The Europeanization of Healthcare

Martinsen, Dorte Sindbjerg

Published in:
Research Design in European Studies

Publication date:
2012

Document version
Early version, also known as pre-print

Citation for published version (APA):
Martinsen, D. S. (2012). The Europeanization of Healthcare: Processes and Factors. In T. Exadaktylos, & C. Radaelli (Eds.), *Research Design in European Studies: Establishing Causality in Europeanization* (pp. 141-159). houndmills basingstoke: Palgrave Macmillan. Palgrave Studies in European Union Politics

The Europeanization of healthcare: processes and factors

Dorte Sindbjerg Martinsen

Chapter eight in Exadaktylos, T. and Claudio Radaelli, C. (eds.) (2012) *Research Design in European Studies: Establishing Causality in Europeanization*. Palgrave MacMillan

Introduction

In various aspects health care constitutes a less likely or critical case of both European integration and Europeanization (Eckstein 1975).[i] As set out explicitly in the Treaty, the organisation of health care is the responsibility of the Member States (art. 168 (7) of the Lisbon Treaty, previously art. 152 (5)). As other social policy areas, national governments have indeed opposed to delegate too much competence to the European Community when it comes to the core of the welfare state. Healthcare continues to be a policy area of high political salience and legacy, and with a large set of national veto-points opposing supranational intervention. Furthermore, it is a policy area of considerable economic attention and fragility, where the need of cost control hampers the introduction of new cross border supplies. Nevertheless, both integration and Europeanization have taken place with considerable speed and substance. When a policy area may be classified as a less likely or critical case of Europeanization, this brings specific challenges to the research design, but may also bring out crucial theoretical and empirical insights regarding which causal factors that mediate or limit processes of Europeanization and its outcome. The second section will look further into case selection and how the classification of a case is an important first step, when drawing one's research design for the study of Europeanization.

Health care integration and subsequent Europeanization are effects of the European community which were never really meant to be. The case examined here may be regarded as the most important initiative taken so far in the area, gradually extending the right to cross border health care and patient mobility. Public healthcare governance in the EU contains a wider set of sub-policies (Lamping and Steffen 2009, pp. 1363-1367), but this chapter examines the specific development

concerning cross border care and patient mobility. In 1998, the European Court of Justice (ECJ) initiated a remarkable process of integration where it interpreted that health care is a service within the meaning of the Treaty and therefore in principle shall circulate freely within the internal market. Understood literally, this would mean that a public good like health care is similar to other internal market products and a patient should be able to have any kind of treatment in another Member State with the costs reimbursed by the competent national health care institution. However, from 1998 onwards the ECJ has maintained that health care is a service within the meaning of the Treaty, but also recognised that in the absence of harmonisation at the supranational level, it is for each Member State to determine the conditions for entitlement to benefits as long as these conditions comply with Community law. The justifiability of national conditions in the light of Community law therefore constitutes the central theme in the Court's ongoing interpretations, through which the integration process unfolds.

The chapter will first discuss research design within case studies on Europeanization and argue that such design will benefit from including considerations on the characteristics of the cause, suggest plausible explanatory factors and specify the outcome variable. The next section examines healthcare Europeanization and on the basis of existing studies looks into plausible explanatory factors in the Europeanization process of Germany, France, The Netherlands, the UK and Denmark. Finally some concluding remarks are provided.

Research Design

When examining Europeanization within or comparatively across policy areas or Member States, the case study method is often applied. This also goes for the present examination of Europeanization of health care. The qualitative case study method is useful when the scholar wants to analyse *why*, *how* and *to what extent* a policy area has become Europeanized. The method thus deals with some of the most central research questions to political science. These questions all contain causality inquires. *Why*; which cause or explanatory factors explain that Europeanization takes place (or has not taken place)? *How*; which cause characteristics and explanatory factors explain the process of Europeanization? *To what extent*; which cause characteristics and explanatory factors explain the outcome of Europeanization?

The case study method is well equipped to uncover complex inter-institutional dynamics, as it provides "a better opportunity to gain detailed knowledge of the phenomenon under investigation" (Collier et al. 2004, p. 87). Whereas the deficit of the method is often found to be the small-*n*, the advantages are that the method enables the researcher to dig into the details and causal factors of a single unit (Gerring 2004, p. 348). The case-study constitutes a method capable of addressing the causal complexity often found when European policies are created in areas of high political salience, when such policies evolve and when they impact nationally in diverse and complex manner such as the present case of EU healthcare regulation (George and Bennett 2005, pp. 19-22).

In practical terms, *process tracing* is one way to map the incidents, organisations, actors, mechanisms and other causal factors that interplay when a specific Europeanization process unfolds. Process tracing enables the scholar to link incidents at the supranational and the national level, and through detailed analysis identify the link between a European cause, intermediate variables and national effects – as they unfold over time. Process tracing aims to identify the causal chain between an independent variable (X) and a dependent variable (Y), and hereby identify the explanatory factors assumed to link X and Y (George and Bennett 2005, pp. 206-207). The method is therefore especially useful when one addresses causal interference in qualitative research (Beach and Pedersen 2010). When tracing the process that links X and Y, one seeks to identify the *explanatory factors*, i.e. the *intervening variables* and *causal mechanisms* in between. Intervening variables and mechanisms are those connecting factors between an input and an output that we need to identify to analytically reconstruct the causal chain (Checkel 2006, p. 363). The identification of the factors in between is analytically essential as cause and effect are unlikely to be immediately related to one another. A long time-span research period will often be needed as Europeanization tends to effectuate gradually or in delayed manner (Panke, this volume), through criss-cross links between a European cause and national intermediate variables that either hinder or mediate the effects of such cause (Martinsen 2007a). A diachronic process-tracing study may uncover complex Europeanization, whereas a more immediate, synchronic study is likely to encounter difficulties in tracing complex dynamics and delayed effects of Europeanization.

