to citizens who can travel to other countries to receive treatment (Garrett, 1998). Additionally, the various providers (from services to products) compete. Healthcare does not operate as an ideal market due to multiple characteristics that are not be discussed at length here (for more information, see Arrow, 1963; Greenwald and Stiglitz, 1986; Rice and Unruh, 2009; and Mwachofi and Al-Assaf, 2011). For example, sick patients are not particularly mobile, especially in the case of emergency care, which limits the impact of economic integration. Individuals who travel for care—barring tourists who need urgent treatment—do so due to limitations in their system, such as waiting lists. Due to insurance and domestic entitlements, people are often not fully aware of the actual cost of healthcare procedures. Travelling to other countries may entail paying the difference between fees, so they are not likely to compete for bargains in treatment.

² Mobility is likely to increase in the future in healthcare as integration deepens through ECJ rulings over patient mobility and policies, such as the Cross-Border Care Directive (2011/24/EU). On 9 March 2011, Directive 2011/24/EU, the application of patients’ rights in cross-border healthcare, was passed. This Directive is referred to as the Patients’ Rights Directive (PRD). The Directive entitles residents of one Member States to the same benefits in other EU countries as they are entitled to in their home countries. Member States had until 25 October 2013 to implement the Directive, though data indicates that the Directive has not been fully implemented to date. Policy areas like these are explored later in this chapter in political integration and in the case study analysis.

Therefore, the “race to the bottom” does not appear to occur based on analysis and trends (Albulescu, et al, 2017; Comas-Herrera, 1999). Even in the face of the financial crisis, pension and healthcare systems have been prioritised over other areas of welfare spending (Diamond and Lodge, 2014). Although topics like cross border care have been high on the European agenda, patient mobility numbers are low (Footman, Knai, Baeten, Glonti, and McKee, 2014). Some scholars point to austerity and fiscal crisis reactions as a new third face of the European Union as countries commit to further oversight by the EU over health spending (Greer, 2014), though this increased role spills over into political integration, to which I now turn.^{3,4}

Political Integration

The second effect of Europeanisation is political integration, which is defined as integration stemming from the “structures and governance of the European Union/European Community” (Beyeler, 2003, p.161). Turning to political integration, research on the effects of European integration on social policy remains limited due to the general lack of direct jurisdiction in the health area at the supranational level. However, as discussed in the previous section, recent scholarship has begun to explore increased Europeanisation of social policy through the application of EU competition and internal market law to hard and soft law development in the realm of EU health (Greer and Vanhercke, 2010; Hervey and Vanhercke, 2010; Lamping and Steffen, 2009).

EU Health Policy

There is an extensive literature that discusses the types of EU health (including Hervey, 2007; Greer, 2009; Baeten, Vankercke, and Coucheir, 2010; Baeten and Thomson, 2011; Greer, 2014; Greer et al., 2014; and de Ruijiter, 2019). Others also explore changes of the Europeanisation process itself (such as Krajewski et

³ The other two faces are policy and markets, which is discussed in the next section. According to Greer, these two faces are already established (2014).

⁴ Economic integration and fiscal constraints are not the focus of this thesis as it develops. These topics are discussed further in the conclusions, however, when evaluating the thesis findings.

al., 2009; Martinsen, 2011; Vollaard, von de Bovenkamp & Martinsen, 2016; Purnhagen et al., 2020; and Greer, 2021).

Overall, the EU does not have its own healthcare system, unlike its Member States. The delivery and financing of healthcare systems falls to the domestic level. However, there is an EU health policy that incorporates a range of policies applicable to these domestic healthcare systems. For some time, there have been scholars exploring the emerging European health policy (Mossialos and McKee 2001). The policy domain is complex and covers a range of topics, which can make it difficult to define (Greer and Kurzer, 2013).

Some policies have health legal bases, including public health, environment, health and safety; and consumer protection. Others involve markets that pertain to health like the European Atomic Energy Community, food safety, agriculture, statistics, social policy, free movement of goods, free movement of workers, free movement of services, research, competition, procurement, taxation as well as freedom, security and justice. A final group relates to the European semester and funding, including European structural and investment funds (see Greer, et. al, 2019, pp.2-3).

The EU policies explored in detailed analysis in the literature cover many subfields. They include topics like pharmaceutical legislation; monopolies and mergers policy affecting hospitals; non-life insurance as applied to health; intellectual property in pharmaceutical and medical technology; clinical trials regulation; medical device law; restrictions on Eurozone spending; employment and safety law; equal pay and equal treatment; the recognition of mutual qualifications; blood safety policy; worker rights policy; patient mobility rights; and many others. This list is not exhaustive but illustrates the breadth of areas as well as the depth of analysis in the discipline.

As such, many types of EU policy impact health. These can broadly be classed into broad categorisations of public health, internal market, and fiscal governance (Greer, et al, 2019; Greer, 2014). Given the diversity of policy areas related to health at an EU level, the field can be described as following a “patchwork” evolutionary process with the EU health policy developing across varied subjects (Hervey and Vanhercke, 2010, p.85).

Key EU Institutions

Another subset of the literature outlines the actors and institutions involved in the Europeanisation of healthcare (including Hervey and McHale, 2004; Martinsen and Vranbaek, 2007; Brooks, 2012; and Martinsen, 2012). There are generally five institutions established in the literature as relevant to the Europeanisation process: the European Court of Justice, the European Commission, the Council, the European Parliament, and interest groups. Some scholars argue that despite increased European integration, health policy remains solely dominated by domestic politics (Kuhlmann and Burau, 2008).

The literature explores which of these actors are leading the process, which is changing over time (de Ruitjer, 2019; Brooks, 2012). According to many scholars, the Commission and ECJ are two main actors driving health policy integration at the EU level (Lamping and Steffen, 2009). Some argue that “uninvited Europeanisation”—unwanted influence of the EU on domestic level due to spillover from other areas of supranational policy—has occurred through labour and product regulation (Greer, 2006). The theories vary depending on if they are concentrating on healthcare policy or public health policy (Brooks, 2012).⁵ Developments in recent years have seen the role of the European Parliament committees and other EU institutional actors increase their presence in health policy (de Ruitjer, 2019), particularly the EU formally adopted the “the Health in All Policies (HiAP)” approach beginning 2006 (Koivusalo, 2010).

The European Court of Justice

The European Court of Justice (ECJ) plays a central role in the application of EU law to healthcare systems and many scholars argue, integral to the Europeanisation of healthcare systems (McKee and Baeten, 2002; Greer, 2006; Hervey and Vanhercke, 2010, pp.90-94; Mossialos, et al., 2010). Health professional mobility, cross-border patient mobility, and medical device and prescription regulation have been addressed by ECJ rulings (Greer 2006). In some cases, the effects on healthcare systems are unanticipated and,

⁵ The distinction between health and healthcare policies are discussed by scholars like de Ruitjer (2019). This classification is explored in the theoretical framework in Chapter 3.

consequently, are difficult for institutions to sufficiently plan and react to rulings (Hervey and Vanhercke, 2010, pp.93-94). There is effectively four EU laws topics that relate to health—consumerism; human rights; the interplay of equality, solidarity and competition; and risk (Hervey and McHale, 2015, pp.7-8).

The cases in the sector include *Molenaar* (1998), which ruled that healthcare benefits could be exported to other MSs; *Kohll* (1998), which extended the interpretation to include dental services; and *Decker* (1998), which applied the standard to prescription eyewear (Hervey, 2008; Lamping, 2001).⁶ The ECJ has played an important role in extending patients' rights to cross border care gradually through rulings relating to the Internal Market (Martinsen, 2005). These ECJ rulings have been influential, because the ECJ is interpreting the law designed for other sectors' problems to have relevance in healthcare systems (Duncan, 2002; Mossialos and McKee, 2002, pp.23-72).

Decisions have extended rights individual residents to whom domestic systems have historically denied access. Many limitations on the power of the ECJ exist; European law must be applied to the individual claims brought up in court (Cichowski, 2007; Conant, 2006; Conant, 2002). Many of these decisions pertain to the four economic freedoms: free movement of goods, persons, capital, and services (Gerlinger and Urban, 2007; Paulus, Evers, Fechner, der Made, and Boonen, 2002). For example, the ECJ ruled under the free movement of goods and services that Luxembourg social security had to reimburse unauthorised healthcare service charges in another EU Member State. Afterwards, the ECJ extended this logic to apply to all aspects of medical care, including hospital treatment in the *Smits* and *Peerbooms* rulings. These services must be covered regardless of the patient's type of healthcare coverage (Mossialos and McKee, 2002, pp.23-72; Mossialos, McKee, Palm, Karl, and Marhold, 2001).

Consequently, scholars contend that increasingly ECJ rulings give individual citizens exit options from insufficient healthcare systems (Martinsen, 2005). Others have pointed to the critical role that the ECJ has played with

⁶ See *Gereas-Smith and Peerbooms* (2001), *Vanbraekel* (2001), *Müller-Fauré* (2002), *Leichtle* (2004), *Watts* (2006), and *Stamatelakis* (2007) for more ECJ rulings regarding health issues later included under the free movement of goods and services (Hervey 2008). Annex A2.1 contains summaries of these and other significant ECJ rulings in healthcare.

regard to policy activism, including in health (Leibfried, 2010). Over time, many ECJ rulings have applied EU policy to domestic healthcare systems (Den Exter, 2018; Hervey, Young and Bishop, 2017; Brooks, 2012; Hervey and Vanhercke, 2010; and Greer, 2008). As a result, the ECJ has been of primary focus in the literature (Brooks, 2012). EU law that has both supremacy and direct effect on national law can, subsequently, impact domestic healthcare systems (Hervey and Vanhercke, 2010, pp.93-94). As a result, EU law has become its own healthcare policy subfield (Brooks and Guy, 2021).

European Commission and Other EU Actors

Political integration of healthcare systems has not only occurred through the ECJ, but also through the European Commission. MSs have transferred much power to the Commission with regard to public health emergencies. This increase in power has led to the development of EU-level health networks and norms through EU health agencies and the Directorate-General for Health and Food Safety (DG SANTE) (Lamping and Steffen, 2009). Thus, EU-level health capacities have increased over time, raising its importance on the EU agenda (Greer and de Ruijter, 2020; de Ruijter, 2019; Lamping and Steffen, 2009). Arguably, there have been periods that have curbed European Commission activity in health specifically, such as under the Juncker Commission (Brooks and Bürgin, 2021).

Member states have also begun to adopt this application of hard EU law to domestic systems through the utilisation of soft law. Consequently, a “new governance” has emerged in EU health policy through the creation of networks and the development norms among EU institutions and MSs. This law-like behaviour steers MS activity concerning health. This emergence of soft law governance extended beyond DG SANTE into broader and more diverse facets of EU government as much healthcare intervention has occurred through other DGs. Member states have had to more and more incorporate the role of the EU in their healthcare system and adjust their political resources accordingly (Greer, 2006). The Open Methods of Coordination (OMCs) has also enabled the Commission to expand its role directly into social policy and healthcare regulation, particularly as it relates to healthcare expenditure, coverage, and access (Greer and Vanhercke, 2010; Lamping and Steffen, 2009). Recent

scholarship—including de Ruitjer (2019) and Greer, et al (2019)—explores the role the various European political institutions play as well as the role of actors as well as civil society in the Europeanisation process in detail.

Impact on Domestic Systems

Many studies explore how specific EU policies affect domestic healthcare systems. There is a wealth of literature on varied EU policies and the Member States comprising of extensive case study analysis, including in comparative contexts. For example, the case implementation of the PRD in Denmark and Bulgaria, for instance, illustrates the importance of domestic factors like institutional misfit, salience and administrative resources in the transposition of policy; it also demonstrates reluctance on the end of domestic actors (Martinsen and Vasev, 2015). In the case of Denmark, the increasing impact of the EU on healthcare systems is creating its own institutional legacy and an EU healthcare model with a unique structure, actors, and core principles (Martinsen and Vrangbæk, 2008).

Exploring the national impact of judicialisation in healthcare in Spain and Denmark showed both systems resistant to change (Mayoral and Martinsen, 2017). In another area of policy, Guy (2019) discusses the influence of competition policy on healthcare, particularly in hospitals, by comparing developments in different countries. The case study analysis of this field is growing and shedding light on the dynamics at play in the Europeanisation process, often on a case-by-case basis.

The Changing Nature of EU Health

The Europeanisation of health is a changing process. The financial crisis influenced the impact of the EU in the sector (Karanikolos, et al, 2013). As a result of the financial crisis, Member States are subject to new economic monitoring and governance under the European Semester the “Europe 2020” strategy (Azzopardi-Muscat, et al, 2015). New governance tools are emerging in health, such as EU networks, that change the interplay between the EU and health systems (Martinsen, Schrama, and Mastenbroek 2021). The concept of EU health and social policy is evolving too (Kilpatrick, 2018).

Some scholars argue that the role of the EU in health is increasing through “co-operative federalism” through the use of “non-healthcare” legislation, ECJ rulings, fiscal governance, “joint decision traps” (Vollaard, Van de Bovenkamp, and Martinsen, 2016, p157). This increase in EU health policy development occurs without the EU sharing costs, which are born by Member States (Vollaard, Van de Bovenkamp, and Martinsen, 2016). Some argue that Europe is moving towards a healthcare union with healthcare consumption, production, and provision within the EU (Vollaard, Van de Bovenkamp, and Martinsen, 2016). The EU health policy has developed in a manner that “makes it difficult for the EU to formulate a health policy that actually focuses on health” (Greer, 2021, p.90).

It is important to note that others believe that the literature on the relationship between EU law and health systems is “unduly pessimistic” as the EU lacks much of the competency and legitimacy in domestic healthcare systems (Hervey, 2007). Nonetheless, crises like the coronavirus pandemic and the resulting EU action can highlight the “web of health competence” in EU policy that, when taken together, is stronger than its component parts (Purnhagen, de Ruijter, Flear, Hervey, and Herwig, 2020). Although there is no specific healthcare policy field in the EU, some pose if there is a growing “European healthcare union” comprising of the various aspects of EU health policy (Vollaard and Martinsen, 2016). The current coronavirus pandemic is expected to further drive this process forward (Brooks and Guy, 2021).

The literature on the effects of European integration on healthcare systems is extensive and complex. Many studies focus on EU specific legislation, a topic area, or the EU’s impact on a particular country. There is a large focus on the courts and the legal elements, particularly as the ECJ increased its activity in the area. Crises facing Europe have also led to scholars re-evaluating approaches to Europeanisation. The lack of consistency in terminology complicates the fields’ development. There is debate in the literature over many of the key aspects. The field has a lot of insights on what has happened in health but its predictive power as a whole is not well developed. However, the literature is evolving alongside policy developments.

Literature Review Conclusions

In general, four broad literatures that relate to healthcare systems have been examined. The first body involves the institutional and comparative political analyses; this literature explains differences in and categorises welfare state and health policy, which describes differences between countries and the impact of government on these institutions. The second classifies domestic healthcare systems and utilises demographic and economic variables, as well as limited political controls, to account for some cross-national and temporal change. The third qualitatively explores the impact of European integration on domestic policy. The final section explores the Europeanisation of healthcare systems and policy. This thesis builds off of these literatures, strongly rooted in the Europeanisation fields, to develop the theoretical model presented in Chapter 3, then through case study analysis in Chapters 4, 5, and 6. This research attempts to combine aspects of these literatures to test the existing explanations, provide support and insight through new qualitative data (particularly through interviews), and contribute to exploring the role of the EU in healthcare system change.

The first set of literature, which examines advanced industrialised economies, established the connection between the economy and the government. Classification systems for welfare regimes exist and are continually being developed and perfected. Various influences on the development and evolution of welfare regimes are explored, including constitutional, ideological, political, and economic factors. Pressures and new issues result in continual system change. Additional texts incorporate particular components of the welfare state, such as healthcare systems, that do not always fit into established explanations. As such, it needs to be developed with time.

The second set of the existing literature develops unique regime categorisations of healthcare systems. No consensus currently exists on the number of system types or on the critical dimensions of the classification. The discipline warrants further development in the interplay between this literature and that of political economies and welfare regimes. This literature could benefit from more exploration of the evolving nature of healthcare systems—focusing on demographic and general economic changes—not on political forces.

The final two literatures on Europeanisation examines the effects of the EU on domestic policy and on health. Issues surround the operationalisation of the main concept, though some of that is due to the fact that the process of Europeanisation itself is ever-changing. Methodology in the field focuses on case study analysis primarily due to a lack of quality and comparability of data (Sverdrup, 2007). Additionally, the literature's focus on the uniqueness of health systems prohibits generalisability about the broader repercussions of political-economic changes (Levi-Faurb, 2007). The EU remains in a transformative stage, so the resulting theory in the area is complex and can always be developed further (Wincott, 2003). Thus, more systematic, comparative analysis over time with clear expectations and evidence could help to apply Europeanisation studies to political systems and healthcare systems generally.

European integration is changing and developing as new challenges arise. These developments have ramifications for healthcare systems and health policy. Healthcare research development can further investigate how European integration affects domestic healthcare systems. A theoretical model of healthcare could help connect fields, address gaps, test theories, and highlight unusual findings. It is also necessary to update the literature with detailed study of cases and new forms of data, such as interview data.

An intensive comparative study of health policy and European integration will add insight into the literature. Case study analysis provides concrete examples to help test and demonstrate the theories underpinning the literature. It also provides for the development of broader theory on the full effects of supranational governance indirectly and directly on social policy. Chapter 3 thus builds on the existing literature and sets out the theoretical framework that serves as the foundation of this thesis.

Chapter 3

Theoretical Framework and Research Design

Introduction

This chapter comprises four sections—the argument in brief, the theoretical framework in detail, the research design, and the conclusion. Drawing from the analysis of existing explanations in Chapter 2, the first half of Chapter 3 outlines the theoretical framework of the thesis. First, the argument in brief, which seeks to answer the research questions, is presented. Then, the hypotheses are laid out in detail. These predicted expectations are rooted in the assumptions of the theoretical model. Specifically, the Europeanisation factors that impact domestic healthcare systems and the feedback mechanism stemming from this interaction are outlined.

The second half of Chapter 3 details the research design of the thesis. The methodology employed to test the theoretical framework through qualitative analysis of the collected evidence is described. Then, the case study selection is explained and justified. The qualitative research focuses on three case studies of Germany, Ireland, and Spain. Following this methodology discussion, a brief conclusion finishes the chapter and sets the stage for the evidence presented in Chapters 4, 5 and 6, which test the assumptions theoretical model.

Theoretical Framework

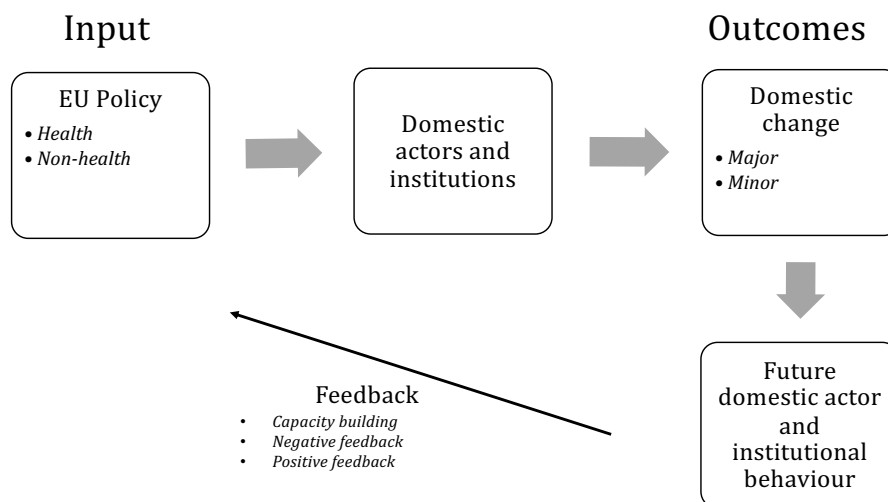
The first part of this section lays out the argument in brief on how Europeanisation affects domestic-level healthcare systems. The second part explores aspects of this model in detail.

Argument in Brief

This thesis seeks to answer the questions: to what degree does European integration affect domestic healthcare systems? Do pressures created by the EU alter domestic healthcare systems? What is the nature of such change—is it uniform, varied, or differential across Member States? How do domestic institutions and actors influence this process of Europeanisation? What insights does interaction of EU policy and domestic systems provide to us about the Europeanisation process and healthcare institutional development?

This thesis argues that European integration impacts domestic healthcare systems. The model outlined generalises about domestic change while allowing for variation. Political integration stems from supranational policy developments. As a result, EU policy matters when examining domestic-level healthcare system development. However, this supranational-level impact occurs from a variety of European policies and policy areas. Domestic change stemming from the EU level is influenced and shaped by the actors and institutions—including historical legacies—at the domestic level. The outcomes lead the system to react and feedback into the Europeanisation process. *Figure 3.1* below theoretically illustrates how political integration of Europeanisation (the input) impacts domestic healthcare systems (outcomes) and then encourages feedback (feedback) into the process.

Figure 3.1: The Political Impact of Europeanisation on Domestic Healthcare Systems



First, *Figure 3.1* illustrates that European integration is an influential factor in healthcare systems change. It must be considered as an input in addition to established domestic factors. The explanation later in this section includes the elaboration of the different types of European healthcare policy. The *input, EU integration of healthcare, is disaggregated into two types of policy*—one stemming from health policy (policies that originated in DG SANTE⁷) and the other originating in non-health policy (policies developed in other Directorates-General). The policy categorisation is defined, justified, and detailed with examples later in this chapter. As explained in the literature review, the area of the Europeanisation of healthcare is highly complex and complicated. This conceptualisation is important to generating expectations and hypotheses.

Secondly, *Figure 3.1* shows that the *healthcare systems are influenced by the application of EU policy at the domestic level*. The domestic actors and institutions interact with the supranational policy. The third step is how *the policy impacts the domestic healthcare system*. The domestic influence will depend on the level of “misfit” with the system, the adaptability of the system, and the capacity of the system. Most influential outputs impact the day-to-day implementation of healthcare systems operations. EU-level developments do not regularly encourage or force domestic policymakers to make large changes to institutional arrangements. The nuances of the outcomes are discussed in this chapter.

Finally, the *interaction between the EU and domestic healthcare systems is bi-directional*. Specifically, it is not solely a top-down process of the EU impacting domestic systems. There is also a bottom-up feedback mechanism too, and, in some cases, an encouragement of supranational policy developments in this field. The extent of the EU-level policy impacts the actors and institutions at the domestic level and structure their behaviour in the future with regard to the

⁷ In 2014, the Directorate responsible for health-related issues was renamed Directorate General for Health and Food Safety (DG SANTE). Previously, it was known as the Directorate-General for Health and Consumers (DG SANCO). Over the years, the DG has undergone changes in its scope and its name. For consistency, it will be referred to as “DG SANTE” throughout the thesis. The history and evolution of the DG is accounted in detail by various scholars, such as de Ruijter (2019).

specific policy and to EU policy more generally. Consequently, domestic actors in the healthcare sector experience increased awareness of the influence of EU policy based on the impact on domestic policy. When possible, these actors and institutions try to capitalise on benefits or limit costs from the application of supranational policy to the domestic level in the future after witnessing the influence of Europeanisation. This increased engagement generally occurs with those involved in the delivery and organisation of care, not the elected officials.

This research does not claim that European integration solely explains healthcare system change, nor does it explain all cross-national and temporal system variation. However, as the size and scope of the EU increases, the influence of supranational institutions and their policy outputs must increasingly be considered in conjunction with existing explanations to better understand the complexities of domestic developments. The impacts of the EU on welfare states should not be underestimated, even during times of crisis. This thesis explores the intricacies of political integration through a qualitative analysis of the impact of EU policy on healthcare systems. The economic dimension warrants further investigation in the future, but it requires in-depth statistical and case studies that cannot be adequately covered in this thesis. As a result, the remainder of this thesis explores the process of the Europeanisation of domestic healthcare systems as presented in *Figure 3.1* in-depth, across different systems in a varied manner. The chapter concludes by outlining the research design and methodology.

Europeanisation of Healthcare Systems: The Interaction of EU and Domestic Factors

The theoretical framework is broken into four component arguments derived from *Figure 3.1*, which I now summarise and explain. The *first argument (I)* breaks down the anticipated input in the Europeanisation process presented in *Figure 3.1* by differentiating between health and non-health policies. The *second argument (II)* explains the predicted importance of the Working Time Directive-related policies and rulings as a critical juncture for domestic actors, highlighting the applicability of EU policy developments to healthcare systems. The *third argument (III)* outlines the expected outcomes of Europeanisation on domestic

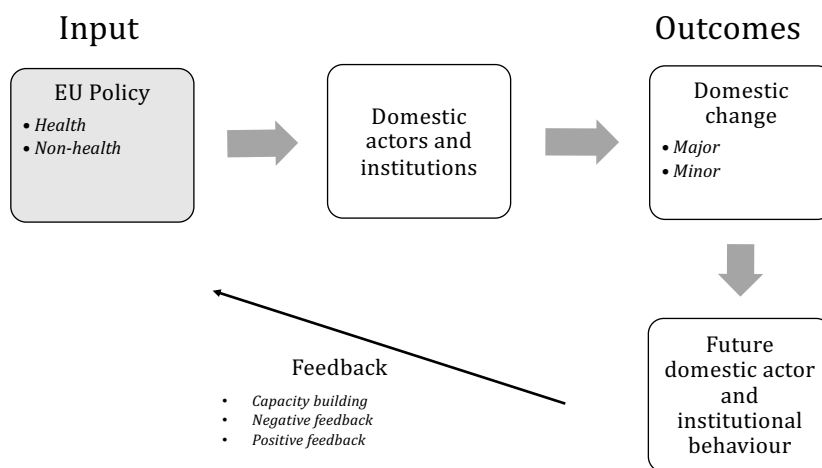
healthcare systems, categorising them as major or minor impacts. The *final argument (IV)* explores the theorised domestic feedback mechanism into the Europeanisation process. A brief summary then transitions to the research design of the thesis, which tests the explanatory power of this model.

I. Policy Dimensions of Europeanisation of Healthcare

EU healthcare policy can be described as following a “patchwork” evolutionary process as the “with some limited exceptions, the European Union has no legal competence to adopt EU law in the field of health care” (Hervey and Vanhercke, 2010, pp.84-85). This often piecemeal and patchwork development of EU healthcare policy impedes its classification and generalisation as “EU health care law and policy is formed from a variety of provisions that constitutionally ‘belong’ to different policy domains, principally those of the internal market, social affairs, public health, enterprise and economic policy” (Hervey and Vanhercke, 2010, p.85).

As highlighted in *Figure 3.2*, this argument pertains to the input in the Europeanisation process, EU policy. EU policy that affects healthcare can be disaggregated into one of two main categories: health and non-health policies.⁸

Figure 3.2: The Proposed Policy Dimensions of Europeanisation



⁸ The terminology differentiation between healthcare and public health policies is key, as is discussed later in this chapter. Scholars including De Ruijter (2019); Hervey, Young and Bishop (2017); Hervey and Vanhercke (2010) provide detail and examples of these two areas.

In addition, both direct and indirect policies can also be disaggregated into two different levels of commitment—binding and non-binding. Binding policies must be implemented, whereas non-binding policies do not have a legal obligation. The types are summarised in *Table 3.1* below, which includes regulations, directives, decisions, recommendations and opinions as defined by the EU (European Commission, 2021; EUROPA, 2018).

Table 3.1: Examples of Binding and Non-Binding Legal Acts

Legal Acts	Categorisation
Regulation	Binding
Directive	Binding (<i>implemented through national laws</i>)
Decision	Binding (<i>to company or country it is addressed</i>)
Recommendation	Non-binding
Opinion	Non-binding

The two types (health/non-health) and two commitment levels (binding/non-binding)⁹ result in four categories of EU policies, as *Table 3.2* below illustrates.

Table 3.2: The Theoretical Policy Categorisations of Europeanisation

Type of EU Policy	Level of EU Policy Commitment
Health	Binding
Non-health	Non-binding

a. Health Policies

DG SANTE “is responsible for EU policy on food safety and health” (DG SANTE, 2021a). Healthcare policy, like other social policies, is categorised as a second-order EU policy where decisions on the delivery and organisation of care are primarily left to the discretion of individual MSs at domestic level.

⁹ It is important to note that “binding” with regard to EU policy has limitations with regard to enforceability. This distinction is further explored in the case study analyses in Chapters 4-6 as well in the conclusions in Chapter 7.

Due to the evolving nature of EU policy, it can be difficult to distinguish between EU public health policy and EU healthcare policy (De Ruijter, 2019). As such, EU healthcare policy is defined in the literature as “relating to the provision of medical care and individual health” (De Ruijter, 2019, p.78). The EU lacks a legislative competence in healthcare policy, but it does have some authority in public health as designated under EU treaties (De Ruijter, 2019, p.87).

The European Commission initiates policy and legislation as well as monitors its enforcement. Most of EU health policy has now moved in to the remit of DG SANTE (De Ruijter, 2019, p.98-100). As a result, *direct Europeanisation* occurs when health-specific EU legislation is passed. Such supranational policy is relevant and applicable to domestic healthcare systems. In this model, *direct Europeanisation is defined as supranational policy developments in health policy*. Specifically, this supranational policy is defined as stemming from the Directorate-General that covers health, DG SANTE. It is this department of the Commission that engages EU countries’ health departments and ministries as well as health experts.

As outlined by DG SANTE, “the EU can adopt health legislation under the Treaty on the Functioning of the European Union: Article 168 (protection of public health), Article 114 (single market) and Article 153 (social policy)” (2021b). *Table 3.3* below lists examples of current EU health legislation, as outlined by DG SANTE (2021b).

Table 3.3: Examples of Health Policy

Examples of Current EU Health Legislation
<ul style="list-style-type: none">• Patients' rights in cross-border healthcare• Pharmaceuticals and medical devices (pharmacovigilance, falsified medicines, clinical trials)• Health security and infectious diseases• Digital health and care• Tobacco• Organ, blood, tissues and cells

With regard to health policy, domestic healthcare actors are able to track developments stemming from DG SANTE by tracking its developments and

proposals. Other policies in health include open methods of coordination (OMCs) in health policy. These include “coordinating and facilitating the exchange of best practices between EU countries and health experts” (DG SANTE, 2021b). These are voluntary collaborations between various MSs and the EU that set goals and encourage information sharing in the health arena through non-binding policies, programming and funding.

b. Non-Health Policies

Healthcare systems, as part of domestic welfare states and economies, inevitably are impacted *indirectly* by other EU policies. These non-health policies are defined as those falling under legislative mandate and scope that are not categorised explicitly under health policy. These are policies originating in the other Directors-General (DGs) besides DG SANTE.¹⁰ Examples of indirect non-health policy begin with those relating to the internal market. They have developed and evolved over time, and continue to do so. They include examples of areas of non-health EU policy discussed in literature and is summarised in *Table 3.5*¹¹ on the next page (such as De Ruitjer, 2019; Greer, et. al, 2019; Hervey, Young and Bishop, 2017; Martinsen, 2015; Greer, 2014; and Hervey and Vanhercke, 2010).

These non-health policies have the potential to impact healthcare as they are related to the functions of the healthcare system, such the delivery and financing of services. These policies are developed and monitored by DGs outside of DG SANTE. Given the range of potential areas and the large number of DGs, it is an extensive list of policy proposals, developments, and implementation to monitor and track. Given the “patchwork” (Hervey and

¹⁰ There are currently twenty-seven DGs in the European Commission. DG SANTE is one of them. Policies originating from the other twenty-six DGs are classed as non-health policies. The number of DGs based on the number of Member States. The topics covered by each DG are set during each new European government. As such, the names of the DGs and their scope vary with time. The limitations of theoretical classification is explored in the remaining chapters through both case study analyses and concluding analysis.

¹¹ There is a large range of policies that can be categorised as non-health EU policy. The literature review in Chapter 2 discusses this concept. The table provides a summary of some of the key topics from the literature. This list evolves and changes with time.

Vanhercke, 2010) and sometimes perceived “uninvited Europeanisation” (Greer, 2006), non-health policy covers a wide range of EU policies. As a result, it is expected that domestic actors will not always anticipate the effects of these policies on domestic healthcare systems.

Table 3.4: Examples of Non-Health Policy Areas

Examples of Current EU Health Legislation
<ul style="list-style-type: none">• Agriculture policy• Consumer protection¹²• Data protection• Employment right• Environmental protection• Fiscal governance• Informed consent• Intellectual property• Internal market (e.g. competition, mergers and state aid)• Mobility of professionals• Safety at work• Technology• Trade

In conclusion, the first argument outlines the types of supranational policy and their impact on domestic healthcare systems. Two types of EU policy developments should affect domestic healthcare systems. The first is policy explicitly in the health sector and the second incorporates non-health policies that spill over into health care from other EU policy areas. Both types of EU policy should impact the domestic healthcare system. Moreover, EU policies should be either binding or non-binding in the nature of their commitment. Member states are expected to transpose binding policies,¹³ but they should have

¹² Consumer protection prior to 2014 was located in the Directorate-General for Health and Food Safety (DG SANCO). Over the history of the Commission, its location and that of health has moved. From 2014, consumer protection was moved out of the DG responsible for health, now DG SANTE.

¹³ The principle of binding and non-binding policies are explored later in the thesis. Binding and opt outs are explored in the evidence and analysis presented in Chapters 4-7.

discretion in incorporating non-binding policies at domestic level to implement as they see fit.

II. Working Time Directive as a Critical Juncture

The Working Time Directive (WTD) is the model defined as a series of policies and rulings relating to the EU regulation of working time.¹⁴ It references the Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time. It also includes the Directive 93/104/EC, Directive 2000/34/EC, and documents on the 2004-2012 initiative, which were amended to become the current Directive 2003/88/EC (See DG EMPLY, 2021).¹⁵

European Court of Justice (ECJ) rulings that interpret this Directive, particularly with regard to its applicability to healthcare services is also included. ECJ rulings held up the WTD with respect to healthcare and extended its scope. Integral rulings include *SiMAP* and *Jaeger* judgments¹⁶ ruled that on-call time counts as working time, regardless of whether or not work is completed while on-call.¹⁷ Thus, the WTD and subsequent interpretations by the ECJ stipulates that on-call time be considered work, and the opt-out to work more than 48 hours a week was only possible with trade union agreements. Interpretations of the WTD and how it is applies to domestic systems continue to examined by the ECJ.¹⁸

As the section of the Europeanisation of healthcare policy literature outlines in Chapter 2, various EU policies are applicable to domestic healthcare

¹⁴ Scholars such as Hervey, Young and Bishop (2017), Brooks (2012), Hervey and Vanhercke (2010), and Greer (2006) explore the dynamics of the ECJ and health policy in detail.

¹⁵ DG EMPLY (2021) for further information and clarification on aspects and development of the Working Time Directive.

¹⁶ *SiMAP* is a 2002 case brought forth by Spanish doctors. *Jaeger* is a 2003 case taken by a German doctor.

¹⁷ In some MSs, individual doctors could opt out of the 48-hour maximum voluntarily (NHS Employers, 2013).¹⁷ The dynamics of individual countries are explored in the case study chapters, Chapter 4-7.

¹⁸ For example, in a 2019 by the ECJ, employers must track the time and attendance of employment (Court of Justice of the European Union, 2019).

systems. Over time, many non-health policies¹⁹ have been interpreted by the ECJ as applying to domestic healthcare systems (Hervey, Young and Bishop, 2017; Brooks, 2012; Hervey and Vanhercke, 2010; and Greer, 2008). Key domestic actors should increasingly pay attention to supranational developments as the EU laws such as those in the internal market, competition, and employment law must be enforced by healthcare systems.

Healthcare systems are highly reliant on personnel to deliver healthcare services, particularly in hospital settings. Therefore, policies that impact personnel and the delivery of care is expected to have a large impact on the healthcare systems, assuming that systems comply with the requirements.

As established in the literature, critical junctures impact path-dependent institutions, including healthcare systems (Collier and Collier, 1991). They occur when events result in uncertainty about the future of an institution's arrangement and lead to change in the institution's development that persists over time (Capoccia, 2015, p.148). Size does not necessarily equate with impact. At critical junctures, "small and contingent events" can shape the projection of other events down the line (Capoccia, 2015, p.150; David, 1985; David, 1994).

Various results are possible following critical junctures, potentially affecting countries differently (Goldstone, 1998; Mahoney, 2000). In this theoretical model, a critical juncture is defined as being marked by crisis—either a once-off event or a series of related events—that instigates (1) *ideational* and (2) *policy institutional change* as established in the existing literature (Hogan and Doyle, 2007, p.884). As a result, with regard to the Europeanisation of healthcare systems, the WTD should be defined as a critical juncture and be characterised by a series of key events and subsequent domestic ideational and institutional change. The WTD instigated the Europeanisation dynamic hypothesised in the theoretical framework.

This theoretical model anticipates that the WTD should serve as a critical juncture in the process of the Europeanisation of healthcare systems. The argument purports that the WTD significantly impacts domestic healthcare systems in the EU, regardless of their institutional characteristics and actor

¹⁹ The first dimension of the model, the input, which is presented in section explores the distinction between health and non-health EU policies.

arrangement. The focus on the WTD and its role as a critical juncture was highlighted consistently in the high-level interviews, which is why it forms a central tenant of the explanatory framework. The uniformity and varied impacts are explored in the case study analyses.

The model also highlights the importance of the WTD for domestic healthcare systems' institutions and actors; awareness of the role of the EU and engagement in the EU process should increase as a result of the WTD. The theoretical model posits that prior to the WTD, many actors and systems did not consider EU policy, but instead focused attention primarily on domestic-level factors. The WTD as a critical juncture has prompted an awareness at the domestic level, and consequently, various local, regional and domestic healthcare actors mobilised and/or developed the infrastructure necessary to monitor developments in EU policy and lobby European institutions when necessary.

Figure 3.3: The Working Time Directive as a Critical Juncture

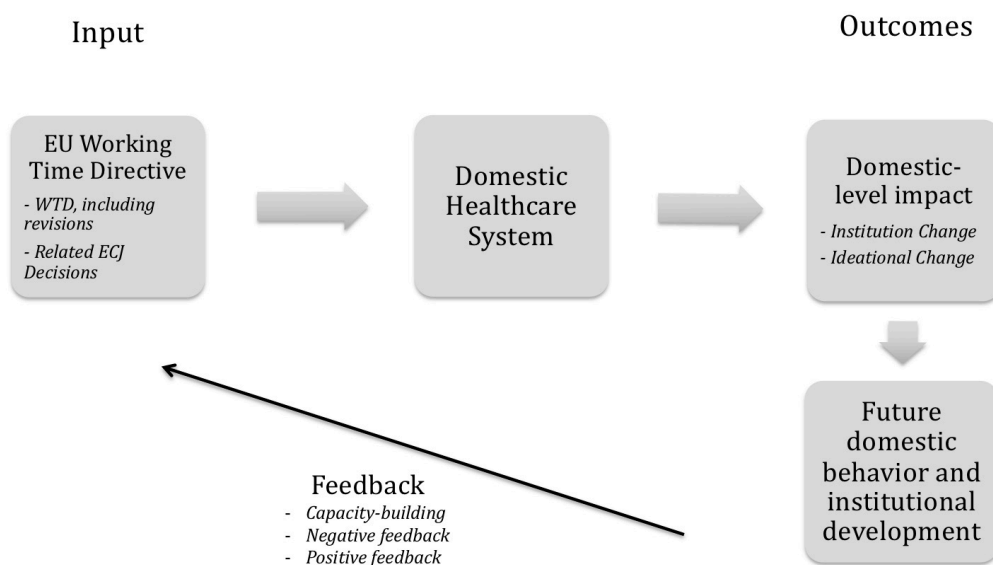


Figure 3.3, which is presented above, summarises the impact of the WTD on domestic healthcare systems as a critical juncture. The model does not indicate that there was no impact of Europeanisation on domestic healthcare systems prior to the WTD. Instead, it defines the WTD as a critical event followed by ideational and institutional change in EU healthcare policy development, as it illustrated the wide-reaching effects of EU law across MSs. It is expected that the

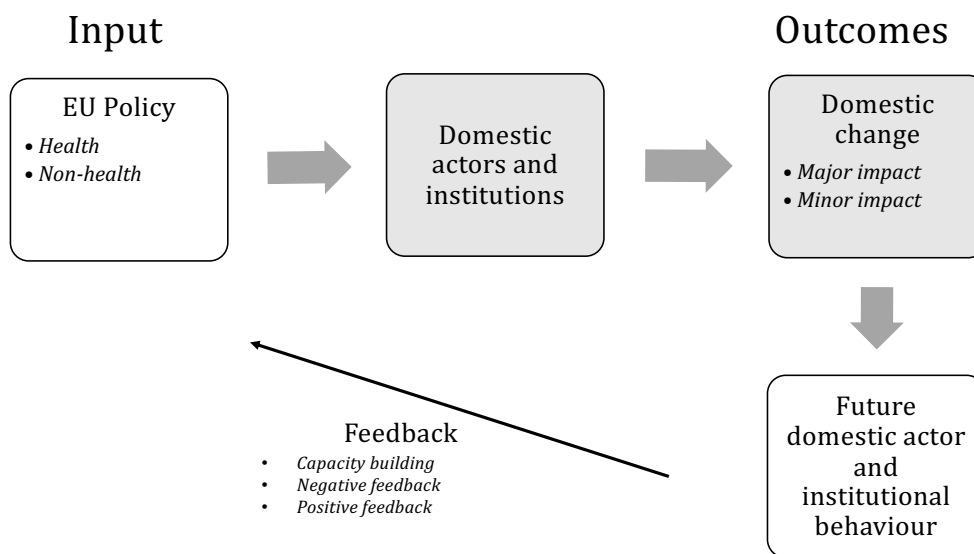
WTD should highlight the importance of supranational policy to actors across European domestic healthcare systems across Europe in a widespread and lasting manner.

