
Health care reforms and the crisis

Furio Stamati and Rita Baeten

Report 134

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Brussels, 2014
©Publisher: ETUI aisbl, Brussels
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Print: ETUI Printshop, Brussels

D/2014/10.574/31
ISBN: 978-2-87452-330-4 (print version)
ISBN: 978-2-87452-331-1 (online version)

The ETUI is financially supported by the European Union. The European Union is not responsible for any use made of the information contained in this publication.

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Introduction

The recent crisis has allowed European policymakers – national and supranational – to propose unprecedented levels of social spending cuts. The health sector has become an easy target for cost containment, due to its size and potential for improved efficiency (Baeten and Thomson 2012). Moreover, EU-level policymakers have increasingly engaged with health care issues. The Memorandums of Understanding signed by the Troika (that is, the European Commission, European Central Bank, and International Monetary Fund) with Greece, Ireland, Cyprus, Portugal, and Romania contained detailed instructions for health system reform, subject to quarterly reviews. But EU guidance is becoming more widespread for other Member States as well. Country-specific Recommendations on health and long-term care have increased both in number and in their level of detail (Baeten 2013; Baeten and Thomson 2012).

And yet, concerns about the trends, levels, and efficiency of health spending largely predate the recent crisis (European Commission 2011; Wendt and Thompson 2004). Key drivers for expansion range from technological progress, population ageing, and increasing demand, to the very way health systems are organised (OECD 2010). While these developments all point to the need to regain long-term financial sustainability, reforms might also be ideologically driven and seek a reallocation of responsibilities among health stakeholders (Mladovsky *et al.* 2012a; Okma *et al.* 2010). Cuts to public spending on health may thus come at a time when more – not fewer – resources are required, for instance to cope with the adverse effects of unemployment and population ageing on public health (Baeten 2013; HOPE 2011; European Commission 2011). Against this backdrop, what can be said about the most recent reforms? How do they fit into the picture? What is driving them and what should be expected from the post-crisis health agenda?

The present project deals with this topic by analysing the policy changes that have occurred since 2008 in 10 EU Member States. The main focus is on changes in the allocation of responsibilities for health care financing, provision, and regulation (Wendt 2009; Wendt *et al.* 2009; Moran 1999; 2000), brought about by processes of privatisation/re-nationalisation, reorganisation, and liberalisation/re-regulation (see Böhm *et al.* 2012; Mladovsky *et al.* 2012a; Okma *et al.* 2010). Particular attention is paid to the role and effects of the new economic governance instruments of the EU, especially CSRs and – where applicable – MoUs. The final aim is to observe whether health care reform patterns in the EU show signs of convergence, divergence, or clustering,

discussing their effects on the evolution and structure of health systems and system clusters in the region (Böhm *et al.* 2012; Wendt 2009).

The report is structured as follows. Section 1 provides an essential conceptual and methodological framework. Section 2 discusses the role of the EU and EU governance in domestic health reforms since the global crisis. Section 3 provides an in-depth illustration of the main reform trends across our ten country cases, focusing on the three health system dimensions of financing, provision, and regulation. One last section draws a number of comparative conclusions and indications for further research.

1. Conceptual framework and methodology

Health systems across Europe are in a state of flux. Technological progress, cultural and political transformations, and radical changes in the guiding principles of government intervention and public administration have put traditional health models to the test. Over the last three decades at least, postwar health care systems have had to run just to stand still; despite continual evolution, they have struggled to keep up with the ever-changing demands of society. What is more, they have done so while having to cope with increasing constraints on their long-term financial sustainability. The recent global economic crisis, in its various iterations, and the ensuing agenda of cost containment and austerity have further restricted the room available to fulfil – or even accommodate – these partly conflicting ambitions (see Pavolini, Palier, and Guillén 2013 for a discussion).

The result has been to add further intricacy and nuance to one of the most institutionally and organisationally complex sectors of advanced welfare states. What one can discern by looking at recent trends is a rich and ambitious agenda where very technical parametric reforms co-exist with grand, ideologically driven projects of systemic overhaul (Cylus *et al.* 2012; WHO 2013). The overall policy direction certainly suits a market-liberal and neo-liberal approach to public services, with increasing emphasis on decentralised decision-making, private provision, and patient choice. At the same time, however, the big picture is hardly one of clear-cut convergence towards a unique European or Western model. Neither is it one of persisting divergence, where traditional models simply keep growing apart, building on their respective philosophies and legacies (Montanari and Nelson 2013; WHO 2000). Instead, processes of diffusion, learning, national and supranational interplay, and domestic political dynamics are all entwined, interacting in a context of slow growth and hard budget constraints, which is occasionally perturbed by unpredictable exogenous shocks (Gilardi *et al.* 2009; Karanikolos *et al.* 2013). So, where are European health systems heading? What can we expect from 21st century health policy in the very cradle of the welfare state?