When the scholar undertakes his/her Europeanization study and aims to uncover such causal complexity, a carefully drawn *research design* serves as a helpful analytical guide. We suggest here that when designing the research model that serves as the analytical wallpaper, it will be useful to

include considerations of *the classification of the case*, the *characteristics* of the independent variable, i.e. the *cause*, the *intermediate variables* assumed to matter within and across units and finally specify the *dependent variable* as part of the research design, i.e. does this study examine Europeanization as a process or an outcome variable (Exadaktylos and Radaelli, this volume). And if it includes an outcome variable, what kind of Europeanization effect and eventually to what extent has taken place (Töller, this volume)?

The classification of a case

When undertaking within-case analysis (Bennett and Elman 2006, pp. 455-457) such as health care Europeanization or studies of other policy areas, a meaningful first step is to classify the case in terms of its likelihood of theory confirmation or invalidation. That is, is this a least-likely (critical) or most likely case to confirm a theoretical or empirically generated hypothesis? Such classification tells us something about the generalisability of the case and how its analytical results may contribute to more general theory development.

In this way, a case can be selected for strategic-theoretical purposes. The case may then aim to test a theory or findings of other studies, to test their more general application. If the case *a priori* seems unlikely to support theory or analytical findings of other studies, it constitutes the 'least likely' case or, on the contrary, a 'most likely' case. The 'least likely' case may confirm the theory or existing studies against odds. The propositions of the theory thus appear stronger and more likely to hold in other (more likely) cases as well. It has gained explanatory value. As for example when Europeanization of a policy area is unlikely due to national characteristics, actors or the lack of direct supranational competence, but is found to take place. The opposite account is true for the 'most likely' case. If contrary to expectations it invalidates the theory, that theory has been significantly weakened. The 'least likely' case is thus foremost tailored to confirmation, and the 'most likely' case to invalidation of a theory (Ekstein 1975, p. 119). By choosing one's case strategically along the continuum of 'least likely' and 'most likely', the case study becomes a most suitable method for testing and improving theories and existing studies: "A single crucial case may certainly score a clean knockout over a theory" (Ekstein 1975, p. 127).

Research design; cause, explanatory factors and outcome

When designing the analytical model for one's Europeanization study, the characteristics of the independent variable, the *cause*, should also be considered, because the degree of coerciveness and thus the imperative to Europeanize may vary considerably from one EU regulatory area to the other. One needs to specify the degree of institutionalisation and adjustment pressure that the European cause, driving Europeanization, exerts (Schmidt 2002). According to Schmidt's 'Europeanization flow chart', adjustment pressure varies in relation to the degree to which rules are specified (Schmidt 2002, p. 901). But other characteristics of the cause are likely to be decisive to the process of Europeanization too. First of all, Schmidt's degree of *rule specifity* and coerciveness need to be taken into account. A directive or regulation may both be binding rules, but their individual articles set out to detail Member States' obligations may be very specific or very vaguely formulated, open to interpretation and mirroring political compromise. When vaguely formulated the national executives have more discretionary space on how to implement. Non-binding rules also vary in the extent to which they specify the normative obligation to be followed on Member States. Secondly, the *means of regulation* vary. Within some areas judicial policy making plays a larger role than in others. An area which is mainly or heavily regulated by the case-law of the European Court of Justice may undergo distinct processes of Europeanization. Other areas may be supported by regulatory agencies that exert some regulatory authority within the policy areas, formulate recommendations and interpret the extent and meaning of the regulatory scope (Thatcher 2005; Martens 2008). Thirdly, *time* is likely to matter on the characteristics of a cause. When a policy area has been integrated for decades, it tends to be more detailed and its regulatory scope wider. Within such areas, actors and institutions have had more time to agree on objectives, instruments and confront misapplications. Time also implies that most causes are dynamic and the European imperative to change at a given T_2 may vary significantly from T_0 when the regulation was initially adopted. Some Member States may be less willing or capable to adapt to the ongoing dynamism of European integration, thus ignoring incremental change as it takes place.

The characteristics of the independent variable, the cause, further affect the subsequent *intervening variables and mechanisms* in play. The research design should consider which intermediate variables are likely to influence the Europeanization process and its line of causation. Hence we move beyond a simple causal logic which only addresses how X causes Y, and according to which causation means "if X then Y" and the logic runs as "X is a cause of Y because without X, Y would not have occurred" (Mahoney and Goertz 2006, p. 232). Explaining variables extend the line of

causation since such variables link cause and effect. The proposition of causal mechanisms is that Y may not occur even though X is there, if causal mechanisms and other variables in between are not present or if there presence directly hinder causation between X and Y. Furthermore, intermediate variables may also intensify the effects of a cause and thus facilitate a process of change. An analytical focus on explaining variables highlights that there seldom is an automatic relation between X and Y.

In many ways this is what studies of Europeanization tell us. In fact, causal mechanisms and other sets of intervening variables are crucial to most Europeanization studies. The recent critique raised by Gerring (2010) on what he calls 'mechanism-centered explanations' therefore questions central parts of Europeanization research. Gerring argues that 'mechanism' has too many meanings and may mean different things to different people (ibid.), thus becoming too linked to the specific case. Without doubt this often goes for Europeanization case studies, where there is no consensus to what constitutes a mechanism and thus what we are trying to measure (Exadaktylos and Radaelli, this volume). Here a mechanism is understood to be related to actors and their action, i.e. the activities and behaviour of entities, relying on Hedström's definition according to which a mechanism "refers to a constellation of entities and activities that are organized, such that they regularly bring about a particular type of outcome, and we explain an observed outcome by referring to the mechanism by which such outcomes are regularly brought about" (Hedström 2008, p. 321).