III. National Variations of the Europeanisation of Healthcare Systems

The first argument outlines the inputs in the Europeanisation process, specifically through health and non-health policies. This third dimension (III) explores how these EU forces interact with domestic healthcare institutions and actors. The model posits that both unified and differential impacts are apparent across European healthcare systems resulting in national variation in Europeanisation. These variations are shaped by pre-existing domestic institutions and actor arrangements.

Consequently, this argument (III) summarises the outcomes from the Europeanisation process and is highlighted in Figure 3.4. below.

Figure 3.4: The Domestic Impact of Europeanisation



According to this argument, the institutional structure and the interest in the system should shape the response to pressures from internationalisation (Swank, 2002, p. 3). Specifically, supranational policy should lead to both minor and major change in the domestic systems. Based on the existing literature, major changes are defined as the “disruption of continuity” and cause

“observable changes to adjustment for the purpose of stability” (Streeck and Thelen, 2005, p.8).

Due to the patchwork, incremental and often varied nature of the input in the Europeanisation process, the theoretical model predicts that EU policies should have varied effects on domestic health systems, including nominal or no effect in some instances. Within a given domestic healthcare system, some EU policy developments should be more influential on the domestic level than others. Moreover, across countries, the different institutional and actor arrangements should lead to varied outcomes. In line with the literature, Europeanisation at domestic level should be characterised by “goodness of fit, mediation, change” if countries decide to implement EU policy (Saurugger, 2014, p.191)

Although there is no one accepted model that dominates the literature, healthcare systems categorisations typically include certain key dimensions in their typologies—the delivery, organisation, and financing of healthcare, as well as the access to care. Thus, changes to the arrangement of the delivery of healthcare systems should classify as a major impact.²⁰ Major effects result in domestic policy change, ideational impact, alteration in the organisation of healthcare services, and/or sizeable adoption costs. In contrast, minor changes are incremental, characterised by “reproductive and adaptive” change (Streeck and Thelen, 2005, p.8). The characteristics of these impacts are summarised in *Table 3.5* below.

Table 3.5: Characteristics of EU Policy Impact on Domestic Healthcare Systems

Major impact	Minor impact
<ul style="list-style-type: none"> • Domestic policy change • Ideational impact • Effect on the financing and/or delivery of healthcare services • Adoption cost 	<ul style="list-style-type: none"> • No, superficial or limited domestic policy change • No or minimal ideational impact • No or minimal institutional impact • No or low adoption cost

²⁰ Changes to the institutional arrangement to domestic level healthcare services would classify as a major impact. However, due to the lack of an EU mandate in healthcare policy such as this has not occurred to date.

a. Major Impacts

Major impacts should be rarer and less frequent than minor ones generally (Streeck and Thelen, 2005, p.6). Given the dominance of domestic control of healthcare systems, this trend should be particularly pronounced with regard to the Europeanisation of healthcare policy.

In theory, major impacts could occur from health and non-health policy. However, EU health policy covers a limited scope based on EU treaties as previously discussed. The model expects that major healthcare changes should primarily result from non-health policy rather than health policy given the limited scope of EU health policy. Across all systems, personnel and staffing are integral to healthcare delivery, organisation, and financial planning. The model would predict that EU policies that affect healthcare system delivery, organisation, and financing of healthcare impacting areas like staffing, for instance, should have a significant impact on the domestic system. Access to care is another core component of healthcare systems. The framework would also posit that EU policy developments affecting healthcare access would also exert a major impact on healthcare systems. Major impacts should stem from policies that are binding in nature; institutional legacies and lock-in effects should prevent non-binding policies from causing major change.

b. Minor Impacts

The theoretical model anticipates that minor impacts result from both health and non-health policies. Minor impacts should comprise the majority of Europeanisation effects and should occur more frequently than major changes with regard to the Europeanisation of domestic systems. European policies that are more minor should not impact the entire domestic healthcare system with relatively small transposition requirements. These policies may have an impact on a limited aspect of the system affecting the day-to-day operations or management of the healthcare system. Given the diverse structures and arrangements across the EU, minor policies should have a varied effect depending on the institutional and actor organisation in the domestic context.

Minor policies could be binding or non-binding in nature, depending on their scope and impact. Due to the size of domestic healthcare systems, small

impacts could translate to tangible implications and large costs. In addition, ignoring many of these smaller policies in aggregate could lead to an underestimation of the overall impact of the Europeanisation process on domestic healthcare systems over time.

These two dimensions summarise the central components of Europeanisation on EU MSs. Therefore, I posit that the impact of EU direct and indirect policies should vary, some minor and others major, depending on the scope and applicability of the policy to the domestic-level system. Major policies should stem from binding legislation, whereas minor policies could be binding or non-binding in their commitment nature.

c. National Variations

Some consequences of European integration affect all MSs regardless of their structure while others exert differential impacts depending on the domestic system arrangement. As institutions are vital to welfare state development (Huber, Ragin and Stephens, 1993; Thelen, 2004), the pre-existing healthcare system arrangements should influence the extent of these impacts on MS healthcare systems and structure policy response. Thus, some MS reactions to the Europeanisation of healthcare systems should vary amongst the system typologies. This expectation is in line with the goodness of fit, mediation, and change explanations prevalent in the Europeanisation literature. Misfit of EU policy with domestic structures should result in change at domestic level.

Therefore, I posit that the institutional arrangements of domestic healthcare systems should structure how and what EU policy affects them. If there is a misfit between EU policy and the domestic healthcare system, the MSs should experience noticeable effects of European integration. On the other hand, if a policy has the goodness of fit, the healthcare system should not experience much domestic change. This goodness of fit should relate to the institutional and actor organisation. In addition, historical legacies and struggles factor into this interactive effect of Europeanisation.

As a result, the model predicts that major EU legislation should have some impact on all domestic healthcare systems. The extent of this impact, the outcomes, and the MS reaction, the feedback, depends not only on the policy

itself, but also on the domestic-level institutional arrangement with which it has an interactive effect. With regard to more minor legislation, if and how much a country is affected should depend on its domestic healthcare arrangement. Systems should be impacted by European policy in areas in which the system is weak. It is important to note that although this is where countries are more susceptible to change, the impact would not be necessarily detrimental to the MS, although actors in the system may perceive as “good” or “bad” development. Domestic systems confront particular issues with which their institutional arrangement does not have a “goodness of fit” with the EU policy (including Börzel and Risse, 2003; Radelli, 2003; and Cowles, et al, 2001).²¹ It is important to note that this goodness of fit explanation focus does not fully account for whether domestic systems adjust to Europeanisation when there are weak pressures (Gürkan and Tomoni, 2021; Ladrech, 2010). *Table 3.6* provides an overview of the anticipated interaction between the input and the outcome of this national variation.

Table 3.6: Types of EU Policy and Their Impact on Domestic Healthcare Systems

		EU Policy Type	
		Health	Non-Health
Domestic Significance	Major Impact	<ul style="list-style-type: none"> • Impacts all MSs • Binding policy • Anticipated but varied effects, depending on the domestic institutions and actor arrangement 	<ul style="list-style-type: none"> • Impacts all MSs • Binding policy • Potentially costly and unexpected effects, depending on the domestic institutions and actor arrangement
	Minor Impact	<ul style="list-style-type: none"> • Impacts all MSs • Binding or non-binding policy • Varied impact depending on the domestic institutions and actor arrangement 	<ul style="list-style-type: none"> • May impact some or all MSs • Binding or non-binding policy • Varied impact depending on the domestic institutions, actor behaviours, and policy area

Therefore, institutional arrangements, actor organisation, and historical legacies at the domestic level, which are explored in detail through case study

²¹ The model is not trying to access the impact—whether positive or negative—of the change. Rather, it is trying to conceptualise when change occurs. In theory, Europeanisation could improve a domestic system through change even if it is at an added short-term cost or adjustment.

analysis chapters, should determine how the input (EU policy) is translated into the outcomes (domestic-level healthcare change). As previously discussed, Europeanisation may have largely occurred through incremental application of non-health policies to the domestic healthcare system.

The impact should be particularly evident in healthcare system administration, which can make it difficult to capture through policy analysis. Legislators are not expected to regularly consider the EU when drafting domestic policy. When the EU is considered in domestic health legislation formation, it typically should be to avoid adverse effects from EU policy. Therefore, the expectation is that European integration should mainly affect day-to-day healthcare administration application of legislation, rather than on regularly altering the electoral politics and legislative change. Thus, there is not much expectation of electoral and partisan change from Europeanisation as some scholars anticipate in the literature.

This expectation is that European integration impacts domestic policy, but does so in different manners depending on the institutional arrangement. EU developments can impact policymaker behaviour. In cases when EU policy could potentially have a significant and adversely-perceived impact on the running of the system or an important value in the system, MSs should try to influence European policy to prevent the issue, whether it is through exemptions or by killing legislation. If EU policy has been implemented or its passage is likely, when possible, the country should adopt a policy to minimise the disruption to their existing domestic arrangement. These phenomena are explored in detail in the case study analysis.

IV. Feedback Mechanism: The Cost of Europeanisation

When Europeanisation causes adaptational change in healthcare system—a top-down impact, it should illustrate the relevance of EU policies to domestic actors. EU developments should be monitored in future by MSs in order to adjust, or minimise the need for adjustment. In addition, there should be a domestic interaction with the Europeanisation process itself. Therefore, domestic actors, realising the relevance of EU policy—should monitor EU policy and try to mitigate or capitalise on the impact of EU legislation, in future. Change aversion

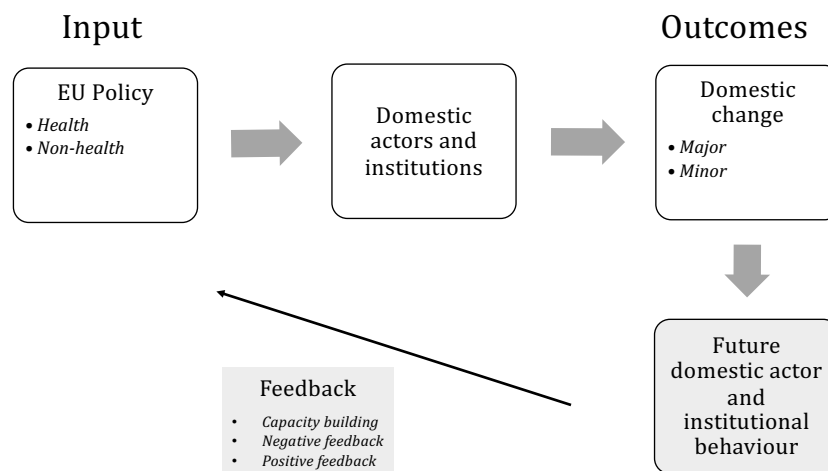
should be anticipated if Europeanisation in the past had noticeable adjustment costs that were negatively perceived by system actors. These actors who encounter the impact of domestic misfit should be most aware of EU policy applicability domestically, and try to minimise the future need to adapt.

The policymaking process can be defined by “dual and contrasting characteristics of stability and dramatic change” (Baumgartner and Jones, 2002, p.1). Institutions not only affect policy but are influenced by it. The feedback mechanism can begin with *capacity-building* at EU-level, which enables domestic actors to monitor and engage in the policymaking process. The policymaking process can affect how institutions function and are structured through both positive and negative feedback (Baumgartner and Jones, 2002, pp.2-5). *Negative feedback* is defined as the “homeostatic process or a self-correcting mechanism” that counterbalances pressures (Baumgartner and Jones, 2002, p.9). Strong institutions, which can try to neutralise pressures, have relatively stable policies. Nevertheless, institutions try to counteract pressures. It is important to note that part of this feedback mechanism is in line with Greer’s concept of “uninvited” Europeanisation as a domestic misfit and something to avoid.²²

On the other hand, this model also includes *positive feedback*. *Positive feedback* is more erratic, reinforces the status quo often through clustering of events and can lead to sudden change (Baumgartner and Jones, 2002, pp.14-16). Actors are more likely to act when they anticipate that success and benefit, which results in momentum. Furthermore, institutions are biased in their design, so actors are likely to focus on the dimension of the problem that the institution was designed to tackle. As a result of positive feedback, institutions may be altered and issues framed in a different manner (Baumgartner and Jones, 2002, pp.28-35). This interactive feedback mechanism of Europeanisation on the domestic actors is summarised in *Figure 3.5* on the next page.

²² This concept is explored in the case study analysis and thesis conclusions as there is an inherent normative underpinning to this model.

Figure 3.5: The Feedback Mechanism of Europeanisation



Negative feedback has a more substantial impact on domestic actors than does positive feedback, particularly when elevated costs are involved (Baekgaard, Larsen, and Mortensen, 2019). Domestic actors should also be selective with regard to their feedback; they are more likely to be responsive to feedback when there are “certain ideational and material incentives” (Sarigil, 2009, p.135). Namely, when policy implementation costs cause system “friction” that leads to “dramatic policy punctuation,” typically after a period of “stasis” (Jones et al., 2003).

Europeanisation should cause domestic actor capacity-building with regard to EU policymaking. Both negative and positive feedback should result from EU policy. After witnessing the high cost of a lack of involvement in policymaking after the WTD, domestic healthcare actors should mobilise through both official and unofficial channels to track policy that could potentially impact healthcare in order to avoid potentially adverse domestic consequences. Some positive feedback should occur if the institutional arrangement predisposes the system to potential benefits from Europeanisation through the goodness of fit and adaptability; domestic actors should track legislative developments and attempt to influence EU policies to capitalise on potential benefits. Domestic actors should be more responsive to negative feedback than to positive feedback, particularly when policies prove to be costly. Domestic-level actors should not be passive with regard to Europeanisation effects and seek to influence them when possible.

As outlined in the domestic variation argument, MSs ability to influence European policy should vary with its domestic institutional arrangements. Not all MSs have the same capacity to exert influence, but all should have some presence in healthcare at an EU level once the impact of Europeanisation on the domestic level is evident through increased domestic actor awareness. The organisation and centralisation of the system should be critical to the lobbying capacity of domestic actors, which I explore in greater detail in the case study analysis in Chapters 4, 5 and 6. Countries with domestic healthcare actors who are well-organised and centralised should be more effective in mobilising at an EU level to minimise perceived negative impacts and capitalise on perceived and potentially positive ones than those who are less organised..

Theoretical Framework Summary

Thus, the Europeanisation of domestic healthcare systems should be a complex phenomenon. Supranational developments should occur through health and non-health policies through both binding and non-binding legislation. EU policy domestic effects should be major or minor. The impact of European policy on domestic healthcare systems should be structured by pre-existing institutional arrangements. Many of these impacts may be difficult to detect and should present in the administration and management of healthcare systems rather than in health policy developments, though instances of both are examined through case study analyses. Finally, the significance of supranational developments that impact healthcare may encourage domestic healthcare actors to mobilize at EU level in an attempt to influence future developments. Analysis of Germany, Ireland and Spain tests this explanatory model in practice.

Research Design

This section of the chapter provides an overview of the research design and methodology employed by this thesis. This study seeks to test the theoretical model expectations outlined in the previous section. The design tests various assumptions to determine what dimensions of the model are accurate and which warrant further development. It also explores unexpected results and draws insight for the direction of future research.

European integration, particularly political integration, has been shown to be difficult to capture through quantitative variables; somewhat crude measures of complex concepts are used due to a lack of data as well as an inability to fully capture political results in a numerical variable. Disaggregating between economic and political effects of European integration is also difficult as many potential political impacts stem from economic policy, such as ECJ rulings in health, and may overlap. The case study analysis focuses on EU political integration and utilises qualitative analysis of case study evidence.

As a result, the qualitative analysis in Chapters 4, 5, and 6 serves to establish a significant and detectable effect of Europeanisation across MSs over time by exploring its political dimension. This analysis helps to improve the understanding of the dynamics with regard to the impact of Europeanisation on domestic healthcare systems. It explores theories established in the literature through in-depth analysis of three specific countries. The analysis aims to shed light on the dynamics occurring in these three Member States specifically. Based on the results, steps are made to draw insights into the broader implications of the findings and the potential for future research. Limitations of the explanatory model developed and alternative explanations are also explored through these case study analyses.

The qualitative analysis not only looks at the impact of European integration on domestic level systems but also examines the feedback from domestic institutions to the supranational level. This amount of detail and understanding requires detailed qualitative analysis. As a result, qualitative analysis of healthcare system reform is key to the project's research design for establishing and testing the causal mechanism that connects European political integration to domestic health reform as well as testing out existing theories prominent in the research. Case study analysis is utilised to explore healthcare change and insight and perspective into the dynamics of this change. The cases selected represent a variety of domestic arrangements across the EU.

Case Study Selection

Three case studies have been selected for the thesis—Germany, Ireland, and Spain. The three countries are diverse and have varied institutional features that allow for in-depth analysis of the significant factors of interest.

As discussed in Chapter 2, there is no consensus in the literature on how to categorise the healthcare system. However, there are common elements that are prominent in the literature. The three cases have been selected to reflect much of the diversity in European healthcare systems. The three countries differ on various dimensions: size (small or large), regional government structure (federal or centralised), healthcare organisation (national health service, social insurance model, or hybrid), healthcare funding (social insurance, tax-funded, or hybrid), age of health system (two long-established and one recently-developed) and health expenditure as a share of GDP.

All three countries have some of the same characteristics to aid in the comparative analysis. All three are from Western Europe and joined the European Community or European Union prior to the 1990s. All three are also members of the Eurozone, although healthcare expenditure itself is not the focal point of the thesis or the variation to be explained. These commonalities enable exploration of the impact of the other differing characteristics.

In addition, the author's knowledge of the case countries, including knowledge of relevant languages, was a factor in the case selection as it aided in the analysis of case material and conducting of interviews. *Table 3.7* on the next page provides a brief overview of the case studies selected. As such, the institutional characteristics can be compared and contrasted.

It is important to note that Central and Eastern Europe are not included in the case study analysis. These countries have unique healthcare system trajectories as formerly part of the Soviet Union. These Eastern and Central European countries joined the EU at a later stage than did Western Europe. As such, they were not selected as cases, particularly as they were not EU Member States during much of the period explored in policy analysis. Future studies should explore the dynamics at play in this region as it is vital to understanding the impact of Europeanisation on healthcare systems. As a result, there are limitations in the findings and their generalisability, which is discussed in the

conclusion. Nonetheless, the findings shed insight into the Europeanisation of healthcare systems, which can be used as a basis for future study.

Table 3.7 Summary of Case Study Characteristics

	Germany	Ireland	Spain
<i>Small or large country?</i>	Large	Small	Large
<i>Federal or centralised?</i>	Federal	Centralised	Federal
<i>National health service or social insurance model?</i>	Social insurance (corporatist) model	Hybrid—a national health service with private provision	National health service
<i>Tax-funded, social insurance, or private insurance funding?</i>	Social insurance	Tax-funded (with significant private insurance)	Tax-funded
<i>Health system establishment</i>	Long-established	Long-established	Recently-established
<i>Location in Europe</i>	Western	Western	Western
<i>Eurozone country?</i>	Yes	Yes	Yes
<i>Year Joined European Community/EU</i>	1958 (West Germany)	1973	1986
<i>Health expenditure as as share of GDP in 2019 (OECD, 2020)</i>	11.7%	6.8%	9.0%

Method of Analysis

Healthcare system change dynamics have been explored through semi-structured elite interviews, political discourse, and policy developments. Preliminary research using academic and media resources has been conducted to determine trends in domestic health reforms, to identify key domestic healthcare actors, and to pinpoint major legislative efforts. Elite interviews have been performed with key domestic actors in the healthcare and other related fields. These included politicians and healthcare-related organisations and interest groups such as non-profit health groups, patient organisations, doctor’s organisations, hospital organisations, and pharmaceutical companies. These interviews with actors are at the heart of the research design.

Trips were organised to Berlin, Brussels, Dublin, and Madrid to conduct elite interviews. Forty political elites and key healthcare actors in the healthcare sector were interviewed in the four cities during a five-week travel period. The Konosuke Matsushita Memorial Foundation primarily funded the overseas

travel, and the Graduate Studies Office at Trinity College Dublin provided some support.

A second round of follow-up one-on-one interviews were conducted with key actors in the healthcare sector in the case study countries to fill in gaps in interviews across the case study MSs. Particular attention was devoted to elites and health actors in Catalan cities (due to the regional nature of healthcare in Spain) ²³ and to administrative elites in related sectors that impact health, such as DG Employment Social Affairs and Inclusion.

The findings from the interviews greatly informed the theoretical model development and steered the direction of the resulting qualitative research. The interviews were used to pinpoint policy examples for analysis in the case study research. As such, the interview data formed a key factor for the selection of policies examined in the case study analysis.

Conclusion

Conclusions and analysis are then presented before the results are outlined in Chapters 4, 5 and 6. Building on existing models outlined in Chapter 2, this chapter devises an explanatory framework incorporating policy inputs, domestic actors, system outcomes and a feedback mechanism to the impact of Europeanisation on domestic healthcare systems. The framework comprises of four arguments that explore the policy dimensions of Europeanisation, the WTD as a critical juncture, the Europeanisation of domestic healthcare systems, and the feedback mechanism. The theoretical framework is rooted in the existing literature and inspired by the interviews with key domestic and EU actors.

The theoretical model predicts how both health and non-health supranational policy applied to healthcare states may impact domestic healthcare systems. The extent of the impact of these EU policies depends on the existing domestic institutional arrangements. Some of these influences could be major and others are minor; some could impact all MSs and others could affect

²³ Some European Commission offices are based in Luxembourg, not in Brussels. For example, DG SANCO has office in both Brussels and Luxembourg, but some departments are only based in Luxembourg. Much of the relevant staff for DG Employment is based in Luxembourg as well.

some. Much of the influence could be on healthcare system administration and management rather than on policy, which can be difficult to capture and detect. Potential effects of EU policies should instigate domestic-actor feedback. However, the domestic healthcare system arrangements should structure the ability of a MS to respond to external, EU pressures.

Chapters 4, 5 and 6 explore three MSs—Germany, Ireland and Spain—in detail in order to provide a more thorough understanding of the causal mechanisms driving the influence of European integration on domestic healthcare systems. Chapter 7 summarises the findings, discusses alternative explanations, assesses the theoretical model in light of the presented evidence, and discusses the contribution of this thesis to the development of the literature.

Chapter 4

Adapting to a Changing Context: The German Case

Introduction

Chapter 4 explores the first case study, Germany. This is a large-sized country with a federal arrangement. In comparison to the other federal case, Spain, German is highly-organised and corporatist in its nature. The healthcare system is financed through social insurance with high coverage. It is one of the highest spending healthcare systems in Europe. The services are largely managed by quasi-public actors. As are all three cases, Germany is a long-standing MS in the EU, part of the Eurozone, and a Western European state, which are standardised across cases to aid in generalisability and differentiation between the cases.

The effects of Europeanisation on the German healthcare system initially involved goodness of fit, mediation and change with regard to Europeanisation with particular emphasis following the WTD. Here, I find that major policies had a sizeable effect on the domestic level, notably the WTD. Europeanisation is evident in the implementation of existing health policies, and it plays a limited role in the stimulation of new regulation, though it is a consideration in domestic policies.

In Germany, the domestic-level supranational impact is particularly pronounced in areas with misfit with EU policy, such as worker rights. The focus of the German system on quality rather than cost alters the impact of some EU developments, like the PRD. Overall, the German system adapts to the changing European context relatively quickly. There are some initial adjustment costs,

particularly with regard to unexpected developments. Then, the organised nature of the system with strong corporatist roots quickly adapts. The feedback mechanism is particularly evident with interest groups mobilising at the supranational level to shape EU developments. These domestic actors are especially active in blocking policies that have the potential to adversely impact on the existing domestic arrangement in line with much of the expectations in the literature.

Chapter 4 comprises of four substantial parts. The first briefly summarises the background information on the development, characteristics and recent reform efforts in the German system. The second section lays out the anticipated domestic effects of the Europeanisation on the German case based on the theoretical model. The third part presents the main findings, including evidence from interviews with German domestic actors, which also serves to guide the focus of the thesis. Thus, case study support for the theoretical framework is examined and the expectations of the model is tested. As a result, deviations from the expectations of the case study analysis are explored. The final section, the conclusion, recaps the central case findings.

Section 1—Background to the German Healthcare System

The German healthcare system has a long history leading to its present organisation. A brief background sets the stage for the case study analysis. The first subsection summarises the German system's origins. After, the system arrangement is outlined. Then, a short synopsis of recent reform efforts illustrates the system changes and priorities. Understanding the healthcare system's historical dynamics and characteristics is important to the national variations aspect of the model.

German Healthcare System Development

The German healthcare system is the oldest in the world, stemming from the 1883 law requiring health insurance to be managed by sickness funds²⁴ for

²⁴ Sickness funds cover most of the population in Germany, barring those with very low incomes, some public sector workers and some self-employed individuals. High-income individuals can choose to opt-out for private

certain types of employment. Despite a Bismarckian desire to create a state-run system, labour and business groups retained control over the health system. In the late 1800s and early 1900s, reforms stemmed from healthcare professional (HCP) demand. Much conflict ensued between sickness funds and HCPs. For examples, doctors struck and lobbied challenging regulation imposed on them by sickness funds. In 1900, a doctors' union was founded to effectively petition sickness funds (Blümel, et al, 2021; Döring and Paul, 2010; Busse and Riesberg, 2004).

After a series of doctor strikes, the German government sought to resolve the conflict from 1913. Commissions comprised of the two groups became mandatory for contract agreements. Additional commissions were set up in the 1920s to address benefits and outpatient care delivery. At the same time, co-insurance contributions were introduced following the economic recession. In 1931, ambulatory doctors became the only group that could provide outpatient care despite objections, and regional physician associations were permitted to negotiate directly with sickness funds. Inpatient and outpatient care became further separated (Döring and Paul, 2010; Busse and Riesberg, 2004).

Compulsory health coverage expanded for existing employers to cover pensioners and dependents. Certain restrictions persisted.²⁵ Physician power continued to increase, and sickness fund power decreased. Following World War II, the system had limited resources, ad hoc administration, and varied regional arrangements (Busse and Riesberg). Sickness funds and corporatist arrangements were reinstated after the war.

insurance. Sickness funds provide a large range of healthcare services, which they are obligated to provide by law and cannot discriminate. They are non-profit and financially independent. Premiums are paid for employees. The sickness funds negotiate prices for their members and contract services to medical providers. There are currently more than 300 sickness funds in Germany from which people can choose. Employers and employees equally pay the premiums for sickness fund through payroll deductions. At the point of delivery of care, employees may have to pay a co-pay for services in addition to the premium.

²⁵ These restrictions included the denial of coverage to Jewish people and members of the Socialist party. Immigrants were also required to contribute to but were excluded from benefit receipt.

The 1970s economic crisis shifted focus to sustainability and financing. The Health Insurance Cost-Containment Act of 1977 set up sectorial cost-containing committees (Döring and Paul, 2010; Bandelow, 2009). German reunification led to the reinstatement of the statutory insurance system. Reunification generated many issues for healthcare system reform: controlling costs, updating technologies, increasing care equity, and quality (Busse and Riesberg, 2004, pp.19-26).

German Healthcare System Arrangement

The German healthcare system had the highest per capita spending in the EU in 2018. It is a sizeable employer in Germany—comprising of over million people, more than a tenth of all of those employed (Blümel, et al, 2021). The system is primarily funded by Statutory Health Insurance (SHI) contributions, which covers about 85% of the population (Busse and Blümel, 2014).²⁶ Household out of pocket spending is low (Blümel, et al, 2021).

The 11% of the population opts out of SHI by demonstrating sufficient means to cover their healthcare needs and has Private Health Insurance (PHI).²⁷ All citizens must be covered by SHI or PHI, with the exception of about 4% of the population who are covered by sector-specific government schemes, such as the military (Busse and Blümel, 2014). Thus, the SHI scheme covers most of the population. The sickness funds pay healthcare providers for member care. Hospital and physicians are the main payment recipients. Hospitals receive service payment from funds and infrastructure money from Länder governments (Busse and Blümel, 2014).

Overall, the system has a complex, decentralised structure (Blümel, et al, 2021). There are sixteen German states, Länd governments. These governments, in conjunction with the federal government, delegate power to the membership-based, self-regulating corporatist bodies. The Federal Joint

²⁶ About 70 million people in Germany

²⁷ Most individuals' healthcare services in Germany are covered by quasi-public non-profit sickness funds that are funded by payroll taxes and are mandated to provide a range of services by law. Those with high incomes, meeting a mandated income threshold, can opt out of this system and elect for private health insurance.

Committee²⁸ determines what services must be covered by sickness funds and sets the quality-of-care assessment (Busse and Blümel, 2014; Busse and Riesberg, 2004). Thus, the German healthcare system distributes decision-making authority between Länder governments, the federal government²⁹ and organisations that represent civil society (mainly payers and providers of health services). Much of the power for care delivery and regulation is with membership-based patient and HCP organisations (Busse and Blümel, 2014; Busse and Riesberg, 2004).

Quasi-public sickness funds also have significant power, working together with physician associations to determine care financing and delivery (Busse and Blümel, 2014). The federal legislature has increasingly gained power in the German healthcare system since the 1980s as federal law supersedes local law. However, the system is characterised by much autonomy and decentralisation; corporatist bodies—including sickness funds and physician associations—administer health services. Historically, the German system has struggled with approval, quality and inequity issues (Busse and Blümel, 2014). In recent years, there has been a decline in capital investment in the system as well as struggles to recruit certain types of healthcare professionals (Blümel, et al, 2021).

Recent German Healthcare Reform

In the 1990s and 2002, health reform topped political objectives (Altenstetter and Busse, 2005). Both the Christian-Democratic Liberal and Social Democratic-Green governments pursued similar policies. Statutory insurance structures and corporatist bargaining were maintained. Efforts were made to increase competition, improve healthcare quality, separate healthcare delivery from financing, modernise professional training and treatments, and alter statutory health insurance requirements. Most reforms occurred when the system was coping with deficits (Busse and Riesberg, 2004). Sickness fund and physician associations, as well as the Ministry of Health responsible for managing

²⁸ The Federal Joint Committee comprises of representatives from the national federal associations of providers, payers and hospitals.

²⁹ Bundestag and the Ministry of Health

negotiations, maintained strong positions throughout the reform efforts (Bandelow, 2009; Carrera, Siemens, and Bridges, 2008).

Cost containment began in 1977 and has continued through recent reforms. Cost containment led to HCP group fragmentation. The fiscal crisis and large differences across sickness funds prompted further cuts. Efforts over the last two decades have sought to maintain set contribution rates in order to retain economic competitiveness.³⁰ Choice and benefits were generally not restricted; cost-saving measures focused on increased competition between funds and hospitals (Toth, 2010; Bandelow, 2009; Busse and Riesberg, 2004; Carrera, Siemens, and Bridges 2008).

Competition between sickness funds was introduced in 1993 and represented an incremental deviation from historic practice, now separating healthcare from employment. These reforms sought to avoid increases in social insurance contributions through structural efficiency reforms that emphasised user choice. Cost containment reform was difficult to achieve. Progress was mainly accomplished through ministerial negotiations with opposition parties, generating a unified front. The economic crisis in the 1990s enabled passage of legislation despite strong interest group, including physician and pharmaceutical, opposition (Hassenteufel and Palier, 2007; Amelung, Glied, and Topan, 2003; Pfaff and Wassener, 2000; Wilsford, 1994).

Beginning with the Health Structures Reform Act in 1992, efforts in the mid-1990s aimed to increase patient cost-sharing and enact uniform benefits. Reforms strove to reduce the demand of services through the use of co-payments and rationalisation of service. Simultaneously, sickness funds resisted restrictions for cost-containment and introduced market mechanisms. In 1998, some changes were reversed following strong public demand (Carrera, Siemens, and Bridges, 2008; Busse and Riesberg, 2004).

A second wave of reform increased patient cost-sharing in the 2000s. Actors sought to adjust the existing system rather than alter its pre-existing

³⁰ Employers and employees both contribute to statutory insurance funds. Concerns rose about German economic competitiveness in the EU and global economy if employers and/or employees had to increase their spending on health to tackle rising deficits.

structure and increase coordination within various aspects of the system. The Statutory Health Insurance Modernization Act of 2004, a compromise between the Social Democratic Party and Christian Democratic Party, was instigated by concerns over rising insurance contribution rates and low-quality benefits (Busse and Riesberg, 2004). Costs were shifted to patients and members, although the legislation strengthened some patient rights.³¹ Further rationalisation and medication cost controls were enacted (Toth, 2010; Carrera et al, 2008; Busse and Riesberg, 2004).³²

Contribution rate limits, membership obligations, and co-payment levels were also adjusted in the 2000s in order to assist Eastern Germans who could not afford the scheme. Reforms also tried to prevent sickness funds from selecting based on risk due to equity concerns. In 2001 and 2002, roundtable discussions between doctors, sickness funds, hospitals, business, and labour were held. Income thresholds for statutory membership were also dropped to lower private health insurance use (Busse and Riesberg, 2004).

During the 2000s, particular controversy surrounded prescription drugs. Public and political dissatisfaction aided the passage of 1990s cost-control reforms for medications despite the strength of the pharmaceutical industry (Wilsford, 1994). However, the industry combatted these efforts. In 2001, the prescription drug expenditure limits were legally lifted.³³ The pharmaceutical companies sued sickness funds for indirectly controlling cost. As a result, 2001 legislation enabled the Federal Ministry of Health to set prices. The Federal Constitutional Court and ECJ, however, ruled in favour of fund price determination (Busse and Riesberg, 2004).

A Federal Joint Committee replaced committees of physicians, sickness funds and hospitals, and increased coordination. Physician associations were reorganised to prevent small, unstable groups. Health centres with a variety of

³¹ A patients' rights commission was created. Denture coverage was added, but contributions towards the funds only came from special denture-specific employee only contributions.

³² Prescription drug regulations are now the strictest in the world following these reforms (Carrera et al, 2008, p.992).

³³ Savings were not as high as expected due to price manipulation and ignoring of components of the law.

providers were created to better coordinate patient care. ECJ rulings were incorporated into law to allow reimbursement for care from throughout the EU, but allowed sickness funds to deduct for higher costs from other locations. The benefit losses, increased cost-sharing, and increased exemptions led to citizen criticism. Large savings by sickness funds were witnessed beginning in 2004 (Busse and Riesberg, 2004).

Generally, German health reform has prioritised choice and quality over cost savings. Rationing has not been implemented effectively. Federal law sets general structures and co-payment levels. However, doctors' groups and sickness funds continue to make the majority of decisions. The main issues remaining are the high costs, the viability of the pay-as-you-go structure dependent on worker income, care fragmentation, the ability of funds to compete, transparency and accountability, quality care assurance, and changes from EU patient flow (Busse and Riesberg, 2004).

In 2005, the Grand Coalition prioritised healthcare. During the policymaking process, private health insurers, sickness funds, and healthcare professionals resisted many of the changes that would drastically alter the overall existing system structure. Some wealthier states resisted financing changes that they believed would disproportionately shift the funding burden to themselves (Lisac, 2006). The funding base was broadened to include some taxes, although most occurred through increased employer and employee contributions. General taxes primarily cover children's insurance. Much resistance against the plan came from insurers in particular (James, 2006). The main political parties had different visions of the radical transformation of the German healthcare system (Hassenteufel and Palier, 2007).

In 2007, the government enacted the Statutory Health Insurance Competition Strengthening Act, which aimed to increase delivery, insurance competition and quality. The legislation was successfully enacted despite interest group resistance. However, the incremental reform did not subject funds to much change in competition and did not adequately address the funding issues. The two parties had to compromise, diluting the content. Moreover, the provisions of the Act were slowly implemented (Bandelow, 2009 Carrera, Siemens, and Bridges, 2008 Hassenteufel and Palier, 2007).

Healthcare reform has received much attention on the German political agenda. Some legislation has passed despite opposition. However, interest groups have been highly influential in the reform process. Physicians are one of the key groups with regard to changes, especially with regard to management reforms that would diminish their power (Carrera, Siemens, and Bridges 2008). Sickness funds are also highly influential. Reforms have tried to change the sickness fund dynamics, but legislation has generally increased competition without largely altering its overall system structure.

Despite the power that organised interests hold, politicians and health experts have increasingly played a role in reform efforts and have been able to overcome interest group resistance when reform was necessary for economic wellbeing. Moreover, certain groups have proven to be more resilient than others. With sufficient political support, reforms against physician interests have been passed. However, historical development has illustrated that legislative opposition from regional governments is difficult to surmount (Hassenteufel and Palier, 2007; Altenstetter and Busse, 2005, p.132). German healthcare policy development illustrates both the importance of interest groups to reform and the ability of politicians to pass legislation against opposition if societal need is deemed high enough.

Reforms to the healthcare system occur quite regularly in Germany. In 2019, an average of one piece of legislation passed per month on the topic. Recent reforms have focused on access, quality assurance, coordination, and digitisation. The disconnect between emergent and primary care remains a challenge (Blümel, et al, 2021). Sickness funds and healthcare professionals have primarily driven German health policy, with sickness funds increasing in strength over time. Cost control efforts and rationalisation of care, supported particularly by sickness funds, were implemented. Government officials were able, at points, to implement major reforms despite interest group protests during times of economic crisis. Some of the more significant legislation, such as in the early 1990s, were reversed and the old system characteristics reinstated to some degree due to pressures once crises had been minimised.

Major restructuring of the system, supported by political parties and coalitions as well as by the general public, has been thwarted, if not drastically

altered, by sickness funds, insurers, and regional governments. Often incremental reforms that do not fully fix the issues in the system have been enacted instead of originally-proposed large-scale system restructuring. The pharmaceutical industry has also been able to overturn many reform efforts thereby avoiding cost containment. In addition, sickness funds and other influential interest groups have utilised policy to their benefit. Overall, major changes have required crises to override interest group resistance. Even when change is needed, interest groups are able to influence and alter the policy for their benefit. The private sector and quasi-private sector interest dominance of the social insurance system in Germany have led to the resistance of some reforms at the expense of system viability and equity.

Section 2—Theoretical Expectations: The German Case

This section outlines the anticipated impact of Europeanisation on these systems by employing the theoretical framework. This section sets the stage for presenting the empirical evidence of the German case.

Healthcare systems rely heavily on personnel and technology, particularly on personnel. Therefore, policies affecting these tenants may cause issues with goodness of fit and may be particularly impactful in Germany. These developments may derive from non-health policies. Also, policies that influence access to and reimbursement of health services may impact the German system. There are a variety of policy areas that may have an impact on financing and delivery of services, from environment to employment. The scope and scale of the impact of EU policies may be contingent on domestic characteristics. One would expect EU policies, especially those pertinent to personnel, technology, finances/reimbursement and service delivery, to impact the German system.

One may expect that as the scope of policy to develop in a piecemeal fashion within non-health policy areas increases, so too may German actor awareness and mobility. The WTD may increase actor and institutional awareness of the impact of Europeanisation due to domestic impacts, characterised by ideational and institutional change. The WTD may also serve to encourage the mobilisation of healthcare actors at the supranational level. The WTD and its aftermath demonstrates the process of the Europeanisation of

healthcare systems from start to finish with regard to one specific EU policy. Now, I turn to the expected impact of this supranational policy on the German domestic level.

Quasi-public healthcare organisations may be involved in the development and implementation of these EU health policies automatically through connections with the Council and national Ministries of Health (MOH). There may be an initial adjustment period for the system, especially for adjusting to the development of unexpected policies. More often than not, these supranational health policies should have a minor impact on the domestic-level.

Many outcomes may vary based on the institutional arrangement of Germany; the hallmark is being “consensus-oriented system” (Greer, 2009, p.122). The federal government works with experts at the regional-level to deliver healthcare services (Greer, 2009, p.115-117), but the government only provides basic regulation outlining contribution rates and other regulations like compulsory insurance coverage.

In Germany, the MOH is relatively weak compared to other EU countries (Greer, 2009). The federal level, especially the legislature, may be expected to have minimal interaction with the EU compared to other actors who deal with the day-to-day issues of healthcare implementation. Compared to the other cases, which Chapters 5 and 6 present, the domestic-level government interaction with supranational actors may be relatively low due to the weak role of the federal government in the domestic system. The need for government representation at the EU-level may lead to slightly more power for German federal actors at the supranational-level compared to those at the domestic-level.

As previously discussed, the corporatist actor organisations in the healthcare sector work together, including with the influential Joint Committee, and primarily drive system development in Germany. As a result, societal actors may have to deal with these non-health effects rather than legislative ones. Government officials may have some knowledge as they represent Germany at the EU-level. However, the day-to-day management as well as more system change may be carried out by the corporatist organisations at the regional-level and through professional organisations.

If EU policy has significant misfit with German domestic policy, one may not expect to see reactionary domestic policy. Based on the trends, one may anticipate doctors and sickness funds—powerful and well-organised in Germany—to be especially strong at the EU-level as they are relatively powerful and well-organised in a domestic context.

The German healthcare system reforms have focused on containing costs, raising cost-sharing for patients, and increasing competition (Worz and Busse, 2005). Corporatist healthcare systems do not cope well with social or economic changes, because their institutional arrangements are relatively rigid (Moran, 2000, pp.154-158). The system may have issues when the EU exerts significant pressure on aspects with which the German system have historically struggled, such as equality and rapid response. For example, one area that has been a recurring issue may be HCP shortages (Dieter, 2014). Areas such personnel, may be subject to external pressures from the EU. In addition, policies that encourage a loss of personnel, i.e. a movement from Germany to another MS, may be detrimental to the system's functioning.