A way to meet the critique of Gerring, while maintaining that causal mechanisms may be one set of explanatory factors decisive to causality processes in Europeanization, could be to let one's research design specify the plausible causal mechanisms alongside the intervening variables that the subsequent analysis will test for.[ii] That is, setting out explicitly and in relation to theory as well as existing studies what we assume are the significant variables and mechanisms that link independent variable X with dependent variable Y, and thus constitute part of the causal chain of the given Europeanization process?

As demonstrated by the findings of Exadaktylos and Radaelli's meta-analysis, Europeanization studies operate with a wide and quite different set of explanatory factors (Exadaktylos and Radaelli, this volume). Researching the impact of such different variables demands again different analytical grips. It takes a different handle to examine mechanisms, focusing on actors and actions, compared

to the intervening variables of for example national institutions, preferences and positions of a group of actors or type of political system. These different sets of explanatory factors may be equally important for causal inference, but they require analytical distinction in the sense that the exemplified variables cannot produce outcomes themselves, but may heavily influence the way individuals act (Hedström 2008, p. 322).

Whereas intervening variables can be seen as 'extraindividual entities' (Hedström 2008) and 'static' before paired with specific actors and action, mechanisms are relational and behavioural (Exadaktylos 2010, p. 34). Together variables and mechanisms constitute the explanatory factors between cause and effect and the way they condition one another is essential for causal inference in Europeanization analysis. In concrete, plausible important intervening variables in our research design are likely to count national institutions, the core executive, bureaucracy, type of political system, pressure groups/NGOs, preferences, the judiciary, political parties and media among others. Mechanisms, on the other hand, relate to what those institutions or organisations do, have done for decades, interpret or respond to European causes, and count mechanisms such as institutional compatibility, the legacy of national institutions, discourse, ideas, norms, frames, socialisation, identity, opportunity structures, veto positions, compliance culture among others (Knill and Lehmkuhl 2002; Falkner et. al. 2005; Exadaktylos and Radaelli 2009).

When preparing our research design, hypotheses on intervening variables and causal mechanisms can be formulated. In addition, more crude process tracing questions may be useful to give direction to what we are looking for and help to compare what we find.

Table 8.1: Process tracing questions

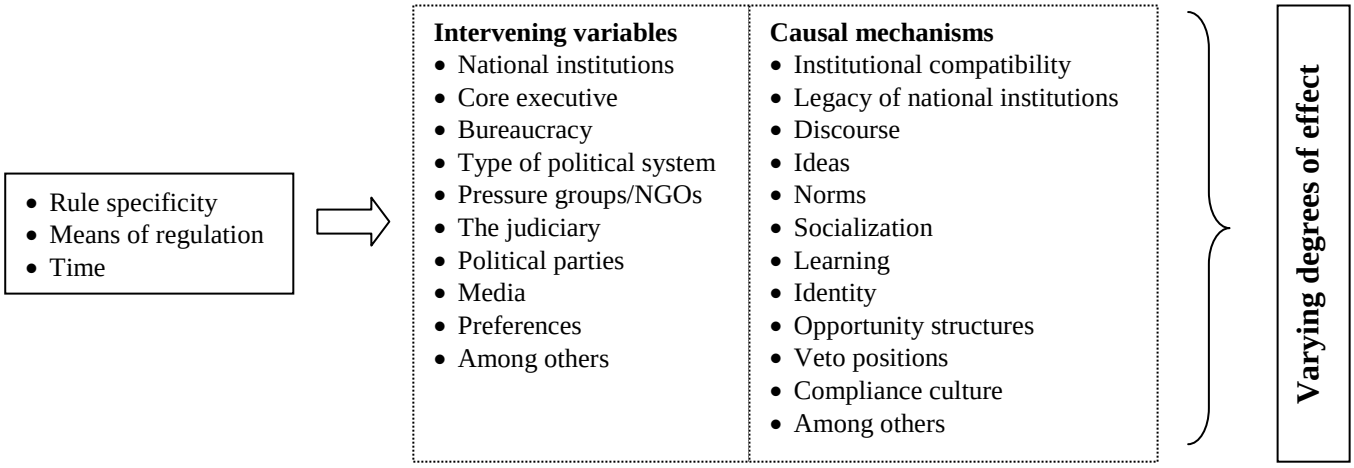
Process tracing questions in relation to intervening variables and causal mechanisms		
	Intervening variables	**Causal mechanisms**
Which intervening variables or causal mechanisms do we assume constitute part of the causal chain within a given case study?	Example: • Bureaucracy • Political system • Pressure groups	Example: • Socialisation • Discourse • Identity
	Hindering variables or mechanisms	**Mediating variables or mechanisms**

Do we assume that their presence hinder or mediate the process of Europeanization	Example: • Bureaucracy • Political system • Discourse • Identity	Example: • Pressure groups • Socialisation
Eventually why different variables or mechanisms are assumed to have different functions	Explanations with reference to theories and existing studies	

When conducting within case studies we may find explanatory factors that we did not consider in the first place. Furthermore, comparative case studies across policy areas or Member States are likely to point out that whereas some intervening variables or mechanisms are highly important to the Europeanization of some policies or to the process in some Member States, they are not in others.

Having considered plausible causal mechanisms finally brings us to the dependent or *outcome* variable of the research design, where we may hypothesise different degrees of effect ranging from retrenchment to transformation (Radaelli 2003; Töller, this volume). A research design encapsulating the line of causation between X and Y may take form as in figure 8.1.

Figure 1: Research design examining the Europeanization of a policy area



Cause ***Explanatory Factors*** ***Outcome***

Which intervening variables and causal mechanisms potentially play a part will vary from case to case. Our first explorative steps in the research area will instruct which explanatory factors are considered important, more in depth analysis is likely to introduce others and refine the research design. The within or comparative case studies will then test which ones constitute part of the causal chain and eventually why. The different components to establish a research design for the examination of causality within healthcare Europeanization will be discussed in more detail in the following section.

The Europeanization of health care

Regarding the classification of the health care case, if placed on a continuum between 'least likely' and 'most likely' cases, it more accurately represents the 'less likely' case. Not 'least likely' in a strict sense, because internal market principles have implications for public goods, however, 'less likely', because Member States maintain the prerogative to organise their health care systems and have repeatedly refused harmonisation moves from the European Union. The autonomy to decide on welfare policies has been jealously guarded by the Member States. Integration, compromising national welfare competencies, is thus 'less likely' to happen. As a less likely case of Europeanization, we hypothesise that:

H_1: intervening variables and causal mechanisms generally oppose Europeanization;

H_2: due to the characteristics of the cause and the opposing character of explanatory factors, Europeanization is weak both as process and outcome

When examining the *characteristics* of the independent variable, the *cause*, we find that so far the integration process has mainly taken place by means of judicial policy-making. Nevertheless, as the European Court of Justice has integrated quite dynamically since 1998, rule specifity has increased over time. This has so far happened without political decision-making, but currently the Commission's proposal for a Directive on patients' rights in cross-border healthcare is being negotiated.[iii] The cause as the input to Europeanization is therefore characterised by judicial policy-making being the regulatory means. The rule specifity has grown over time, as the ECJ has gradually extended the meaning and scope of the conditions under which one has a right to receive healthcare in another Member State. However, the fact that the policy area is regulated by means of

judicial policy-making is decisive to the subsequent Europeanization process as Member States may not accept the full wording and meaning of the rule of law, but re-interpret what the Court has said more in line with their own understanding and preferences (Martinsen and Vrangbæk 2008). The authoritative status of judicial policy-making continues to be questioned at the national level (Conant 2002; Wasserfallen 2010). As regulatory means, judicial policy-making may be both highly effective as it is not bound by constituencies and at the same time clearly limited, as Member States re-interpret their obligation to comply. Health care integration as the research design's independent variable is therefore characterised by judicial policy–making as regulatory means and a certain degree of rule specifity open to interpretation, and by being a dynamic process of integration indeed, where individual case-law has added on over time and gradually but considerably extended the regulatory scope over time. The time period runs 1998-2010.

Between 1998 and 2010, the ECJ laid down that health care is a service within the meaning of the Treaty, which shall in principle circulate freely. Judicial policy-making thus meant that the territorial closure of the national health care sectors was severely put under adaptive pressure. The European imperative to change was quite fundamentally contradicting the traditional organisation of the public sector; territoriality versus free movement principles (Ferrera 2005; Martinsen 2005). In its ongoing case-law interpretations, the judiciary laid down that the free movement principles apply to all health care services independent of how that health care service is financed or which health care system provides it.[iv] Jurisprudence, however, also lay down that under certain conditions national restrictions to cross border health care were justified. Such restrictions need to be proportional and justified (Martinsen 2009), and the Court distinguished between non-hospital care and hospital care.[v] Judicial policy-making asserted that the EU citizen has the right to receive non-hospital care in another Member State, without that right being authorised before hand by the respective national health care institutions. The cost of care shall then be reimbursed subsequently up to what that treatment would have cost back home by the competent healthcare institution. On the other hand, Member States may make the right to hospital care subject to certain conditions. According to the Court, it is justified that that the right to hospital care in another Member State is subjected to prior authorisation by the competent healthcare institution, entitling the patient to receive a specific treatment in another Member State and subsequently have the cost of care reimbursed up to what the same treatment would have cost in ones home Member State. In this way the Court on the one hand justifies a significant degree of national control, on the other hand it

makes such control subject to conditions. In the same line of case-law, the Court also laid down that the national authority is obliged to issue the authorisation if the same treatment cannot be provided without undue delay back home and the decision whether to authorise or not has to be based on international medical science and not purely national considerations. Furthermore, the procedure on how to apply and the condition under which to receive such authorisation has to be assessable, transparent, based on objective, non-discriminatory criteria and refusal on granting authorisation has to be open to be challenged in judicial or quasi-judicial proceedings.[vi] The Court has also clarified that there can be made no distinction as to whether healthcare is privately or publicly provided. Private healthcare may be consumed abroad even though that is not allowed in the domestic system.[vii]

Health care integration thus constitutes a dynamic cause that has its content and meaning mapped and specified over time. In many ways, it is integration by bits and pieces, two steps forward one behind, and in its fragmented manner, remains open to interpretations, reinterpretations and misunderstandings.

Explanatory factors within healthcare Europeanization

Existing studies on the implementation of the patient mobility case-law have mainly examined the impact in the old Member States, whereas we lack knowledge about implementation processes in Southern and Eastern Member States. In a comparative light, they point to different *explanatory factors* in play, but a similar outcome, namely that the principle of territoriality has been weakened in the organization of national healthcare. A principle which for so long has bound healthcare consumption to national territories (Vollaard 2009). The degree to which the principle has been weakened however, varies, as do the explanatory factors. This highlights the need to examine processes of Europeanization comparatively, over time and across Member States. Existing studies thus give us good suggestions on plausible intervening variables and causal mechanisms, facilitating or opposing X to cause Y. Their explanatory value may then be tested in unexamined Member States, as well as in other policy areas.