The German system may be able to quickly implement administrative EU requirements as this capacity is extensive as a social insurance system given its relatively high spending, quality, and access, in comparison to other European systems. This domestic structure may largely limit implementation costs in Germany. Germany has modern technology and a high service capacity (some argue that it is too high a capacity) that may serve to attract patients from other countries.

The influence of EU developments on the domestic healthcare system may influence German actors. Awareness of the applicability and importance of EU policy developments by these institutions and domestic actors may result in the provision of feedback to the EU-level to affect future change in the Europeanisation process. One would expect that the German domestic healthcare sector build capacities at the supranational level to monitor and, if necessary, impact EU policymaking. As the main actors in the German healthcare system are well-organised in a hierarchical, quasi-public fashion, this would help with capacity-building.

Thus, the consensus-oriented system, with its high expenditure and streamlined organisation compared to other MSs, may have a relatively strong feedback mechanism on future EU policies. These interests may stop disadvantageous EU policy (both negative and positive feedback) and also employ EU policy for domestic benefit.

With regard to the EU, scholars have established, that the system aims to “preserve federal balance shapes German EU policy” (Greer, 2009, p.114), so there may be strong negative feedback to prevent changes and retain its institutional hallmarks. Healthcare interests may be expected to work to maintain the existing structure and avoid adverse consequences from supranational integration. Many actors may lobby even if that national government itself has limited engagement in the policymaking process (Greer, 2009, pp.121-122). German key actors can, therefore, be influential and actively lobbying the EU level as in other policy areas. However, the primary lobbyists are expected to be from the quasi-public health organisations, rather than the relatively weak actors in government. The German system itself may be slow compared to other European countries to implement policies, but its actors should be relatively quick to mobilise in reaction to developments due to the corporatist and organised nature.

EU politics affect the central tenets of the German healthcare system. As the social insurance systems are relatively high-spending compared to other European healthcare systems, Germany should be less impacted by policies that influence the financing and access to care than would other MSs. The social partners play a strong role in implementing and shaping domestic developments. In the German case, the organised and consensual nature of the system coupled with the relatively high spending and benefits of the domestic system provides for a strong feedback mechanism and sizeable capacity at the EU-level. This strong feedback mechanism is expected to enable the actors in the German healthcare system not only to minimise many potential adverse effects, but to also capitalise on supranational developments, when possible. The empirical evidence presented in the next section tests the theoretical framework and these predictions.

Section 3—Empirical Evidence: The German Case

The background information and the expectations for the German healthcare system in the first two parts of this chapter serves as the base for this case study. The German analysis relies on elite interviews and secondary evidence exploring the dynamics highlighted by these actors. The findings support the theoretical framework and illustrate that generalisable trends are evident in Germany. Simultaneously, the social insurance structure exhibits exclusive responses based on its points of weaknesses and strengths, which create vulnerabilities for and opportunities to capitalise on Europeanisation.

This section summarises the empirical evidence gathered on the German case. The results explore and test the predictions of the theoretical model developed in Chapter 3 by examining the policy dimensions of Europeanisation, the importance of the WTD, German response to Europeanisation and the feedback mechanism. The strengths and the weaknesses of the theoretical model are outlined based on these results. Surprising findings are highlighted. Alternative explanations are discussed. Methodological strengths and weaknesses are explored. The section concludes with a summary of the political impact of Europeanisation on the German case.

German High-Level Interviews

In January 2012, interviews with thirteen high-level leads from the healthcare sector were conducted in Berlin. The breakdown of the elite interviewees is summarised briefly in *Table 4.1* and in more detail in the *Appendices* and is referred to as G1 through G13, Jan 2012. As described in the sections above, the German system is a social insurance model centred on self-governance with much responsibility for implementation at the Länder level following the corporatist organisation of hierarchical peak groups representing the various key actors across the healthcare sector. Thus, it is vital to interview both government officials, who generally write the legislation, and industry professionals and organisations who implement the policy and run the healthcare system itself.

Table 4.1: Germany Interview Composition

Category	Number of Interviews
Government—legislative	5
Government—bureaucratic	3
Insurance	3
Medical	1
Hospital	1

Consequently, organisations representing the multiple facets of the healthcare sector were approached. These national-level organisations communicate with and represent local administration, particularly with regard to supranational matters. These umbrella associations keep up-to-date with local-level issues and concerns of their members in order to best represent them. High ranking and experienced officials have been interviewed as they represent insurers, doctors and hospitals. Many regularly dealt with EU matters.

The national hospital federation (DKG) has twenty-eight member organisations that represent over two-thousand hospitals. (Deutsche Krankenhausgesellschaft e.V. [DKG], 2016a). This collective organisation is in a distinctive position to generalise about hospital impact, particularly as the high-ranking officials regularly deal with EU topics on behalf of the association's members. A representative from private insurance, which represents 10% of the population, and a representative of public insurance through sickness funds, were interviewed; also a member of a national organisation that represents the one hundred and forty-six sickness funds in Germany and helps to shape the care they provide (Busse, 2013).

The Representatives from the Bundestag that have been interviewed primarily had worked as physicians before they were elected to public office, which is characteristically unique to the German parliamentarians. These elected officials can also address the issues from the perspective of the physician, providing more in-depth insight into the research question. Governmental officials, career bureaucrats, were also approached from the Federal Ministry of

Health (BMG) who were senior-level official who had European experience and expertise.

The perception of the influence of the EU varies amongst the high-level domestic actors, yet some generalisable findings are evident with regard to the impact of the EU on the German healthcare system. The evidence is a combination of interview and secondary material analysis. The findings are presented in the next sections. First, the case of the Working Time Directive, which is examined in all three cases for comparative purposes as well as due to its significance, is discussed in detail. Then, the evidence on Europeanisation is explored. The reactions of the German institutions with examples are then discussed. The feedback mechanism is examined.

Germany and the Working Time Directive as a Critical Juncture

The theoretical importance of the WTD is outlined in Chapter 3, and now I explore its empirical significance in the German case. As is shown in this section, the WTD serves as critical juncture for the Europeanisation of the German system, marked by key events and subsequent domestic change. The WTD instigates the Europeanisation dynamic hypothesised in the theoretical framework. The WTD highlights the importance of supranational policy, particularly non-health EU policy, as an external input into the domestic healthcare system. As expected, the German healthcare system responds to external pressures generated by the EU and the outcome exhibits some traits characteristic of its social insurance structure, particularly with regard to collective bargaining. Moreover, the WTD helps to validate the general applicability of the theoretical model as a whole.

As discussed in Chapter 3, EU policy places restrictions on the working conditions of employees, applicable to doctors and other healthcare professionals. The **key events** in this critical juncture are a series of Directives and ECJ rulings, including the Council Directive 93/104/EC³⁴ and subsequent

³⁴ The Council Directive 93/104/EC of 23 November 1993 concerning certain aspects of the organisation of working time is the original EU law outlining restrictions on working time that were subsequently applied to healthcare professionals.

revisions, Directive 2000/34/EC and Directive 2003/88/EC. Thus, the body of EU policies and ECJ decisions comprise the EU input in line with the theoretical model. These regulations limit weekly and daily hours, require breaks and holidays and place restrictions on night work. Specifically, the WTD stipulates through subsequent interpretations by the ECJ, that on-call time be considered work, and the opt-out to work more than 48 hours a week was only possible with trade union agreements.

The requirements under Directive 93/104/EC and subsequent revisions caused visible *institutional policy change* in the German healthcare system, illustrating the impact, one of the criteria of a critical juncture by causing change through domestic policy. The WTD was transposed into domestic policy through the German Law on Working Time (ArbZG). The legislation was amended through the Law of Reforms of the Labour Market in 2003 as well as other amendments in 2004 and 2006—including an amendment to Article 229 that clarifies provisions in the healthcare working time, such as working versus rest time—transposed Directives 93/104/EC and 2003/88/EC (DKG, 2004, p.2; Banse, 2006; Friedrich et al 2011, pp.1377-1378).

In addition to incremental EU policy developments, including the initial regulation and two revisions, various ECJ cases have been heard with regard to the applicability of the regulation to the health sector, most notably its application in Germany and Spain.³⁵ On top of the reduction of long working hours and workweeks for doctors, the WTD scope has been expanded through a series of ECJ decisions, notably those pertaining to on-call time, with effects on the German healthcare system legislation (Dribbusch, 2006; Eurofound, 2008). Therefore, the WTD as an *EU policy input* comprises as a series of events—including revisions, challenges and clarifications—over time. The German system did not immediately implement the WTD in its entirety, but it was forced to incorporate following ECJ decisions on its applicability and scope, an additional series of *key events*.

³⁵ Please see Chapters 2 and 3 for a more extensive discussion of the role of the ECJ in Europeanisation and listing of ECJ decisions about the WTD. Some decisions related to German cases. Others originate from other MSs, but are applicable to Germany.

The ECJ has upheld the application of the WTD to domestic healthcare systems beginning with the Spanish *SiMAP* (2000) decision.³⁶ Some actors—HCPs, namely doctors—recognised the applicability of non-health policies to their working conditions and employed the WTD to challenge domestic policies, bringing suit to apply the WTD not only to working hours, but also to on-call hours. Thus, **ideational change** is apparent with domestic actors recognising, applying, and enforcing the WTD's applicability at domestic-level. In *SiMAP* (2000), the ECJ ruled that the WTD applied not only to working hours but also to on-call hours of doctors. The ruling categorised on-call hours as working hours, which thereby limited all hours—both on-call and working—to the 48-hour workweek maximum. The German healthcare policy did not view on-call hours as working time. National law in Germany governing doctors' on-call time did not change immediately following the *SiMAP* (2000) decision (Hänlein and Craney, 2004, p.61). However, as discussed above, these principles were eventually incorporated through amendments to ArbZG once the applicability was upheld (DKG, 2004; Banse, 2006; Friedrich et al, 2011) thereby leading to **domestic outcomes** through policy change.

Two notable German cases and subsequent ECJ rulings—*Landeshauptstadt Kiel v Jaegar* (2003) C-151/02³⁷ and *Pfeiffer v Deutsches Rotes Kreuz, Kreisverband Waldshut eV* (2005) C-397/01-403/01³⁸—challenged existing practice in Germany with regard to doctor on-call time. *Jaegar* (2003) held that on-call time when doctors were at the hospital constituted working time, not rest time, even when the doctor was sleeping. As a result, a section had to be included in the Law on Reforms in the Labour Market in January 2004 to incorporate the decisions about on-call time, eliminating the words “on-call” and replacing them with “working hours” (Dribbusch, 2006; Eurofound, 2008). In characteristic **social insurance response**, collective

³⁶ *Sindicato de Medicos de Asistencia Publica v Conselleria de Sanidad y Consumo de la Generalidad Valenciana* (2000) C-303/98 or *SiMAP* (2000), for short, ruled that on call hours counted as working hours covered by European working time regulations. This ruling will be discussed in more detail in Chapter 6, which explores the Spanish case study as the ruling pertained to the Spanish healthcare system.

³⁷ This decision will be referred to as *Jaegar* (2003).

³⁸ This decision will be referred to as *Pfeiffer* (2005).

bargaining of HCPs was integral in the negotiations over on-call time (Dribbusch, 2006; Eurofound, 2008), illustrating the *ideational impact* and *feedback mechanism* on some actors who utilised EU-policy to try to make gains in a historic domestic system conflict. Those actors, i.e. hospitals, that would bear the cost of this policy resisted the institutional change.

At the time of the passage of ArbZG reform, hospitals worried that the new provisions could require up to 61,000 full time doctor positions at a *domestic cost* of three to four billion Euros. Consequently, hospital budgets were increased by 0.2% the following year to help cope with the increased costs from the change in working time regulation. The *Pfeiffer* (2005) decision extended this logic, not permitting the Red Cross to exempt emergency health professionals from WTD requirements. The WTD proved to be further problematic for some system actors when it was applied to training doctors who traditionally worked long hours in 2004³⁹ (DKG, 2004; Hänlein and Craney, 2004, pp.62-63; Banse, 2006; Greer, 2009, pp.44-46; Friedrich et al, 2011, pp.1377-1378; G10, Jan 2012; G11, Jan 2012). Thus, the WTD has financial and organisational implications. The collective bargaining over the WTD not only challenged the working condition in Germany, but also lead to bargaining over pay (Dribbusch, 2006).

As previously mentioned, the WTD adaption, though significant to the German healthcare system, did not occur over-night, rather over the course of more than a decade as the provisions of the WTD and its application to domestic health systems was challenged by some institutional actors through the ECJ. In fact, the WTD did not have to be fully implemented in the health sector until 2009 where fines for non-compliance became possible with fines of up to €15,000 per hospital. Individual opt-out provisions were put into place in Germany for healthcare professionals (Banse, 2006; Friedrich et al, 2011). There was a *feedback effect* apparent with HCP and hospital reaction as clarifications were made between being on-call and on-duty to avoid shifts (Dribbusch, 2006; Eurofound, 2008). Nonetheless, the WTD serves as a period of crisis, events drawn out over a series of time in Germany, leading to institutional and

³⁹ The training of doctors could be extended to take up to eight years to meet the WTD requirements (DKG, 2004, p.10).

ideational change that altered the healthcare system's development, meeting critical juncture criteria. Accordingly, the WTD exasperated long-standing issues between hospitals and HCPs, with both respectively resisting and capitalising on Europeanisation based on their own interests.

The WTD proved to be *costly* to the German healthcare state, especially with regard to doctor staffing, an issue with which the system struggled prior to the WTD. Hospitals had to employ an estimated 7,000 to 27,000 healthcare professionals to comply with the WTD, a difficult undertaking in a system that struggles to fill all open positions. The cost of implementing the WTD in German hospitals alone was estimated between €0.7 billion and €1.7 billion annually,⁴⁰ a large expenditure that could have potentially been avoided had the healthcare sector effectively lobbied for an opt-out to the stipulations during the drafting of the Directive (DKG, 2004, p.3; Jakubowski and Hess, 2004, p.132; Banse, 2006; Greer, 2009, pp.44-46; G11, Jan 2012). For example, from 1997 to 2001, the number of openings for doctors published in the *Deutsche Ärzteblatt*, the German physician's journal, doubled with much demand increase attributed to the WTD (Jakubowski and Hess, 2004, p.134). However, the hospitals did not realise the potential adverse impact and applicability to their practice during the supranational policymaking process, a finding made apparent throughout interviews with key actors.

As a result of the WTD, German hospitals had to drastically alter their *staffing arrangements*, because personnel schedules typically did not meet the minimum standards with regard to hours worked per week and mandatory rest periods set by the WTD. Hospitals throughout the country had to negotiate new collective bargaining agreements to improve working conditions in the 2000s, which included new shift arrangements and increased staffing levels due to WTD requirements with significant increases in costs. Hospitals had to also implement new budgeting and management structures to cope, competing with one another for the limited number of doctors. These changes were not without adverse effects (Friedrich et al, 2011; Maschmann, et al, 2013, p.713; G11, Jan 2012). For instance, in 2006, 13,000 doctors went on strike for twelve weeks

⁴⁰ The Hospital Institute and Hospital Association reports estimation varied between 700 million and 1.7 billion Euros respectively.

over a new agreement that included adaptations on working time. Eventually, a compromise was reached, but issues stemmed from implementing the WTD (Dribbusch, 2006; Friedrich et al, 2011). The WTD resulted in large structural reforms for hospitals that some argue were overdue and necessary, which led to large cost and organisational changes (Friedrich et al, 2011). Thus, the high costs and implementation changes of the WTD led to **ideational change** amongst healthcare actors, highlighting the importance of EU policy to domestic developments. The German case shows how the system is particularly susceptible in areas like personnel, where it has historically struggled.

The WTD was not only a concern for hospital organisation, but it was also an issue for many HCPs individually, particularly doctors and nurses, as the twenty-four-hour shifts were profitable and drastically increased their base salary; much of this overtime was no longer permitted in the new arrangements, resulting in both **institutional and ideational changes** for HCPs as well. For example, some doctors, such as those in emergency departments, would work 80 to 90-hour weeks, so a restriction on hours drastically affected their pay, which was particularly problematic as Germany does not pay doctors particularly well compared to other EU MSs leading to issues with recruitment (Banse, 2006; Dribbusch, 2006; Friedrich et al, 2011; G1, Jan 2012). About 70% of training doctors in Germany consider moving abroad after finishing school to other European countries, so inner-EU poaching remains a concern (Friedrich et al, 2011; Dalli, 2012). Although it was not easy for Germany to adjust to the WTD, interviewees stated that implementation went quite smoothly according to the doctor trade unions. Hospitals had to replan their working schedules, but they adapted with less, albeit still substantial, long-term costs than originally expected (G2, Jan 2012; G3, Jan 2012; Maschmann, et al, 2013, p.713).

Studies to-date provide mixed evidence with regard to the benefit of the measures of the WTD in Germany. Debate surrounds whether or not the WTD results in improved patient care, questioning if the additional costs imposed reap sufficient benefits (Kirkcaldy et al, 1997; Ritcher et al, 2014; Rosta and Gerber 2007; Waurick et al, 2007; G10, Jan 2012). A tension persists between rested HCPs and possible rationing, recruitment and continuity of care concerns. Moreover, not all German HCPs support mandatory WTD limits, leading to a

professional divide. Although the WTD arguably led to more jobs in Germany, all posts could not necessarily be filled, especially with potential pay cuts from the limit on working hours. Additionally, some further argue that limits have been detrimental to training by restricting the necessary training hours required or requiring extra training years (Benes, 2006; Pounder, 2008; Friedrich et al, 2011; Cuschieri and Turchetti 2011).

The importance of the WTD to domestic healthcare and the system's evolution was evident throughout the case study analysis of Germany. There was a concrete regulation that led to system change and a definitive institutional effect in the organisation and in the policy. Moreover, the WTD led to an ideational change in Germany. For instance, all domestic actors that were interviewed, even legislative officials who generally downplayed the domestic impact of the EU on health, discussed the WTD and its effect, particularly those responsible for the payment and/or delivery of services (G1-G12, Jan 2012). A hospital association representative characterised the WTD as "a very expensive awakening moment" as, until this point, domestic actors had been focusing on domestic factors affecting health policy (G11, Jan 2012). Some questioned if the European government overstepped with the WTD (G3, Jan 2012).

Domestic healthcare actors did not track developments—barring a limited number in DG SANTE—in broad EU policy that may influence healthcare systems prior to the WTD, which changed in the 1990s and 2000s as the Directive was transcribed into national law in Germany. For example, a hospital association official discussed how the Directive highlighted the need to pay attention to the EU-level, especially in areas outside of health policy (G11, Jan 2012). Seemingly small policies could have a large implication on health systems financially and day-to-day operations if ignored (G11, Jan 2012; G2, Jan 2012).

The WTD resulted in both an institutional and ideational shift in Germany. This is not to say that the domestic actors accepted the changes imposed by the WTD without fight. The series of ECJ rulings and delay in full implementation into national law in Germany discussed earlier illustrate the resistance to system change by some interests. Domestic healthcare actors mobilised at the supranational level as a result of the WTD, working with and lobbying relevant institutions including the European Parliament and Commission on relevant EU

policies, including the WTD (DKG, 2004; Dalli, 2012; DKG, 2014). Hospitals, which were arguably adversely hit the hardest by the WTD, seem to have mobilised the most effectively of the German interests at EU-level. Various actors in the German healthcare system, most notably the hospital organisation, worked hard to revise the WTD, including an unsuccessful attempt in 2009 through an EU consultation when no revisions passed due to lack of agreement (Friedrich et al, 2011). Efforts continued by some German actors to revise the WTD for the healthcare sector (DKG, 2014).

Domestic health actors learned from the WTD that it is best to work with EU officials to obtain exemptions or to alter draft policy before it adversely affects the large system rather than trying to apply for retrospective change (G2, Jan 2012; G11, Jan 2012). Some groups, like hospitals, are particularly active at the EU-level with permanent staff devoted to tracking and influencing developments. Therefore, the WTD led to an ideational shift for German domestic actors, highlighting the importance of monitoring and affecting EU developments pertinent to health, further supporting the importance of the WTD in the German context.

Table 4.2 summarises the central findings of this section illustrating the WTD, and related EU policy stemming from it is a critical juncture input for the Europeanisation of the healthcare system in Germany. These developments

Table 4.2: Critical Juncture Summary for Germany

Critical Event(s)	Ideational Change	Institutional Change
<p>Regulation</p> <ul style="list-style-type: none"> • Directive 2003/88/EC & 2009 implementation • Directive 2000/34/EC • Directive 93/104/EC <p>ECJ Decisions</p> <ul style="list-style-type: none"> • <i>Jaeger</i> (2003) • <i>Pfeiffer</i> (2005) 	<ul style="list-style-type: none"> • Domestic importance of EU policy (direct and non-health policy) • Employing EU policy to advance interest group's domestic position • Importance of monitoring and lobbying at the EU level 	<ul style="list-style-type: none"> • Working Time Act of 1994 (ArbZG) • Amendments to ArbZG in 2004 and 2006 • Fiscal costs • Hospital reorganisation • Unsuccessful WTD amendment attempts • Alteration of domestic policy to circumvent some aspects • EU level mobilisation

affected both ideational developments affected both ideational and institutional change. Notably, the ideational shift drew healthcare actors attention to supranational policy developments, not only domestic factors, particularly to non-health policy that could influence the German healthcare system.

Now that the importance of the WTD for the process of Europeanisation in Germany is established, I examine German evidence and explore the dynamics of the Europeanisation process in this domestic context.

Europeanisation of the German Healthcare System

The findings validate the theoretical expectations and establish that the input, EU policy, can be divided into two types, health and non-health. The case study analysis also supports many of the predictions on the outcome of the Europeanisation process in Germany.

Types of EU Policy

The evidence backs up the theoretical argument that there is a limited volume and scope of health policy at the EU level. Nonetheless, these EU policies should be adopted at the domestic level in Germany when they are passed. Due to the limited amount of direct EU policy, the impact of health policy is predominantly minor. The only noted case of major policy is the Patients' Rights Directive (PRD), which stems from the clarification and codification of a series of related ECJ rulings outside the health sector. However, the interviews were conducted when the PRD was being transcribed into national legislation—the focus from the actors appears to be based on uncertainty and not supported from the evidence on the PRD that emerges.

The evidence points to a limited impact of EU policy on the social insurance system in Germany. These policies were briefly mentioned in interviews as areas, but did not receive much attention due to the minimal misfit with policy or implementation cost. The high spending and standards in the German system have led to relatively minimal adjustment costs by most actors.

The German evidence confirms the model predictions with regard to non-health policy. The more significant effect of Europeanisation comes from developments outside of health that spill over into health. I provide an overview

of a few of these policy examples highlighted by the experts interviewed and explored in case study analysis. The organised nature of the German system appears to adapt relatively quickly to Europeanisation and has mobilised in the EU policymaking process. I know provide an overview of the evidence relating to the PRD.

Patients' Rights Directive

The only EU health policy cited in the interviews as potentially major with its potential impact in Germany was the Patients' Rights Directive (PRD).⁴¹ This policy codifies rights for people from one MS to receive care paid for by their healthcare system in another MS. The German system appeared to be ready to implement the policy quickly as it did not involve much mediation effort. The relatively quick effect of European integration pertains to the national transposition of the policy. The Patients' Rights Directive had to be implemented by the end 2013. However, due to ECJ rulings over the years, particularly those in 1998 and 2001, Germany was one of the first MSs to incorporate ECJ rulings, transposing it into national law by the passage of the Statutory Health Insurance Modernization Act of 2004 that required sickness funds to cover and reimburse healthcare from in the EU and EEA without prior approval from sickness funds (G2, Jan 2012; Kifmann and Wagner, 2014; German Bundestag, 2016; BMG, 2016).

By the time of passage of the Patients' Rights Directive, the prime impact was the implementation of national contacts, which provides advice to citizens from other MSs. Some debate has occurred as the sickness funds do not want responsibility for national contact points due to cost (G2, Jan 2012; Kifmann and Wagner, 2014). Nonetheless, contact points have been put into place, funded jointly by sickness fund and dental organisations (EU-PATIENTEN DE, 2016). Other requirements, such as transparency on services and quality information, were met by the existing reporting structure, such as an online register of German hospitals (G11, Jan 2012). The disagreement was in how the policy was

⁴¹ Directive 2011/24/EU on patients' rights in cross-border healthcare

implemented without much debate on questioning if the policy would be implemented.

Initially, there was some concern that past ECJ decisions with regard to patient mobility⁴² and the resulting Directive would hurt the domestic healthcare system by increasing expenditure and making cost containment difficult (G8, Jan 2013; G12, Jan 2012; MG, Jan 2012; NG, Jan 2012; Kifman and Wagner, 2014). However, much of healthcare competition has proven to be over service quality rather than treatment cost. Germany is a high-spending system with relatively high patient satisfaction and short waits, so large cross-border movement to skip the queue was not expected (G8, Jan 2013; G9, Jan 2012; G11, Jan 2012; TK, 2009). Some Germans travel occurs to nearby countries like Bulgaria or Hungary, for a limited number of cheap optional and/or cosmetic procedures, like aesthetic or dental surgery. However, a large movement of Germans to other countries was not expected in the near future due to the high satisfaction with the German system as well as barriers including traveling when sick (G3, Jan 2012; G11, Jan 2012). Hence, the relatively high-cost German social insurance system has less concern about patient mobility than lower spending ones.

Secondary evidence, including surveys of German patients as well as statistics collected by insurers, supports this claim. Studies from large sickness funds have found that patients have not travelled in large numbers outside Germany for healthcare services; they received treatment abroad to save money on selected treatments or to combine treatment with a holiday (TK, 2009). Some sickness funds have taken additional measures for the provision of care abroad, such as informational hotlines to help those travelling for care and contracting with providers in other countries (Kifmann and Wagner, 2014). Some surveys indicate a potential for more travel in the future with a quarter to a third of those insured indicating potential intention to travel in the future for healthcare services (Wagner et al, 2010; Kifmann and Wagner, 2014).

The evidence indicates that Germany benefits more than they lose from the Patients' Rights Directive. In either case, the impact and adjustments that

⁴² These ECJ rulings are discussed in the Literature Review in Chapter 2. In addition, these developments are explored more in the non-health policy section.

had to be made were minimal in practice. The German healthcare system has a high capacity with little delay for treatment and high satisfaction with service quality, which potentially benefits healthcare tourism (DG Health and Food Safety, 2015; G3, Jan 2012; G8-G9, Jan 2012; G11, Jan 2012; G12-G14, Jan 2012; DKG, 2014). Some patients from other MSs, like Ireland, are traveling to Germany for treatment and care as a result of entitlements under the Directive (Shannon, 2014; MacMahon, 2013).

However, movement to date is not a source of massive amounts of additional revenue, so the extent of its impact remains unclear. Only about one percent of health expenditure in Germany comes from abroad, and it comes mostly from people on holiday rather than people traveling explicitly for care. (G12, Jan 2012; TK, 2009). About 70,000 hospital patients annually come from other countries mainly from the border regions of Germany (G11, Jan 2012). Thus, a large short-term effect of medical tourism from the Directive is not anticipated. Some parts of Germany, like Bavaria, are capitalising on the Directive, marketing itself as a medical tourism destination (Gerl, 2015). Therefore, the potential of medical tourism was a perceived EU benefit (G3, Jan 2012).

There is some control that, down the line, patients could use the Patients' Rights Directive to circumvent domestic cost-containment mechanisms, such as those imposed by the DRG reimbursement arrangement in Germany. However, sickness funds can also use Patients' Rights services to reduce costs in Germany. There is potential for inequitable utilisation contingent on the ability to travel. The largest concern pertains to the unique competition between sickness funds—sickness funds may actively promote cross-border services to attract individuals who are cheaper members or a lower risk profile (Kifmann and Wagner, 2014, pp.60-61). These concerns are not largely supported by evidence to-date and require monitoring over the next decades.

The cross-border mobility entitlements have led to German healthcare policy and organisational change both before and after the passage of the Directive. Thus, it has led visible modification, adapting in order to try to achieve stability, notably through the Modernization Act in 2004 and by sickness funds adaptation based on the social insurance arrangement. Thus, the Directive is

classified as a major effect. However, due to the general satisfaction of patients of their care and the high cost of the German social insurance system, this impact is limited. Some analysis indicates that the impact may grow over time, particularly as the German population ages, and patients learn to use services, like contact points. There is concern over some impact that is unique to a social insurance model, such as risk selection. There is a noticeable influence, but the German system appears to have adjusted quickly and relatively effectively.

Evidence also indicates some direct effect from binding regulations, which must be transposed at domestic level. The scope of EU healthcare policy remains limited in the German case, as predicted, due to the limited scope and volume of EU health policy. When health policy is passed, evidence indicates that the structured and comprehensive German system adapts relatively quickly to most direct regulation through minor policy adjustments and transposition when necessary. German health actors, like the BMG and Bundestag, are involved in and input into the often-lengthy EU policymaking process, which appears to minimise any unexpected EU influence after the initial shock.

Minor EU health regulation often sets minimum standards, which the German system often meets prior to the passage of the legislation as a relatively high-spending and innovative European system. Major developments in health, therefore, seem to stem out of need and demand of MSs rather than by EU efforts to increase health competencies. The larger effect of Europeanisation stems from developments through non-health policies, though the German system appears to adapt to these changes, particularly after learning lessons from the WTD.

German Variation of Europeanisation

The evidence illustrates that overall, European integration influences the German healthcare system. Some actors perceive this influence as an unwelcome, over-encroachment intervention at supranational level, which the feedback mechanism also describes. Most EU-level developments stem from policies outside the healthcare sector that apply to health policy. The greatest point of friction, disconnect between domestic and EU forces, occurs with the WTD then followed by patchwork policy development.

Based on both direct and non-health policy evidence, German has high general awareness of the EU, especially the quasi-public organisations. All interview domestic actors noted some influence of the EU on the German healthcare system, including the WTD. A recurring theme with domestic actors was the exceptionalism of the German healthcare system organisation in comparison to other MSs, which impacted the outcome (AG, Jan, 2012; G2, Jan 2012; G6, Jan 2012). Two policy examples are explored to show some findings that support the national variations argument. The first pertains to professional mobility and qualifications. The second covers a range of (minor) non-health policies.

Professional Mobility and Qualifications

The healthcare sector, particularly hospitals, is highly reliant on personnel. As a result, European issues pertaining to professional mobility and qualifications substantially impacts the German system. Various policies, notably under the Service Directive (Directive 2006/123/EC) and the Professional Qualifications Directive (2005/36/EC), pertain to the movement of HCPs. The impact of these policies on two large sects of HCPs—doctors and nurses—varied based on the existing issues at domestic level, with professional mobility exacerbating pre-existing domestic issues.

The Service Directive sets out the freedom of establishment in other MSs, and the Professional Qualifications Directive codifies the mutual recognition of professional qualifications (G1, Jan 2012; G3, Jan 2012; G8, Jan 2013; JG-G11, Jan 2012). Some actors expressed concern over the possibility of HCPs with low-level training relocating to Germany from other MSs (G1, Jan 2012; G3, Jan 2012; G8, Jan 2013; DKG, 2014). The Health Committee examined the Service Directive and asked the EU questions about health services (German Bundestag, 2015) over concerns that the healthcare system should not be subject to the “same regulations that are applicable to commercial services provided largely within a free market” (DKG, 2005, p.45).⁴³

⁴³ Some health services obtained exemptions due their unique nature that is not conducive to market principles, though the freedom of establishment remained. As a result, health services were dealt with separately leading to the

EU professional mobility requirements has been transposed into domestic policy. In Germany, the Medical Practitioners' Acts standardises the general requirements for education, but the Länder level is responsible for physician and specialist education, training and testing. A doctor with a specialty qualification can move freely. The HCPs has supported the Professional Qualifications Directive, but expressed concerns over legislative issues, including the lack of requirements over the training content (G3, Jan 2012; German Medical Association, 2015). The Directive requires three or four years for certain specialties unlike the five to six years required in Germany (G3, Jan 2012; German Medical Association, 2015). Domestic actors worried that doctors from other MSs with lower qualification could replace more educated, Germany-trained specialists (G3, Jan 2012; DKG, 2014).

German specialist training regulation incorporates the Professional Qualifications Directive into domestic policy through the Federal Government's Recognition Act of 2012, Medical Practitioners' Act (section 10) and the update to Licensing Regulations for Physicians. The content did not shift significantly. Rather, procedure was implemented for the application and obtaining of medical licenses through amendments like Article 18. This change has resulted in extra administrative burden requiring the employment of experts in each Länder health authority. These experts answer questions for those doctors leaving or moving to Germany and issue licenses (G3, Jan 2012; German Medical Association, 2015). The relatively high standards of the social insurance system limited the cost in the application of these regulations.

In actuality, despite the mobility across the EU, Germany has not had an influx of foreign doctors pushing out German doctors. Instead, the main issue around professional mobility pertains to doctors and other HCPs leaving Germany. The German healthcare system has struggled with doctor shortages for some time (Grieshaber, 2006; Urbina, 2014; Torry, 2015). Concerns over free movement pertained to the possibility of exasperating the issues (G1, Jan 2012; G3, Jan 2012; G8, Jan 2013).

development of the Patients' Rights Directive, as discussed previously (German Bundestag, 2015).

This shortage is increasing over time, particularly since the late 2000s. Medical education in Germany is free with the taxpayer paying up to two hundred thousand Euros to educate and train a doctor. Following the completion of training, many doctors then leave for other MSs like Sweden and Denmark resulting in the loss of well-qualified individuals (G3, Jan 2012; G8, Jan 2013). Germany also had one of the highest rates of qualified workers leaving Europe as well as the highest rate of recognition of qualifications. From 2003 to 2013, doctors followed by nurses were the most mobile of all qualified workers leaving Germany for other European countries, with an average of 3,000 doctors leaving Germany annually for higher paid positions in other countries (Grieshaber, 2006; Urbina, 2014; Torry, 2015).

The federal government has passed laws to increase the attractiveness of the healthcare profession in Germany, particularly in rural areas (G8, Jan 2013; Tuffs, 2011). Nonetheless, cross-border mobility of professionals impacts the healthcare system, particularly hospitals (G11, Jan 2012). Thus, the mobility overall hurts the healthcare sector by exasperating the shortage (G3, Jan 2012). At present, many hospitals in Germany employ foreign doctors. Estimates for the shortage of doctors in Germany range from five thousand to ten thousand presently from a combination of doctors leaving Germany coupled with an increasingly aging population. The WTD worsened the issue with stricter requirements. The EU provides an opportunity to fix this shortage by attracting other doctors (G3, Jan 2012; G7, Jan 2013; Torry, 2015). From 2009 to 2014, the number of foreign doctors entering Germany increased by 57%, with foreign doctors accounting for 10% to 15% of doctors in German hospitals. However, foreign doctor hires come at a cost of an estimated extra €20,000 per doctor on average (Torry, 2015). Worker mobility has been welcomed by parts of the domestic healthcare system as a potential solution to alleviate staff shortages as long as Germany's high-quality standards for training are not altered (DKG, 2014).

The modernization of the Professional Qualifications Directive, which passed in 2013 (Directive 2013/55/EC), was a topic of focus for key actors, particularly for the HCP and hospital organisations. At the time of interviews, this was a contested issue; the proposed amended legislation would affect the

healthcare system by setting automatic recognition of healthcare professionals when minimum training was met (European Commission, 2013). The extensive doctor training in Germany met minimums. However, German nurses have lower levels of training compared to the rest of the EU in contrast to doctors who have relatively more training than in other countries. Specifically, in Germany, nurses typically have ten years of education through a combination of apprenticeship and education, so they have two years less of education than they do in other EU countries (G1, Jan 2012; G7, Jan 2013; G10, Jan 2012). As a result, there was a “heated discussion” in Germany on increasing nursing training from ten to twelve years due to EU policy working to harmonise nursing education and training (G1, Jan 2012).

Domestic policy has not excluded nurses with ten years of school from working in Germany. There is a nursing shortage in Germany due to low wages, severe working conditions and physical and psychological demands, so new restrictions would worsen the situation (G1, Jan 2012; G10, Jan 2012). At the time of the interviews, there were 300,000 full-time equivalent nurses, with 400,000 individuals working in these positions. German hospitals are responsible for the training of nurses, splitting training between apprenticeship and classroom training in hospital-owned facilities. Of the 400,000 nurses, half of them have ten years of education, so switching to twelve years would have been problematic, particularly during times of a nursing shortage (G11, Jan 2012; Schlegel and Tagesspiegel, 2015).

Actors have unsuccessfully lobbied the EU to reduce the total years. However, the amendments were rejected by the European Parliament as twenty-four of twenty-six of the MSs already had the twelve-year education requirement. As a result, nurses from the other MSs can work in Germany. Nurses from Germany can only work elsewhere if have the required education. The Bundestag did not want education laws changed in Germany at the time of interviews, explaining that the EU only had the power to regulate the recognition of the qualification but not the education itself (G7, Jan 2013; EFN 2012). The modernization of the Professional Qualifications Directive was discussed in depth by the Health Committee, which rejected the proposed provisions on training for nurses and midwives. The concerns expressed by the Committee

were ultimately reflected in a motion for a resolution, which stressed that the admission requirements for entry to nursing and midwifery training should continue to be ten years of general education rather than being raised to twelve years. The new text of the Directive adopted in the summer of 2013 now provides for two equal admission routes. As a result, German nursing qualifications will continue to be automatically recognised throughout Europe (German Bundestag, 2016). Consequently, major alterations did not need to occur in the end due to revisions to proposed EU policy.

National policy extended its nursing training for new entrants to meet the EU minimum through the Nursing Act. However, the national qualification laws were not changed for already-qualified nurses in Germany. Interviewees discussed the lack of enforceability by the EU and inability for the healthcare sector to adjust with the current level of nursing training (G1, Jan 2012; G7, Jan 2013; Bleedle, 2013; Federal Ministry of Education and Research, 2016). In the end, after successful lobbying, German nurses will be automatically recognised under EU policy, minimising the adverse impact (German Bundestag, 2016).

Evidence indicates that the application of Internal Market with regard to the harmonisation of qualifications to the German healthcare system has been problematic to some extent, requiring modifications to domestic policy. The pressures exacerbate the existing issues with HCPs. Interestingly, the same policy and principles with professional mobility manifest differently in Germany for doctors and nurses due to the unique institutional structure with regard to training. The concern of the effect of the Directives appears to be larger in theory than in practice. The system adjusts relatively quickly with incremental changes, thereby classifying it as a minor impact. The nursing qualification issue illustrates that the strength of the EU is limited in some regard.

Range of Non-Health Policies

A range of non-health policies can affect the different German actors depending on their role in the system due to its social insurance organisational nature. For instance, sickness funds are concerned about EU policies such as the General Data Protection Regulation, Insurance Mediation Directive, EU's value-added tax reform and free trade agreements (DKV, 2014a). There was a high level of

awareness and information about a range of these EU policies, which other types of systems may not have tracked to the same level of detail.

The non-health EU policy inputs discussed in the previous section involve the EU Emissions Trading System (EU ETS) Directive, the Late Payments Directive (2011/7/EU) and the VAT Directive (Directive 2006/112/EC). In all three cases, draft regulations, if ignored, would be applicable to various facets of the healthcare sector resulting in negative externalities, notably costs. As a result, healthcare actors effectively mobilised to prevent policy change, avoiding a major impact. The impact is briefly summarised as the feedback phenomenon discussed in greater detail in the evidence supporting the final argument (IV).

Following the WTD and the increase in non-health policies applicable to health in the 1990s and 2000s, various German actors began monitoring EU developments (GKV, 2014a; DKG, 2014; BMG, 2016; German Bundestag, 2016). The EU ETS cap and trade system draft policy applied to large hospitals in Germany with energy plants. Buying certificates for the fifteen hospitals would cost an estimated two million Euro per year (G11, Jan 2012; Department of Energy and Climate Change, 2012). Similarly, the Late Payments Directive would impose costs to hospitals and other healthcare providers as existing health sector practice and timeline would not fit the thirty-day window for businesses, resulting in additional large fees resulting from late payment (EurActiv, 2010; G11, Jan 2012; DKV, 2014a). Finally, the 2001 Commission proposal to reform the VAT Directive applying VAT to many medical costs. The German insurance funds, which pay for health services, worried that the change would add a 19% cost increase to many services, an increase was not affordable and worked for exclusion from the exemption, leading to three-percent more contributions to social insurance funds without additional benefits (G2, Jan 2012; GKV, 2014a). Therefore, in all three cases, German domestic health actors tracked potentially non-health policy proposals, determined the potentially adverse domestic effects of these policies, and mobilised to affect change.

Moreover, not only did key actors effectively monitor developments, they mobilised to alter the regulation prior to passage. In the case of the EU ETS Directive, the German Hospital Federation, the domestic actor that was to be impacted by this non-health policy, collaborated with UK counterparts with

similar concerns to get exemptions for hospitals in Article 27 of the Directive (G11, Jan 2012; Department of Energy and Climate Change, 2012; DG CLIMA, 2016). With regard to the Late Payments Directive, the German Hospital Federation again mobilised, collaborating with hospitals throughout Europe effectively lobbying for amendments in the European Parliament. In the end, these amendments, drafted by a German MEP in Internal Market Committee lowered the fee and extended the period for hospitals due to the non-market aspects of health (CPME, 2010; EurActiv, 2010; G11, Jan 2012). Like the EU ETC and Late Payments Directives, exemptions to the medical profession were lobbied and included in the VAT Directive (Irish Tax and Customs, 2014). These three non-health policies highlight a different effect of Europeanisation than the previously discussed policies. In these instances, non-health policy was not thrust onto the German system retrospectively. Instead, actors track developments and obtain exclusions to prevent adverse, unintended effects preventing unwanted impacts at domestic level thereby minimising Europeanisation impact.