The *legacy of national institutions* impacts on healthcare Europeanization. Vollaard identifies two families of healthcare states; a ‘command and control’ healthcare state and a ‘corporatist’ healthcare state (Vollaard 2009, p. 311). The distinction into two healthcare families can also be found

elsewhere (Ferrera 2005, p. 124; Martinsen 2007b, pp. 26-27). The 'command and control' type of state runs public healthcare as a *National Health Service* system, where healthcare rights are granted on the basis of residence (Cornelissen 1996). A person is entitled to healthcare because s/he is a citizen or a habitual resident, and not qua individual contributions paid to a specific scheme. Healthcare expenditure is generally financed by taxes. The planning is state-led and healthcare is provided by publicly owned healthcare services. The system is governed by elected politicians and the public administration at local, regional and central level (Vollaard 2009, p. 311). In practice, more and more citizens may rely on private provision of healthcare, and elements such as patient choice and market principles of the sector has grown over the years (Hagen and Vrangbæk 2009). The model is found in the UK, the Scandinavian countries, Southern Europe and in some of the East European Member States. The 'corporatist' healthcare state organizes healthcare provision differently. It is a *social insurance-based model,* where market participation generally gives access to a social security scheme, including healthcare and the degree of this participation decides the level of entitlements. The provision of healthcare is largely regulated by hospitals and health insurance funds within a public law framework. Also the social partners have a say on the provision and the rights of their Members. The state takes part in the corporatist arrangement, and may influence by means of public law, but all in all the role of the state is more withdrawn (Vollaard 2009, p. 312). We find the corporatist healthcare state in France, the Netherlands, Belgium, Germany, Luxembourg, Austria and in some of the East European Member States (Martinsen 2007b, p. 27). The different healthcare states differ as to whether they provide healthcare as benefit in kind, or by a principle of reimbursement, where the patient first pays for the treatment and is subsequently reimbursed by the competent healthcare fund.

In his comparison of Germany and Denmark, Kostera finds that healthcare institutions in Germany are comparatively better equipped to adapt to the pressures for change from the EU (Kostera 2008, p. 24). On the other hand, the national institutional legacy of Danish healthcare has made Denmark much more hesitant in changing its legislation (Kostera 2008). Kostera furthermore finds that the institutional setting of the Danish healthcare system makes it (de facto or assumed) more economically vulnerable to cross border provision of healthcare (Kostera 2008, p. 29). He therefore points to the *economic variable* as a explanatory factor, which constitutes an obstacle between X and Y. The general importance of this finding could then be tested in other Member States with national health service systems.

However, as processes of Europeanization are dynamic the *time* component proves to be important when examining explanatory factors, and whether they oppose or facilitate the causal link between X and Y. National institutions undergo reforms, not least in the healthcare sector. Martinsen and Vrangbæk find that Danish *healthcare reforms* come to mediate the impact of ECJ jurisprudence. As patient choice constitutes a vital part of domestic healthcare reforms, the principles contained in the European integration process greatly correspond what happens back home. Therefore it becomes increasingly difficult to ignore the imperatives from Europe, and Denmark needs to adapt to some extent to the ECJ jurisprudence, however not in full (Martinsen and Vrangbæk 2008). In this sense, it is possible to speak about 'synergies of Europeanization', where domestic change patterns correspond to European ones and hereby facilitate change.

The importance of domestic reform agendas is also found in the work of Obermaier (2008; 2009). His research substantiates that one reason why the UK government decided to remove firm territorial restrictions in the National Health Service Act was that it fitted the Labour government's agenda to make the NHS more market-oriented. That also accounts as a causal mechanism for Germany. Political preferences played a role when Germany decided to transpose the ECJ ruling, because it was in line with the CDU/CSU preferences on greater patient choice (Obermaier 2008, p. 749). We thus have political *preferences* added as an intervening variable, identified in the Europeanization of healthcare. Change of preferences may come to change essential parts of a blocking *institutional legacy*, i.e. a mechanism, thus facilitating change.

As a more general intervening variable, the role of the *core executive* and the *bureaucracy* is pointed out. The Danish central administration creatively re-interpreted the meaning of the ECJ jurisprudence, and more specifically what constitutes a service within the meaning of the Treaty (Martinsen and Vrangbæk 2008). Its creative re-interpretation was restrictive and hereby limited the scope of Danish healthcare that could be consumed in another Member State. The Dutch core executive and health authorities first claimed the Dutch system largely compatible with the case-law of the ECJ, thereby as a first response refusing that jurisprudence obliged it to change its legislation (Vollard 2009, p. 360). The same resistance is documented by Obermaier and found in the cases of the French, German and UK government (Obermaier 2008, p. 737). The executive and the bureaucracy are identified as key explanatory factors, decisive to the success or failure of EU

induced change. The opposition of the core executive and the bureaucracy implies that effect is indeed delayed or the full effect even hindered in the long run.

The central position of the executive and the bureaucracy suggests that the extent to which their administration of EU obligations are left unquestioned, or checked and balanced by other domestic or supranational actors or institutions becomes crucial. To what extent is the national administration of EU obligation open to contest and trial? Obermaier's work identifies the *national judiciary* as an important variable (Obermaier 2008; 2009). Although the role of the national judiciary tends to be disregarded in political science, Obermaier points out that it plays a decisive function as check and balance to how bureaucrats translate and transcend the EU imperative into national legislation and administrative practices. In France, a multiplication of court cases put more and more pressure on the French administration to end legal uncertainty and implement, which it finally did (Obermaier 2008, p. 745). The fact that the UK had its Watts case before the European court, brought forward by the British judiciary, meant that no national health service system could maintain that the ECJ jurisprudence did not affect their national system. Also in Germany, the national judiciary played a vital role to the Europeanization of health care, when national court cases started to address the matter and examine its impact to patients in Germany, wishing cross border care (Obermaier 2008, pp. 749-750). In 2003, Germany finally transposed the ECJ rulings. Concerning the Netherlands, Vollard also emphasises the role of the Dutch judiciary. Whereas the early case-law was met by an uproar and deep concern among Dutch politicians (Vollaard 2009, p. 337), the fact that Dutch courts sent the preliminary references of both the cases Smits-Peerbooms *and* Müller-Faure and Van Riet directly forced the Dutch government to adapt the rulings. First in 2003, by abolishing the prior authorisation procedures for pharmaceutical goods and outpatient treatment (Vollaard 2009, p. 365), and second, with the healthcare reform in 2006 to allow the costs of in-patient treatment provided in another Member State as well as elsewhere in the world to be reimbursed up to what the same treatment would have cost in the Netherlands. On the other hand, the absence of social courts is set to partly explain the lower degree of Europeanization of healthcare on Denmark (Kostera 2008; Martinsen 2005).

Another explanatory factor which may disturb the administrative autonomy of central administration to alone define how to implement the case law of the Court are decentralised semi-public health authorities. *Insurance funds* in Germany thus started to implement the ECJ

jurisprudence in order to put an end to legal uncertainty before the German government choose to implement by the statutory health insurance modernization act in 2003 (Obermaier 2008; 2009). In contrast, Obermaier (ibid.) finds that the hierarchical and centralised structure between the French government and insurance funds in part explains the slower and more gradual implementation process in France. French insurance funds were not in capacity to put pressure on the central administration's delayed implementation, had they wished to do so. According to Obermaier this in part explains why it took France until 2006 to comply with the ECJ jurisprudence (Obermaier 2009). There was no decentralised administrative pressure to adapt. A hypothesis generated on this behalf would be that the more centralised and monopolised administration and implementation is the less effect of unwanted Europeanization. It takes dispersed power and administration thereof to generate successful Europeanization in the less likely case. Along this line, *the media* is also found to constitute an important intervening variable to healthcare Europeanization in the UK. An aggressive press campaign focusing on the problems of the NHS put pressure on the UK government to reform the system (Obermaier 2008, p. 746). This suggests that when the legacy of established national institutions is in question, dynamics of change – also when supranational – gain more momentum.

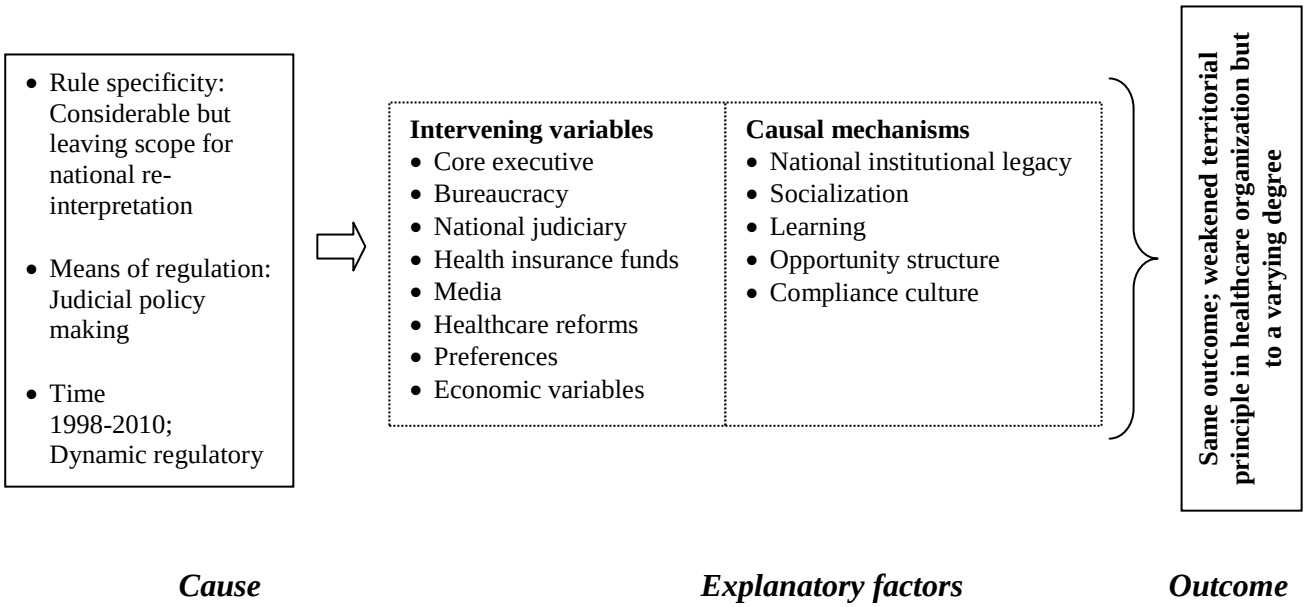
Existing studies identify mainly different intervening variables in the five Member States that they examine, whereas the importance of mechanisms is not stressed to the same extent. In all studies, intervening variables are decisive to the Europeanization process of a less likely case that in fact takes place, but these certainly condition how actors act and thus are related to mechanisms. In general, the core executive and the bureaucracy are found to hinder the process in the first place. However, all the examined Member States have other variables and patterns over time that pull towards Europeanization and reduce the administrative autonomy, which at first constitutes obstacles to Europeanization. Thus we must assume that over time mechanisms such as socialisation, learning, change in opportunity structure and compliance cultures play a role – relevant for future investigation.