Despite initial domestic concerns, competition stemming from free movement of services from other MSs has not been a large issue in Germany. The high cost and short wait of the German social insurance system appears to be competitive relatively to others in Europe, especially national health services who rely on a rationalisation of services.⁴⁴ In fact, some efforts have been made to capitalise on free movement due to the service capacity of the German system. In theory, concerns do exist with regard to maintaining the quality of goods and services in the German healthcare systems in light of free movement. However, this influence to date appears to be minimal in practice.

Policies impacting employment regulations and free movement prove to be important to Germany. The domestic system historically struggles with HCP shortages, so supranational developments in this sector are domestically important. EU policies influencing healthcare professionals are tracked and influenced by domestic actors as evident in the case of nursing qualifications. The mobility of professionals continues to affect Germany with many young

⁴⁴ This phenomenon is discussed in Chapters 5 and 6 on Ireland and Spain respectively.

HCPs emigrating to other European countries. However, the mobility is also utilised to help alleviate shortages through efforts to attract healthcare professionals from other MSs. Given this social insurance nature, most of the impact has been on the financiers and deliverers of healthcare and not on the government with respect to the implementation of EU policies. *Table 4.3* provides an overview of the types of EU policy and their impact in Germany.

Table 4.3: Summary of the Input and Outcome in Germany

EU Policies (Input)	Domestic Impact (Outcome)
<ul style="list-style-type: none"> • Dominance of minor not major policies in health policy • Cross Border Care Directive only cited example of major health policy • No cited examples of non-binding non-health policy⁴⁵ • Importance of personnel topics in non-health policy domain • WTD as source of domestic system friction followed by patchwork Europeanisation of non-health policies • Higher impact of non-health policies than direct • High level of awareness by domestic actors, particularly by corporatist groups • Actor concern over impact of the EU on the social insurance system's structure • Strong tracking of EU policies by some domestic actors 	<ul style="list-style-type: none"> • Exacerbates existing domestic issues, like staffing • Minor impact (anticipated) • Power of and engagement by quasi-public bodies at EU-level, mirroring domestic dynamics • Low implementation cost due to spending and technical nature • Limited change to implement most policies due to domestic standards and prior adaptation • Larger impact of non-binding policies than the model predicts (importance of information) • Opportunity to benefit from Europeanisation harnessed in some areas by select actors • Proactivity preserving quality and safety of the system

The role of the BMG appears to have been slightly strengthened by Europeanisation as the BMG, not social actors, predominantly represent the domestic system in various EU policymaking institutions. There is some disconnect between the quasi-private social insurance structure and the EU institutional arrangement, though groups like hospitals and sickness funds have openly worked to increase their involvement, which the next section discusses.

⁴⁵ This finding warrants further investigation to determine if they do not exist or there is a lack of awareness due to their significance.

The evidence also demonstrates that the highly-organised hierarchical nature of the German healthcare system has led to a high awareness of supranational developments, including awareness of soft policies. The German actors track supranational developments and mobilise to influence European policy when deemed necessary. The patchwork development of non-health policies can prove problematic with regard to monitoring. However, there is a strong desire to preserve the existing domestic structure amongst German healthcare actors with various domestic actors expressing the need to protect the domestic system from supranational over-encroachment. I now explore this feedback phenomenon argument in the German case in detail.

The Feedback Mechanism

As a result of predominantly incremental influences, particularly those unanticipated and costly impacts like the WTD, healthcare actor behaviour has rationally altered. Domestic actors have mobilised to lobby at the EU-level to monitor developments and alter policy as needed, if possible.

The analysis also illustrates that the EU-level mobilisation is not unidirectional, i.e. only monitoring developments or applying policy domestically for interest's benefit. Rather, this supranational arrangement also serves as a discernible feedback mechanism that appears to shape the Europeanisation process itself. The evidence indicates that following the WTD, German healthcare actors organise to actively monitor, and when deemed necessary, influence EU developments. Consequently, they seek to prevent potential adverse effects down the line.

Capacity-Building in EU Policymaking

The hierarchical and organised nature of the social insurance system allows the German domestic actors to adapt relatively quickly, particularly in comparison to other MSs, as is demonstrated in Chapters 5 and 6. German actors are able to utilise their existing structure and adapt it to the EU level. Due to this efficient mobilisation, German domestic actors are able to exert influence over EU developments. This hierarchy allows both bottom-up and top-down feedback from domestic actors for monitoring EU policy developments, disseminating

information about EU policy to the domestic level, and soliciting feedback from domestic actors on policy.

The central actors in the domestic system, the social partners, have become the main German influencers on EU policy developments pertinent to health. Therefore, hospitals, healthcare professional organisations, and insurers all actively monitor supranational developments and participate in the EU policymaking process when they feel it is necessary (G1-G3, Jan 2012; G6-G12, Jan 2012; TK, 2008). These payers and providers of care appear to be the most active German actors at the EU-level in health, particularly the hospitals and the insurers, monitoring developments and influencing them when possible. These organisations designate staff explicitly to working on EU and international policy. They also provide information and publications—such as position statements—on their sites explicitly to influence EU policies (GKV, 2014a; German Medical Association, 2016; DKG, 2016b). For example, the HCP representative explained that the association tries to influence proposals by presenting its position to European Parliament and Council (G3, Jan 2012). Another described how the insurers' organisation altered its structure to incorporate EU developments (G8, Jan 2013).

Many of the domestic actors are also active in supranational-level organisations in addition to monitoring policy developments domestically; German actors are not only part of these European bodies, but, in many cases, take a leadership role, helping to shape the European agenda. For example, the CEO the German Hospital Federation served as President of the Board of the European Hospital and Healthcare Federation (HOPE), an EU body representing hospitals, at the time of the interviews, through 2014; he continues to sit on the Board to shape the strategy and input into the EU policymaking process (G11, Jan 2012; HOPE, 2016). Similarly, the German HCP representative—the President of the German Medical Association—to CPME, the Standing Committee of European Doctors, has sat on the Board for many years, elected Vice President from 2008 to 2011 and currently serves as the Treasurer of the Board (CPME, 2016). Both CPME and HOPE are highly involved in EU policymaking from initiation through finalisation. Similarly, the sickness funds actively participate

in the European Social Insurance Platform and its Health Insurance Committee, which affect consultations and policies (GKV, 2016).

Hospitals were adversely affected by the WTD, teaching them that if they “only lobby on national level, the decisions are taken away” (G11, Jan 2012). As a result, German hospitals have been one of the most effective actors with regard to mobilising at the EU-level and possess a large working knowledge of the EU policymaking process. The hospital organisation has its own representatives that travel to Brussels and collaborate with other MS hospital organisations. The hospital works at local, national, and European levels to not only shape policy but also learn from others. It networks with scientific, bureaucrats, Council, Commission, and Members of European Parliament. As the European Parliament has gained more influence in the co-decision procedure, the hospital organisation has increasingly worked with MEPs, particularly those from Germany. Officials also have a close working relationship with the NHS as a good informal contact (G11, Jan 2012; DKG, 2016a; DKG, 2016b; DKG, 2014; DKG, 2004). For example, the Commissioner for Health publicly spoke to the members of the German Hospital Federation in 2012, addressing various concerns (Dalli, 2012). Thus, German hospitals are “strongly involved in EU politics” and policy (G11, Jan 2012).

In summary, all domestic actors in the German system have developed some monitoring capacity for EU developments in a manner that employs the existing domestic organisation structure. In many cases, some have also formed organisational capacity at the European level. The elected officials have the least, followed by the BMG with the payers and delivers of care having the most. This finding is not surprising as it is similar to domestic operations in which the federal government plays a limited role in healthcare services. I now explore how these organisational capacities are utilised to provide feedback to the European system, beginning with the primary perceived objective of this feedback mechanism, the prevention of adverse developments in EU policy.

Negative Feedback

The previous section establishes that German domestic healthcare actors monitor policy at EU-level to varying degrees, albeit some, like MPs, do so

begrudgingly. This development is not merely for monitoring developments to transpose into national practice in a unidirectional manner. Instead, this organisational shift serves as a way to influence policy, most notably by preventing adverse and unwanted impacts like the WTD. Thus, the negative feedback mechanism appears to be the strongest resulting feedback—avoiding unwanted costs and organisational changes, in line with the existing literature (Jones et al., 2003).

The domestic actors regularly input into policy relevant to the healthcare system through networking and advocacy efforts, including inputting into EU policy consultations. For example, German actors from across the healthcare sector—notably from the BMG as well as providers and payers for care—regularly contribute to consultations and write impact reports on a range of topics including, but not limited to, patient safety, technology, working time, professional qualifications, Patients' Rights, migration, and the single market (DG SANCO, 2013; DKG, 2004; DKG, 2015; German Medical Association, 2011; GKV, 2015a; GKV, 2015b; GKV, 2015c; GKV, 2014b; GKV, 2016; TK, 2008; TK, 2009). Germany is one of the active MSs in providing feedback and input for EU consultations affecting the healthcare system.

Much of the efforts with regard to influencing EU policy seeks to prevent unwanted domestic changes as experienced at a fiscal and organisational cost under the WTD. This dynamic illustrates institutional stability at domestic level that confronts friction from Europeanisation followed by punctuated changes, as outlined in the theoretical model. Experts frequently discussed the disconnect between EU market pressures and social insurance system as well as a lack of understanding of the German healthcare system structure. Actors indicate that they seek to prevent EU legislation from drastically altering the social insurance structure (G1-G2, Jan 2012; G6, Jan 2012; G9, Jan 2012). One official even stated that actors are “fierce on defending” the system from the influence of Brussels (G1, Jan 2012). Stopping policy developments generally does not receive much attention, but is an important component of the feedback mechanism and the resilience of domestic institutions. However, as one German expert stated, one of his/her largest successes comes from preventing European legislation,

gaining exemptions, rather than lobbying for policy developments (G11, Jan 2012).

The German healthcare actors mobilise to block potentially adverse policy, including the lobbying for amendments for the healthcare sector. This was evident in cases such as the EU Emissions Trading System (EU ETS) Directive, the Late Payments Directive (2011/7/EU) and the VAT Directive (Directive 2006/112/EC). In all three cases, the initial proposals would have applied to the domestic healthcare system, notably hospitals and sickness funds with perceived negative effects, including high implementations costs. The relevant healthcare actors monitored developments and effectively mobilised to affect change during the consultation stage, before the policy was passed. These three policies, as discussed in the previous sections, demonstrate that the relevant domestic actors effectively tracked EU developments pertinent to health.

Positive Feedback

Interviews and secondary analysis indicate that the prime feedback mechanism is mobilising to prevent unwanted Europeanisation of the German system, negative feedback. However, key actors did not view all integration influence as detrimental. In fact, some policies and developments have proven to be helpful to domestic actors, such as OMCs and the Patients' Rights Directive, which was discussed in the evidence. The hierarchical organisational structure at domestic level facilitates positive feedback, enabling the actors to mobilise at the EU level and to shape the agenda as leaders in supranational organisations to lobbying regulations. The strong finding of positive feedback was a surprising result that the theoretical model underestimates.

Organised German interests have now learned to work to influence European policy to avoid adverse effects. For example, when the Prevention from sharp injuries in the hospital and healthcare sector Directive (2010/32/EU) was drafted, German interests, like the hospital federation, worked to have their needle protection standards used for the EU guidelines. Needles with protection caps are ten times more expensive than standard,

conventionally-used needles, so German hospitals avoided unneeded conversion costs when Europe adopted their standards (G11, Jan 2012).

This enabled Germany to avoid conversion costs as well as profit from the export of their standard to other MSs, leading to only moderate adaptations to transpose the policy, adjustments mainly pertaining to training and reporting (Weber, 2013; Weber, 2019). These elites effectively lobby to not only avoid additional costs, but also benefit from the use of German standards. The German healthcare system has worked to adapt to pressures from the EU in the area of workplace standards. This phenomenon is difficult to measure and track, but is important feedback nonetheless (G11, Jan 2012).

As the evidence from the second argument (II) describes, the HCPS, particularly the doctors, used the WTD and applied it to domestic level, through a series of ECJ rulings. Hospitals and HCPs disagreements are a historic issue recurring in the German system. HCPs utilised EU policy to benefit their own interests, thereby capitalising on EU developments. Therefore, the effect is not solely top-down. Despite German successes in preventing adverse legislation and shaping EU policy to its benefit, limits to the success of this feedback mechanism are also apparent.

Limitations to the German Feedback Mechanism

Overall, the German actors have adapted to Europeanisation by mobilising at the EU-level and successfully inputting into the policymaking process. However, some EU policies have introduced unwanted ideas, such as market principles, that do not fit the social insurance model with concern expressed that intervention may damage the German healthcare system. There is also a perceived lack of understanding by the EU officials of the German healthcare system, according to interview evidence (G1, Jan 2012; G2, Jan 2012; G6, Jan 2012; G9, Jan 2012; G10, Jan 2012). Therefore, all German efforts to influence health-related policy have not been successful. A prime example is the unsuccessful German attempts to revise the WTD.

As explained in the evidence for the first argument on the critical juncture of Europeanisation (I), the WTD proved to be costly, particularly to German hospitals. There is a lack of a unified domestic position with regard to the WTD's

application in Germany. After the passage of the policy and following ECJ rulings upholding and extending its applicability, some German actors unsuccessfully lobbied EU institutions—including the European Parliament, Commission and Council—to obtain exemptions for the healthcare sector through revisions to the WTD (DKG, 2004; Dalli, 2012; DKG, 2014).

Summary

There are both top-down and bottom-up effects of Europeanisation on the domestic system. The EU impacts the German healthcare system in which domestic-level actors monitor EU developments, influence EU policymaking and employs EU legislation to influence domestic changes.

Table 4.4 below summarises the central findings for the feedback mechanism of the German case. The corporatist system, due to its pre-existing domestic arrangement, seems to exhibit a strong feedback mechanism, particularly by quasi-public domestic actors.

Table 4.4: Feedback Mechanism Summary for Germany

Capacity-Building	Negative Feedback	Positive Feedback
<ul style="list-style-type: none"> • Domestic monitoring of EU policymaking develops following WTD • Hierarchical quasi-public organisation adapted for EU-level • Quasi-public actors dominant at EU-level mirroring domestic power dynamics • Limited government role—BMG representing as government official • Lack of MP involvement 	<ul style="list-style-type: none"> • Dominance of negative feedback as primary feedback • Strong role of quasi-public bodies, particularly hospitals and sickness funds • Focus on influencing the drafting stage of the policymaking process 	<ul style="list-style-type: none"> • Not central feedback mechanism but added benefit • Capitalising on EU opportunities when possible (strong EU representation) • Employment of EU policy by domestic actors to gain ground in historic domestic battle

The German actors, including the BMG and particularly the payers and deliverers of healthcare services, have mobilised to a large scale at a supranational level to preserve their system from perceived EU encroachment as well as to benefit from policy and networking.

However, the EU-level success of the German domestic feedback mechanism is not unfettered. Domestic actors do not have limitless power shaping the agenda and encounter issues, particularly when retrospectively trying to obtain policy revisions. Nonetheless, the Europeanisation at domestic level has led to a discernible feedback mechanism to EU level indicating that the domestic actors interact with the process of Europeanisation, which the evidence indicates is particularly pronounced for the social insurance case.

Section 4—German Case Conclusions

In conclusion, the case study analysis illustrates various trends pertaining to the Europeanisation of the German healthcare system that support the theoretical construct outlined in Chapter 3. Firstly, validating the predictions of the first aspect of the theoretical model (I), EU policy influences can be disaggregated into two inputs that affect the German healthcare system. Both health policies and non-health policies applicable to health are evident in Germany. The EU policies can further be disaggregated into binding and non-binding policies.

In support of the second argument, the WTD as a series of directives and ECJ rulings, serves as a critical juncture in the German healthcare system with substantial costs and alterations. The WTD resulted in both institutional change through health policy and organisational changes as well as ideational change amongst domestic healthcare actors, notably hospitals and healthcare professionals. HCPs have been able to capitalise on the WTD through collective bargaining to improve working conditions and pay despite resistance from hospitals. Overall, the WTD drew domestic institutions and actors' attention to the impact of the EU, highlighting that supranational factors affect the German healthcare system.

Reactionary efforts were made to try to develop structure to effectively monitor and influence EU legislation moving forward, particularly health policies, to avoid another unanticipated impact. Few alterations have been successfully implemented after the fact, though clarifications in definitions in domestic policy help to lessen the implementation cost.

The scope of EU health policy remains limited. The German analysis points to the bulk of this policy comprising of non-binding legislation, primarily

restricted to voluntary policy and OMCs. The most significant health policy was the Patients' Rights Directive, though the implementation so far turns out to be minor.

As expected, the German evidence shows the non-health policies have been viewed by domestic actors as more problematic than have the health policies. These policies can originate in a variety of DGs, not only in DG SANTE, so they are harder to track and monitor. Non-health policies often involve coordination with non-health actors in policy areas, like Internal Market and employment, though they can spill over into areas as far-reaching as environmental policy and tax policy. Health actors do not necessarily have a seat at the table during the initial stages of the policymaking process and may have to affect change later in the process, such as through amendments in the European Parliament rather than initial drafting in the European Commission. Nonetheless, the organised nature of the German system seems to have adapted, developing EU expertise, actively working at the EU level.

Building off of this, the feedback mechanism in the German healthcare Europeanisation experience appears to be exceptionally strong. After the costly setback from the WTD, key societal actors—particularly hospitals, insurers and healthcare professional organisations—have devoted significant resources to EU policy, successfully influencing policy and often preventing the passage (or enacting amendments and exceptions) to potentially detrimental policy. The German domestic actors learn to capitalise on policies that influence healthcare, as was seen with regulation of needle caps legislation. The domestic actors in a social insurance system operate through decisions often outside policy itself, so this feedback appears to strongly occur through these corporatist organisations rather than through legislation. The regulations on nursing qualifications have demonstrated that despite effective lobbying by Germany, all adverse effects of European integration cannot be avoided. However, as illustrated with the WTD, some concessions may be made through slight modifications to domestic practice in keeping with the EU policies.

Overall, the German healthcare system works to preserve its social insurance structure as much as possible when supranational developments pressures result in change. These domestic actors also respond in characteristic

manners in keeping with their institutional placement, relying on techniques like collective bargaining. It was often noted that the EU could adversely affect the system and that its corporatist roots were particularly “vulnerable.” The German healthcare system has strived to maintain its social insurance model despite EU pressures. The relatively high spending, quality and service access as well as organisation of the social insurance system appear to aid in the adoption of EU policy.

Additionally, the societal actors in Germany, not the government, were most aware and active with regard to EU integration. The federal level is relatively weak compared to other actors in the German healthcare system as self-governance remains strong. The power of the BMG has increased as it often represents the German healthcare system officially on EU bodies. German hospitals, insurers, and healthcare professionals are most aware of and influenced by European integration compared to other actors. These German actors who have been most influenced by European policy have transformed their organisations in order to actively impact it. The corporatist structure of hierarchy within the association makes the system quite well suited to effectively adapt and convert, transferring local concerns to national level societal actors who then lobby at an EU-level. After a learning period, German health actors are relatively active at the EU-level compared to other MSs, regularly publishing position papers and influencing legislation.

Overall, the German case study illustrates that the healthcare system has been subject to pressures from European integration in areas, particularly through non-health policy areas like employment. However, the highly coordinated system adjusts to pressures and works to preserve its independence, effectively lobbying in many cases to prevent influence at EU level. Thus, over time, Germany adapts and, in some cases, capitalises on increasing pressures from the EU on the domestic healthcare system. The national health services react to pressures in other manners that are characteristic to their arrangements, which I present in the next two case studies on Ireland and Spain. to which I now turn in Chapters 5 and 6.

Chapter 5

Complying with Europeanisation: The Irish Case

Introduction

The second case analysed is Ireland. It is an established national health service (NHS). Ireland has some important characteristics to note for its selection as a case. It is a small country. The system is centralised, particularly after the 2005 reform efforts. It is funded by general taxation but also has a significant private insurance base, making it a hybrid with regard to financing. Ireland has a relatively smaller healthcare system as a proportion of the GDP in comparison to Spain and Germany. Like the other cases, Ireland is an established Member State in the European Union, a Western European country, and part of the Eurozone, which makes it the same on these dimensions.

As hypothesised by the model, the EU factors expected to affect all types of domestic healthcare systems are apparent in the Irish case. Ireland shares some common trends with the German and Spanish cases. The case study analysis of Ireland finds various instances of Europeanisation effects due to misfits between EU policy and domestic policy. I find that the major policy frequently discussed, the WTD, has a sizeable effect on the Irish system. The evidence demonstrates that domestic actors have much awareness of the EU influence on the Irish system. This effect is particularly apparent in actors who serve in the health service administration, which contrasts the quasi-public organisation that dominates the German social insurance case.

The domestic institutional arrangement in Ireland, as it does in Germany, influences the Europeanisation process outcomes and feedback mechanisms. In

Ireland, the domestic-level impact of the EU is particularly pronounced in areas where goodness of fit differences exist between EU and Irish policy, including worker policies. The organised and centralised nature of the system allows some room for adaptation and monitoring of EU developments. The feedback mechanism is apparent with monitoring but is limited with regard to mobilisation at the EU level, while its adaptability as a system is limited as it is quite rigid.

Support for the national variations argument is apparent in the Irish case. Ireland has a unique historical development, with the Catholic Church and healthcare providers playing central roles in the development. This affects its organisation to date, including the lack of public provision of primary care to all (it remains means-tested as it did during its development stages). Other institutional characteristics—like the disaggregation of health policy in the Department of Health and the provision of care by the Health Service Executive—have implications for the Europeanisation effects. Ireland, including its healthcare system, faced a lot of pressure in the wake of the financial and economic crisis of 2008.

Chapter 5 comprises of four parts. The first section summarises the development, characteristics, and recent reform efforts in the Irish system. The second section lays out the expectations for the Irish case using the theoretical model developed in Chapter 3. The third part presents the main findings from the Irish case study, structured from the evidence from the interviews with domestic actors. The analysis of the case study tests the theoretical framework, including the policy dimensions of Europeanisation, the Working Time Directive as a critical juncture; the national variation of domestic Europeanisation, and the feedback mechanism. Thus, the case study provides evidence for the applicability of the theoretical construct. The analysis explores deviations from the predicted effects, alternative explanations, and surprising outcomes. The final section summarises the central case findings.

Section 1—Background to the Irish Healthcare System

Ireland serves as the case for the established national health system. First, a summary outlines the development of the Irish health system to the modern day.

Then, the arrangement of the domestic system is described. Finally, recent reform efforts are briefly presented in order to understand domestic changes and system development. The origin, arrangement, and evolution of the domestic healthcare system illustrate its institutional dynamics and set the stage for exploring how they fit in to, and interact with, the process of Europeanising healthcare systems.

Irish Healthcare System Development

The modern-day Irish healthcare system has evolved from its origins in the late 1800s to provide essential care to the poor and those in need, a substantial proportion of the Irish population at the time. The development of the Irish healthcare system occurred through a series of critical junctures over the nineteenth and twentieth centuries. Prior to the enactment of a series of legislation, Irish healthcare relied on voluntary hospitals and medical charities, with the first voluntary hospital being established in Dublin in 1718 (Geary, 2018; McDaid et al, 2009; Harvey, 2007; Adshead and Millar, 2003). Religion and mortality in particular played an important role in the foundations and development of the modern-day Irish healthcare system with lasting institutional repercussions (Heavey, 2019).

The Irish Dispensary System began with the Poor Relief Act of 1851. Before this Act, Boards of Guardians had medical officers and healthcare dispensaries⁴⁶ for the poor. The 1878 Public Health Act regulated water while providing care to those with Tuberculosis. Over time other policies were introduced that gradually increased the role on the government in the health sector. However, resistance in Ireland was met from the Catholic Church and medical professionals, who successfully stopped various proposed legislation. Specifically, there have been multiple efforts to provide universal primary care in Ireland, but they have been blocked these joint efforts (Health Insurance

⁴⁶ There were a few hospitals in Ireland at the time. Due to geographic barriers, much of the population could not access the hospitals. Dispensaries provided some healthcare services within neighbourhoods in an outpatient manner (Geary, 2018).

Authority, 2018; Smith and Normand, 2011; McDaid et al, 2009, p.19; Harvey, 2007; Adshead and Millar, 2003; Barrington, 2000).

During World War II, the government began discussing establishing a national health service which was being established at the time in the United Kingdom. Some health professionals (doctors), parts of the government, and the Catholic Church initially resisted the development. The Irish Hospitals Sweepstake started in 1930, using horse racing revenue to fund hospital development. Following much domestic debate, the Ministers and Secretaries Act of 1946 created the Department of Health. Health services were provided by local authorities under this act from 1946 to 1970. Then the Health Act of 1953 was passed, providing the majority of the population with free or low-cost hospital and specialist care; about 15% of the population was not covered by this Act as high-earners, but they were able to obtain private health insurance to cover their medical costs (Geary, 2018; Lynch, 2018; McDaid et al, 2009, pp.19-20; Harvey, 2007; Adshead and Millar, 2003).

Over time, the system expanded in size and scope to provide services to the general population as well as to regulate healthcare. The rates of those covered by private insurance increased too with time. The Health Act of 1970 was passed, creating eight regional Health Boards and providing all Irish residents with care entitlements—some free and others based on income/age. The series of Health Acts in 1947, 1970 and 2004 created the basis for the modern Irish healthcare system (Lynch, 2018; Brady and O'Donnell, 2010, p.5; McDaid et al, 2009, pp.19-20), which I now briefly describe.

Irish Healthcare System Arrangement

The Health Service Executive (HSE) is the central component of the Irish healthcare system and has an annual budget in excess of thirteen billion Euros. The HSE is the largest employer in Ireland. The HSE directly employs 65,000 staff and a further 35,000 employees through organisations funded by the system. The HSE comprises about a quarter of total government spending. Public hospitals comprise nearly half of the system spending. The public healthcare system and its infrastructure have been criticised for failing to keep pace with the economic growth in Ireland. There has been a large growth in Irish health

spending, but it is coupled with increasing public dissatisfaction and concerns about systematic underinvestment (Health Insurance Authority, 2018; O'Shea and Connolly, 2012; McDaid et al, 2009; Harvey, 2007; Wiley, 2001).

The Irish healthcare system comprises of both public and private healthcare, though it is mainly funded by tax revenue at a rate of over 78% of total health expenditure. A substantial private health system also exists alongside the public arrangement for those who can afford it, with about half of the population having private health insurance. Residents in the state are entitled to public health care services, which can include cost-sharing. Medical and GP cards enable qualified residents to access services at a reduced cost or for free, based on means-testing and other criteria, such as age or severe illness). Nearly a third of the population has free access or low-cost access to health services at the time-of-service utilisation through these medical cards. Those who are not ordinary residents can access health services, but they incur the economic cost (Health Insurance Authority, 2018; O'Shea and Connolly, 2012; Brady and O'Donnell, 2010; Smith, 2010a; McDaid et al, 2009).

For ordinary Irish residents, there are two types of eligibility for health service access and cost-sharing. The first, the third of the population with medical cards, has public access to primary and secondary care with little or no cost. The second, about two-thirds of the population, has secondary access with cost-sharing but has no primary care entitlements. As many in the secondary have private insurance and there are access issues throughout the country, there is a critique that Ireland is a "two-tier system" with regard to health, which is discussed in more detail later in this chapter (Smith, 2010a, pp.344-346). The evidence indicates a general acceptance of the entitlements, but concern over issues over access to services (Wiley, 2001, p.79). These access issues became especially pronounced following the fallout of the financial and economic crisis of 2008 in the wake of austerity (Thomas, et al, 2014).

Prescription and general practitioner (GP) care is typically paid for by the patients themselves unless they meet certain income thresholds or age

requirements to receive a medical card.⁴⁷ Those with medical cards do not pay for visits to the doctor and have small co-sharing fees for prescriptions. Hospital services are also fully covered for those with medical cards. There is a fee structure for hospital inpatient services for the population that does not have a medical card. Hospital outpatient services are covered for Irish residents, though waiting lists are in operation for the service (Brady and O'Donnell, 2010). In light of the waiting lists and cost sharing, as previously stated, much of the population has private health insurance, which supplements their care from the public service. Public and private patients both have access to public hospitals. As a result, issues surround certain groups like medical cardholders and insured patients gaining access faster to services (O'Shea and Connolly, 2012; Brady and O'Donnell, 2010; Smith, 2010a;).

The healthcare services are organised and delivered by the Health Service Executive (HSE). The Health Service Executive (HSE) was created in 2005 to manage the services and be accountable to the Minister of Health. The Ministry of Health oversees the policy. The HSE manages public health services in Ireland as well as its budget. The HSE is responsible for public health, hospitals and care. The HSE comprises four administrative areas across Ireland. As most healthcare funding is paid publicly in Ireland, the HSE oversees a substantial proportion of the healthcare system. Prior to the establishment of the HSE, eight regional boards governed health services, overseen by the Department of Health, which was in charge of general finances and policy (Brick et al, 2012; Brady and O'Donnell, 2010; McDaid et al, 2009). This structure is expected to be transformed and many changes from 2005 reversed under the current Sláintecare initiative (Burke, et al. 2018). I now briefly explore recent reforms in Ireland that led to the present-day structure.

Recent Irish Healthcare System Reforms

There has been much public and political criticism of the Irish healthcare system over recent years. As a result, reforming the Irish healthcare system is a regular

⁴⁷ Older people in Ireland are eligible for Medical Cards based on their age. Medical cards have also been introduced in recent years for children of certain ages.

subject of public debate and high on the political agenda. Healthcare in Ireland has been described as a politically problematic “black hole” (Wren, 2004, p.1). Reforms have been slow and have not fixed longstanding issues of concern, like the waiting times for secondary services and queues for urgent care. There has been a recent push to change to universal insurance to improve access, promote equity and improve technology. However, the shift has not yet been fully actualised (O’Shea and Connolly, 2012, p.1363-1369). After a series of policies in the 1970s setting up the modern-day system, there was a lack of major reorganising change for more than thirty years until 2005 (Wiley, 2005).

Despite its mainstay position on the public and political agenda, the Irish healthcare system structure did not change much in the 1980s and 1990s. Regional health boards were originally created under the Health Act of 1970 and operated until the reforms of the 2000s. The Irish system experienced spending retrenchment in the 1980s followed by drastic growth in the 1990s; most policies during this time comprised of limited strategies and policies, not significant reforms. Health Boards continued to provide most care in the country regionally with variations dependent on location. Reform efforts have been limited in practice (Health Insurance Authority, 2018; Burke, 2016; Smith, 2010a; McDaid et al, 2009; Wiley, 2005).

Some policies were passed in the 1990s, though no major structural reform occurred. The Indicative Drug Target Saving Scheme of 1993 looked to set targets for drug patient drug spending through GPs in light of large health spending increases at the time. The Waiting List Initiative of 1993 worked to try to tackle long lists, though the impact of the policy was limited and did not resolve the ongoing issues. Other groups were set up in the 1990s to monitor services following concerns over quality. In 1997, the Freedom of Information Act increased patient rights to information, and in 1998, cross border health measures were set up to cooperate with the UK to help tackle waiting list. Following some budget overspends in the 1990s, focus shifted to increasing system transparency as well as accountability, and the 1990s also witnessed the development of the first national strategy for the system as a whole (Health Insurance Authority, 2018; McDaid et al, 2009; Byers, 2008; Wiley, 2005).

More substantive reforms began in the 2000s to better combat disease, overcome system fragmentation and reduce inefficiencies in services. The Health Strategy of 2001 reviewed different types of health funding, but found no reason to change from the tax-based Irish structure. Strategy documents from 1986, 1994 and 2001 were part of the “evolutionary process” that led to the major system organisational changes in the 2000s (Wiley, 2005). The Health Strategy of 2001 led to a series of reforms of the Irish healthcare system from 2001 to 2007. These policies worked to enact a unified national approach to healthcare services as well as provide higher payments to doctors and pharmacists (Health Insurance Authority, 2018; McDaid et al, 2009; Wiley, 2005).

At the same time, policies were passed to monitor the delivery and quality of services. The Health Insurance Authority was also set up to monitor private health insurance following an EU directive. The Health Information Quality Authority (HIQA) was created to support quality services. Under the 2003 Health Service Reform and the 2004 Health Act, the Irish healthcare system was reorganised and centralised into its modern form (Health Insurance Authority, 2018; Brady and O’Donnell, 2010; McDaid et al, 2009, p.22-24; Wiley, 2005).

The Health Service Reform Programme of 2003 resulted in the largest change in recent decades—reorganising of the Department of Health and Health Boards into the centralised HSE. The HSE organisational structure went into effect in 2005, directly delivering care as well as collaborating with other providers of care. Historically, the Irish healthcare system has been decentralised, but criticism has led to recent developments and increased centralisation (McDaid et al, 2009).

Small reforms occurred in the 1980s and 1990s in Ireland. However, for decades, there were no significant reforms. Following large expenditure increases in the 1990s, large organisational changes were put into place in the 2000s. Recent reform efforts in Ireland focused on administration and budgets rather than ongoing issues like equity. As a result, many ongoing issues, like inequities and waits, have not been solved by reform. There is also a lack of full implementation of reforms. In Ireland, political influences force a focus on short term solutions with regard to operations rather than policy changes that target

issues like equity and access (Byers, 2010). Public focus has drawn attention to topics like wait lists and wait times and not to issues like the private insurance arrangement that underpin system inequities (Nolan and Nolan, 2005).

The financial and economic crisis of 2008 had huge implications for the Irish healthcare system. From 2009 to 2013, HSE financing dropped by 22%, leading to increased rationalisation in the system as well as increased cost sharing. The austerity measures put the health service under additional strain (Burke, 2016; Thomas, et al, 2014). The new initiative, Sláintecare, looks to reform the organisation of the HSE for the first major time since 2005 with a shift back to decentralisation into regions, albeit larger regions than pre-2005 initiative (Burke, et al. 2018).

The Irish system has been categorised as being “complex and inequitable” (Smith, 2010a, p.343). The system in theory is universal, but issues surround the quality of services, long waitlists, lack of community-level services and varied priority access to services. The complexity of the organisation is compounded by the role that private healthcare and insurance plays in the system, with the public and private aspects interacting with one another. There is a lack of a list of all publicly available treatments. Recent policy developments have been critiqued for not fully understanding and appreciating the complexity of the Irish healthcare system and exacerbating inequities in access (Burke, 2016; Thomas, et al, 2014; Brick et al, 2012; O’Shea and Connolly, 2012; Byers, 2010; Smith, 2010a; Wiley, 2001).

Moreover, institutional characteristics and lock-in effects are evident throughout the Irish healthcare reform process. The Irish system exhibits a strong path dependence. The system lacked a unifying national strategy until the 1990s (Byers, 2010; Wiley, 2005; Adshead and Millar, 2003). Now, pressures are to on the system to decentralise back into governing regions. The lack of a common national approach exacerbated persisting inequities, shortages and inefficiencies. These inequities become more pronounced following the austerity measures throughout the late 2000s (Burke, 2016; Thomas, et al, 2014).

Large issues surround access to services and equity in Ireland. There are documented differences in the use of health services by income. Recent reforms

have not addressed these concerns. The Irish system, by comparative standards, for this second category has high cost-sharing and a lack of primary care coverage for much of the population. The public system is particularly reliant on secondary care rather than primary care. For those without a medical card, there is no protection from costs incurred in primary care (Smith, 2010a; Wiley, 2005). Yet, primary caregivers are the “gatekeepers” who write referrals for services (Smith and Normand, 2012, p.212). Thus, the entitlements are complex in Ireland with significant cost-sharing for the majority of the population. These issues are further compounded by a lack of transparency (Burke et al, 2018; Smith, 2010a; Byers, 2008).

The structure and costs of the system affect service use and have repercussions for efficiency. For example, at the individual level, emergency hospital care can be used instead of primary care due to personal out of pocket costs (Smith and Normand, 2011, p.213). Thus, the system can discourage appropriate primary care usage due to costs (Brick et al, 2012, p.274). There is an intersection between public and private healthcare services. Half of the private hospital care occurs in public hospitals, which compounds access, efficiency and equity problems (Smith, 2010b, p.166). Doctors who work for the public system on salary can also see patients privately for fees.

The Irish system struggles with staffing issues, which compound the system that struggles to keep up with demand. Some reforms have tried to fix these issues. Ireland has a low number of physicians relative to its population. There is also a shortage of consultants (Burke et al, 2014; Brady and O'Donnell, 2010). These personnel issues heighten existing issues with waiting lists and wait times, making it difficult to reduce the waits.

In summary, issues surround access, efficiency, quality with access being particularly pronounced (Heavey, 2018; Brick et al, 2012). There is a conflict in Ireland between the goals of equity in the NHS arrangement and its orchestration in practice. The public system dominates but the private also plays a role. There are issues with the share of public versus private users of the public hospitals (Smith and Normand, 2011; Wiley, 2001). Generally, “inequity and inefficiency” are recurring problems for the Irish healthcare system (Brick et al, 2012, p.292). Recent reforms have not solved many of the recurring issues with access and

equity. The system is complex with various unusual organisational arrangements due to its historical developments. The next section explores the predictions on how the Irish healthcare system should react to the pressures stemming from Europeanisation.

Section 2—Theoretical Expectations: The Irish Case

In this thesis, the Irish healthcare system is the established national health service case study with a significant private provision and insurance market. It is also a centralised system at the time of analysis, though this is proposed to change in the coming years. Both health and non-health policies may impact the Irish healthcare system. The Irish system may experience similar impacts from common pressures from Europeanisation as do other systems, like the WTD. In addition, the particular institutional structure of Ireland and the issues challenging the domestic level may interact with Europeanisation to produce unique impacts as illustrated by evidence in the Irish case.

As the system is funded primarily by general tax revenue; cost containment and access issues are central to the organisation, management, and reform efforts. The domestic arrangement typically restricts costs through the use of waitlists and other measures. Forces, such as competition from other countries that circumvent these waiting periods and other regulatory measures, has the potential to have a significant influence on the case. These systems typically struggle with existing demand and resources, so the system could be pressured by policy misfits and adjustments that impact resources. Some European health policies may be pertinent to the Irish domestic healthcare system, like with the Patients' Rights Directive (PRD). There may be some non-binding policies, like networking, that are applicable to the domestic system and may be useful to a resource-short service like Ireland. The number of health policies relevant to the domestic level should be limited in line with the model predictions.

The WTD may serve as a significant EU policy affecting the Irish healthcare system, and, thereby, serving as a key input in the Europeanisation process. This critical juncture may result in noticeable effects defined by increased actor and institutional awareness of the impact of Europeanisation.

Consequently, the WTD may also lead to the mobilisation of Irish actors at the supranational level. The WTD may serve as a critical juncture for the Europeanisation of the Irish healthcare system with the potential to impact hospital delivery of care. The Irish system is heavily dependent on hospital care, more than most other systems, so the WTD may be particularly important. The WTD should affect the Irish healthcare system from the input to the outcome and resulting feedback mechanism.

Ireland spends nearly half its health care financing on hospitals, so it may be strongly influenced by policies that affect hospitals. Consequently, hospitals in Ireland, and as a result, the HSE broadly, may be especially subjected to pressure from applicable EU policy. Outcomes should vary based on the institutional arrangement of the Irish healthcare system. The Irish healthcare system rations and operates with a two-tier system of entitlement based on the possession of a medical card or not.

Ireland has a highly-regulated and exceptionally-designed⁴⁸ insurance market, which has largely expanded over recent years. The private system plays an important role in the Irish healthcare system. The organisation of insurance may be especially subject to indirect Europeanisation from market policies with regard to insurance.

Ireland has historic issues with spending, access and equity. Recent reforms have tried to address these challenges, but they have not been resolved. Domestic actors may welcome networking opportunities to learn from other countries that may have had more recent success than Ireland in resolving ongoing issues. EU policies may impact long-standing domestic conflicts.

Moreover, established national health service systems often do not quickly invest in new and costly technology, which may interact with Europeanisation pressures if those pressures involve technology. As the systems are governed by domestic policy, changes should be easily implemented, though difficulty can be encountered commandeering funding for these developments. EU requirements could force changes that would not otherwise occur at the domestic level when there is no goodness of fit in EU and domestic policy.

⁴⁸ Exceptional refers to the presence of only one insurer in the Irish market for an extended period of time.

Domestic level actors may have to play “catch up,” adjusting to pressures after the fact and would thus have limited ability to affect change to developments in the face of general system shortage.

EU policies that influence these aspects, like personnel, may impact Ireland when there is an issue with the goodness of fit. Policies that affect personnel impact Ireland when it results in added costs, as much of the domestic discourse reform focuses on resources and access. These developments may typically derive from indirect policies. A variety of policy areas may also impact Irish healthcare system financing. One would expect EU policies—such as those affecting personnel, technology, finances/reimbursement, and service entitlement—to impact the Irish system; EU pressures on these areas may put further strain on these pre-existing issues in Ireland.

With regard to institution response, Irish actors are employed by the HSE, their behaviour may be limited by bureaucratic restrictions. The knowledge of these EU policies may be highest in those within the Department of Health and the HSE, who craft policy and provide services respectively. These actors may feel the pressures from Europeanisation more than others, like politicians, as they are heavily involved in the day-to-day running of the healthcare system.

The influence of EU developments on the domestic level may influence Irish domestic actors, who, in turn, provide feedback to the EU level in order to shape the Europeanisation process. Moreover, the Irish healthcare system is primarily administered by the HSE. The policy is mainly created by the Department of Health. Both the DOH and HSE are bureaucracies. The Irish system, as a result, may struggle to quickly adapt to pressures and opportunities from European integration. Its bifurcated structure between the HSE and DOF may affect the Europeanisation process.

One would expect that the Irish domestic healthcare sector may develop capacities at the supranational level to monitor and input into the EU policymaking process. Irish actors may initially focus on Europeanisation developments from health policies that the DOH represents at the supranational level. Since 2005, the Irish system has been centralised under the HSE, so one may expect to see most of the feedback coming from this central organisation. However, there is a historic lack of centralisation, and unification is a relatively

recent development in Ireland. Consequently, the Irish system actors may be limited in their capacity and ability to provide feedback—both positive and negative— to the Europeanisation process due to its recent unification coupled with the DOH/HSE bifurcation.

In conclusion, the theoretical model elements may be evident across the Irish case study analysis. The WTD may serve as a critical juncture with ideational and institutional change. There may be clear input from EU policies, both direct and indirect. The outcomes may be dependent on the institutional dynamics that are characteristic of the established national health service. There may be a feedback mechanism, though it will be limited in its abilities due to the organisation of the Irish healthcare system. The next section now explores the Irish case study results to test these predictions.

Section 3—Empirical Evidence: The Irish Case

The background information and theoretical expectations for the Irish healthcare system from the first half of this chapter serve as the base for this section, the empirical evidence. The Irish case study analysis largely relies on a combination of high-level interviews and supporting evidence. These semi-structured interviews guided the focus on the case study analysis. The findings support the theoretical framework. The evidence illustrates that similar trends are as evident in Ireland as they are Germany and Spain. Simultaneously, national health service interacts with Europeanisation generating results exclusive to the Irish system arrangement.

This section summarises the empirical evidence from the Irish case. The results of the case study analysis are disaggregated into three categories based on the theoretical model developed in Chapter 3—the example of the Working Time Directive (WTD), Europeanisation of the Irish system, and the feedback mechanism. The section concludes with a summary of the findings and limitations of the findings and case study.

Irish High-Level Interviews

In January and February 2012, interviews with twelve high-level leads from the healthcare sector were conducted in Dublin. The breakdown of the interviewees

is summarised briefly in *Table 5.1* below and in more detail in the Appendices and will be referred to as I1 through I12, Jan/Feb 2012. As described in the sections above, the Irish system is centralised and largely reliant on the HSE and the Department of Health. Thus, it is vital to interview both government officials, who generally write the legislation, and bureaucrats who implement the policy and run the healthcare system itself.

Table 5.1: Irish Interview Composition

Category	Number of Interviews
Government—bureaucratic	6
Government—legislative	3
Insurance	1
Medical	1
Industry	1

Organisations representing the multiple facets of the healthcare sector at the domestic level were approached for interviews, as well as government and bureaucratic representatives. High ranking and experienced officials were interviewed; many had regularly dealt with EU matters. The small size of the Irish case impacts the diversity and number of the interviews. As such, the findings are highly reliant on government sources. In addition, the quasi-structured nature of the interviews relied on the opinion and forthcoming nature of those interviewed.

There are methodological limitations as a result with implications for the findings. The interviews provided insight into where Irish actors viewed the impact of Europeanisation. The case study could benefit from more interviews in future that are structured and focus on explicit aspects of the model and concrete EU policies. The interviewees were questioned in a broad manner to avoid biasing their responses. As a result, there is potential for a lot of fruitful insight and development through extensive follow-up.

Ireland and the Working Time Directive

The theoretical importance of the WTD was briefly outlined in Chapter 3, and now I explore its empirical significance in the Irish case. The WTD serves as a case to test the various theoretical explanations of the model. The WTD was the only policy cited across the interviews, though more interviews should be conducted in future that inquire about specific policies and are thus less reliant on actors volunteering information, a methodological shortcoming of this study. Examination of this evidence not only allows for nuanced exploration of the dynamics at play in Ireland but also allows for comparison with the other two cases, Germany and Spain. Exploring the case of the Working Time Directive in the Irish context provides insight into the Europeanisation process and the usefulness of the theoretical model constructed in explaining developments.

The evidence demonstrates that the WTD serves as a critical juncture for the Europeanisation of the Irish system, marked by key crisis events and subsequent domestic change. The WTD highlights the Europeanisation dynamic hypothesised in the theoretical framework and is the primary example of major impact apparent in the interview evidence for the Irish case. The WTD highlights the importance of EU policy, particularly indirect, on developments on the Irish healthcare system, illustrating ***ideational influence***. However, the model does not fully anticipate the domestic mediation response. The enforceability of the WTD particularly comes into play in the Irish case. Although Ireland is impacted by the WTD, the healthcare system appears to mitigate some change impacts by not fully enforcing the Directive.

The WTD results in policy changes by the Department of Health and implemented by the HSE with regard to healthcare professional hours, on-call time, and training. ***Institutional change*** is evident through a series of policies passed to incorporate the WTD into the domestic policy (Department of Health, 2014). These changes implement the series of policies that constitute the WTD as well as ECJ rulings clarifying the policy in the healthcare arena (HSE, 2014). Thus, this ***series of related events***—EU Directives and ECJ rulings—serve as a critical juncture that leads to lasting changes in the Irish domestic health system both ideationally and institutionally.

The WTD was broadly incorporated into Irish employment regulation through the Organisation of Working Time Act 1997 (WRC, 2019). In 2003, *the Report of the National Task Force on Medical Staffing* reviewed the staffing in order for rosters to be compliant with working time regulations and laid out minimum requirements (Department of Health, 2003). Working time hours first went into effect in Ireland 2004 (The Medical Independent, 2017). The Haddington Road Agreement also includes provisions to incorporate the WTD (Department of Health, 2014). Therefore, ***policy institutional change*** incorporates WTD requirements specifically into healthcare policy. The first legislative incorporation in the Irish case is the Statutory Instrument of July 2004 (S.I. No. 494 of 2004) which transposed the WTD into law (Department of Health, 2014).

Despite the relatively quick legislative adoption of WTD requirements, a major impact on the domestic system, Ireland has struggled to implement the requirements of the WTD. The European Commission gave Ireland formal notice of its noncompliance with the WTD in healthcare in 2009 (Compton, 2013). The issues that continue to be monitored by the HSE and professional organisations highlight the continued non-compliance, particularly with regard to junior doctors, the majority of whom work a total number of hours beyond those permitted under the WTD (Fagan, 2020).

As a result, a high court case taken by the Irish Medical Organisation (IMO), which represents doctors, was taken against the HSE with regard to working hours and conditions in 2010 (O'Carroll, 2015). The IMO utilisation of the WTD at domestic-level illustrates ***ideational change*** with regard to the applicability of EU policy to the domestic-level. In January 2010, a High Court Settlement Agreement between the IMO and HSE was reached resulting in additional ***institutional changes*** in the healthcare service organisation. Non-Consultant Hospital Doctor (NCHD) Contract of 2010 enacted various aspects of the WTD. The contract prohibits NCHD from working 24-hour on-call shifts at the hospital. It also does not allow for splitting shifts, requires certain notice periods for schedules and prohibits HCPs from working more than one job if all working time is more than 48 hours (HSE, 2014). The agreement also designated that certain training time was not working time (Department of Health, 2015a).

Therefore, changes with breaks and other employment rights were put into place in hospitals based on implementing the WTD (HSE, 2014).

Despite the further institutional changes, the Irish system rates of WTD did not reach desired rates due to difficulties changing the *path-dependent system*. Staffing shortages and budgetary issues, *characteristics of the national health service system*, made implementation difficult, particularly for some overstretched hospitals. The Irish system, highly reliant on secondary care, was highly affected by the financial, delivery and organisational pressures stemming from the WTD.

The IMO maintains that the WTD requirements are regularly breached for doctors (Wall, 2015). The IMO mobilised to push further Irish change to implement the WTD and improve HCP conditions, illustrating further *ideational change*. The IMO formally complained to the European Commission in 2012, which had the potential to result in fines for non-compliance with the WTD for Ireland as the period for domestic transposition had passed (Compton, 2013).

To raise public awareness, a historically important component of healthcare policy change in Ireland, of the WTD issues, the IMO ran a “24 No More” campaign in 2013 (The Medical Independent, 2017). Junior doctors have threatened strike if working time measures are not put into place (Compton, 2013). The IMO also organised a strike to protest the lack of implementation of the WTD conditions in 2013 (O’Carroll, 2015). The strength of HCPs, especially doctors, and the role of public discourse are components of healthcare reform characteristic of the Irish system, illustrating *path dependency* and characteristic responses to pressures.

Following the complaint by the IMO, the DOH submitted a plan to the European Commission in 2012 on how Ireland would fully implement the WTD in a timely manner (Compton, 2013). The IMO pushed that Ireland would be compliant with the WTD by 2014 (Compton, 2013). The HSE and IMO had negotiations through the Labour Relations Commission (LRC) in the autumn of 2013 that led to an agreement on scheduling in 2014 (Department of Health, 2014). The IMO monitors compliance with the WTD and publishes it online (IMO, 2019).

As a result, a strategy was devised by the DOH and HCPs through the Labour Relations Commission (LRC) to implement the WTD with a joint committee being developed to oversee the WTD implementation into practice (The Medical Independent, 2017). As part of the 2013 LRC agreement, the National Verification and Implementation Group was created to monitor progress and measure compliance (Department of Health 2015b). From 2013, each hospital in Ireland had to be represented on the EWTD Implementation Group, which meets every two weeks. The Implementation Group also includes HCP representatives, notably doctors, consultants, and nurses' organisation. The Implementation Group is overseen by the National EWTD Verification Group (HSE, 2014). Hospital compliance with the WTD is monitored through data collection, CompStat, and the HSE also lays out a formal structure for complaints and non-compliance (HSE, 2014). Therefore, in line with its recent reforms, the Irish system enacted change ***characteristic of its institutional arrangement***, highly administrative and technical in nature.

Again, despite the reforms, there was not system-wide compliance with the WTD in Irish hospitals. In November 2013, the European Commission referred a case to European Court of Justice due to Irish non-compliance with WTD. The European Commission did not believe Ireland had made significant progress in domestic implementation (Department of Health, 2014).

Issues with "NCHD recruitment and retention" led to the *Strategic Review of Medical Training and Career Structures* in 2014 (Department of Health, 2014). The HSE also publishes guidance on how to comply with the WTD (HSE, 2014).⁴⁹ The Irish government argues that it is becoming increasingly compliant with the WTD. Compliance with WTD weekly working hours maximums increased from 30% in 2011 to 40% in 2015 and to 68% in 2015 (Wall, 2015). Irish hospital

⁴⁹ The HSE provides various strategies and guides for incorporating the WTD into practice including but not limited to: the Report of the National Joint Study Group on Working Hours of NCHDs (2001); the Report of the National Task Force on Medical Staffing (2003); Report of the Hospital Activity Analysis (2005); the European Working Time Directive and Non Consultant Hospital Doctors—Final Report of the National Implementation Group (2008); Guidance on implementation of the EWTD and LCR 19559 (2009); Guidance on implementation of the EWTD Vol II (2009); and Guidance to management on NCHD Contract (2010) (HSE, 2014).

compliance with the WTD was at 70% in 2015. NCHDs weekly hours fell from 60 hours in 2009 to 51 hours in 2015 (Cullen, 2015). Rest hour compliance reached 98% in 2015 (Wall, 2015).

In February 2014, the IMO complained to the European Commission that junior doctor training and education in Ireland violated the WTD (Department of Health, 2015a). In 2015, the European Commission brought a case against Ireland to the ECJ with regard to junior doctors-hospital time dispute over education and training hours, with focus on mandated rests over 48-hour periods following a complaint by the IMO (Cullen, 2015). The DOH admitted that it had not been able to achieve full compliance with some WTD standards but was actively working to implement them (Cullen, 2015). Issues with recruiting and maintaining NCHD staff continues in Ireland (Cullen, 2015). Legislation pertaining to the compliance of the WTD did not at first cover junior doctors in the Irish healthcare system (Compton, 2013).

In 2015, the Minister of Health indicated that large **organisational changes** would be needed for Ireland to be compliant with the WTD, including recruitment of additional doctors and system-wide reorganisation of hospitals (Wall, 2015). From 2013 to 2015, the HSE hired an additional 400 doctors to work towards meeting WTD requirements, and a new hospital structure is being implemented as well (Department of Health, 2015a). Therefore, the WTD resulted in large **adoption costs** as anticipated.

The DOH admitted that it would take at least until 2017 for hospitals to be compliant with WTD requirements for doctors (Wall, 2015). Annually, €15 million was withheld from budgets of public hospitals. Fines were implemented based on a lack of compliance to help increase WTD adoption (The Medical Independent, 2017). In 2015, Irish hospitals had to pay over €3 million in non-compliance fines (The Medical Independent, 2017). There was large variation in hospital performance based on the fines with various hospitals facing annual fines in excess of €200,000, and other hospitals receiving no fines (The Medical Independent, 2017).

There are issues between the HSE and hospitals with implementation and tracking of WTD requirements, with some hospitals not reporting (The Medical Independent, 2017). The hospitals have had more success in implementing daily

hour restrictions and break mandates; due to understaffing, the weekly hour requirements have been harder to meet (The Medical Independent, 2017). In addition, there is criticism that fining hospitals that are struggling worsens their situation and increases existing inequities.

Despite the implemented change, in 2016, the Minister of Health expressed concern that continued lack of implementation could result again in referral by the European Commission to the ECJ (The Medical Independent, 2017). The ECJ upheld the Irish policy that “protected training time” is not working time (Department of Health, 2015b).

Nonetheless, the Irish system has struggled to fully implement the WTD due to its cost impact and has had issues with these transposition requirements. The WTD has exasperated issues with staffing, resulting in increased numbers of healthcare professionals leaving the staff-short system (Condrón, 2019). The reaction to the WTD comprises of conflict and compromise between the DOH, HSE, hospitals and HCPs, particularly doctors, to devise sufficient solutions. Other recent ECJ rulings on unpaid overtime could have repercussions for the Irish healthcare system compliance with the WTD (Mulligan and Walsh, 2019).

In terms of the *ideational impact* of the WTD, the influence appears to be the strongest with professional organisations and government bureaucrats. As discussed, the HCPs, particularly the IMO, has used the WTD to try to improve long-standing staffing shortage and working condition issues. Those actors in charge of policy and service implementation had the most to discuss with regard to the WTD (I3, Jan 2012; I4, Jan 2012; I8, Jan 2012; I9, Feb 2012; I11, Feb 2012; I12, Feb, 2012). The HSE largely discussed costs (I3, Jan 2011; I9, Feb 2012), and the DOH employment issues (I4, Jan 2012; I8, Jan 2012), which mirrors how they divide responsibility with regard to service management and policy development. The legislative officials had some awareness and knowledge of the WTD (I6, Jan 2012; I10, Feb 2012), but it was not significant to them. This may be due to their role in day-to-day system running or their political positioning.

The case of the WTD in Ireland exhibits a significant lag in implementation of EU policy. In line with the theoretical model, established NHS systems struggle to contain costs and have long waits. Regulations concerning WTD further compound historic domestic issues. In Ireland, this is further

complicated by the complex system that has only in recent decades been organised nationally. The WTD appears to have intensified issues with equity.

The Irish case demonstrates that domestic actors seek, as they historically do, administrative and technical solutions to EU pressures as they have to deal with other domestic challenges. The HSE and DOH are reacting to the pressures from Europeanisation and try to find solutions. HCPs, particularly doctors, are vital in domestic policymaking and have tried to use Europeanisation to improve working conditions. *Table 5.2* summarises the main dimensions with examples of the WTD as the critical juncture for the Europeanisation of Ireland.

Table 5.2: Critical Juncture Summary for Ireland

Critical Event(s)	Ideational Change	Institutional Change
<p>Regulation</p> <ul style="list-style-type: none"> • Directive 2003/88/EC & 2009 implementation • Directive 2000/34/EC • Directive 93/104/EC <p>ECJ Decisions</p> <ul style="list-style-type: none"> • <i>SiMAP</i> (1998) • <i>Jaegar</i> (2003) • Hearing Case 2014/00897 (2014) • <i>Deutsche Bank SAE</i> (2019) 	<ul style="list-style-type: none"> • Domestic importance of EU policy (direct and indirect policy), particularly for HSE, DOH and HCPs • Employing EU policy to advance HCPs' domestic position • Disputes over HCPs schedules and hours • Importance of monitoring at the EU level 	<ul style="list-style-type: none"> • Organisation of Working Time Act 1997 • Doctors in Training Regulations of 2004 • NCHD Contract 2010 • Haddington Road Agreement 2013 • Labour Court Recommendation 20837 of 2015 • Implementation Group and National EWTD Verification Group • Adoption costs • Changes in financing, delivery and organisation of services <ul style="list-style-type: none"> • Alteration of policy to minimise impact • EU level monitoring • Lagged implementation

As anticipated by the theoretical model, the Irish healthcare system responds to external pressures generated by the EU. The outcome also exhibits some traits characteristic of its NHS arrangement. Ireland has been struggling to fully comply with the domestic requirements, which lead to the European

Commission bringing a complaint to the ECJ. However, there is a lack of enforcement by the EU that the model does not adequately anticipate.

Moreover, the WTD shows the feedback effect of Europeanisation on domestic actors, not only supporting the second component argument of the WTD as a critical juncture, but also validating the general applicability of the theoretical model as a whole, including other three component arguments on EU input, domestic outcomes, and resulting feedback. The impact is most apparent with those who deliver healthcare services, monitor the day-to-day running and oversee detailed policies—HCPs, particularly doctors, the HSE and the DOH.

The WTD thus impacted the Irish healthcare system and serves as a critical juncture. The overextended and complex system has struggled to efficiently implement the requirements in line with theoretical predictions. The adoption costs have been high and led to much organisational change. The policies were implemented in 2004, but their compliance remains an issue. Various EU policies also impact the Irish healthcare system. The next section examines the different types of EU policies that appear in the Irish case and their impact on the Europeanisation process.

The Europeanisation of the Irish Healthcare System

The WTD has had both major institutional and ideational impacts on the Irish healthcare system, which has struggled to obtain full compliance with its requirements despite organisational and financial alterations to implement. This EU policy has particularly affected the DOH, HSE, hospitals and HCPs which had already struggled with staffing shortages and over-burdened service, characteristic of its NHS arrangement that has limited resources, and in the Irish case, complex organisation. This critical juncture exemplifies the process of Europeanisation in Ireland.

Types of EU Policy

The findings from the Irish study illustrate that there are various inputs, in both health and non-health policy influenced from EU policy, in the process of Europeanisation of the Irish domestic system. The majority of the EU policies

are indirect in their impact, though there are some noted direct impacts too in support of the model. Additional Europeanisation effects, including outcomes from EU Insurance Regulations and the Patient Rights Directive, are apparent, supporting the theoretical predictions that Europeanisation has generalisable outputs across domestic healthcare systems as well as country-specific results based on the interaction with the domestic institutional arrangement. However, the only major impact apparent in the analysis is in the WTD. The other EU policies highlighted by interviewees appear to only result in minor adjustments in Ireland based on the case study analysis.

As predicted by the theoretical argument, the amount of EU health policy applicable to the domestic level in Ireland is limited. Impactful EU health policies comprise both binding and non-binding policies, as expected. Domestic actors had varying degrees of knowledge of EU policy and different views on its importance; DOH, HSE, and professional organisations were most aware and involved in EU policies. The majority of the volume of direct policies are minor policies in their impact. The largest effect with regard to direct policies is evident with the PRD due to the NHS nature of the system and its historical challenges of cost control. Actor concern was high on this topic, likely due to the timing of the interviews. The importance of non-binding policies is greater than anticipated by the model, illustrating the importance of networking, information, data and funding in the healthcare content.

Generally, there is limited binding EU policy that must be implemented by the Irish healthcare system. The PRD was the only binding policy with a perceived major effect that was discussed in the interviews. The cost and organisational implications of the PRD are particularly noted for the NHS. Other minor policies were mentioned to varying degrees. The perceived benefit by some domestic actors of direct policies was larger than anticipated in the Irish case. Safety, data, e-health and medication policies were included as areas in which being part of the EU benefitted Irish healthcare and increased standards and practice (I1, Jan 2012; I4, Jan 2012; I7, Jan 2012).

In line with the theory, there is a large range of EU policies discussed in the interviews. A weakness of the design, intended to avoid leading interview subjects, was to ask broadly about EU impact on the Irish case. As a result, case

examples were provided during the interviews; exhaustive lists were not provided. The PRD and Medical Device Regulations serve as examples of the input and outcomes of EU policies on the Irish domestic healthcare system to illustrate some of the central findings.

The Patients' Rights Directive

As previously discussed, the PRD codifies a series of ECJ rulings and outlines entitlements to travel within the EU to access healthcare services. Domestic actors frequently discussed the importance of the PRD, including its implications for access to services and cost (I1, Jan 2012; I3, Jan 2012; I4, Jan 2012; I6, Jan 2012; I9, Feb 2012; I10, Feb 2012). One official noted that the PRD might be the “biggest” impact of EU policy domestically (I10, Feb 2012). As the background section of this chapter explains, Ireland struggles with service access and controlling costs, so this policy is important to system functioning and reform. The findings illustrate the perceived importance of the PRD to domestic actors, but also a gap in the evidence supporting its impact.

The PRD was passed in 2011, and the Irish legislation has been enacted to transpose the policy at the domestic level. Irish residents are entitled to the public healthcare services they would receive in Ireland abroad in another MS and can be reimbursed for the services (HSE, 2018). The policies that led to the PRD led to the development of the National Treatment Purchase Fund in Ireland (I6, Jan 2012). The National Treatment Purchase Fund (NTPF) was created in 2002 to allow funds for treatment abroad, though it was primarily used in the first years for private care within Ireland (Wiley, 2005).

Care abroad has increased with time due to the cross-border care and notably the PRD, which requires not only the right to access but also a system to support patients who seek services abroad. Travelling for health services to circumvent long waiting lists, “health tourism” results (I9, Feb 2012). The measures from the PRD officially were fully enacted in Ireland in 2014 and their utilisation has steadily increased over time; the HSE reimbursed €29,000 in 2014 (Shanahan, 2019). By 2016, the HSE had paid €2.4 million to patients who received care abroad; this figure grew to €7.5 million by 2018 (O'Regan, 2018). However, there have been large delays in patient reimbursement in PRD in

Ireland (Bermingham, 2019). The HSE has had to evaluate its staffing needs to implement the PRD in light of increasing demand (The Medical Independent, 2019).

The Irish healthcare system struggles with waiting lists, a measure that helps to control costs. The PRD in theory could be a major impact on the Irish healthcare system. In 2017, the Irish government faced a €34 million bill for treatments citizens had abroad (Cullen, 2017). There have also been issues with hospital reimbursement; the HSE failed to collect for many services received by non-residents from other MSs in Ireland due to organisational billing challenges (I3, Jan 2012). The PRD has helped patients on public waiting lists receive care. The PRD could be costly, and the HSE continues to lag in full, effective implementation of the Directive. However, the update in the use of the PRD is limited, resulting in system change that appears to be minor in practice.

Irish Variation of Europeanisation

The remaining policies of note from the case study analysis comprise of various non-health policies that have implications for Ireland, largely due to its institutional arrangement. The findings highlight the diversity of EU policy affecting healthcare systems. The cases provide some interesting insights and show the potential for the development of the model. A more systematic analysis could help in future.

The case study analysis shows the importance that non-health EU policies have in the Irish context. The results also show that the Irish system has and continues to struggle to adjust to the high costs associated with implementing EU policies. They strive to incorporate them into policies, but they often pose financial and organisational strains on capacity, an issue particularly prominent in the established NHS case. Thus, major policies like the WTD and the Third Non-Life Insurance Directive have large implications for the organisation and delivery of care, which is explored in the cases below (I3, Jan 2012; I4, Jan 2012; I5, Jan 2012; I11, Feb 2012). Minor policies also have a visible impact. Domestic actors highlighted the costs of implementing EU policies, including Directives, and the subsequent pressure on the budget (I3, Jan 2012; I4, Jan 2012; I5, Jan 2012; I11, Feb 2012).

Non-health EU policies relating to the single market and employment are impactful and influence developments, especially with regard to hospital services (I4, Jan 2012; I7, Jan 2012; I9, Feb 2012; I11, Feb 2012). The evidence for the second argument shows the major effect of an indirect policy, the WTD, on the Irish case. This section illustrates the indirect impact of EU policies on the Irish case by presenting a few examples of these policies that were highlighted during the elite interviews. There is a bias and a limitation of the case selection as a result. However, they do shed light on the dynamics at play.⁵⁰

Medical Device Regulations: Role of the Economy

Some EU policies were discussed in the interviews that are not central foci of the Europeanisation of health literature as a whole. This seems to result from the interaction between economic and healthcare forces in Ireland. For example, medical device industry is relatively large in Ireland, so it was discussed in various interviews. I now explore this example.

The Irish evidence shows that many minor policies are applicable to Ireland including but not limited to safety, data, e-health and medication policy; many pertain to standards and practice (I1, Jan 2012; I4, Jan 2012; I7, Jan 2012). Medical Device Regulations are one example of this type of legislation with

⁵⁰ A range of other minor policies have implications for the Irish healthcare system. They were discussed in interviews but were not able to be explored in depth due to limitations in what the thesis can cover. For example, the Late Payments Directive, 2011/7/EU affects the payment of suppliers, including those in the health sector (I9, Feb 2012). The Irish transposed this policy in the Prompt Payment Returns, which requires the HSE to pay suppliers within 15 days of billing (DBEI, 2019). Despite the policy, the HSE was fined €9m in late payments over the 18-month period from mid-2013 to late 2014 (Connolly, 2015). The HSE organisation has lagged in compliance with the legislation at a large cost to the system.

In other areas, EU policies have benefited Ireland. Due to the large market for pharmaceutical companies, the benefit of the EU market and standard regulations was highlighted (I1, Jan 2012). EU membership has helped the Irish pharmaceutical industry grow (European Commission, 2019c). The free market and open borders have helped Ireland when it experiences medicine shortages; 60% of medications in Ireland come through UK (O'Regan, 2018). Therefore, EU non-health policies can have positive and negative impacts on the Irish domestic system. Negative impacts can have repercussions for existing domestic challenges.

minor, but not insignificant, impact. Ireland is a large medical device supplier. Ten percent of Irish exports is medical devices. Ireland is the second-largest medical device exporter in the EU after Germany (Keena, 2018). As a result, there are market implications of this health policy as well.

EU Medical Device policies have been enacted beginning in 1993 and have undergone a series of EU amendments. The Directives have been transposed into Irish policy by the Irish Medicines Board Act 1995 and the Medicinal Products Regulations 2007 (SI 540/2007). The Health Products Regulatory Authority (HPRA) oversees medical devices and the National Standards Authority of Ireland (NSAI) is the notification body that ensures legislative compliance (Kavanagh and Farrell, 2016).

During the drafting of the most-recent Medical Device Regulation, the Irish Member of the European Parliament and Vice President of the European Parliament, Mairéad McGuinness, was central in policy negotiations (Keena, 2018). The EU passed two policies amending Medical Device Directives, Regulation 2017/745 and Regulation 2017/746, in 2016 that changed EU policy from the last twenty-five years from a Directive to a Regulation (HPRA, 2016).⁵¹ The New Regulation seeks to harmonise policies across Europe (Behan et al, 2017). In response, Irish initiatives have been put forward to comply, including centralising and increasing expertise (Behan et al, 2017). HPRA is responsible for drafting policies to implement the Regulation (HPRA, 2016).

Recent changes to Medical Device Regulations amendments from 2018 take effect in 2020. In response to the policy changes, Germany and Ireland submitted a paper at the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) on the need to delay implementation due to manufacturing compliance capacity and issues with the undersupply of notification bodies that certify medical devices⁵² (Taylor, 2018). The Irish National Standards Authority has high standards but has capacity issues only approving hundreds of products (Keena, 2018).

⁵¹ Directives have to be transposed into national policy. Regulations are directly applicable from EU-level (HPRA, 2016).

⁵² “Only two notified bodies, BSI UK and TÜV SÜD, are currently designated against the incoming device regulation” (Taylor, 2018).

Therefore, Ireland is complying with the EU policy, but is encountering capacity issues, which is a similar dynamic to the WTD evidence that argument II presents. The costs and administrative issues that are prevalent domestically have implications for directive compliance. Lags are often evident and significant costs result.

Competition and State Aid

Ireland has an overlap between public and private healthcare. Private health insurance began in 1957 under the Voluntary Health Insurance Act, creating the Voluntary Health Insurance Board, which is now VHI Healthcare. There was only one health insurance provider in Ireland until 1994 (HIA, 2016). Private healthcare plays an important role as previously discussed in the Irish healthcare system. Historically, there are many regulations of the Irish health insurance market. Until the Third Non-Life Insurance Directive, this Irish market was not open to competition (Wiley, 2005).

The EU has passed legislation pertaining to requirements for the internal market with regard to insurance. The Third Non-Life Insurance Directive⁵³ was introduced to increase competition in the insurance industry (Wiley, 2005). This Directive had large implications for health insurance in the private sector leading to the introduction of competition and eventually, risk equalisation (I2, Jan 2012; I4, Jan 2012; I6, Jan 2012).

In order to transpose the Third Non-Life Insurance Directive, the Irish government had to introduce competition to the health insurance market. Consequently, a new insurer, BUPHA Ireland, opened in 1997 (Wiley, 2005). Ireland also was approved for some exemption from the EU to allow the it to require that insurers have community ratings for costs, open enrolment of individuals and lifetime overage through the Health Insurance Act of 1994 and the Health Insurance Regulations of 1996 (Wiley, 2005).

Based on this exemption, VHI Healthcare has had different regulatory and statutory requirements than other insurers in Ireland and has not had to show

⁵³ Council Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance

financial viability as it is State-owned. VHI Healthcare has historically not been overseen by the Financial Regulator. The Financial Regulator, or another MS equivalent, has monitored all other health insurance companies (HIA, 2007). A series of reforms in the 2000s adjusted the Scheme (HIA, 2016).

The Health Insurance Authority (HIA) formed in 2001 to oversee private health insurance. The HIA also was given responsibility for equalising risk in order to allow for community rating by transferring funds to insurers in light of its organisation and regulatory structure. The Risk Equalisation Scheme, which went into effect in 2003, has been the subject of domestic debate (HIA, 2016; Wiley, 2005). In the 2000s, the Risk Equalisation Scheme was challenged and upheld in the national courts (HIA, 2016) as well as by European Commission State Aid decisions (HIA, 2007).

Ireland has a unique organisation, including its private insurance regulations (Wiley, 2005). Over recent decades there has been a rise in health insurance costs and a historic lack of public debate. The private factors interconnect with the public ones, particularly through public hospital care, so health insurance affects domestic structure (Wiley, 2005). Regulations pertaining to insurance not only affect private healthcare but public, too, by proximity. EU insurance policy does not appear to have this pronounced impact on other case studies, so it appears to be a product of the institutional arrangement in Ireland.

Internal Market and Professional Qualifications

As in the other cases, Internal Market and Professional Qualifications EU policies that are applicable to health impact the Irish domestic case. Examples of these policies include the free movement of professionals and mutual recognition of professional qualifications (I1, Jan 12; I9, Feb 2012). These policies are applicable to the healthcare system in all MSs.

HCPs have the right to establish across EU MSs under EU free movement requirements. The Professional Qualification Directive—Directive 2005/36/EC and the amending Directive 2013/55/EC—allows a licensed HCP in one MS to automatically practice in another. The Directive met some resistance in Ireland despite notable staffing shortages. An Bord Altranais, The Dental Council, the

Medical Council, and The Opticians Board and the Pharmaceutical Society of Ireland called on the Irish government to put safeguards into place that require HCPs from other countries to register when practising in Ireland (Medical Council, 2005). Under the EU Directive, Ireland automatically recognises various HCP qualifications with the production of the European Professional Card certification and registration (Citizen Information Board, 2019). Irish policy set up the Health and Social Care Professionals Council at CORU was created to register HCPs (Department of Health, 2019).

As previously discussed, the Irish domestic system has historically struggled with the retention and recruitment of HCPs, particularly doctors. Despite Irish training of HCPs, large numbers of migrating to places with better conditions, which further compound staffing shortages (Ring, 2019). There is a recurring retention issue in Ireland. As a result, Irish-trained doctors have been leaving the country (Glinos, 2015).

Ireland has been recruiting doctors from abroad through extensive campaigns. As a result, the system is becoming increasingly dependent on foreign doctors, with increasing proportions from other MSs (Ryan, 2017). Ireland has witnessed an influx of doctors trained abroad (Glinos, 2015). As of 2019, nearly two out of three doctors in Ireland had some qualifications from outside of Ireland (Ring, 2019). Evidence has found that they are leaving Ireland due to working conditions and discouraging others to come to Ireland (Nolan, 2008). Therefore, HCP organisations are recommending improved working conditions and better salaries to increase HCP recruitment (Ryan, 2017).

Some studies indicate that EU mobility benefits wealthier MSs and hurts poorer ones, redistributing resources (Glinos, 2015). The Irish case indicates that EU mobility encourages the movement of Irish-trained HCPs. Understaffing and working conditions discourage the retention of other doctors, further reinforcing the domestic shortage and poor conditions.

Networking and Europeanisation

The literature outlined in Chapter 2 discusses OMCs and other non-binding policies. The case study analysis surprisingly found these non-binding mechanisms to be more dominant in the Irish case than the model would predict.

Domestic actors highlighted the importance of policy advice, networking, learning from others, health information, reports and data (I5, Jan 2012). One legislative official explained that learning and idea exchanges was the “main” impact of the EU on healthcare systems (I10, Feb 2012). For example, the Irish system spends significant amounts on prescriptions and has been able to employ information from OMCs to reduce costs (I3, Jan 2012). Projects and European funding benefit in the health sector were also referenced by Irish domestic actors (I1, Jan 2012; I5, Jan 2012).

There are various non-binding EU activities with regard to patient safety including the working group on patient safety and quality of healthcare and Joint Action on patient safety and quality of healthcare. EU policies include the Council Recommendation on patient safety, including the prevention and control of HCAI (2009) and Recommendation on the prevention and control of healthcare associated infections (Health First Europe, 2019).

Ireland has been actively engaged in non-binding EU policies and activities with regard to patient safety to learn and improve practice. In recent years, patient safety has become a priority of the Irish healthcare system. In 2008, the Department of Health published a report on and enacted policies to improve patient safety (Department of Health, 2008). Many of the measures are in line with the EU Recommendations on Patient Safety (2009/C 151/01) (IMO, 2014). Ireland actively participates in EU patient safety projects (Department of Health, 2011).

Various organisations have been subsequently set up to improve Irish patient safety. The National Clinical Effectiveness Committee (NCEC) was created in 2010, and the National Patient Safety Office (NPSO) in 2017. The responsibilities of HIQA are expanded under the Health Information and Patient Safety Bill (OECD/European Observatory on Health Systems and Policies, 2017). However, issues in Ireland of resource and staffing shortages have made the application of various policies difficult (IMO, 2014). Domestic actors in Ireland thus use non-binding policies to help improve services and gain insight that can be applied to the system.

The evidence the study shows that similar trends with regard to Europeanisation are evident in Ireland as they are in other MSs. The WTD serves

as a critical juncture. There are EU policy inputs from health and non-health that result in domestic-level outcomes. Thus, major and minor effects of the EU are evident in the Irish case with regard to many EU policies that are also affecting other MSs.

EU policies developments can be difficult to predict for Irish acts as they can derive from a variety of policy areas. Nonetheless, with regard to binding policies, the Irish system is forced to transpose this policy. The DOH and HSE often enact and enforce the implementation at national level. The HCPs, notably the doctors, have been actively involved in the debate and discussion around non-health policies that affect them.

The implementation of non-health policies often comes at a adjustment cost, particularly for the HSE. This added layer of regulation proves to be an issue for the HSE and Department of Health, especially with the WTD. Pressures to budgets and staffing, particularly in hospitals, from these EU policies can worsen existing domestic issues. Unique impacts are also evident based on the structure and organisation of the Irish case. The Third Non-Life Insurance Directive affected Irish healthcare system design and delivery of care, which has a complex structure that includes private health insurance. The next section explores this phenomenon in more detail by explaining how the Irish system has interacted with EU policies.

However, the Irish institutional arrangement and existing domestic issues affect the Europeanisation process. In areas where Ireland has struggled, including staffing shortages and budget containment, EU policies and regulations has worsened existing challenges. This finding is evident with regard to policies like the WTD, PRD and professional mobility. Hospitals, which are understaffed and struggling to contain costs witness large impacts. The HCPs are active in EU and domestic policymaking processes with regard to these policies. In addition, there are pressures that have a unique impact in Ireland, like with the Third Non-Life Insurance Directive.

The Irish system is not particularly adaptive to change. Ireland struggles to implement policies that are costly in a system that already struggles domestically with funding. EU pressures not only can worsen existing issues, but

the domestic actors have encountered delays, lags and incompletions in implementation as evidenced with the WTD and Late Payments Directive.

Although most regulations come at added cost, can also add benefits to the healthcare system. The Health Information and Quality Authority in Ireland, which improves healthcare, developed because of Europeanisation. Perceived benefits are also seen with regard to issues like patient safety. The Irish pharmaceutical industry has grown from the participation in the single market. *Table 5.3* below summarises the main inputs and outcomes of the Irish case.

Table 5.3: Summary of the Input and Outcome in Ireland from Interviews

EU Policies (Inputs)	Domestic Impacts (Outcomes)
<ul style="list-style-type: none"> • Health policy impact is minor • PRD cited referenced as a significant impact but is minor based on evidence • No cited examples of non-binding non-health policy • Dominance of non-health EU policies and their impact • Importance of personnel, capacity, and cost-related topics as they pertain to non-health policy • WTD as source of domestic system friction followed by patchwork Europeanisation of non-health policies • High level of awareness and knowledge by some domestic actors, particularly by HSE, DOH and HCPs • Actor concern over the impact of the EU on costs 	<ul style="list-style-type: none"> • Large policy misfit with EU policy with existing domestic struggles, like staffing shortages and cost curbing (Europeanisation mirroring domestic dynamics) • High implementation cost of EU policy due to rationing and spending issue dominant the system • Difficulty in implementing some changes, including lags and lack of compliance • Technical and administrative adoption of policies but lag in compliance • More of a perceived value for non-binding policies than model predict (importance of sharing) • Perceived opportunity to benefit from Europeanisation harnessed in some actors, notably HCPs • Perceived benefits with regard to quality and safety of the system • Gap between policy and practice

Therefore, the Irish system tries to implement EU requirements, enacting domestic changes. However, existing domestic issues have resulted in examples of difficulty in achieving full compliance. The system tries to cope with the pressures, but has fallen behind in the implementation of various policies, resulting in costs and, in some cases, court cases and fines. The Irish system has

benefited as well to some degree. The next section explores the Irish evidence for the final argument on the impact mechanism.

The Feedback Mechanism

The case study indicates the presence of a feedback mechanism into the Europeanisation process with domestic actors in Ireland. The organised and centralised structure of the HSE and Department of Health should aid in the supranational mobilisation; however, due to the public nature of the organisations (rather than the corporatist organisation in Germany), the ability for these domestic actors to affect change on EU policy is limited. Moreover, the systemic capacity issues at domestic-level may compound this effect. Some domestic actors are more active than others. These findings support the model expectations of an interactive Europeanisation process.

Capacity-Building in EU Policymaking

One official discussed that a large impact of the EU was its effect on capacity building (I5, Jan 2012). Irish actors have mobilised at EU level for policy advice, information, reporting, data and networking in policies and projects (I1, Jan 2012; I3, Jan 2012; I5, Jan 2012; I10, Feb 2012). The capacity building depends on the role within the domestic system.

Following the reform that centralised the Irish healthcare system, Irish health effectively mobilised at not only domestic but also supranational-level. Departments are devoted to EU policy to aid in domestic implementation. However, as the evidence from the previous two sections illustrates, there are capacity issues that limit the ability of domestic actors, notably the HSE and DOH. The divide in responsibility between the DOH and HSE with regard to their responsibilities impacts which actor mobilises and for what consideration. Therefore, the DOH officially represents Ireland at EU-level as the policy arm and translates to broad Irish legislation as needed (Permanent Representation of Ireland, 2019). However, the HSE must enact and comply with regulations, so there is some disconnect.

Many of the interest groups that are powerful at domestic level are active at an EU level or work with umbrella organisations to represent them at EU-level.

Previous evidence also shows that HCPs, particularly doctors, have been active in mobilising with regard to EU policy areas. The Irish Medical Organisation, for example, is a Member of the Standing Committee of European Doctors (CPME), the European Junior Doctors (EJD), the European Union of General Practitioners (UEMO), the European Union of Medical Specialists (UEMS) (IOM, 2018). The Irish Nurses and Midwives Organisation (INMO) is part of the European Federation of Nurses Associations (EFN). Both have been active in structuring the EU policy debate in areas pertinent to health. Ireland has held strong leadership positions in EU level, including holding the presidency of EFN, affecting policy (Kennedy, 2007). Thus, various domestic interests in Ireland have developed EU capacities.

Negative Feedback

The evidence for the Irish case shows varying ability and capacity for Irish domestic actors to prevent adverse EU policy developments. The Irish domestic actors, primarily as part of the HSE and Department of Health, monitor, influence, and seek to minimise the costly policies. The ability for the domestic actors to affect change remains limited in an Irish context.

As the WTD example demonstrates in the evidence for the second (II) argument, the DOH develops policy to implement legislation. The Irish system is historically good at creating administrative and technical solutions. However, the HSE struggled to comply with the EU Regulations and fully implement the WTD to the point that domestic HCPs complained to EU-level and went on strike at domestic-level. Cases were taken by the European Commission against Irish healthcare WTD implementation. The lack of compliance proved costly to the Irish system for the WTD and other policies, such as the Late Payments Directive. The DOH and HSE have struggled when trying to avoid costly domestic system changes.