Despite the difference of the explanatory factors across Member States, we have a similar *outcome*, namely the weakening of the territorial principle within the organization of national healthcare. A weakening which, however, manifests to different degrees. France, Germany and the Netherlands come to implement the jurisprudence of the Court more or less in full, whereas the UK and

Denmark are more reluctant compliers. The legacy of national institutions and administrative autonomy in the two systems could be hypothesised as key explanations, but that would need to be tested across a larger set of cases.

Figure 8.2 pictures a healthcare Europeanization research design drawn on the basis of existing studies.

Figure 8.2: A Research design on healthcare Europeanization



Concluding remarks

Existing studies demonstrate that a rather diffuse cause, by means of judicial policy-making and open to re-interpretation, may produce a similar outcome in different Member States. The causal chain between X and Y are constituted by different explanatory factors that either facilitate, diminish or hinder the full effect of X. The five Member States which have been addressed above point out that the cause in itself cannot explain the process of change but neither can a single intervening variable or causal mechanism. Instead we have a combination of explanatory factors that drive implementation (Obermaier 2009). This shows that case studies of Europeanization need to address both variables and mechanism (Gerring 2010).

So far the study of healthcare Europeanization has mainly examined the processes in the old Member States. Germany, France, Netherlands, Denmark and the UK examined above all belong to EU-12. Here the legacy of national institutions, the core executive and bureaucracy are central

explanatory factors which have opposed the EU induced process of change, whereas the national judiciary and other factors which challenge the administrative autonomy of bureaucracy pull towards greater Europeanization. We know little about causation in Southern and East European Member States and future process tracing studies will have to examine the explanatory value of the factors pointed out above in a more EU wide setting. So far the response of existing studies' to H_1 and H_2 is that also in the less likely case of Europeanization, specific intervening variables and causal mechanisms come to pull Europeanization and drive an outcome, which otherwise would have been severely hindered and even more delayed.

The causal link between X and Y thus depends on the explanatory factors in between, and no simple causal logic assuming 'if X, then Y' would capture the Europeanization process take place. Furthermore, process tracing also documents that the counter-factual logic does not apply either. If a counterfactual logic would run, then Y would occur even without X, so we have not identified the actual cause that has produced the identified outcome. The processes traced for the five different Member States substantiate that the strength and preferences of opposing intervening variables and causal mechanisms, i.e. the legacy of national institutions, core executive and the bureaucracy, ran counter to the outcome identified. Had it not been for X (EU judicial policy-making) and facilitating explanatory factors, Y (a weakened territorial principle) would not have occurred. Therefore, the process-tracing method also stands as a useful instrument when testing counterfactual hypotheses on EU integration and Europeanization.

References

Beach, D. & R. B. Pedersen (2010) "Process tracing: metode, design og forskningslogik" in Andersen, L.B., K.M. Hansen & R. Klemmesen (eds.) *Metoder i Statskundskab* (København: Hans Reitzels Forlag), pp. 215-238.

Bennett, A. and Elman, C. (2006) "Qualitative Research: Recent Developments in Case Study Methods", *Annual Review of Political Science*, 9: 455-476.

Checkel, J. T. (2006) "Tracing Causal Mechanisms", *International Studies Review*, Vol. 8 (2), pp. 362-370.

Collier, D., Mahoney, J., and Seawright, J. (2004) 'Sources of leverage in causal inference: towards an alternative view on methodology' in Brady, H. and Collier, D. (eds.) *Rethinking Social Inquiry: Diverse Tools, Shared Standards,* (Lanham, MD: Rowan Littlefield), pp. 85-102.

Conant, L. (2002) *Justice Contained – Law and Politics in the European Union* (Ithaca/ London: Cornell University Press).

Cornelissen, R. (1996) "The Principle of Territoriality and the Community Regulations on Social Security (Regulations 1408/71 and 574/72)", *Common Market Law Review* vol. 33, pp. 439-471.

Eckstein, H. (1975) "Case Study and Theory in Political Science" in Greenstein, F. L., & Polsby, N. W. (eds.) *Strategies of Inquiry* (Addison-Wesley Publishing Company), pp. 79-137.

Exadaktylos, T. (2010) *The Europeanization of National Foreign Policy: the case of Greece and Germany vis-à-vis the Eastern Enlargement of the European Union*. PhD Thesis, University of Exeter.

Exadaktylos, T. and Radaelli, C.M. (2009) 'Research Design in European Studies: The Case of Europeanisation'. *Journal of Common Market Studies*, 47(3): 507-530.

Exadaktylos, T. and C. Radaelli (2011) “Do we need distance to get close? Looking for causality in Europeanization studies” in Exadaktylos, T. and C. Radaelli (eds.) *Research Design in European Studies. Establishing Causality in Europeanization* (Palgrave Macmillan).

Falkner, G., Treib, O., Hartlapp, M. and Leiber, S. (2005) *Complying with Europe. EU Harmonisation and Soft Law in the Member States* (Cambridge: Cambridge University Press).

Ferrera, M. (2005) *The Boundaries of Welfare. European Integration and the New Spatial Politics of Social Protection.* Oxford: Oxford University Press.

George, A. and Bennett, A. (2005) *Case Studies and Theory Development in the Social Sciences*, Cambridge, MA: MIT Press.