HCPs and other actors have been more effective in mobilising to avoid negative feedback. For example, HCPs were effectively able to require registration of foreign HCPs with regard to mobility of HCPs. Recent developments of Ireland DOH partnering with Germany to delay the implementation of Medical Device Regulations illustrate that that, with time,

DOH is capacity-building to alter policies and not just comply with them. Similarly, the Irish pharmaceutical industry is active heavily at EU-level. For example, the Irish Pharmaceutical Healthcare Association actively opposed EU efforts to weaken incentives for new medication development (Mallee, 2008). Organised interests in Ireland have been effective at EU-level, including mobilising with EU-wide umbrella organisations.

Positive Feedback

The DOH represents Ireland officially with regard to health policy, which aids Ireland in altering health policy during the policymaking process; however, their capacity is mainly limited to health policies in this regard. For example, the Minister of Health has used the EU Employment, Social Policy, Health and Consumer Affairs Council to encourage MSs to work together to reduce prescription medication prices, a spending concern in Ireland (Department of Health, 2017).

In addition, organised interest groups, like HCPs and the pharmaceutical industry, have developed EU monitoring and have actively built capacity, including joining European umbrella interest groups. As the WTD illustrates, the IMO employed the WTD to advance its domestic interests in improving workplace conditions, staffing and working hours. The IMO complained to the European Commission, resulting in ECJ cases. The IMO also actively inputs into the European policymaking process through issues like patient quality as discussed. Thus, Ireland has been working to positively input into and affect the EU policymaking process, though there are limits to their capacities.

Limits to the Irish Feedback Mechanism

The Irish healthcare system is highly bureaucratic, complex, and thus static. This organisational issue coupled with over utilised services and budgetary strain limits its EU-level mobilisation. The Irish system has struggled with reacting to EU policy, so it has limits on how proactive it can be with shaping EU policy. The Irish system does not appear to have the additional resources and capacity to capitalise on developments at EU level for the most part. The interaction with domestic actors is largely reactionary, particularly with the HSE struggling to

fully comply with legislation like the WTD and PRD in a timely-fashion. As the DOH mainly represents the Irish system, they primarily can monitor health, not non-health, policy developments. As non-health policies are important to health, this has domestic implications.

Summary

There is a discernible feedback mechanism evident in the Irish system, but it primarily comprises of monitoring and attempts to implement. The Irish system appears to be developing feedback mechanisms and gradually increasing their use over time. Domestic actors have mobilised to varying degrees in the EU policy arena. There is evidence of negative and positive feedback, though the Irish feedback mechanism remains limited due to organisational and resource issues. This feedback mechanism may be developing with time. *Table 5.5* summaries the feedback mechanism evidence for the Irish case.

Table 5.4: Feedback Mechanism Summary for Ireland

Capacity-Building	Negative Feedback	Positive Feedback
<ul style="list-style-type: none"> • Domestic monitoring of EU policymaking develops following WTD • Centralised organisation of DOH and HSE • Strong DOH representative role • Divide between DOH policy representation and HSE implementation • Active role and streamlined organisation of HCPs and interest groups 	<ul style="list-style-type: none"> • Dominance of negative feedback as primary feedback • Delay in implementation and limits to feedback from DOH/HSE • Increasing capacity of DOH in health policy areas • Effectiveness of interest groups with EU level umbrella organisation partners 	<ul style="list-style-type: none"> • Not central feedback mechanism but added benefit • Beginning to capitalising on EU opportunities when possible • Employment of EU policy by HCPs to gain ground domestically

Section 4—Irish Case Conclusions

Various trends are apparent in the Irish case study analysis presented in this chapter. First, the findings support the anticipated effects stemming from the theoretical model. EU policy influences can be disaggregated into health and

non-health policy, which impact the Irish domestic healthcare system. Both are evident in the Irish case, though there are more non-health policies, which on the whole, also appear to be more impactful on domestic institutions and actors. However, the range of these policies is quite diverse, which impedes generalisability. The EU policies can further be disaggregated into the binding and non-binding policies. Non-health policies do not appear to include non-binding policies, at least in this primary analysis, which potentially warrants further study. These findings may result from the nature of the interview process rather than the lack of existence. The EU policy area is broad in scope, so it is not fully captured in this analysis of the Irish case. A thorough follow-up analysis of Ireland on its own would help further differentiate and understand these impacts.

The case study analysis supports the theoretical model as it pertains to the WTD as a critical juncture in the Irish healthcare system. The WTD resulted in both institutional change through health policy and organisational changes as well as ideational change amongst domestic healthcare actors, including hospitals and healthcare professionals. The Irish healthcare system struggles with the adoption of this policy due to budget and staffing issues it has faced for a prolonged period of time, leading to compliance issues with the EU government. Fines and other ramifications further exacerbate system issues, like limited budgets for hospitals historically struggling with their capacity. The WTD illustrated the importance of supranational policy to Irish domestic actors, including HCPs that employed the WTD to advance their domestic interests in historical conflicts. The case shows the strongest evidence supporting the predictions of the theoretical model. It is important to note that this policy was examined in greater detail than others, which may partially explain the finding.

Following the WTD, actors in the Irish healthcare system appeared to mobilise to monitor EU legislation moving forward, particularly in non-health policy areas. The unexpected and non-health impact of the WTD had major effects on the Irish healthcare system, characterised by ideational and institutional change. The evidence supports not only the second component of the theoretical model, but also supports the theoretical model as a whole. Thus,

how the WTD influenced Ireland shows the dynamics of the EU input causing domestic institutional change and resulting actor feedback.

The scope of EU health policy remains limited, comprising mostly of minor policies. The case study analysis points to the bulk of health policy comprising of non-binding legislation. Interviews expressed concern about the significant health policy, the PRD, on the Irish healthcare system. It led to unforeseen costs due to the inability to collect reimbursement from other countries and uptake of the services by Irish residents who wanted to circumvent long queues, which have historically helped to contain system costs. However, these results pre-date the implementation of the PRD Directive itself and point to a large influence of the non-health policies, such as ECJ rulings, proceeding the PRD. Due to the history of the PRD and presented evidence, the impact of the PRD appears to stem from its policy development prior to the Directive adoption. The results indicate that the model is weak with regard to explaining major health policy developments—the Europeanisation process may not allow for the development of major health policy as it stands. Nonetheless, the PRD seems to illustrate that Europeanisation also appears to heighten some existing equity and resource issues with which the Irish case has historically struggled.

As expected, the Irish case evidence shows the non-health policies have been impactful on whole, particularly the WTD. These policies can originate in a variety of DGs making them harder to track. Non-health policies often involve coordination with non-health actors outside of the conventional health areas. The divide between the HSE and DOH in policymaking and implementation appears to lead to a more pronounced disconnect than in the German case, for example.

Building off of this, there is a feedback mechanism apparent in Ireland stemming from Europeanisation as predicted by the theoretical expectations of the last argument (IV). After the costs for the system from the WTD and Third Non-Life Insurance Directive, key domestic actors monitor EU developments to avoid the detrimental policy, which is in line with expectations from the model and the literature. The DOH represents Ireland at EU, but the HSE is responsible for the budget and delivering care.

The Irish domestic actors are on a whole largely aware of the influence of the EU, illustrating ideational impact. The DOH generally appears to transpose EU policy relatively quickly. However, the HSE appears to struggle in cases to implement it, as the WTD illustrates. Therefore, the Irish case seems to work to comply with EU policies, but it can struggle as an established NHS due to capacity issues.

Overall, the Irish domestic case is influenced by pressures of European integration, particularly through non-health policy areas. Unlike the German case, it is not able to adapt as much due to its organisational arrangement. An alternative explanation for this finding could be the relatively small size of the Irish state—further case analysis of Ireland and other small Member States would help to shed more light on this dynamic. Nonetheless, Ireland's centralised nature allows monitoring of developments. In addition, the capacity for positive feedback is limited. However, the Irish system does seem to benefit from non-binding policies that increase safety, provide health information and brainstorm policy solutions, which indicate benefit from information sharing and networking; this finding is surprising as it is not a central prediction of the theoretical model. The results do indicate that more exploration of the domestic improvements resulting from Europeanisation, as opposed to the focus on uninvited Europeanisation, is warranted. For an established NHS system with tight budgets, the value of OMCs and networking appear to be of added benefit.

Ireland is a system that historically struggles with staffing and resource shortages. Various EU policies have heightened these existing domestic issues in line with concepts of the goodness of fit, mediation, and change. System-specific impacts seem to have occurred from EU insurance policies due to the complex public-private mix in Ireland. The impact of the EU on this insurance element of Ireland is an interesting finding that should be further explored. The evidence shows how the institutions react in characteristic manners.

The Irish case illustrates the dynamic, broad, and complex manner of Europeanisation of domestic healthcare systems. It illustrates some common impacts of the EU, notably with the WTD and the PRD. The timing of the interviews likely affects the responses as both policies received a lot of press at the time. These methodological issues should be improved in future to further

be able to understand the dynamics at play behind the findings. However, the other policies highlighted in the interviews are strongly connected to unique dynamics and legacies at the domestic level—this finding highlights the complexity and the individualised nature of the Europeanisation process. The difficulty to generalise across studies is apparent as a result. The theoretical model tries to provide a general idea of how the EU impacts domestic systems. Given the breadth of EU policies, the predictor power of the model proves to be limited. Improved methodology, including policy-focused case studies, could help provide clarity in future. The case study analysis of Ireland provides some surprising findings, interesting results, and points to a range of EU policies. Methodological weaknesses of under-specification adversely affect the findings.

The final case study, Spain, which is presented in Chapter 6, is also a national health service. It has various characteristics that differ compared to Ireland, which has relevant to testing the theoretical model explaining the Europeanisation of domestic healthcare systems.

Chapter 6

Developing with Europeanisation: The Spanish Case

Introduction

The final case explored in this thesis is Spain. Spain is a large case country like Germany. It is funded primarily by general taxation with a small private insurance market. There is strong regionalism in the delivery of care and services, as in Germany. The system developed more recently than the German and Irish healthcare systems. The size of the Spanish system as a share of the economy is between that of Germany and Ireland. Like Germany and Ireland, Spain is a long-standing EU Member State, is located in Western Europe, and part of the Eurozone, which aids in the comparison of the cases as it reduces the variables.

In support of some expectations of the model, Chapter 6 demonstrates that some of the impacts that are evident in Spain are experienced in Germany and in Ireland, particularly with regard to influences on personnel issues surrounding working time. When the goodness of fit issues arise, adjustments occur at the domestic level in the healthcare system, or rather at the regional level in Spain. Spain shares some commonalities with Ireland due to its national health system structure.

This chapter illustrates that European integration does affect Spain, notably in areas where there is policy misfit. As a healthcare system with relatively high equity, the evidence indicates there is fewer goodness of fit issues that lead to change, at least in terms of what has been detected in the analysis. Of the three case studies examined, Spain exhibited the weakest impact and

knowledge of Europeanisation by its healthcare actors. As is explored in the chapter, this finding might be a result of its national institutions, issues with the methodology, or some combination of alternative explanations

With regard to a feedback mechanism, Spain demonstrates less support for the theoretical model predictions. There is not a lot of feedback mobilisation in the Spanish case, particularly when compared to the other two cases. The decentralisation and lack of coordination between the regions and the national government has impacted the Europeanisation process on the Spanish healthcare system, particularly with regard to the feedback mechanism.

This chapter consists of four parts. The first section of Chapter 6 briefly outlines the development of the Spanish healthcare system, its central regime characteristics and recent reform efforts. The second part explores the anticipated effects of Europeanisation on the Spanish healthcare system based on the theoretical model predictions. The third part presents the main findings from the analysis centred on the findings from the interviews of key Spanish healthcare domestic actors and the subsequent case study analysis. The analysis is presented using the four-component arguments established in the theoretical framework exploring the policy dimensions of EU policy, the Working Time Directive as a critical juncture, the Europeanisation of the Spanish case, and the feedback mechanism and the cost of Europeanisation. Thus, case study support for the theoretical framework is examined. Deviations from the expectations of case study analysis are also explored, including methodological issues and alternative explanations. The fourth and final section concludes the analysis, summarising the findings for the Spanish case, setting the stage for the Conclusion in Chapter 7.

Section 1—Background to the Spanish Healthcare System

The Spanish healthcare system roots in the early twentieth century, but did not develop into its current structure until the second half of that century. A brief description outlines the origins of the Spanish health system as well as its organisational arrangement. Then, a short synopsis of recent reform efforts is presented in order to understand changes to the system to illustrate the priorities of that healthcare system. The Spanish healthcare system origins,

characteristics, and evolution aid in conceptualising the Spanish institutional arrangements, and they help to understand its development and subsequently, how it is affected by the European Union.

Spanish Healthcare System Development

The Spanish healthcare system (Sistema Nacional de Salud, SNS) began in the early 1900s. It covered mainly low-income workers through public social insurance schemes based on employer and employee contributions. Only a small proportion of the citizenry was covered under the system until the 1960s. The Basic Social Security Act of 1967 led to a large increase in the percent of the population covered by the arrangement with it expanding to cover over eighty-percent of the population by 1978. A large system of publicly owned hospitals was created in the 1960s and 1970s, which soon after dominated the hospital market. During the twentieth century, priority was given to developing specialists; general practitioners remained divided and a coherent primary care system did not develop. Ambulatory care remained underdeveloped due to resistance by powerful doctors (Duran, Lara, and Waveren, 2006; Rico and Costa-Font, 2005).

There were many issues facing the healthcare system when Spain transitioned to democracy in the 1970s. There was a lack of system organisation and coordination. The primary and preventative healthcare sectors were underdeveloped. Many citizens were not covered by the system and large inequality existed across people covered by the system. In 1977, all programs and services became the responsibility of the Ministry of Health and Social Security, and the 1978 Constitution entitled all citizens to healthcare under the regional system administered by the National Institute of Health (Duran, Lara, and Waveren, 2006).

In the 1970s and 1980s, Spain began to incrementally transform its system from a social health insurance arrangement to a national healthcare system as existed in most southern European countries at the time. Changes began after the large victory of the social democratic party (PSOE) in 1982 and several general union strikes. The Basque pioneering extension of coverage to non-insurance members prompted central government expansion of benefits at

a national level. First, health centres with a variety of HCPs for their staff were created in 1984 to provide access to primary care for Spanish residents. The ruling social democratic party developed the General Healthcare Act of 1986. This legislation changed the Spanish system from a social insurance system to a national healthcare service administered by autonomous communities (ACs) at the regional level (Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006; Rico and Costa-Font, 2005).

By 1989, incremental reforms had led to the creation of a national healthcare service, and the system had become nearly universal and highly funded from general taxation sources rather than social contributions. Limited decentralisation of services began in the 1980s as well. In the 1980s, additional reforms were passed that aimed to increase healthcare access and improve services. Health expenditures rapidly increased during this time—the fastest in the EU from 1985 to 1990—due to increases in coverage as well as rises in doctor salaries (Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006).

Spanish Healthcare System Arrangement

Spanish healthcare expenditure has been increasing over recent years, though it remains below the average expenditure level in Europe. Spain spent 8.5% gross domestic product on healthcare in 2007. Spanish healthcare spending is broken down among hospital care (54%), pharmaceutical spending (19.8%), primary healthcare (16%) and public health as well as prevention (1.4%) (García-Armesto, et al, 2010). The system expenditure decreased significantly in 2009 due to the economic crisis. However, it increased steadily back to 9.2% of GDP by 2015. Spain has the highest life expectancy in Europe (Bernal-Delgado, et al, 2018).

The Spanish healthcare system hallmarks are universal coverage (including coverage for irregular immigrants) that replaced the old social insurance model, and devolution of healthcare to the regions. The SNS system covers 99.5% of the population. The SNS is funded publicly (71%) mainly through general taxes (94% of public funding) and is run primarily by the public sector. Services are free at the point of access for patients, with the exception of required co-payments for pharmaceutical medications for people under the age

of sixty-five. There is a minor private voluntary insurance (PVI) that is growing in Spain, but covers about 13% of the population with some variation among the regions, accounting for about 5.5% of healthcare expenditure. Outpatient expenditure comprises the remaining 22.4% of healthcare expenditure (Bernal-Delgado et al, 2018; García-Armesto, et al, 2010; Duran, et al, 2006,).

The regional-level—seventeen autonomous communities (ACs), as the existing health literature calls them—is organised to deliver healthcare services since 2002 as services were devolved. The SNS is primarily regulated under the 1986 Healthcare General Act and 2003 SNS Cohesion and Quality Act. Healthcare is about 30% of AC budgets. The regional ministries of health generate health policy and are responsible for planning. The regional health service provides healthcare services. The ACs are also increasingly responsible due to recent reforms for revenue generation and expenditure in Spain. The SISNS comprises of the regional ministers of health with the national minister as chair who coordinates SNS in Spain through consensual recommendations. At the national level, the Ministry of Health and Social Policy (MSPS) has limited authority in certain areas such as pharmaceutical policy and ensuring equitable healthcare service throughout Spain. Some other national Ministries, such as the Ministry of Labour and the Ministry of Education are involved to some degree (García-Armesto, et al, 2010; Duran, et al, 2006).

The Spanish healthcare system fares well from an international perspective with regard to coverage, access, equity, quality, safety and satisfaction measures of the healthcare system as well as on population health. Overall, the system “[obtains] quite good value for money” (García-Armesto, et al, 2010, pp.xxvii-xxix). However, there is much variation in utilisation and outcomes across the ACs. Reforms in Spain have focused on “universal coverage, primary healthcare, financing and management, public health and research” (Duran, et al, 2006, p.xviii).

Recent Spanish Healthcare System Reforms

In the 1990s, dissatisfaction with increasing costs of the healthcare system and long waits to utilise services emerged. As a result, a commission was appointed in 1991 to determine the problems and recommend solutions, and its report

mainly focused on containing system costs and reorganising the service for care improvement. Large public concern from the report developed due to fears that healthcare system privatisation would lead to the downfall of a universal system. The Popular Party won the 1996 national election and strove to increase the role of the private sector and physicians in healthcare (Bernal-Delgado, et al, 2018; Duran, Lara, and Waveren, 2006; Laugesen, 2005; Rico and Costa-Font, 2005).

The introduction of competition into the healthcare system was proposed in strategic plans in 1998, but major reforms in this area have remained limited. Regions allied with unions and other associations against central government attempts at centralisation. Some organisational reforms were implemented to improve healthcare system management. Again, large-scale efforts did not progress far, though regions have been more successful than the state as a whole in implementing legislative change. Much of the 1990s reform nevertheless focused on containing healthcare costs through reforming the existing regional system by limiting budgets and by connecting budget growth to economic growth (Bernal-Delgado, et al, 2018; Duran, Lara, and Waveren, 2006; Laugesen, 2005,).

Spain continues to lack wide-scale competition in the healthcare system, particularly within the insurance industry and among doctors. While some services have been contracted to private sectors, most privatisation efforts have been difficult to implement. The highest income earners are not included in the system and have to rely on private health insurance. Some ACs have tried contracting out services. In 1999, employers began to receive tax breaks for providing health insurance to its workers. Privatisation remains limited due to public disapproval for large-scale market policies in healthcare (Petmesidou and Guillen, 2007, Duran, Lara, and Wavern, 2006).

Due to negative public reactions to the first commission, another commission was appointed by parliament in 1996 to review the healthcare system and suggest reform solutions. Political support for incremental rather than radical change and protection of universality and equity in the system were stressed. In healthcare, professional groups have not been highly unified and as a result, have not had a large impact on healthcare reform. In some cases, though, unions, particularly representing the public sector, as well as national

associations of citizens, of insurers, and of pharmaceutical companies have been able to effectively influence reform legislation (Bernal-Delgado, et al, 2018; Duran, Lara, and Waveren, 2006; Rico and Costa-Font, 200).

Coverage by the system was a major component of reform efforts in addition to increasing system efficiency and reducing cost. In 1999, healthcare coverage was expanded to non-Spanish residents. By 2003, over ninety-nine per cent of the population was covered by the law; the Law on Cohesion and Quality defined the benefits available to most people in Spain. Various efforts were made to decrease waiting list times—the most common complaint of the public against the system—by raising the supply and by increasing options for patients on waiting lists. Strategies for achieving this varied across ACs. National and regional efforts have also been made to assess the level of healthcare technology from 1991 onwards. Coverage was also extended during this time, and long-term care rights guaranteed an arrangement for all citizens in 2005 (Bernal-Delgado, et al, 2018; Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006).

Increased access to primary care has improved to some degree over the past two decades. However, reform was slow to implement during this time, and reformers have been unable to change the system as desired to focus on this level of care. Legislation seems to have improved quality while issues continue to surround accessibility and comprehensiveness. This policy goal has been absent from recent political reform discussion. Mental healthcare benefits were also defined and regulated to guarantee access. A foundation was created to link between various regional organisations and mental health. However, mental health facilities remain undeveloped compared to other components of the healthcare state and other countries' mental health arrangements (Duran, Lara, and Waveren, 2006; Larizgoitia and Starfield, 1997).

The two largest categories of recent healthcare reforms involved the financing and organisation of the service. In 1999, reforms began to be implemented to separate funding and rely more on tax revenue over time, though in many ACs the reforms have been unsuccessful in practice. Decentralisation reforms continued throughout the 1990s as more ACs became

independent over time (Petmesidou and Guillen, 2007,; Duran, Lara, and Waveren, 2006).

As of 2002, all ACs had decentralisation. Thus, ACs gained control over the organisation and provision of services, and the state established the standards. Innovations, particularly in regards to equity, in healthcare administration have occurred due to regional autonomy. Some of this innovation, especially pertaining to the expansion of benefits, has led to national reforms and extensions. The decentralisation led to increases in healthcare expenditures and financing challenges. Inequality issues across ACs have not been fully resolved. There is evidence that despite some inequality, increased efficiency of services has been achieved to some degree due to decentralisation. Regional resources appear to generally be efficiently allocated based on health needs (Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006,; Rico and Costa-Font, 2005).

Some centralisation has occurred in the healthcare system despite decentralisation of healthcare services to ACs. Efforts have been made to implement an information system for the entire country to coordinate care across ACs in 2002, though there is much room left for development. In 2003, the Law on Cohesion and Quality resulted from a negotiation between the political parties in parliament to outline the responsibilities and quality of care across the country despite the decentralisation of healthcare administration. Individual patient rights in the system were outlined. The Law also tried to increase collaboration across ACs. Services covered and not covered by the Spanish system have been clearly detailed by the government (Bernal-Delgado, et al, 2018; Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006).

Cost control reform in Spain has mainly been aimed at increasing efficiency of services, rather than limiting and rationing access to service by implementing measures such as budgets for health centres and patient choice of doctors. Legislation was passed aiming to contain prescription drug costs. A quasi-independent National Medicines Agency was created in 1999 to reduce some responsibilities that had been on the Ministry of Health. In 2005, the Pharmacy Commission approved the Strategic Pharmaceutical Policy Plan to guarantee Spanish inhabitants access to affordable and quality medications. It

also aimed to reduce overall prescription drug costs to the healthcare system. Prescription drug costs have not been curtailed in Spain despite legislative efforts and consume a large proportion of the national budget. Commitment by the public and politicians to free, universal healthcare has proven to make cost control efforts difficult to implement in Spain—unions, user interest groups, and the public generally have blocked multiple efforts to curtail benefits (Petmesidou and Guillen, 2007; Duran, Lara, and Waveren, 2006).

In 2012, new policy was enacted to oversee coverage, benefits, and participation in the system. Despite the decrease in spending from 2010 to 2015, the health cover of Spain is more than 99% of the population with care strongly rooted in primary care systems. Reform efforts of recent years, particularly since the economic crisis, have focused on keeping the health system sustainable, addressing governance issues, expanding coverage, and increasing cost-sharing, especially for pharmaceuticals. Despite austerity measures, equity in healthcare remains at the heart of the Spanish healthcare reforms. The health system proved resilient relative to many other countries in the EU during the economic crisis. (Bernal-Delgado, et al, 2018; Córdoba-Doña, et al, 2018).

Much change has occurred in the Spanish healthcare system though the central tenants remain the same. Major institutional changes have been enacted through incremental changes in financing and ownership. Unions and regional governments have been pivotal actors in regard to reform efforts. Regional governments retain much control over purchasing services and employing healthcare workers. Unions have a large impact on HCP salaries. The two groups together have thus been able to dominate policymaking. Not all efforts to alter the system have been successful. Private interest groups have been weak in the policymaking process and with the increasing market share of the public sector, have become increasingly weak. Public specialists and hospitals, not private providers, were approached for advice for reforms. Thus, recent attempts to privatise have not been successful. However, federalism appears to have enabled some efficiency and equity improvements in the national health services as ACs experiment, compete, and cooperate. The relative resources and powers of various actors thus appear to be key to explaining the evolution of the Spanish national health service (Rico and Costa-Font, 2005).

Spanish reform efforts have largely been influenced by public opinion, trade unions, and public HCPs. Regional governments gained increasing control during reform efforts with system reorganisation designed to increase system efficiency and quality and to expand access. The large changes to the Spanish arrangement, including the extension of benefits and coverage, improvement of equity, and increasing patient choice, have had widespread support by these groups. These interests have been successfully able to block reforms—such as privatisation and rationalising of services and benefits—recommended and at points, pushed by commissions and political parties. Private groups, which comprise a small share of the market, have not been able to exert a large influence on policy. Large-scale pharmaceutical cost controls and the lack of extension of competition to the healthcare market have illustrated the strength of the public sector and the weakness of the private sector. The worldwide trend of increased healthcare marketisation has been dampened in Spain due to public commitment to access to care and the healthcare system support of the existing structure.

Therefore, interest group politics appear to have much impact on healthcare reform efforts. The institutional arrangements—the existing healthcare structures—shape how and which interests are able to exert influence on policy. Change of the arrangement of the SNS has been resistant to liberalising reforms. Spanish reforms illustrate the importance of understanding the varied interest group and institutional dynamics to explain policy change and stagnation. The economic crisis strains national governments and provides an opportunity for more in-depth exploration of interest group influence on health policy reform efforts.

Section 2—Theoretical Expectations: The Spanish Case

The Spanish healthcare system serves as a recently-developed national health system that is in a relative state of transition and flux in comparison to the other two case studies (Germany and Ireland) explored in this thesis. As previously discussed, many systems have, in recent decades, changed from social insurance systems to national health services structures, which may have implications for the Europeanisation process.

As the system is funded primarily by general tax revenue; cost containment is central to the organisation and management of this system. The domestic arrangement typically restricts costs through the use of waitlists and other measures. Competition from other countries that circumvent these waiting periods and other regulatory measures could in theory influence these systems. These systems typically struggle with existing demand and resources, so the system does not fare well with pressures that increase demand.

Moreover, established national health service systems often do not quickly invest in new and costly technology. As the systems are governed by domestic policy, changes should be easily implemented, though difficulty can be encountered commandeering funding for these developments. Requirements may lead to policy misfit and therefore, changes that would not otherwise occur at the domestic level. However, domestic level actors may have to play “catch up,” adjusting to pressures after the fact and would thus have limited ability to affect EU developments.

As outlined in the theoretical model, European integration (the input) may affect the existing Spanish institutional arrangement, resulting in change (the outcome). The process may impact future domestic actor and institutions (the feedback mechanism). The WTD is also expected to be a critical juncture for this process. The domestic institutional arrangement of the SNS should have ramifications for how EU policy influences domestic developments.

As outlined in Chapter 3, EU policies may serve as the inputs in the Europeanisation process. However, some, albeit not all, supranational developments relevant to domestic systems may occur through EU health policy. The effect of the EU on domestic level healthcare systems may predominantly be through non-health policies applicable to health. Within Spain, each AC operates its own healthcare system, in essence, resulting in seventeen separate healthcare systems. As described in the German and Irish cases, trends are visible across healthcare systems. Healthcare systems allocate large proportions of their health spending on personnel, with the most money going to hospital care. The general structure of hospitals in Spain is like the rest of Europe, heavily reliant on personnel and technology. EU policy developments that influence these areas may impact the Spanish case.

EU policy developments may typically derive from non-health policies. The scope and scale of the impact of Europeanisation may depend on Spanish domestic institutional characteristics. One would expect EU policies, especially those pertinent to personnel, technology, finances/reimbursement and service delivery may impact the Spanish case. Again, hospitals in Spain may also prove to be particularly susceptible to EU policy misfit and pressures from European integration. Moreover, one may again expect Europeanisation to occur in piecemeal fashion within non-health policy areas. Now, I consider these ideas derived from the theoretical model related to the WTD as a critical juncture.

According to the theoretical expectations, WTD may serve as the critical juncture and major input. The WTD may have implications for domestic institutions, particularly given the system's low costs relative to other EU countries. As a result, the WTD and its effects may lead to increased awareness and subsequent ideational change for domestic actors. The WTD may highlight EU policy to the Spanish healthcare system. The WTD may also mobilise domestic actors in the EU policy arena, particularly with regard to non-health policies. However, this influence may be limited due to the decentralised nature of the healthcare system and relative weakness of the federal government healthcare. The WTD may impact training and personnel costs for the Spanish system, with ramifications particularly for hospitals trying to contain costs with regard to training and personnel staffing amongst HCPs who have historically worked long hours. The Spanish system may work to try to reduce the impact of the WTD.

As described earlier in the chapter, the Spanish healthcare system reforms have focused on providing universal coverage, increasingly delegating power over healthcare delivery to the local level, and more recently, containing costs. Recently-developed NHSs struggle to effectively contain costs over time and have issues with organisation as the system is not long-established and still in development (Moran, 2000). Another area that has been a strength as well as a struggle for Spain is the disconnect between national and local levels as the recently-developed system is in perpetual flux. Areas such as these are subject to pressures from the EU.

Nevertheless, the Spanish healthcare system remains one of the most cost-effective systems in the EU. It may struggle if forced to implement measures by the EU if the system is not already compliant. As Spain, like many of the Mediterranean countries are a warm destination, there may be pronounced pressure from patient mobility as individuals travel for leisure and relocate for retirement during their older years (a costly age for the healthcare systems). Issues like Patients' Rights Directive may serve more as challenges rather than opportunities for the efficient Spanish healthcare system. This system has low cost and universal care that may attract patients from other countries and is unlikely to lose significant numbers of patients to travel to other countries as the system has high satisfaction with its residents, in comparison to many other domestic healthcare systems. Europeanisation may affect the ability to ration in Spain due to increased pressures.

When European integration affects the Spanish healthcare system, domestic actors may react to these supranational pressures and mobilise to provide feedback into the Europeanisation process. One would expect that the Spanish domestic healthcare sector may try to organise to monitor and influence EU policy pertinent to health, though its capacity may be limited due to the disconnect between ACs and the federal government with regard to healthcare. Spanish domestic actors may initially focus on Europeanisation developments from health policies and may struggle to influence non-health policies.

In Spain, the Ministry of Health is relatively weak as the AC communities are largely responsible for healthcare organisation and delivery. The federal level may have limited interaction with the day-to-day issues of healthcare implementation that arise from EU membership. The issues stemming from the EU may not be primarily in the healthcare field, but rather in areas that indirectly influence healthcare, like employment. Government officials may have some knowledge as they represent Spain at EU-level, but may only have limited knowledge of differences in organisation and functioning across the various AC. With regard to the EU, this may be particularly problematic as the policymakers and representatives to the EU are from the national level, but healthcare delivery remained at the local level, resulting in a disconnect.

The Spanish healthcare system comprises of two hallmark features—universality and subsidiarity to local regions. The federal government works with experts at the regional-level to deliver healthcare, but only provides basic regulations. The structure, organisation, and funding of the healthcare systems are increasingly responsibilities of the ACs. The ACs are the main deliverers of healthcare. The system is highly regionalised. This institutional structure may interact with the Europeanisation process.

Section 3—Empirical Evidence: The Spanish Case

This section builds off of the previous two sections—background information on the Spanish healthcare system and the theoretical expectations—through case study analysis of key domestic actor interviews and supporting evidence. The analysis supports some of the predictions laid out in the theoretical framework. The findings demonstrate common impacts of Europeanisation on the domestic level cross-nationally. Simultaneously, the recently-developed national health service exhibits various struggles with regard to European integration due to unique aspects of its institutional structure.

The third section summarises the empirical evidence for the Spanish case. First, the interviews are presented. Then, the results of the case study analysis are examined to test the theoretical model expectations. The evidence illustrating the WTD as a critical juncture is presented. Then, the findings relating to the Europeanisation process and its dynamics in Spain are summarised. Finally, the analysis as it related to the feedback mechanism is outlined. This section identifies strengths and the weaknesses of the theoretical model as well as the empirical evidence. The results and conclusions are presented, including a discussion of surprising findings and alternative explanations.

Spanish High-Level Interviews

Key healthcare domestic actor interviews were conducted in Spain in Madrid in January and February of 2012 with high-level actors from both government and from the healthcare sector. A second set of interviews was conducted in Catalonia in May 2014 in order to obtain some the regional perspective in order

to fill some gaps from national interviews. The interview breakdown is summarised in *Table 6.1* and in detail in the Appendices.

Table 6.1: Spain Interview Composition

Category	Number of Interviews
Government—bureaucratic	4
Insurance	2
Government—legislative	1
Medical	1
Pharmaceutical	1
Academic	1

As described in the sections above, the Spanish healthcare system is a universal healthcare system with most responsibility for healthcare systems at the AC level. Spain was often described in the interviews as comprising of seventeen separate healthcare systems. The Spanish welfare state historically operates with high autonomy at the regional level. Thus, it is vital to interview actors at national and local levels who implement policies and run the healthcare system.

At national-level, various individuals were interviewed. Three high-ranking officials from government were interviewed. In addition, two experts from the private insurance sector were interviewed. With regard to healthcare professionals, representatives from a medical organisation and the pharmaceutical sector were included in the research; two areas of importance from the existing literature and the theoretical model. Finally, an academic with expertise in healthcare and social policy was interviewed.

Representatives were interviewed from both local and national levels. Three of the interviews were at the AC level in Catalonia, a region noted by many individuals during the interviews. Interviews at the regional level included a former Catalanian Minister of Health, a career bureaucrat from the Catalonia Health Department and a local official who worked in healthcare delivery as well as academia. Important information was obtained from the local interviews. Future research should explore the various regions in more detail in order to

obtain a more complete and representative understanding of the differentiated effect in Spain as the effect will vary across the regions. Nonetheless, the regional interviews illustrated that the effect of the EU was more evident at the local level than at the national level in Spain. The interview data structured the topics and focus of the resulting case study analysis.

Spain and The Working Time Directive

As discussed in Chapters 2 and 3 as well as explored in the case studies of Chapters 4 and 5, the WTD is an indirect EU policy pertaining to employment rights with potential influence on domestic healthcare systems. It also serves as the case to explore the expectations of the theoretical model process from start to finish. The WTD and subsequent ECJ rulings, ***a series of critical events***, applied and expanded the policy to cover healthcare professionals as well as their on-call time. The Spanish case transposed the policies domestically. However, evidence indicates a lack of enforcement and circumventing of restrictions. Consequently, various ECJ cases pertaining to the WTD were raised by Spanish professional organisations. This included the *SiMAP* case⁵⁴, which challenged the application of the WTD in the Spanish healthcare context and was brought forward by the Spanish public health doctors' union (Sindicato de Médicos de Asistencia Pública or SiMAP). The ECJ applied the WTD and ruled that on-call hours in the health centre qualified as working time if they are required to do so (Matheson, 2015).

The WTD was transposed into Spain legislation through the Law for Health Professions of 2003 (López-Valcárcel et al, 2006, p.123). Therefore, there was ***institutional change*** with regard to policy. However, no region in Spain was fully complying with the standards by 2006 (López-Valcárcel et al, 2006, p.123). The lack of compliance illustrates feedback and domestic kick-back to the regulations.

The ***feedback mechanism*** is further apparent in the Spanish reaction to the WTD. Spain obtained a temporary opt-out to some provisions of the WTD for health care professionals through 2013 (Hervey and McHale, 2015). This

⁵⁴ *Sindicato de Médicos de Asistencia Pública v Conselleria de Sanidad y Consumo de la Generalidad Valenciana*

opt-out was put into policy through Law No. 55/2003, Framework Statute of statutory staff in health services. The opt outs expired in 2013 (Eurofound, 2015). The Spanish system does not directly legislate for on-call hours (Eurofound, 2008), which appears to further provide Spain with some flexibility with regard to fully implementing the WTD. It also illustrates importance of collective agreements rather than legislation and the power of unions, an ***institutional characteristic of the system*** in Spain (Eurofound, 2008).

The Spanish qualitative analysis focuses heavily on the on-call implications of the WTD. Although this issue arises in the German and Irish cases, these systems were concerned with the broader net hour restrictions. In Spain, “there was a big discussion on duty time” due to EU regulations limiting working hours (S2, Jan 2012), illustrating ***the institutional and ideational impact***. The time on duty for doctors counts as normal working, so the WTD proved to be challenging for small hospitals and healthcare. Officials argued that it made large hospitals nearly “impossible” to run in Spain (S2, Jan 2012). Therefore, Spain confronted similar issues to Ireland and Germany of not adequately monitoring indirect EU legislation and were forced to comply with the WTD. Thus, the WTD proved to be ***costly*** to the Spanish healthcare system.

The WTD was controversial and problematic (S7, Feb 2012), illustrating the ***ideational impact*** of the WTD on Spanish domestic healthcare actors. A domestic actor complained that those policymakers that had negotiated the WTD “had no idea how health systems work” and did not realise the resulting “huge” implications the policy would have for regional healthcare systems. The WTD had large unintended consequences for healthcare finances as well as organisation (S10, May 2014).

The WTD proved to be problematic for some regional Spanish health authorities, ***exacerbating existing domestic health system issues*** in line with the theoretical model predictions. Doctors are contracted under the public system with relatively low base salaries. The system historically allowed doctors to work privately to supplement their income. However, the controversy developed over the restrictions the WTD places on total hours worked. An estimated third of all doctors in Catalonian region, for example, work overtime

to supplement their salaries, which the WTD challenged (S8, May 2014) contrary to health professional wishes.

However, the domestic actors and institutions seem to have adapted to the WTD supporting the argument on the *feedback mechanism*. Thus, with regard to the WTD, the system is able resist change to some degree. The Spanish system also indicates that it resisted domestic compliance to try to maintain its existing arrangement.

Table 6.2: Critical Juncture Summary for Spain

Critical Event(s)	Ideational Change	Institutional Change
<p>Regulation</p> <ul style="list-style-type: none"> • Directive 2003/88/EC & 2009 implementation • Directive 2000/34/EC • Directive 93/104/EC <p>ECJ Decisions</p> <ul style="list-style-type: none"> • <i>Jaegar</i> (2003) • <i>Pfeiffer</i> (2005) 	<ul style="list-style-type: none"> • Domestic importance of EU policy (health and non-health policy) • HCPs challenging implementation of EU policy • Importance of monitoring and lobbying at the EU level 	<ul style="list-style-type: none"> • The Law for Health Professions of 2003 • Law No. 55/2003, Framework Statute of statutory staff in health services) • Fiscal costs • Changes to shifts • Some opt-out until 2013 for health sector • Lack of recording and enforcement • European Commission requirements to comply and track

For example, studies indicate that in Spain, healthcare systems do not fully comply with the requirements as they pertain to the WTD. There is evidence that Spanish doctors report hours that are less than they are working to appear to be compliant with working time restrictions when they are not in practice (The Lancet, 2010). There is a lack of recording hours, overtime pay and overall implementation (Vražić, 2015). Many doctors in Spain are working more than 48-hour week without compensation (Temple, 2014).

Consequently, HCPs have been active in trying to enforce the WTD in Spain. Junior doctors in Spain brought a case to the ECJ in which the ruling maintained that even when sleeping, on-call hours constitute working hours and

are restricted by the WTD (The Lancet, 2010). In March 2013, HCP trade unions complained about the lack of compliance, including weekly limits and mandated rests. The violations were particularly pronounced for training HCPs. In 2014, the European Commission instructed Spain to better track its time as WTD requirements were not being met (Eurofound, 2015), illustrating **ideational impact** on HCPs with regard to the applicability of EU policy to the domestic level

In conclusion, the WTD illustrates that EU policies influence the Spanish healthcare system, including non-health policy. The impact of the WTD, like the other two cases, was major, resulting in both ideational and institutional alterations. The Spanish system opted out and resisted changes to minimise the negative feedback. Eventually, compliance was ordered by the EU. The power of HCPs is apparent in the WTD, an institutional characteristic of Spain, as they enforced eventual compliance. The next section looks more broadly at the policy dimensions of EU policy as they apply to the Spanish context and their resulting domestic impact. The WTD illustrates the impact of the EU on domestic healthcare systems, but does also highlight issues with enforceability of policy by EU institutions.

The Europeanisation of the Spanish Healthcare System

The findings from the case study analysis support central tenets of various dimensions of the theoretical model. Namely, there is an EU policy input that comprises of both health and non-health policies. These EU policies interact with the insecure national health service. Binding policies must be transposed into national practice. Due to the developing and decentralised nature of the Spanish healthcare system, there does not appear to be the as consistent and discernible impact of the EU as it is in the German and Irish case. This finding may stem from disorganisation, however, rather than the absence of an influence. It also could point to issues with the methodology, including the timing and semi-structure nature of the interviews. It also may support alternative hypotheses about the impact of the EU on domestic systems, particularly in Spain. Further in-depth follow-up of the Spanish system would help shed more light. Nonetheless, some impacts are evident in the analysis.

Types of EU Policy

The Spanish case illustrates that direct EU policies impact domestic healthcare. Binding policies in health that must be implemented domestically are limited. According to one actor, the “EU is influencing national policies in many ways” (S7, Feb 2012). There are specific regulations on topics like human tissue at the EU-level where the European mandate is established (S7, Feb 2012). However, the topics brought up are diverse and relatively minor in their scope.

Nonetheless, when these policies are adopted, they have an impact on the Spanish case. The Spanish government transposes binding health policy. Binding health policies that arose in the Spanish case are summarised. The Patients’ Rights Directive (PRD) illustrates again where the interview data suggests that a major impact is expected. However, in actuality, the evidence like in the Irish and German cases does not point to a lot of patient mobility. In fact, data in Spain seems to indicate that the Directive led to a drop in foreign hospitalisations (Amuedo-Dorantes, et al, 2021). The dynamics of the PRD are briefly presented, which allows comparability to both the German and Irish cases. There are limitations with the interview data as the PRD was being implemented at the time. Nonetheless, it raises an unexpected finding of the anticipated effect being larger than the actual effect. Again, like in the other cases, this appears to be due to the fact that the PRD largely codified a string of ECJ rulings.

Patients’ Rights Directive

PRD is a major health policy impact in all cases studied. However, this policy appears to be particularly important to the Spanish system as perceived by the actors interviewed (S2, Jan 2012; S6, Jan 2012; S8, May 2014; S10, May 2014). The system had to adjust legislation and the organisation of care to cope with the requirements and extra demand, respectively. The large influx of patients from other MSs had implications for the Spanish system.

From 2010, there was little structural change made to the Spanish healthcare system. Reforms focused on sustainability. One of the other main areas of reform from 2009 was the transposing of the PRD requirements. Based on this policy, RD 81/2014 on cross-border health care was enacted to allow for

patients to obtain treatment abroad, covered by the SNS. In addition, the National Registry of Health Care Professions (RD 640/2014) was created to collect information across the ACs (Bernal-Delgado et al, 2018). .

The tourists and pensioners that Spain receives from throughout Europe concerns domestic actors as it can be costly for and burdensome on the health service. (S2, Jan 2012; S6, Jan 2012). Domestic worry surrounds the potentially adverse effects of the PRD on the Spanish citizenry by impacting access to services (S2, Jan 2012; S6, Jan 2012). Local health departments have been examining waiting lists as a potential solution in order to minimise the adverse effects of movement of patients from other EU countries on Spanish citizens (S10, May 2014).

The PRD offers potential opportunity for health tourism to Spain by attracting patients due to low costs in comparison to other MSs. In the long term, the PRD may change how to ACs manage services (S2, Jan 2012; S10, May 2014). The impact of the Cross-Border Healthcare Directive was not fully seen at the time of the interviews. The Directive will result in importing patients, attracting them to the efficient system rather than export them. The prices in Spain are low compared to other countries in Europe (S10, May 2014). Another potentially expensive issue that concerned domestic actors was that people might temporarily move to a Spain in order to receive a treatment that they cannot receive in a timely fashion from back home (S8, May 2014), which could result in negative feedbacks through costs.

Figures from PRD usage shows that, within the EU, patients travelled the most to Spain and France (European Parliament, 2019). For example, €11 million of the €34 million Ireland paid for claims for healthcare abroad went to Spain (Cullen, 2017). In 2013, the European Commission took action against Spain when hospitals rejected EU patients' travel cards due to cost pressures (Footman et al, 2014). However, Spanish residents do not appear to be travelling to receive care themselves (Amuedo-Dorantes, et al, 2021).

Domestic actors worry about the cost of the PRD to Spain. In Spain, there is concern that the PRD could cause issues with billing as many health providers do not traditionally bill but would need to do so to reclaim costs from visitors.

There will be an issue with primary healthcare centres as they do not traditionally bill for services. A system was set up as a result (S2, Jan 2012).

Additional costs stem from the reporting requirements under the PRD. Hospitals and healthcare services in each country must publish statistics on costs, efficiency, quality and waiting lists. The reporting adjustment costs for Spain are minimal as these accountability measures were already published prior to the WTD (S10, May 2014).

An issue unique to the Spanish decentralised system was highlighted by the local interviews. Catalonia cannot bill the country of origin when patients come from other countries. The region is not allowed to bill other countries. Only one state can bill another. As a result, for many years, Catalonia was unable to bill for care received by non-Spanish residents, such as seasonal residents. The new PRD helps to alleviate this issue to some degree (S8, May 2014).

With regard to the Patients' Rights Directive, the main concerns came from regional officials due to issues in reimbursement that the decentralisation of the national healthcare system causes, a structural obstacle that was not found in other European countries like Germany. Concerns surrounded the increased cost for governments as Spanish healthcare is primarily funded through tax revenue. Older individuals from other MSs have not paid into the system for years and can adversely affect costs. As Spain delivers universal, effective, and low-cost care, there is no concern over losing patients. The data seems to support those Spanish patients are not travelling for care (Amuedo-Dorantes, et al, 2021). The influx of travellers for care has been perceived not just as a burden on the healthcare system but also as a growth opportunity by the government (Finotelli, 2021). Spain has the potential to be a centre for medical tourism (Tapia et al, 2020).

Overall, the PRD appeared as if it would be of major impact. Across the three case studies, the effect seemed to be the most sizeable for Spain, but it still did not meet the criteria of being of major impact. This finding may be due to the high approval of Spanish services, the relatively low cost of the services compared to other countries in Europe and a large number of both retired people and tourists in Spain.

Spanish Variation of Europeanisation

In the Spanish system, as one actor explained that “the European effect on the Spanish healthcare system has been minimal” (S6, Jan 2012). In comparison to Germany and Ireland, the perceived effect of the EU on health services appears to be low. Part of this finding seems that it could stem from a relatively efficiently run Spanish healthcare system that is not influenced by pressures from misfit given the nature of the Spain system. The Spanish system is perceived as high quality and high efficiency. This finding opens the door for more detailed future research.

One policy area in particular, that had interesting findings from the interview and case analysis, pertained to pharmaceuticals, which play a central role in the Spanish healthcare system.

Pharmaceutical Policy

The pharmaceutical sector is one of the most regulated parts of the Spanish economy and recent reforms have focused on drug pricing (Bernal-Delgado, et. al, 2018). During the interviews, the role of the EU in pharmaceuticals was discussed extensively, particularly by comparison to the other two cases. Many actors had a lot of knowledge on the topic. Given the overall perception of a strong EU impact, the dynamics and highlighting of pharmaceuticals are interesting findings. These impacts were evident through hard and soft policies.

The Spanish domestic actors pointed to the role that the EU plays in monitoring and coordinating to ensure minimum quality standards and safety (S7, Feb 2012). For example, The Royal Decree 577/2013 from 26 July 2013 was enacted, amending the Law 29/2006, 26 July, on the guarantees and rational use of the medicaments and health care products. This Spanish policy implements the EU Pharmacovigilance Directive 2010/84/EU and EU Regulation No 1235/2010 (Ortiz, 2014).

This Spanish policy pertains to information on safety and the availability of medicine. The legislation increases communication, participation and transparency as it pertains to medication safety. It outlines the role of the Spanish Agency for Medicines and Health Products. The European Commission monitors compliance with the Directive (Ortiz, 2014). This Royal Decree also

implements the Falsified Medicines Directive, 2011/62/UE (Bernal-Delgado et al, 2018). Spain has struggled with counterfeit medicines with its illicit trade worth about €1.4 million in 2015 (IRACM, 2017). The impact of these EU policies is generally classified as minor but can have implications for the safety and organisation of the health system. Implementation costs and policy changes are minimal as existing domestic policies and organisations were adjusted to the new standards.

Domestic actors noted some positive results stemming from Europeanisation. Working with other countries was discussed in interviews. The pharmaceutical industry was referenced as a policy area that benefited Spain (S4, Jan 2012; S6, Jan 2012; S7, Feb 2012). Pharmaceuticals comprise a large proportion of Spanish healthcare spending, so cost savings in this area are present on the reform agenda.

The pharmaceutical industry in Spain works closely with officials in other countries, such as in Ireland. Government officials from the various MSs meet on the pricing of pharmaceuticals (S6, Jan 2012). DG SANCO supports coordination across countries, and representatives from the Spanish healthcare system are actively involved in their activities (S7, Feb 2012). According to the European Federation of Pharmaceutical Industries and Associations (EFPIA) price cuts saved five EU countries, including Spain, ⁵⁵ over €7 billion from 2010 and 2011 (Deloitte, 2013). Therefore, information-sharing and networking have influenced Spanish pharmaceutical prices. It is an interesting finding that was not expected based on the model theoretical predictions.

Overall, the findings from the Spanish case support the theoretical model arguments on the input and outcome of Europeanisation. Other non-health policies were evident in the case study analysis of Spain, like the movement of professionals, though their influence would require more systematic exploration

⁵⁵ Greece, Ireland, Italy, Portugal and Spain

to include.^{56,57} The effects of the EU are largely minor in Spain with the exception of the WTD, in line with the other cases. *Table 6.4* summarises the inputs and outcomes in the Europeanisation process from this section.

Table 6.3: Summary of the Input and Outcome in Spain from Interviews

EU Policies (Input)	Domestic Impact (Outcome)
<ul style="list-style-type: none"> • Dominance of minor not major policies in health policy • Patients' Rights Directive only cited example of major health policy • No cited examples of non-binding non-health policy • Importance of personnel topics in non-health policy domain • Higher impact of non-health policies than health • High level of awareness by domestic actors, particularly by HCPs • Actor concern over impact of the EU on system costs 	<ul style="list-style-type: none"> • Exacerbates existing domestic issues, like staffing • WTD and PRD major impact • Increased demand perceived from PRD • Representation at EU-level by national government • Disconnect between national policymaking representative and regional service delivery • Low implementation cost due to spending and technical nature • Limited compliance with the WTD • Larger impact of non-binding policies than the model predicts (importance of resources) • Benefit of Europeanisation in staffing and pay from competition

⁵⁶ Another EU impact referenced by domestic actors in the regional interviews was the construction of a border hospital between Spain and France. The European Development Funds were used in Catalonia to build a hospital on the Spanish-French border on the Pyrenees Mountains; from 2007 to 2013, the Fund contributed €18.6million of €28.6million development costs. The Catalonia and French government split the costs of building the hospital with the help of European regional funding. The hospital provides needed care in light of regional service shortage and cross border services. The hospital is a unique arrangement in Europe and illustrates the benefits that the EU can provide to national healthcare systems (Sanjuán and Gil, 2013; European Commission, 2014; S8, May 2014; S9, May 2014; S10, May 2014).

⁵⁷ In keeping with other cases, various other non-health policies were apparent in the case study analysis. They included the free movement of goods, professionals, and people. Free movement and mutual recognition of qualification policies have implications for HCPs coming into, leaving and remaining in Spain. Studies indicate that the impact of European integration on HCPs in Spain has largely been positive. Mobility of HCPs is highly important to Spanish healthcare relatively to other countries (López-Valcárcel et al, 2011).

Spain exhibits some impacts similar to those seen in Germany and Ireland. Despite the less pronounced Europeanisation effect, some interesting findings are evidence that supports the national varieties concept that illustrates the potential for further exploration. Spain has a weaker Europeanisation influence compared to the other cases. This finding may support a national varieties explanation, particularly if there is a high goodness of fit of Spanish policy with EU policy. Moreover, the decentralisation nature may affect awareness of the phenomena. It also may indicate that alternative explanations of a weakening Europeanisation occur in Spain. Finally, it may be a result of the interviews themselves and the limitations of the methodology employed in the Spanish content.

The Feedback Mechanism

Overall, the qualitative analysis indicates that there are lower levels of domestic institution and actor engagement in the Europeanisation process than in the German and Irish case. A comparatively weaker feedback mechanism occurs due to the insecure and decentralised nature of the Spanish system where healthcare is largely regional; the lack of a central organisation and hierarchy impedes mobilisation at the EU-level. Limits in EU-level mobilisation capacity building thus impedes feedback, both positive and negative.

Capacity-Building in EU Policymaking

As discussed earlier, the evidence indicates that there are limitations in EU-level mobilisation of Spanish healthcare actors surrounding effective Spanish input on European legislation.

The federal level generally represents Spain at EU-level. The regional level, as the healthcare service provider, is aware of the costs. However, Spanish regions do not appear to mobilise at EU-level. This finding is in line with the literature that with regard to Europe, regions do not have the capacity, resources or influence to affect supranational policymaking (Hooghe and Marks, 1996). Some more specific regions, like Andalucia, try to ensure they are represented in EU policymaking (Greer, 2009).

The Spanish national government does not appear to be very active and where they are active, are criticized by some at local level as disconnected and unaware of the issues (S9, Jan 2012). The disconnect between the ACs and the Spanish national government as well as lack of coordination between the ACs may result in a lack of information, a concept articulated by some interviewees (S5, Jan 2012; S7, Feb 2012). The EU actor mobilisation of the Spanish government in health is at the top of the hierarchy and not close to regional level. The Minister of Public Administration represents Spain on the Councils pertinent to health (Greer, 2009). Under Zapatero's government in the early 2000s, regions were given the ability to represent in some capacities at EU level.

With regard to the resulting feedback mechanism, the Spanish healthcare system is comparatively weak relative to Ireland and to Germany. The pharmaceutical industry has influence and works with EU level officials (S6, Jan 2012); this sector is relatively well-organised in a cross-national manner independent of domestic arrangements. Other interest groups did not note a particularly large influence of the EU on the Spanish domestic healthcare systems. One group that noted little influence was private insurance (S3, Jan 2012), which is unexpected given the EU policies related to insurance.

There are limitations to the feedback mechanism in the Spanish case in comparison to the Irish and German cases. The Spanish groups participate at low rates at European-level and are not particularly active in the policymaking process through measures like consultation (Greer, 2009). The capacity in Spain has historically been limited, though changes over the recent decade may result in additional regional representation in the EU policymaking process. Despite the limitations in capacity, there is evidence of positive and negative feedback in the Europeanisation of the Spanish healthcare system.

Negative Feedback

The role that the Spanish system plays in shaping and influencing European policies pertaining to health for its benefit or to avoid adverse consequences appears to be limited due to the lack of centralisation and organisation of the domestic actors as explored in the capacity-building section. There also does not appear to be the same degree of an ideational shift in Spain, apart from the

regional domestic actors with service delivery responsibility, as there is in Ireland and Germany, about the importance of supranational policy development.

The engagement in health at a European level by Spanish officials is relatively low compared to other EU MSs (S6, Jan 2012), consistent with findings of other researchers (Greer, 2009). The national level represents the regions at a European-level, but this is more on technical issues and in European projects, less in the policy (S10, May 2014). Generally, the domestic actors did not seem concerned about negative feedback and had a positive view on the role of the EU, albeit it was typically viewed as limited in scope.

Specifically, the example of the WTD shows that the Spanish system did react to resist perceived detrimental change. An opt-out of WTD with regard to health was achieved. Although the “Spanish health care system lacks a culture of lobbying, and that includes Brussels lobbying” (Greer, 2009, p.157), domestic actors are able to mobilise, particularly with regard to feedback into major policies in comparison to minor ones.

Specifically, the lack of coordination between the federal level that speaks on behalf of Spain and Europe through the seventeen different ACs that deliver the healthcare system may impede the ability of Spain to mobilise at EU level. With regard to the EU, scholars have established in the Spanish healthcare system, the states have “fewer power, responsibilities and resources” compared to other MSs (Greer, 2009, p.143). The federal government works with ACs on healthcare issues, but the main responsibility for healthcare is given to the seventeen ACs. This dynamic limits regional mobilisation at the EU level.

However, coordination may occur across Spain to overcome regional obstacles. Some regions may successfully mobilise, but not all based on regional capacities and resources. Many Spanish healthcare elites are positive about the EU and discuss that they will “just accept and go along with EU policies rather than reflect on them” (Greer, 2009, pp.143-144). In summary, the Spanish system thus may simply “deal” with European integration rather than actively engage in the process. The disconnect between the national and federal levels seem to affect Europeanisation.

Positive Feedback

Due to the limited capacity of Spain in providing feedback to the Europeanisation process, there is limited positive feedback. Spain domestic policy has been applied to some EU policies. Regions are not particularly strong with regard to EU capacity. Other actors, as the case of the WTD illustrates, are better organised and effectively use EU policy. Unions for HCPs, a historically influential actor in Spanish health reform, have been able to utilise EU policies to advance domestic interests.

Participation in non-binding policies has resulted in some benefits for Spain. The Spanish healthcare system actors also expressed the importance of European funding and information-sharing. The Spanish healthcare system utilises funding and programming to its benefit, as with the Border Hospital example discussed earlier. Information on pharmaceutical pricing helped reduce drug spending costs in Spain.

Limitations to Spanish Feedback

As the capacity section lays out, there are significant limitations for domestic actors to engage in EU policymaking in Spain. The Spanish government is historically not active in lobbying with regard to health at an EU level. Regions, which administer most of the healthcare in Spain, are not well-represented. There are cases of feedback, but overall, the capacity of Spanish domestic levels to affect supranational change appears limited.

Summary

The central findings with regard to the feedback mechanism are summarised in *Table 6.5* on the next page. Overall, the capacity and policy scope of the Spanish case at EU level appears to be relatively weak. The WTD highlights that there are instances where the domestic actors, if they deem it important, can mobilise to try to affect change. However, in the Spanish case, the focus appears to be on domestic factors with limited concern for EU developments. As was the case with parts of the WTD and PRD, some Spanish actors ignore or circumvent requirements when the system is overstrained.

Table 6.4: Feedback Mechanism Summary for Spain

Capacity-Building	Negative Feedback	Positive Feedback
<ul style="list-style-type: none"> • Spanish government representation dominance at EU-level • Lack of representation of the regions at EU-level (some recent changes) • Lack of a lobbying culture in Spanish healthcare • Some interest group mobilisation (e.g. pharmaceutical and HCPs) 	<ul style="list-style-type: none"> • Dominance of negative feedback as primary feedback • Disconnect between national and regional levels in health impeding mobilisation • Focus on opt outs after policy implementation • Lack of compliance with parts of the WTD and PRD 	<ul style="list-style-type: none"> • Not central feedback mechanism but added benefit • Capitalising on EU opportunities when possible (funding and information) • Employment of EU policy by HCPs for domestic benefit

Section 4—Spain Case Conclusions

In conclusion, the case study results of Spain indicate the weakest detectable effect of Europeanisation out of the three case studies that this thesis examines. This result is not surprising based on the predictions from the theoretical model once it is adjusted for domestic-level factors in Spain, namely its recently-developed structure and decentralised (regional) organisation. However, it could have to do with the level (or lack thereof) of misfit of EU policies with domestic-level. Alternatively, there may be a lack of awareness among those interviewed in Spain, illustrating a methodological issue. This cross-national comparison coupled with the domestic case study evidence points to some interesting potential findings and trends as they pertain to Spain. The developments related to pharmaceuticals point to interesting findings even in a case with relatively weak evidence of Europeanisation.

Firstly, the Spanish case exhibits support for various components of the theoretical model to some degree, but to a much lesser extent than do the German and Irish cases in Chapters 4 and 5. The WTD, as it does in the other two cases, appears to serve as a critical juncture of clear institutional change. There is some ideational change noted by awareness by some of the domestic actors interviewed. However, this ideational change is markedly less strong in

interviews for this case than it was for Germany and Spain. This difference could be due to the selection of those interviewed or a finding stemming from the domestic arrangement in Spain; additional studies' interviews should be conducted to expand the breadth and scope of the qualitative analysis, specifically in Spain across different regions. In the case of the WTD, there is some evidence that indicates that not only has Spain struggled to implement the WTD, but it also may alter its HCP timekeeping in order to mask its full incompliance.

The case study analysis of Spain also supports the other aspects of the theoretical model. The policy dimensions of Europeanisation comprising of health and non-health policies, both binding and non-binding in commitment, are demonstrated by the case. The domestic impact of this supranational development occurs in Spain, but the influence does not appear to be as strong or as wide-reaching as it does in the German and Irish case studies. The feedback mechanism in Spain appears to be relatively weak, which may be due to the organisational challenges the system faces, as the model predicts, or issues in the data examined.

The findings from the analysis can indicate one of two possibilities as it pertains to the outcome variable of the theoretical framework. It is not entirely clear from the case study analysis if there is less of an impact of European integration on the Spanish case or at least less of a perceived impact by domestic actors. Alternatively, the insecure and decentralised nature of the Spanish healthcare system may result in difficulty detecting at the national level. It is important to note that the results are in line with the institutional organisation in the case of a recently-developed system. The Spanish system is an insecure and highly regionalised (decentralised) system that continues to evolve. Therefore, the focus seems to be on domestic-level factors and not European ones.

Consequently, this central finding warrants further exploration and study through more detailed Spanish analysis to determine if the lesser effect in comparison to other European cases is, in fact, less European integration or if it is less awareness of Europeanisation by Spanish domestic actors in comparison to their German and Irish counterparts. Further research should explore

selected examples of policy in greater detail to try to better understand the trends and patterns in Spain. An alternate methodology may need to be employed to more fully understand Spanish developments. The semi-structured interviews are heavily reliant on domestic actor awareness as it relates to Europeanisation. If the Spanish system, or at least many of its domestic actors, are not actively engaged with these supranational developments, the case study analysis may have underestimated the EU influence.

The government actors in Spain, particularly those at the regional level, were most aware and active with regard to European integration. The federal level is relatively weak compared to the regional level in Spain. The regions seemed influenced by European integration compared to other domestic actors and struggled with the disconnect between the national level that works to help make European policy and the local level that is responsible for payment. This disconnect between the provision of services and policymakers is evident in the Irish case too to another degree. An in-depth regional analysis may be required to better understand the Europeanisation of Spain due to its decentralised organisation.

Nonetheless, some trends can be extrapolated from the domestic actor interviews. Domestic actors in the Spanish healthcare system seem the least concerned about the influence of the EU on its system compared to Germany and Ireland. It was often noted that Spain had an effective system that delivered quality care at a low price compared to the other Member States. Therefore, it generally did not seem vulnerable to many of the pressures of European integration to compete on cost and quality, two measures by which Spain performs relatively well in comparison to other European healthcare systems, which supports some of the central tenets of the explanatory framework. This warrants more analysis as it might indicate support goodness of fit arguments and why there is minimal Europeanisation detected. In addition, like in the other two cases, resources and networking appear to be of value to healthcare systems, especially NHS systems, working to figure out how to best maximise limited resources.

Spanish domestic actors highlight one particular area of concern that was relatively more pronounced than it was in the other case studies and that was

PRD. Patient mobility was of interest to the Spanish healthcare system. However, due to the low cost and capacity of the Spanish healthcare system, the potential impact is more of attracting patients rather than losing citizens. The added cost of a large number of pensioners retiring in Spain was of concern. Localities utilised waiting lists in order to avoid the adverse effects of attracting patients from other countries on the national system. Issues arose in Catalonia, for instance, in seeking reimbursement from other MSs to which it was entitled as only the national government, not the region could seek reimbursement. However, many of these issues appeared to be alleviated with time. The data initially indicates that Spain does have more medical tourism than other countries in the EU, but the systematic influence on the system does not appear to be of major impact.

Overall, Spain has been subject to pressures from European integration due to what appears to be from a lack of coordination and centralisation with the federal government that represent the regions at an EU level. Other important topics, like pharmaceutical expenditure, have also been touched by policy. However, the newly developed national system appears to adjust to pressures but does not engage in much lobbying due to centralisation issues that affect capacity. Thus, over time, the combined perceived effectiveness and equity of the Spanish healthcare system has limited the pressures from the EU, which is unusual in a cross-national European context in line with the goodness of fit explanations. The lack of coordination and centralisation, however, has caused some issues, and a general unawareness of the national situation as a whole seems to persist. Therefore, there may be either a lack of a Europeanisation effect or a lack of awareness to some degree of the full extent of the impact of European integration on the Spanish healthcare system or rather on the seventeen different regional healthcare systems in Spain—this finding warrants more analysis.

Chapter 7

Conclusion

Introduction

This dissertation seeks to explore the process of the influence of supranational developments, specifically the EU, on domestic healthcare systems. Many scholars have examined the impact of Europeanisation on domestic systems and how it is changing over time. This process is particularly complicated with regard to healthcare systems due to the breadth and scope of EU health and non-health policies that have implications for its development. Both the EU and healthcare systems are evolving. As such, research must also continually change and re-evaluate explanations. This thesis builds off the existing literature, outlines a theoretical framework, tests the model with qualitative analyses in order to further understand the complex interplay between the EU and domestic healthcare systems. The evidence explores how European integration affects healthcare systems across varied systems while exploring the unique trajectories countries' follow.

Contribution of the Thesis

This thesis makes three main contributions to the existing literature. It strives to review and summarise four relevant literatures relating to the welfare state, healthcare systems, Europeanisation of domestic healthcare systems, and EU health policies. The thesis provides a summary of the state of the literatures. Then, existing explanations are reviewed and tested. The thesis explores common ground and overlapping ground for research where the four literatures can unite to improve the understanding of healthcare systems, of European

integration, and of policy and institutional change. Exploring areas of intersectionality offers opportunities to provide additional insights to further develop and improve literature arguments. The qualitative analysis of three country cases also adds to the existing literature.

The second contribution of the thesis is the addition of new data, particularly through high-quality interviews. Forty political elites from domestic and EU levels were interviewed about the impact of the EU on healthcare systems. This information was used to guide and focus the case study analysis. The model opens the door for further investigation, development and refinement through complementary and detailed analysis and follow-up research. The interviews point to important findings that add additional insight to the literature. The results illustrate the importance of qualitative methods of analysis, particularly in complex subject areas. The political elites offered insights into the Europeanisation process and their experience that other methods of analysis could not shed light on.

The interview results structured the resulting qualitative research. It guided the focus of the thesis and helped to determine where to focus in a complicated subject area. The case study analyses of Germany, Ireland, and Spain provide further contribution to the Europeanisation literature development. Smaller countries such as Ireland, are not as frequently included in the literature as other larger Member States. Exploring additional countries, policy examples, and developments, contributes to the knowledge base of the literature as a whole.

The third and final contribution of this thesis is the outlining of a theoretical framework over time and across countries, which is rooted in the established research. In essence, this thesis works to develop a model for national variations in the Europeanisation of healthcare systems. This theoretical construct employs institutional change constructs to explain the Europeanisation of domestic healthcare systems, whose principles and insights could also be evaluated for their usefulness and applicability in understanding the impact of European integration on welfare states. The model combines welfare state change and healthcare system regime categorisations, which scholars like Wendt and Bramba have highlighted as an important area for

development (2020). This thesis shows that the overarching principles and frameworks from the welfare state literature add insight to healthcare system analysis, particularly when exploring overall trends.

The model highlights not only the importance of the supranational influence from the EU on domestic healthcare systems, but also the significance of a resulting feedback mechanism from domestic actors. In this interactive process, domestic actor response to institutional pressures illustrates the process of Europeanisation as not only top-down, but also has a bottom-up component. How Europeanisation process works remains subject to debate, so this finding adds insight. European integration is not a static or unidirectional process. The domestic institutions and the actors not only react to the pressure of European integration, but also rationally seek to influence future EU policy in some cases, depending on institutional arrangements. Case study evidence supports many elements of the model developed, though there are weaknesses and surprising findings, which are summarised later in this chapter.

Research Questions

On whole, the thesis seeks to determine the degree to which and the manner by which European integration affects domestic healthcare systems across Europe by examining three representative cases—Germany, Ireland and Spain.

The three cases represent much variety with European healthcare systems. They range in the size, financing, and structure of the healthcare systems, including the role that insurance plays in the system. One of the countries are small, the others are large. Two are federal systems, and the other is centralised. The development stage of the healthcare systems also varies. Similarities also exist—they are all Western European countries that are part of the Eurozone. Based on the range of healthcare categorisations, this selection appears to capture a lot of variation in arrangement across Europe. However, there are limitations in the selection, particularly with regard to testing the model in Central and Eastern European countries.

Specifically, the thesis focuses on answering six central questions by presenting a theoretical model rooted in the research and testing it through case study analyses of three countries:

- *How does Europeanisation affect their domestic healthcare systems?* Europeanisation does prove to alter domestic healthcare systems, though there is variation in when and the extent to which it does across systems. In line with the literature, Europeanisation occurs through the goodness of fit, mediation, and change. The concepts of misfit and adaptational pressure appear evident at domestic level based on the evidence.
- *Is a ubiquitous effect of EU policy evident across the diverse domestic healthcare systems?* EU policies can be divided into two main types, health and non-health, with two levels of compliance (binding and non-binding). There is a notable impact of the Working Time Directive across all case studies. Most impacts appear to be minor on domestic systems. Health policy impact is mostly minor as anticipated in the model. The evidence with regard to the PRD results in findings not anticipated by the model. For example, the model predicts impact of PRD to be major, but the observed impact of PRD is minor.
- *Does the European integration have the same impact on all countries, or does it exert different pressures across domestic healthcare systems?* The resulting domestic impact varies depending on the policy categorisation as well as its interaction with the domestic institutional structure and its actors. Major EU policies appear to influence all of the countries examined, though the full extent of the impact and the domestic actor response can vary case by case. However, only one major policy is strongly evident in this thesis—the WTD. Other minor policies impact some domestic systems and not others, or they influence them to varying degrees. Interest group mobilisation and domestic factors interact with the EU policy input resulting in the domestic outcomes, illustrating variation in the feedback effect as well.
- *How does the institutional structure of Europeanisation influence domestic healthcare systems?* Healthcare system structures exhibit common traits, such as their reliance on personnel, despite large structural differences. EU policies pertaining to these characteristics appear to exert common effects based on the evidence. Domestic healthcare system arrangement structures determine the impact of, and response to, Europeanisation.

Countries seem to exhibit particular misfit with EU when they have issues with which they historically struggle. Systems can also capitalise on supranational development, which is a finding that was not strongly anticipated by the model. Healthcare systems and the actors operating within them tend to react and behave in manners characteristic of their institutions.

- *Do non-health EU policies impact domestic healthcare system development?* Both health and non-health policies influence domestic systems in line with the literature on EU health policy. Due to the “chaordic” nature and application of non-health policies particularly, these policies can have unanticipated consequences on healthcare systems as the actors are generally not involved in the EU policymaking process on these subjects, though the evidence illustrates that their involvement at EU level is increasing. The most significant impact of these non-health policies across the case studies examined stems from the Working Time Directive. The WTD impact was evident across the cases and allowed for comparison across the varied structures.
- *How can the Europeanisation of healthcare systems best be conceptualised over time and cross-nationally?* The theoretical model of this thesis outlines the impact of European integration on healthcare systems by incorporating both EU and domestic factors. The dynamic model comprises of four arguments: the policy dimensions of European integration (I); the Working Time Directive as a critical juncture (II); the effects of Europeanization on domestic healthcare systems (III); and the feedback mechanism and cost of Europeanization (IV). The evidence supports many of the predictions of the model. There were some surprising findings from the evidence and apparent weaknesses of the model as a result, which are explored in the general discussion.

Chapter Summaries

Chapter 2 explores three existing literatures that are pertinent to these research questions—the welfare state, healthcare system, Europeanisation of domestic systems, and EU healthcare policy explanations. The literature overviews the

four areas. This thesis capitalises on insights from the literature to build the theoretical model. Therefore, this dissertation focuses on adding insight to the literature through new data as well as an explanatory framework. Chapter 2 sets the stage for the contribution of the thesis and provides the roots for the theoretical model.

Chapter 3 both outlines the theoretical framework and the research design, which serve as the foundation for the thesis. The theoretical model outlines how the Europeanisation process of domestic healthcare systems works with four main dimensions. It outlines the input, interaction, and outcome. In addition, the concept of a critical juncture is added to this process, focused on the WTD. Case studies are selected—Germany, Ireland, and Spain—and justified to test the theoretical framework. The research design is then laid out to test the hypotheses resulting from the model.

Chapter 3 specifically details the theoretical model that the case study analyses test. The model divides the impact of European integration of domestic healthcare systems into four component arguments. The process of Europeanisation comprises of three central components—an EU policy input, a domestic outcome and a resulting feedback mechanism—as well as a fourth aspect, critical juncture for this process, the Working Time Directive. The EU policy input is disaggregated into two main policy types—health policy and non-health policy. Policies can be binding or non-binding with regard to their domestic compliance. As a result, there are four categorisations of EU policy inputs. These policy inputs then interact with domestic level factors, resulting in domestic—level system and policy outcomes. These policies can have either major or minor impacts on the domestic system structured by existing institutional arrangements and domestic actors. As a result of these supranational influences, domestic actors feedback into domestic and EU policies to influence the process in future; the capacity of the actors to react varies due to domestic-level factors. The unique characteristics of the three domestic institutional arrangements interact with these EU level inputs with repercussions for the outcomes from the process. Varieties of the impact of Europeanisation result, based on the pre-existing institutional arrangements and actor behaviour. The theoretical model highlights the importance of

examining not only domestic-level factors in healthcare system change, but also supranational, in this case EU, forces. This mechanism illustrates the importance of looking beyond country borders in an increasingly globalised world. At the same time, the continued relevance of domestic forces should not be underestimated as EU policy interacts with lock-in and “stickiness” of the established domestic institutions.

Chapters 4, 5 and 6 present the case study analyses from key domestic actor interviews and secondary analysis for the three selected case studies: Germany, Ireland and Spain, respectively. The case study analyses help to test the assumptions and expectations of the constructed theoretical model. The significance and importance of the Working Time Directive and other non-health EU policies is evident across the case studies, as expected based in the literature. Common outcomes from Europeanisation are apparent across the studied countries, but there are also significant, differential impacts dependent on domestic institutional arrangements. These varied domestic dynamics structures show how and when the countries respond to Europeanisation. Factors like the system organisation, stage of development, and federalism appear to impact the process.

The case study analyses show the importance of institutional arrangements and domestic factors in structuring the Europeanisation process. Germany adapts relatively quickly to the Europeanisation process after a policy misfit that results in sizeable impacts. The social insurance arrangement enables the quasi-public actors to mobilise to feed into the Europeanisation process in future. The federal government plays a limited role in the Europeanisation process, which is largely driven by quasi-public actors like sickness funds, HCPs and hospitals. The high spending nature and organised structure of the German healthcare systems seem to aid in compliance and transposition of EU policy at domestic-levels.

Ireland serves as the second case. This Irish system is hit hard by the requirements of the WTD due to the large policy misfit and capacity to implement changes. The WTD exacerbates existing issues with which the system has historically struggled, like hospital staffing shortages, and the case struggles to comply with WTD requirements. The Irish case works to comply with EU

policies, though it struggles particularly with EU policies that bring additional costs, as cost containment is a high priority in Ireland. The Irish system is less resourced than the other two cases, which appears to be an important facet of its interaction with the EU. The Irish system, in some cases, capitalizes on Europeanisation, but it largely proves to be limited in its mobilization capacity. Surprisingly, some of the misfits from EU policy, concerning issues like quality and information lead to what is perceived as positive developments. The evidence points to the concept of change, as a result, needing to be reworked in the model as some of its underpinning assumptions may be too pessimistic in nature (i.e. assuming that change is bad). Generally, Ireland works to comply with EU policy, though it's not always able to engage with the process due to capacity and resource issues.

Spain is the final case study and is representative of a recently-developed national health system. Spain exhibits some similar trends of the Irish case due to its nature as a national health system, notably with pressures due to cost. Spain like the other case studies was affected by the WTD and its misfit with its domestic policy. The decentralised nature of the Spanish healthcare system seemed to largely impact the Europeanisation process; this finding was surprising. Federalism in the Spanish and German case appear to interact with the Europeanisation process in different ways based on the evidence. The feedback mechanism appears to be the weakest in Spain in comparison to the case studies, although this may be due in part to methodological issues. Again, like in the Irish case, there was noted benefit from the EU in Spain, as perceived by key actors, including with regard to topics like pharmacovigilance. This finding points to further exploring how the EU has aided domestic systems in developing, particularly with regard to issues which they have historically struggled to address. This seems to be particularly evident in the two national health service cases.

General Discussion

The case study analyses, therefore, highlight the importance of Europeanisation considerations in the development of domestic healthcare systems. The results illustrate the importance of factoring the EU into healthcare systems and more

generalised welfare state explanations of institutional and policy evolution. The model has much explanatory value, but it also falls short in other areas as illustrated by the case study analyses. This thesis supports some theoretical ideas prevalent in the Europeanisation literature, particularly with regard to its applicability to domestic healthcare systems. It is important to note, however, that additional research would be needed to explore this concept in greater detail.

This thesis also demonstrates the strength, including noticeable lock-in effects, and the adaptability of domestic institutions. The findings support the argument that healthcare systems do not have a one-way, reactionary relationship with Europeanisation, but an interactive one, in line with much of the recent literature. The outcomes from Europeanisation influence institutional and actor behaviour to alter their process in the future. Based on the evidence, the German case proves to be more proactive with time whereas the Irish and Spanish cases are more reactive. Nonetheless, ideational change, not only institutional change, is evident to different extents across the cases presented. Domestic actor awareness and, to varying degrees, engagement in EU policies as they pertain to health appears to increase with time. This feedback mechanism, and the bottom-up influence of domestic actors on EU policy in particular, should be examined in subsequent research to better understand how healthcare actors affect change on EU policy. This dynamic is not the central focus of this thesis but offers potential for prospective insights. A surprising finding was the perceived positive effects of Europeanisation by domestic actors, which the model and thesis underestimate. This warrants more investigation in future both with regard to these cases and by exploring more cases to better understand the dynamics.

Building off of the evidence, another surprising finding of the thesis illustrates that there are limitations to cross-border mobility and competition in health in the system analysis. It was a factor highlighted by actors in interviews where their expectations differed from what transpired. This finding could link to the “blaming” of the EU for a perceived negative policy outcome that never transpired. With various actors the knowledge of the EU institutions and policy seemed limited. The timing of the interviews, at a time that MSs were

transposing the PRD, may exasperate this discrepancy between actor expectation and actual outcome. Moreover, actor perception and the real-life observation can often vary.

Much of the thesis seeks to build a bridge between traditional areas of study of the welfare state and healthcare systems. An important part of this is the assertion that healthcare is not exceptional and shares many traits with other social policy areas. However, some of the evidence indicates that there are unique features to the healthcare system that seems to impede the application of principles like competition and mobility. For instance, there is not as much healthcare tourism in actuality as predicted by some theoretical expectations. Future explanations need to take into consideration that country residents generally do not appear to leave in search of improved healthcare services. This has implications with regard to comparison of other policies and how scholars explain the deviation between theoretical explanations and political reality. This difference should be further explored not only in health but also in other areas of social policy.

Historical legacies seem to be particularly prominent in the development of healthcare systems and their Europeanisation, which vary significantly even between countries with similar systems. These interplays could be explored through comparative case analysis of like systems. As discussed, federalism and national health services interact with Europeanisation in varied ways in different systems within this study.

The goals of the theoretical model and the thesis are aspirational. There is a large and complex literature that feeds into the development of the predictions. Some of these predictions prove to hold and others do not. The model is thus able to generalise to some degree. However, the case-by-case basis of different healthcare regimes have large repercussions for the analysis, impeding generalisability.

Alternative explanations for some of the findings need to be further explored. Follow-up interviews and a focus on the same policies in a cross-national comparison would help fine-tune and improve the model. In the thesis, interviews drove the policy selection—however, this resulted in a large variation in policies selected given the breadth of EU policy. The WTD was the only policy

that was included across interviews; structuring the interviews in a more focused manner in future could help improve the focus of the evidence.

The PRD proves not to have major impact in contrast to the model predictions. At first, this is surprising. Examining the literature on the subject, it becomes clearer why this is the case. The PRD was passed to provide more certainty around patient rights, which had been developing through ECJ ruling. Healthcare and domestic actors were involved throughout the development of the Directive itself. Looking at its scope, one might expect it to be of major impact. In essence, the policy moved from the non-health policy area to health policy. An in-depth exploration of this Directive, particularly as compared to the WTD, in select case studies could further help develop and improve the theoretical model assumptions. Given the surprising findings surrounding the PRD in particular, the alternative explanations surrounding health policy need to be developed. In addition, although the definition of health policy has been improved, methodological issues still surround its definition as it could be argued as being circular.

This thesis focuses primarily on the political and policy impacts of the EU on domestic healthcare systems rather than on economic consequences. Economic influences, which are largely hypothesised in the Europeanisation literature, should be further explored and worked into the theoretical model as needed in follow-up analysis, particularly in this period following economic crisis. The methodology and design of this thesis primarily targets conceptualising and capturing the political aspect for practical and theoretical reasons. Quantitative analysis offers potential to further explore and conceptualize the economic impact. As European integration widens and deepens, there is increasing opportunity for these explanations and models to become more dynamic.

Nonetheless, the thesis finds consistent influences as well as differentiated impact of the political pressures of European integration on domestic healthcare systems. The results highlight the need for additional research on the impact of European integration on domestic healthcare systems. The case study analysis from the thesis focused on three countries that are representative of Europe, mostly notably from Western Europe with established

healthcare systems. The applicability of the model to other countries should be explored to determine if the same patterns and trends are evident across other member states of varied size, location and system structure. Often political economic studies focus on the larger Western European countries. It is important to study smaller countries as well as those from all parts of the region. In particular, those systems in Eastern Europe, which have more recently formed, should be examined in detail. This thesis seeks to develop a theoretical framework for the EU policy input broadly. Due to the size and scope of domestic healthcare systems many EU policies have the potential to influence healthcare and warrant more systematic analyses, so the non-health policy input should be examined in greater detail. The model remains weak with dealing with such a breadth and scope of this non-health policy in particular. In addition, the variations within the non-health policy input may be important to evaluating and applying the model.