Gerring, J. (2004) “What Is a Case Study and What Is It Good For?” in *American Political Science Review*, Vol. 98 (2), pp. 341-354.

Gerring, J. (2010) “Causal Mechanisms: Yes, But …” in *Comparative Political Studies*, Online published 28 July 2010.

Hagen, T. and K. Vrangbæk (2009) “The changing political governance structures of Nordic healthcare systems”. In Saltman, R., Magnussen, J. and Vrangbaek, K. (eds.). *Nordic healthcare systems. Recent reforms and current policy challenges.* (McGraw Hill. Maidenhead and New York) pp 107-125.

Hedström, P. (2008) “Studying mechanisms to strengthen causal inferences in quantitative research” in J. M. Box-Steffensmeier, H. E. Brady and D. Collier (eds.) *The Oxford Handbook of Political Methodology*. (Oxford: Oxford University Press): 319-335.

Knill, C. and Lehmkuhl, D. (2002) “The national impact of European Union regulatory policy: Three Europeanisation mechanisms”, *European Journal of Political Research,* 41(2): 255-280.

Kostera, T. (2008) "Europeanizing Healthcare: Cross-border Patient Mobility and Its Consequences for the German and Danish Healthcare Systems", *Bruges Political Research Papers*, no. 7.

Mahoney, J and G. Goertz (2006) "A Tale of Two Cultures: Contrasting Quantitative and Qualitative Research", *Political Analysis*, Vol. 14, pp. 227-249.

Martinsen, D.S. (2005) "The Europeanization of welfare - The Domestic Impact of Intra-European Social Security", *Journal of Common Market Studies*, Vol. 43 (5), pp. 1027-1054.

Martinsen, D.S. (2007a) "The Europeanisation of Equality between Genders. Who Controls the Scope of Non-discrimination?" in *Journal of European Public Policy*, Vol. 14, no. 4, pp. 544-562.

Martinsen, D.S. (2007b) "EU for the Patients. Developments, Impacts, Challenges" SIEPS report, no. 6, http://www.sieps.se/sem/2007/sem_0615/sem_0615_en.html

Martinsen, D.S., and K. Vrangbæk (2008). 'The Europeanisation of Health Care Governance – Implementing the Market Imperatives of Europe', Public Administration, 86:1, 169–84.

Martinsen, D.S. (2009) 'Conflict and Conflict Management in the Cross-border Provision of Healthcare Services'. *West European Politics*, Vol. 32, No. 4, pp. 792-809.

Obermaier, A. J. (2008) "The National Judiciary – Sword of European Court of Justice Rulings: The Example of the *KohllDecker* Jurisprudence" in *European Law Journal*, Vol. 14 (6), pp. 735-752.

Obermaier, A. J. (2009) "The End of Territoriality? The impact of ECJ rulings on British, German and French social policy" (Surrey: Ashgate)

Panke, D. (2011) "Advantages and Problems with Process-Tracing Methodology. The Example of Explaining Delayed Europeanization" in Exadaktylos, T. and C. M. Radaelli (eds.) *Research Design in European Studies. Establishing Causality in Europeanization* (Palgrave Macmillan).

Radaelli, C.M. (2003) "The Europeanization of Public Policy" in Featherstone, K. and Radaelli, C. (eds) *The Politics of Europeanization*, Oxford: Oxford University Press.

Schmidt, V. (2002) "Europeanization and the Mechanics of Economic Policy Adjustment" in *Journal of European Public Policy*, Vol. 9 (6) pp. 894 – 915 .

Thatcher, M. (2005) "The Third Force? Independent Regulatory Agencies and Elected Politicians in Europe" in *Governance*, Vol. 18 (3), pp. 347-373.

Töller, A. E. (2011) "Concepts of Causality in Quantitative Approaches to Europeanization" in Exadaktylos, T. and C. Radaelli (eds.) *Research Design in European Studies. Establishing Causality in Europeanization* (Palgrave Macmillan).

Vollaard, H. (2009a) "Political Territoriality in the European Union: The Changing Boundaries in the European Union: The Changing Boundaries of Security and Healthcare". Dissertation Leiden University, the Netherlands.

Vollaard, H. (2009b), "The Logic of Political Territoriality" in *Geopolitics*. Vol. 14 (4) pp. 687-706.

Wasserfallen, F. (2010) 'The Judiciary as Legislator? How the European Court of Justice shapes Policy-making in the European Union'. *Journal of European Public Policy*, Vol. 17 (8), pp. 1128-1146.

[i] The classification as a 'less likely case' draws on Eckstein's distinction between 'least likely' and 'most likely' cases as a selection criteria within the case study method (Eckstein 1975). The classification as such will be further elaborated in the second section.

[ii] In the conclusion of his critique on mechanism-centred explanations, Gerring emphasises that he does not make an argument against mechanisms as an instrument of causal analysis. Instead he finds that we need "intelligent discussion of plausible causal mechanisms, which should be subjected to testing *to the extent that it is feasible*" (Gerring 2010, p. 20).

[iii] COM (414) 2008 Proposal for a Directive on the application of patients' rights in cross-border healthcare, proposed 2. July 2008.

[iv] See for example cases C-157/99 Geraets-Smits and Peerbooms, 2001 and C-372/04 Watts, 2006.

[v] See case C-372/99 Müller-Fauré and van Riet, 2003. Hospital care was defined as when one has a overnight stay in a hospital of 24 hours. Non-hospital care will then be out-patient care of less than 24 hours.

[vi] Para. 90 of C-157/99 Geraets-Smits and Peerbooms (repeated in the Watts case).

[vii] Case C-444/05 Stamatelaki, 2007.