This research shows that European healthcare systems are large and complicated as is EU policy. Yet, these characteristics do not exclude them from their inclusion in broad explanatory frameworks. These models should be developed, refined and supported through more in-depth research. They illustrate, like many other aspects of the welfare state, healthcare systems are institutions that respond in characteristic manners to external pressures. These systems work to minimise disruption when possible; they are dynamic, not only resisting change but also capitalising on potential in some instances, which warrants more theoretical development. There are limitations on what can be covered by one piece of research, but the dissertation does highlight the potential for more systematic exploration of the topic.

Building off of the thesis findings, the theoretical model developed by this thesis should be altered and tested in a more systematic manner. Using the interview data to guide the design gained important insights. Now, the explanatory framework needs to be refined and improved through more in-depth analysis of each of the dimensions across a broader range of countries.

Although it was not the central focus of this study, the actor semi-structured interviews indicated on multiple occasions, post-crisis, that the EU might have a different effect on healthcare systems than it did before the crisis.

This finding is in line with developments in the literature exploring welfare states during crisis. Anecdotal evidence in the interviews suggested that the crisis offered an opportunity for increased European integration, which should be further explored particularly in light of the recent COVID-19 pandemic response co-operation. European policy might also be utilised by domestic health actors in a new manner following different types of crises (such as financial crisis versus the pandemic). This unexpected result should be explored in additional research as it could further illustrate the dynamic process of Europeanisation and domestic institutional change. Institutions are dynamic and resilient.

Finally, the thesis seeks to better understand the impact of the EU on healthcare systems in a generalisable fashion that accounts for domestic-level factors. The research and explanation draw attention to the importance of supranational considerations by domestic-level systems, and EU-level considerations of Member State systems. Additional research is needed to better understand and more fully develop explanations for this finding. This thesis cannot comprehensively capture all the change over time in multiple countries in large healthcare systems stemming from Europeanisation. The model should be tested on other EU countries as well as expanded to other EEA countries to determine if there is a spill over effect on neighbours.

Additional single country case studies can explore the innerworkings of the interaction in more detail over a large range of policies and over time. Further case studies on single instances of EU policies could provide more insight. The findings of this thesis illustrate that there is a tangible impact that warrants further investigation and adds insight to the existing literature with new data. There are common trends across Member States, but each country's domestic institutions shape the manner in which Europeanisation occurs in their system.

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Appendix 1: Abbreviations

ACs	Autonomous Communities
BMG	Federal Ministry of Health, Germany
CBD	Cross Border Care Directive
DG	Directorate General
DG EMPL	Directorate General for Employment, Social Affairs and Inclusion
DG ENTR	Directorate General for Enterprise and Industry
DG ENER	Directorate General for Energy
DG MARKT	Directorate General for Internal Market and Services
DG SANCO	Directorate General for Health and Consumers
DRG	Diagnosis-Related Group
DOH	Department of Health, Ireland
EEA	European Economic Area
EC	European Community
ECJ	European Court of Justice
EMA	European Medicines Agency
EP	European Parliament
EPSCO	Employment, Social Policy, Health and Consumer Affairs Council
EU	European Union
EUTCD	European Union Tissue and Cells Directives
EWTD	European Working Time Directive
GDP	Gross Domestic Product
HCPs	Healthcare Professionals
HIA	Health Information Authority, Ireland
HIQA	Health Information and Quality Authority, Ireland
HPRA	Health Products Regulatory Authority, Ireland
HSE	Health Service Executive, Ireland
IMF	International Monetary Fund
IMO	Irish Medical Organisation, Ireland
KOF	Konjunkturforschungsstelle (the German word for “cycle research”)
LRC	Labour Relations Commission, Ireland
MEP	Member of European Parliament
MOH	Ministry of Health
MP	Member of Parliament
MS	Member State of the European Union
MSs	Member States of the European Union

MSPS	Ministry of Health and Social Policy
NCHD	Non-consultant hospital doctor, Ireland
NHS	National Health Service
NSAI	National Standards Authority of Ireland
NTPF	National Treatment Purchase Fund, Ireland
OECD	Organisation for Economic Co-operation and Development
OMC	Open Method of Coordination (EU soft law)
OOP	Out-of-pocket
PHI	Private health insurance
PRD	Patients Rights Directive
PVI	Private voluntary insurance
SiMAP	Sindicato de Médicos de Asistencia Pública, Spain
SPC	Social Protection Committee
SHI	Statutory health insurance
SNS	Sistema Nacional de Salud, Spain (Spanish National Health System)
USD	United States Dollars
WRC	Workplace Relations Commission, Ireland
WTD	Working Time Directive

Appendix 2: European Union Legislation

Cross Border Care Directive

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

European Union Tissue and Cells Directives (EUTCD)

Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells.

Amended by the Commission Directive 2006/17/EC of 8 February 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards certain technical requirements for the donation, procurement and testing of human tissues and cells;

Amended by the Commission Directive 2006/86/EC of 24 October 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards traceability requirements, notification of serious adverse reactions and events and certain technical requirements for the coding, processing, preservation, storage and distribution of human tissues and cells

Falsified Medicines Directive

Directive 2001/83/EC on the Community code relating to medicinal products for human use.

Amended by Directive 2011/62/EU

Late Payments Directive

Directive 2011/7/EU on combating late payment in commercial transactions

Medical Device Regulations

Council Directive 93/42/EEC of 14 June 1993 concerning medical devices

Amended by Directives 98/79/EC, Directive 2000/70/EC, Directive 2001/104/EC, Regulation (EC) No 1882/2003, and Directive 2007/47/EC

Mutual Recognition of Professional Qualifications

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

Directive 89/48/EEC and Directive 92/51/EEC

Patient Safety Recommendation

Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections

Pharmacovigilance Directive

Directive 2001/83/EC and Regulation (EC) No. 726/2004

Amended by Directives 2010/84/UE of the European Parliament and Council, of 15 December 2010, on pharmacovigilance and Regulation (EU) No 1235/2010

Service Directive

Directive 2006/123/EC on services in the internal market

Third Non-life Insurance Directive

Council Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance

Amending Directives 73/239/EEC and 88/357/EEC

Transparency Directive

Directive 89/105/EEC relating to the transparency of measures regulating the pricing of medicinal products for human use and their inclusion in the scope of national health insurance systems

Proposed revision of the directive of the European Parliament and of the Council relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of public health insurance systems (COM(2012)0084 – C7-0056/2012 – 2012/0035(COD))

VAT Directive

Directive 2006/112/EC of 28 November 2006 on the common system of value added tax

Working Time Directive

Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time

Appendix 3:

Significant European Court of Justice Decisions

Molenaar (1998)

German principle of territoriality for long-term care provision violates EU law. The benefit (long term care) can be paid out to other MSs. The insured person does not have to receive care in the MS in which he/she resides.

Decker (1998)

A ruling requires for health insurance to reimburse for costs of cross-border (a Luxembourg citizen purchasing eyeglasses in Belgium) healthcare services even without provisions in the insurance guaranteeing access abroad in the EU. There are limits to requiring pre-authorization for healthcare treatment in other MSs (patient mobility in the EU).

Kohll (1998)

A ruling requires for health insurance to reimburse for costs of cross-border healthcare services (a Luxembourg citizen travelling to Germany for dental treatment) even without provisions in the insurance guaranteeing access abroad in the EU. There are limits to requiring pre-authorization for healthcare treatment in other MSs (patient mobility in the EU).

Gereats-Smith (2001)

The ruling builds off of *Kohll* and *Decker* regarding reimbursement of a Dutch citizen for Parkinson's disease treatment received in Germany and Austria. Restrictions on reimbursement for services in other MSs required justification (patient mobility).

Vanbraekel (2001)

The ruling builds off of *Kohll* and *Decker* extending it to hospital care coverage. A Belgian citizen sought reimbursement for receiving orthopedic surgery in France that was initially denied. Reimbursement had to be granted if the denial was not justified (patient mobility).

Smits and Peerbooms (2001)

The case examined in preauthorization for hospital care in another MS could be considered to serve the public interest. The ruling states that health systems are part of the single market, so no MS system is exempt. The rulings prior primarily involved social insurance systems (patient mobility).

Müller-Fauré (2002)

The case involved dental care of a Belgian citizen in Germany. The logic of patient mobility was extended to systems that normally do not provide refunds (patient mobility).

SiMAP (2002) Jaegar (2003)

A Spanish case in which the ECJ rules that on-call time for healthcare professionals counts as working time and is thus covered by the Working Time Directive (working hours).

Jaegar (2003)

Extends the ruling that on-call time for healthcare professionals counts as working time and is covered by the Working Time Directive (working hours).

Leichtle (2004)

The case involved a German citizen receiving care at a German spa. The logic of reimbursement in prior cases was extended to cover taxes (patient mobility).

Watts (2006)

A UK citizen's request to have a hip replacement abroad due to the wait was turned down by the NHS. Mrs. Watts had her hip replaced in France. The case ruled that the failure to grant preauthorization violated Regulation 1408/71 and Article 49, EC. Thus, "undue delay" had to incorporate the needs of the individual in addition to statutory requirements. The logic of *Kohll/Decker* also applies to national health service systems (patient mobility).

Stamatelakis (2007)

The ruling extends the logic of prior rulings. The treatment abroad cannot be restricted on public/private nature (patient mobility).

Appendix 4: German Key Actor Interview List

Country	Abbreviation	Date	Sector
Germany	G1	24 January 2012	Government: legislative
Germany	G2	24 January 2012	Insurance
Germany	G3	25 January 2012	Medical
Germany	G4	25 January 2012	Government: legislative
Germany	G5	25 January 2012	Government: legislative
Germany	G6	25 January 2012	Government: legislative
Germany	G7	26 January 2012	Insurance
Germany	G8	26 January 2012	Insurance
Germany	G9	26 January 2012	Government: legislative
Germany	G10	26 January 2012	Hospital
Germany	G11	27 January 2012	Government: bureaucracy
Germany	G12	27 January 2012	Government: bureaucracy
Germany	G13	27 January 2012	Government: bureaucracy

Appendix Chapter 5: Irish Key Domestic Actor

Interview List

Country	Abbreviation	Date	Sector
Ireland	I1	9 January 2012	Pharmaceutical
Ireland	I2	10 January 2012	Insurance
Ireland	I3	10 January 2012	Government: bureaucratic (HSE)
Ireland	I4	12 January 2012	Government: bureaucratic (DOH)
Ireland	I5	12 January 2012	Governmental: bureaucratic (other)
Ireland	I6	12 January 2012	Government: legislative
Ireland	I7	13 January 2012	Government: bureaucratic (other)
Ireland	I8	17 January 2012	Government: bureaucratic (DOH)
Ireland	I9	6 February 2012	Government: bureaucratic (HSE)
Ireland	I10	8 February 2012	Governmental: legislative
Ireland	I11	9 February 2012	Academic/government official
Ireland	I12	9 February 2012	Medical

Appendix 6: Spanish Key Actor Interview List

Country	Abbreviation	Date	Sector
Spain	S1	16 January 2012	Medical
Spain	S2	18 January 2012	Government: bureaucratic
Spain	S3	30 January 2012	Insurance
Spain	S4	31 January 2012	Insurance
Spain	S5	31 January 2012	Academic
Spain	S6	31 January 2012	Pharmaceutical
Spain	S7	1 February 2012	Government: bureaucratic
Spain	S8	27 May 2014	Government: legislative
Spain	S9	28 May 2014	Government: bureaucratic
Spain	S10	29 May 2014	Government: bureaucratic

Appendix 7:

A Cross-National, Temporal Quantitative Analysis

Introduction

This analysis combines concepts from the existing literatures presented and statistically tests their explanatory power. The cross-country analysis explores the influence of European integration on domestic healthcare systems over time across a variety of advanced industrialised countries building off the work in the healthcare expenditure literature and drawing insight from more recent literature quantifying the impact of Europeanisation. The statistical analysis also includes existing explanations established in the existing literatures as controls. The results are presented and analysed. In doing so, the empirical evidence illustrates that Europeanisation should be considered in concert with existing explanations of healthcare system spending variation. The cross-country analysis sets the stage for in-depth cross-national qualitative analysis to understand the mechanisms behind the quantitative findings.

The thesis as it developed focuses on qualitative evidence and analysis. As such, these quantitative findings have been removed from the main text. However, the quantitative analysis served as the inspiration for the thesis. Europeanisation has statistically significant effect on healthcare expenditure across healthcare systems. There are limitations in the study and the data analysed as expenditure only captures one part of the complex healthcare system. Additionally, interpretation of increased expenditure is complicated—

increased expenditure can result from a wide range of factors (improved access, inefficiencies, administrative burden, etc.).

Nonetheless, health spending is an important component of healthcare system analysis. This finding offers insight into understanding Europeanisation's impact on domestic systems and contribute to the literature. There is a growing literature exploring cross-national temporal analysis of both welfare state and health systems in the context of pressures like Europeanisation and globalisation with increasing data. The approach offers potential for further development and analysis of health and welfare system trends, particularly if data is expanded in breadth and scope to incorporate other measures beyond expenditure. The preliminary analysis offers potential for scholars to develop in future utilising ever-improving data and quantitative methods.

Empirical Evidence: Cross Country Analysis

As described in this thesis, further investigation is warranted to determine to what extent, and how European integration affects healthcare systems. This analysis consists of a quantitative analysis in order to determine general, broad-reaching effects over time and across countries in a systematic and controlled fashion. These findings inspired the resulting thesis to understand the mechanisms behind this influence and to understand the extent of the impact.

As previously discussed, the effects from the EU are not regularly included in quantitative analyses of domestic healthcare expenditure. European integration is a phenomenon that is increasingly prevalent and important to consider in healthcare studies as it can alter both economic and political arrangements. Political-economic forces are often excluded from quantitative analyses of social systems and have not been included in many studies of healthcare systems. These forces can be difficult to capture numerically in comparison to conventional measures like gross domestic product (GDP) and the population age distribution. A systematic comparative study of healthcare systems and European integration may help to add additional insight into understanding full effects of increasing regional integration together indirectly and directly on social policy.

This analysis examines the economic effects of European integration on healthcare system change in Organisation for Economic Co-operation and Development (OECD) countries.⁵⁸ Time series analysis conducted examines the economic and political effects of increased European integration. The three main empirical chapters on the case studies explore the causal mechanisms behind this finding in detail. It is important to note that the purpose of this Appendix is to aid in the understanding the influence of the EU across MSs that both generalises about effects exhibited in all countries as well as differentiates between the impact shaped by varied institutional arrangements. The quantitative analysis examines trends in OECD countries from 1970 to 2008 across twenty-nine industrialised countries, a substantial number of cases and period of time for generalisation of effects. This analysis in the Appendix illustrate that the EU has a tangible, detectable effect on healthcare systems. Consequently, European integration should be considered in statistical modelling of health spending. However, there are limitations to the analysis.

Quantitative analysis is being to employed to examine the effects in order to determine the presence and the extent of Europeanisation of domestic healthcare systems by examining health spending. General trends are identified through quantitative analysis for the EU as a whole, illustrating the importance of the inclusion of European integration to understand broad, political economic trends. The period following the financial and economic crisis, after 2008, is examined only in qualitative analysis performed in the empirical chapters focused on specific countries as the crisis may serve as a large exogenous shock with substantial effects on the quantitative analysis.⁵⁹ This time series analysis has been conducted to preliminarily examine if there are a detectable economic and political effects of increased European integration in order to justify

⁵⁸ The OECD countries are: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States (OECD, 2014).

⁵⁹ Additional statistical analysis, including further study of the interaction of the financial and economic crisis and Europeanisation, could be conducted in follow-up research.

thorough case study analysis. The data, methodology, analysis, and results are presented in this Appendix.

Data and Methodology

This empirical test comprises of a cross-national time series analysis of twenty-nine advanced industrialised countries, including non-EU and non-European country controls over recent decades, from 1970 to 2008. Demographic, economic and political factors established in the literature are included in the study in order to control for these effects. The panel data analysis captures the long-term impact of European integration on domestic healthcare systems in a generalisable manner. The findings demonstrate that European integration has a significant influence on domestic healthcare systems that can statistically be captured when analysing overall spending patterns.

Dependent Variable

One obstacle for both the quantitative and qualitative studies is defining and measuring both the independent and dependent variables. The issue with the operationalisation of the concepts is one of the key hurdles to analyses.

As Chapter 2 describes, many classifications of healthcare systems exist. For example, Wendt (2009) constructs system clusters using four indicators—expenditure, financing, provision, and institutional characteristics—to group nations into healthcare system types (regimes, families). Expenditure relates to overall net national spending on health services, which comprises of public, private and out of pocket expenditure. Financing examines the source of funding for the healthcare system, notably the proportions from public and private sources. The shares of inpatient and outpatient care determine provision. Institutional characteristics include different organisational factors, such as the method of doctor payment and patient access and choice. Four categorisations result based on this typology, three of which are found in Europe (Wendt, 2009, pp.438-442).

The quantitative study focuses on the first dimension, health expenditure. There is consistent and reliable data over time across advanced industrialised countries, and the figure is comparable across countries. Additionally, the

literature consistently utilises total health spending analyses. As a result, established variables explain variation, enabling the addition of the independent variable of interest, European integration. Although differences exist between the healthcare state families on the other three dimensions, health expenditure data captures much of the variation across systems over time and is consistently included in health system classifications. The other three dimensions do not change as much as expenditure temporally, and the quantitative analysis of these components has not been established in detail. In addition, the three dimensions are incorporated to some degree into institutional characteristics, which will be captured by country-fixed effects and justified later in this section.

In follow-up studies, the analysis should also be extended to other system dimensions, such as financing and provision, because expenditure may not capture all reform dynamics, such as changes in the types of benefits and services or access. Similar models could be developed for other areas of social policy to determine if the effects of internationalisation are ubiquitous across welfare state subsets or vary based on policy area. Thus, further studies could explore the additional dimensions of healthcare following the establishment of a statistically significant effect of European integration on expenditure. This preliminary analysis indicates that more extensive quantitative research of this field may prove fruitful to better understanding and capturing trends.

The focus of the thesis is not fully on quantitative analysis. Nonetheless, this quantitative analysis demonstrates that 1) a consistent effect of European integration is evident temporally across MSs and 2) the influence, combined with existing explanations, accounts for variation not explained by conventional domestic-level influences. Results support Pierson's (1996a) arguments that comparativists can no longer consider domestic policy developments in isolation by only considering domestic influences, but also must incorporate supranational factors, namely that of European integration.

Debate exists concerning the best measure of healthcare expenditure. The demographic and political controls remain the same for both measures of the dependent variable. Studies typically quantify social expenditure as a percentage of GDP. As a result, health expenditure as a percentage of GDP (*health*) is utilised as the dependent variable measure instead of health spending

per capita.⁶⁰ There is much variation in expenditure across OECD countries over time to be explained. Annual healthcare expenditure data has been obtained for the period from 1970 to 2008 for all OECD countries (OECD, 2011). *Table A7.2 OECD Countries* summarises the twenty-nine OECD countries included in this analysis as well as those five countries not included due to data limitations. *Table A7.3 Data Summary* also outlines the data sources for and ranges of the healthcare expenditure data.⁶¹

Independent Variables

The independent variable of interest is European integration. Europeanisation can be captured using two components: economic and political integration. Economic integration is defined as “European-level trade, production, and finance.” Economic integration thus stems from the removal of economic barriers in the EU and European Economic Area (EEA) and cross-border movement. European political integration is defined as the “structures and governance of the European Union/European Community” (Beyeler, 2003, p.161). Political integration comprises of laws, regulations, directives and other actions deriving from EU level government. Therefore, European integration is measured through two separate indicators, one for political integration and one for economic integration.⁶²

Measuring these phenomena of European integration has been shown in the literature to be problematic. As previously discussed, there is a lack of a consistent definition of Europeanisation. The difficulty defining the term makes it difficult to measure. In addition, debate surrounds how to capture the complex political-economic force that is the EU as a quantifiable figure. Another problem

⁶⁰ Figure is typically in United States Dollars (USD).

⁶¹ The OECD countries not included in the statistical analysis are: Chile, Korea, Israel, Mexico and Turkey as some control political variables (notably *election* and *left*) measurements were not available for these selected OECD countries. This limitation of data consequently reduced the number of observations in the quantitative analysis. These countries served as non-European controls. However, other controls for systems, which more closely resemble those in the EU both politically and economically from an advanced industrialised country perspective, such as Canada, remain included in the analysis, limiting the concern over the exclusion of the five cases. Details are included in Annex A3.1.

⁶² These two measures are discussed in more detail in the following sections.

with this analysis pertains to the difficulty of disaggregating between the effects of European integration and those of globalisation. The inclusion of non-EU and non-European country controls should help ameliorate the issue of differentiating between the two. Globalisation and Europeanisation are different (Hay, 2006), although interaction may occur between globalisation that should be accounted for in the models. The manner in which the European integration and globalisation are operationalised statistically separates the two effects. Globalisation is discussed in more detail in the control variables section. The disaggregation between political and economic effects of Europeanisation is described now in detail.

Economic Integration

Economic integration is the first of two variables comprising Europeanisation to be utilised in this analysis. The literature has established that economic integration measures should capture patterns of trade resulting from European economic integration rather than absolute levels of trade between MSs. Absolute measures of EU trade do not incorporate changes in levels of economic integration (Beckfield, 2006, p.970). This measure enables the examination of country-specific measures of economic integration.

Accordingly, studies establish that regional economic integration patterns can be obtained by examining the percent of exports to EU countries as a proportion of total exports (Beckfield, 2006, p.970; Sapir, 1992, p.1491). Therefore, the measure varies from 0 to 1. Data on exports has been obtained from the International Monetary Fund's (IMF) Direction of Trade Statistics database. This database is available online from 1980 to present day (IMF, 2011). However, this study examines healthcare systems from 1970, so data is needed predating the 1980 data available online. The IMF's Direction of Trade Statistics Historical data covering 1970 to 1979 has been obtained from the University of Virginia's Geospatial and Statistical Data Center online (University of Virginia, Geospatial and Statistical Data Center, 2003). The data does not begin until 1970, which limits data observations for the study. However, 1970 provides a large time series for the OECD. Data on the proportion of exports from the EU has been obtained annually for the OECD countries. European economic

integration (*EU_econ*) comprises the first of two measures of the effects of the EU. *Table A7.3 Data Summary* summarises the data sources for and ranges of the variable *EU_econ*.

With the measure of European economic integration (*EU_econ*) established on a scale ranging from 0 to 1, what is its anticipated effect on healthcare expenditure? As discussed in the literature review, there are two theoretical directions of the impact of economic competition stemming from increased European integration. The first direction, some scholars (such as Beckfield, 2006, p.969; France and Taroni, 2005; Freeman, 2000, 34-49; Ferrera, 1995; Hitris, 1997) predict a race to the bottom resulting in patient movement across borders to lower costs, so healthcare systems reduce expenditure to more effectively compete with other systems.

The opposite, a rising tide impact, could occur as systems provide better quality or more efficient service, such as a shorter queue, to their citizens who can travel to other countries to receive treatment (Garrett, 1998). Additionally, the various providers (from services to products) compete. Healthcare does not operate like an ideal market due to various characteristics that are not be discussed at length here (for more information, see Arrow, 1963; Greenwald and Stiglitz, 1986; Mwachofi and Al-Assaf 2011; Rice and Unruh, 2009). For example, sick patients are not particularly mobile, especially in the case of emergency care, which limits the impact of economic integration. Individuals who travel for care—barring tourists who need urgent treatment—do so due to limitations in their system, such as waiting lists. Due to insurance and domestic entitlements, people are often not fully aware of the true cost of healthcare procedures. Traveling to other countries may entail paying the difference between fees, so they are not likely to compete for bargains in treatment. *As a result, as European economic integration (EU_econ) moves close to 1 on a scale from 0 to 1, national health expenditure should increase.*

Political Integration

Various measures have been employed to measure EU political integration. Yet, political integration is difficult to measure in a systematic manner stemming from difficulty in quantifying structures, governance and legislation.

Consequently, a range of measures have been devised in order to capture its influence. A binary variable signifying membership or not in a given year has been used by researchers, such as Henrekson, Torstensson, and Torstensson (1997, p.1543). Similarly, the number of years a country has been a member of the EU as well as the funding contribution from MSs to the EU have been utilised to measure political integration (Bornschier, Herkenrath and Ziltener, 2004, p.83). More advanced measures were developed by Beckfield (2004, p.970), which capture the proportion of European Council Directives transposed at the domestic level. Other measures of European integration efforts, such as the proportion of the population approving of European integration and the amount of regional nongovernmental organisations, have also been employed in analyses (Beckfield, 2006, p.970).

Additionally, Thomas Brunell and Alec Stone Sweet developed a measure that is readily accessible and commonly utilised that examines the national referrals to the European Courts. The scholars have collected the data from 1958 to 1998 (Stone Sweet and Brunell, 2000). The data contains the number of Article 177 cases referred by the MSs to the European Court annually. Article 177 created the European Economic Community. The rulings by the ECJ are applicable to domestic law (Beckfield, 2004, pp.969-970), so the measure has been used in studies of European integration (Beckfield, 2004). Consequently, it is useful to capture the political integration and its application to the welfare state. Unfortunately, the data is only available from 1958 to 1998 (Stone Sweet and Brunell, 1999). The Article-177 references are highly and significantly associated with the number of years a country has been an EU Member State, with $r=0.7$ (Beckfield, 2006, pp.969-970).

Various strengths and weaknesses of these measures of political integration exist. However, the political integration measures are highly correlated with each other ($p=0.7$, $p=0.8$ or higher), so they seem to capture the same trends. Studies have shown that the various measures can be used interchangeably. Scholars utilise the number of years in the EU since it captures the same trend as well as more advanced, complicated measures (Beckfield, 2006; Bornschier, Herkenrath and Ziltener, 2004).

As a result, the quantitative analysis substitutes the number of years of membership to avoid losing a decade of data and the accession of several MSs; this serves as the second measure to capture the effects of the EU, namely the influence of political integration (*EU_poli*). *Table A7.3 Data* summarises the data sources for and ranges of the variable *EU_poli*. Again, this measure of the variable is established in the literature (Beckfield, 2006; Bornschier, Herkenrath and Ziltener, 2004). Controls for all other important influences help to strengthen findings.

With European political integration (*EU_poli*) captured in the model by the years of membership in the EU, what is the predicted influence of this external pressure on healthcare system? Political integration at the EU-level adds an additional level of legislation applicable to domestic systems, which is discussed in more detail in the empirical chapters. Key actors in the healthcare systems must also work at EU level in addition to operating at local and/or national levels. Moreover, EU legislation must be implemented domestically. *Therefore, as European political integration (EU_poli) increases, health expenditure should increase as MSs have to transpose and apply an increasingly large body of supranational policy to the domestic level.*

Control Variables

Chapter 2 summarises the literature on cross-national models of healthcare expenditure. As previously discussed, the dominant explanations of expenditure stress economic influences and demographic factors. Some political measures incorporate these and in other studies, though to a lesser extent than the economic and demographic measures. This literature establishes the controls necessary for the cross-country analysis. Four types of controls are included: demographic, economic, political and institutional arrangements. *Table A7.3 Data Summary* in the Appendix includes a summary of these variables as well as their data sources and ranges.

Demographic Controls

First of all, healthcare systems vary in organisational structure. Nonetheless, these systems that treat patients cover the population of the country in some

manner. Therefore, the composition of the population influences expenditure. Population size and the rates of growth are important to health spending. The more people covered by a system, the more will be spent on their healthcare services (Potrafke, 2010). As country-fixed effects will be employed, one measure of population size is needed. Population level (*pop*) is obtained using OECD data (2011) and included in the quantitative study.

The risks of healthcare treatment are higher in certain populations than in others. Academics, including O'Connell (1996) and Barros (1998), posit that young populations and old populations are more likely to utilise healthcare systems than the adult population. Thus, age distribution of the population influences healthcare expenditures. Statistically, young ages have not been shown to systematically increase expenditure. However, older populations have elevated levels of sickness and, consequently, costs (O'Connell, 1996). As the European population is increasingly ageing (older people have higher healthcare costs than do younger demographics), this control variable is integral. The higher the proportion of older individuals, the more the system spends. The proportion of the population over the age of sixty-five is obtained from the OECD (2011) and included in the statistical analysis (*age*).

Economic Controls

As previously stated, healthcare systems are a large proportion of national economies. Moreover, these systems are funded from economic sources, taxes and/or employer and employee social insurance contributions. The systems are, therefore, impacted by economic conditions. Gross domestic product per capita (GDPpc) is one of the strongest predictors of health expenditure across studies (Hitiris, 1997; McCoskey and Selden, 1998; Huber and Orosz, 2003). As GDPpc increases, countries and their citizens have more money to spend on healthcare services. As a result, expenditure rises. GDPpc is included as a control in the analysis (*GDP*), with data retrieved from the OECD database (OECD, 2011).

Other economic factors influence national health spending. Studies have shown that inflation (*inflation*) and unemployment (*unemploy*) lead to variation in spending over time (Hitiris, 1997; O'Connell, 1996). Both measures are obtained from the OECD (2011) and included as controls. Moreover, health

expenditure is affected by trends from a given decade (Barros, 1998). For example, in the 1980s, there was a trend to control healthcare expenditures. This measure encapsulates long-term changes rather than short-term fluctuations and is an established control for time-fixed effects (Barros, 1998). Decade controls are incorporated into the regression analysis for the 1970s, 1980s, and 1990s (*dec_70*, *dec_80*, and *dec_90*).

As discussed above, one of the large issues in the study is disaggregating between the impacts of globalisation and Europeanisation, particularly the European economic integration (*EU_econ*). The role of globalisation has been incorporated into studies of welfare state reform. Globalisation, in some studies, has been shown to increase the composition of government budgets, including healthcare (Dreher, Sturm, and Ursprung, 2008). Many quantitative studies explore the multidimensional influences of globalisation on social expenditures in particular, although there is an argument over the best measure of globalisation. For the purpose of this study, the Konjunkturforschungsstelle (KOF) Globalisation Index is used, which has been effectively utilised in studies of welfare state and healthcare state in particular (Dreher, 2006; Potrafke, 2010). It is an established, reliable and comprehensive measure. The KOF Index is a composite index comprised of twenty-three variables measuring economic, social, and political dimensions of globalisation. It includes data on global trade flows and restrictions; information, culture, and person flow; and international organisation membership and diplomacy (Dreher, 2008). The index varies from zero to one hundred, with advanced industrialised countries average scores ranging from the 50s to 70s during the time period under investigation, with a maximum score in the early 90s (KOF Swiss Economic Institute, 2011). The data is obtained annually for each country online (Dreher, 2008), where globalisation (*global*) is included as an economic control in this study.

Diagnostic test performed show that globalisation and Europeanisation are not highly collinear; the two types of internationalisation appear to be phenomena with independent effects that can be analysed together. Yet, the connection—whether they are distinct forces, related forces, or the same forces—between globalisation and Europeanisation is contested (Hennis, 2001) and necessitates more analysis and additional statistical development. The

measures of European integration and globalisation are not without fault; development of these measures could improve findings. Furthermore, detailed analysis examining for nuanced measures of the healthcare state as a dependent variable would be beneficial in the future.

Political Controls

In addition to demographic and economic controls, limited political impacts on health spending have been examined and need to be included as the third set of controls. Party portfolio instability only has a minor influence on expenditure in the short-run. In the long run, however, some scholars have argued that political instability and volatility variables do not significantly affect health expenditure trends (Huber, 1998). Others have argued that political ideology impacts healthcare systems, with more left leaning parties spending more on health services (De Donder and Hindriks, 2007). Additionally, incumbent politicians arguably alter expenditures for electoral benefit; election years have been demonstrated to increase health spending as elected parliamentarians work to curry favour and votes (Portrafke, 2010).

In order to account for various political forces, data on left party leaning of government (*left*) and election years (*election*) are included in the model, obtained from the Comparative Political Data Set (Armingeon, Engler, Porolisia, Gerber, and Leimgruber, 2011). In addition, another political and institutional force, trade union membership is included. Membership varies significantly across countries and over time. Academically, it is a potential influential force as unions pressure domestic healthcare systems to spend more money on health services for their membership (Garrett, 1998). Trade union membership rates (*union*) is obtained from the OECD (2011).

Institutional Controls

Recently, institutional accounts are incorporated into some explanatory models of health spending. Some countries have unique expenditure trajectories compared to others (Huber and Orosz, 2003). Domestic policy distinctiveness and lock-in effects occur from past policy (Herwartz and Theilen, 2003). Differences in the system type (Barros, 1998), the existence of gatekeepers to

access (Barros, 1998), and the strength of primary care system (Starfield and Shi, 2002) are institutional aspects that arguably lead to cross-national spending variation. These characteristics are described by other dimensions Wendt's regimes (2009). To account for this, the statistical model is analysed with country-fixed effects to control for individual country variation, because large institutional rearrangements in systems generally do not occur. Country fixed effects are built into the statistical programming command used in the analysis, not included as a country dummy control.

Time Series Analysis

As discussed previously, countries are analysed with country-fixed effects to control to account for a host of national differences:

$$\begin{aligned} health = & \beta_0 + \beta_1(EU_poli) + \beta_2(EU_econ) + \beta_3(global) + \beta_4(election) \\ & + \beta_5(left) + \beta_6(union) + \beta_7(GDP) + \beta_8(inflation) + \beta_9(unemploy) \\ & + \beta_{10}(pop) + \beta_{11}(age) + \beta_{12}(dec_70) + \beta_{13}(dec_80) + \beta_{14}(dec_90) + \varepsilon \end{aligned}$$

Results and Analysis

Time series analysis with country fixed effects was conducted from 1970 to 2008 across twenty-nine OECD nations. The results from the regression are presented below in *Table A7.1* on the next page. The statistical significance of explanatory and control variables is marked with asterisks.

There are some missing values from the analysis. Political variables—*election* and *left*—were not available for several OECD countries: Chile, Israel, Korea, Mexico, and Turkey, which reduced the number of observations. However, these countries are not EU MSs and would have served as controls. Other non-EU control countries, such as Canada, remain in the analysis. The included non-EU controls generally had similar levels of political and economic development over the twenty-eight years analysed compared to the MSs.

Moreover, political factor data for Central and Eastern European countries does not begin until 1990 in the Comparative Political Dataset. Notably, the analysis does not incorporate all EU MSs as several EU countries that are not members of the OECD, including Malta and Romania. The current

model is restricted to OECD nations with available data. The dataset should in the future be expanded to include all EU MSs as well as to other advanced

Table A7.1: Total health expenditure as a per cent of GDP, 1970-2008

Independent Variable		
Political European Integration	0.019	***
	(0.006)	
Economic European Integration	0.367	**
	(0.129)	
Globalisation Index	0.038	***
	(0.008)	
Election Year (binary)	-0.082	***
	(0.024)	
Left Government	-0.002	**
	(0.001)	
Trade Union Density	0.001	
	(0.004)	
GDP per capita	0.000	***
	(0.005)	
Inflation	0.005	
	(0.08)	
Unemployment	0.043	***
	(0.012)	
Population Size	0.000	***
	(0.000)	
Population over 65 Years	0.002	
	(0.024)	
Decade Trends: 1970s	-0.875	***
	(0.199)	
Decade Trend: 1980s	-0.593	***
	(0.145)	
Decade Trend: 1990s	-0.398	***
	(0.085)	
Constant	1.926	**
	(0.614)	
R ²	0.794	
Number of Observations	753	

Standard errors in parentheses

***p<0.001, **p<0.01, *p<0.05

industrialised democracies. Particular attention should be devoted to collecting more data on Central and Eastern European countries, if the data exists, which are especially underrepresented in the current analysis. The significant findings

provide support for continued data collection and analysis to determine if the trends persist. Nevertheless, the panel covers many countries of varying organisational and financing structures. The findings are, therefore, generalisable over time and across countries.

In summary, the results confirm previous studies on the effects of political, demographic, and institutional impacts on healthcare systems—elections years, left governments, GDP per capita, unemployment rate, and decade trends—are statistically significant.⁶³ Interestingly, the direction of left government is opposite from academic predictions.⁶⁴ Trade union density is not significant, supporting Pierson's argument (1996b) that interest group structures and the welfare state are changing, so the role of unions in redistribution social policies is being diminished with time. Older populations and inflation do not appear to significantly influence expenditure, which should be examined in more detail in another study. Yet, like left government, this finding is not the focus in this chapter.

All measures of internationalisation—including globalisation and European integration—are statistically significant. Both the economic and political measures of European integration are statistically significant at p-values of 0.01 or less, discussed in more detailed below. Additionally, globalisation positively influenced health spending, confirming the results of various scholars (Garrett, 1998; Rodrik, 1998). The KOF globalisation index is measured on a scale from zero to sixty. For every one-unit increase in globalisation, the percent of GDP devoted to healthcare increased between an estimated 0.022 and 0.053, with 95% confidence.

⁶³ The twenty-nine OECD countries include in the regression analysis Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the United States.

⁶⁴ This finding warrants more investigation as it is an additional contribution to the literature, but is not central to the thesis. Political controls have been utilised in statistical analysis of social spending generally, but not in healthcare analysis. As a result, it will be explored at a later date. There could possibly be an interaction effect of the government with economic conditions, for example.

Again, a central finding of relevance to this thesis is that both the economic and political European integration measures were positively and significantly associated with expenditure, a direction opposite than predicted by much previous literature, such as Beckfield (2006, p.969), France and Taroni (2005), Freeman (2000, pp.34-49), Ferrera (1995) and Hitris (1997). A full 0.1-unit increase in economic integration leads to an increase of between 0.0114 and 0.0619 of health as percent of total GDP (with 95% confidence). However, as it is necessary to note that the measure is a proportion of trade, with one being the maximum; the predicted effect is the change from no trade to full trade integration. In actuality, the rate falls between 0 and 1 with small changes on an annual basis, so the magnitude should be adjusted to 0.01 or 0.1 increments when contextualizing. Therefore, economic integration as captured by changes in trade is statistically significant.

For each additional year a country is a member of the EU (political integration)⁶⁵ health spending as a percent of GDP increases between 0.008 and 0.030 (with 95% confidence). The findings illustrate that the effects of European integration occur from both political and economic integration. Interestingly, political integration has significant annual influence in terms of Euros given the large size of the healthcare state. The causal mechanisms of this finding are explored in greater detail in Chapters 4, 5 and 6. Moreover, the findings illustrate that the effects of European integration appear larger than those of globalisation on health expenditure in line with arguments of some scholars, like Fligstein and Merand (2002), who have demonstrated that Europeanisation is a larger influence on national economies than is globalisation. This analysis shows that a similar effect is evident on the welfare state and on healthcare in particular.

Empirical Test Conclusions

This section has illustrated that Europeanisation, like globalisation, is an external force that positively and significantly influences the healthcare systems over time and across countries. Both economic and political integration are

⁶⁵ This is a proxy for political integration. Please see explanation earlier in the Data and Methodology section for more information. A list of variables, including their source and range, is included in Annex A3.2.

influential. The effect of European integration appears to be larger than that of globalisation, illustrating the importance of political developments (Garrett, 1998; Rodrik, 1998). Even the indirect political effects of Europeanisation, larger economic integration influences, impact healthcare expenditure.

Explanations for the findings must be developed. The results appear to conflict with systematic theoretical predictions of retrenchment from supranational pressures, such as globalisation and the EU. While quantitative analysis is useful in terms of demonstrating the importance of European integration, it lacks the power to explain the potential causal mechanisms at play. In addition, the implications of increased expenditure on health systems is not captured in this study.

This analysis supports the argument that Europeanisation should be considered when examining the dynamics of welfare and healthcare changes, particularly with regard to spending. The preliminary model warrants development to demonstrate the robustness of the findings and to thoroughly quantify the effect of European integration. The implications of these findings in practice also warrant further development. Nonetheless, this study indicates that there is a statistically significant effect of European integration that should be developed alongside traditional qualitative analyses.

Table A7.2: OECD Countries

Australia
Austria
Belgium
Canada
Chile*
Czech Republic
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Israel*
Italy
Japan
Korea*
Luxembourg
Mexico*
Netherlands
New Zealand
Norway
Poland
Portugal
Slovak Republic
Slovenia
Spain
Sweden
Switzerland
Turkey*
United Kingdom
United States

(Source: OECD, 2014)

* Some control political variables (election and left) measurements were not available for these OECD countries. This limitation of data consequently reduced the number of observations in the quantitative analysis.

Table A7.3: List of Variables

Variable	Explanation
Health Expenditure (<i>health</i>)	OECD, 2011 Health expenditure (as % of GDP)
Political European Integration (<i>poli</i>)	Number of years in the EU (strong correlation to Article 177 references)
Economic European Integration (<i>econ</i>)	IMF, 2011 Percent of exports to EU countries as a proportion of total exports
Globalization Index (<i>global</i>)	KOF Swiss Economic Institute, 2011 KOF Index, a composite index comprised of twenty-three variables measuring economic, social, and political dimensions of globalization
Election Year (<i>election</i>)	Comparative Political Data Set (Armingeon, et al, 2011) Binary variable for election years
Left Government (<i>left</i>)	Comparative Political Data Set (Armingeon, et al, 2011) Left-wing parties as a percentage of total cabinet posts, weighted by days
Trade Union Density (<i>union</i>)	OECD, 2011 Trade union density
GDP per capita (<i>GDP</i>)	OECD, 2011 Gross domestic product per capita
Inflation (<i>inflation</i>)	OECD, 2011 Inflation (CPI)
Unemployment (<i>unemploy</i>)	OECD, 2011 Unemployment rate
Population Size (<i>pop</i>)	OECD, 2011 Population level
Population over 65 years (<i>age</i>)	OECD, 2011 Proportion of the population over the age of sixty-five

Decade Trend: 1970s (<i>dec_70</i>)	Binary decade control variable
Decade Trend: 1980s (<i>dec_80</i>)	Binary decade control variable
Decade Trend: 1990s (<i>dec_90</i>)	Binary decade control variable