Recent health care reforms across the EU provide an excellent opportunity to start tackling these complex questions, seminal for the future of European societies. On the one hand, they have produced noticeable transformations in many aspects of domestic health care systems (see Pavolini and Guillén 2013; Mladovsky *et al.* 2012b; OECD 2012; Hassenteufel and Palier 2007), including but not limited to the following dimensions: provision of services; access and coverage; governance and regulation; provider-purchaser relations; and

employment and working conditions. On the other hand, they have testified to the complex interaction that exists between the efforts at the EU level to influence national policy-making, the fiscal and institutional legacies of past policy choices, and domestic political and government dynamics (Baeten 2012; Baeten *et al.* 2010; European Commission 2011; Gilardi *et al.* 2009).

The present report attempts a first step towards updating the empirical accounts of recent health care trends and better understanding whether and how health systems across the EU are becoming “Europeanised”. It does so by looking at the content of the reforms undertaken over the last five years in a representative sample of ten EU countries: France, Germany, Greece, Ireland, Italy, Lithuania, the Netherlands, Romania, Sweden, and the UK-England. It also tries to assess the degree of the EU’s leverage (effective or potential) over national reform patterns, through the critical juncture created by the impact of the global crisis.

The report explores the issue of convergence/divergence among national systems by considering existing variations (the diversity of the so-called models or “regimes”), by considering different dimensions of reform, and by looking out for clusters of countries that can be said to be reforming in similar ways. We are also aware that health policies are defined differently across different national contexts, especially as far as the integration between health and long-term care is concerned. Such a divergence crucially affects the way problems are defined and reform agendas formulated at the national level. In order to maximise our ability to understand national reform patterns, we will not define health care once and for all, but remain attentive to national policy specificities. In terms of reform dimensions, our approach follows the most recent literature (Pavolini and Guillén 2013; Rothgang *et al.* 2010) in conceptualising health systems as tri-dimensional structures consisting of **financing** (e.g. reimbursements, user charges), **provision** (e.g. coverage, privatisation), and **regulation** (e.g. change in governance systems, liberalisation). Accordingly, it asks whether the sphere (state, society, or the market) that used to be mainly responsible for each dimension has been changed or challenged in the process.

In the following subsections we will elaborate on the main building blocks of our approach.

1.1. Research questions and analytical framework

Two main questions emerge from the considerations and research interests advanced above:

- **What are the main recent trends in HC reforms in the EU?**
- **Do we see convergence, persisting divergence, or the emergence of new HC regimes?**

Both can be further specified by two more questions. Concerning the first, we ask:

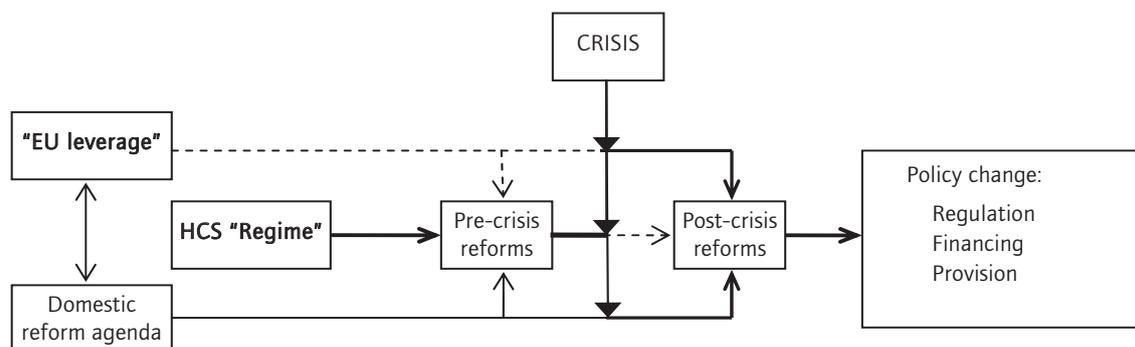
- How are the challenges posed by the crisis being addressed?
- Can conceptualizations of the respective role of the EU and domestic level be disentangled? If so, how do they impact the reform process?

Concerning the second, we ask:

- Which role for state/society/market is emerging in the financing, provision, and regulation of 21st century European health systems?

In order to answer these questions, we start by conceptualising the process of health care reform as mainly driven by three “proximate” factors: the EU’s efforts and opportunities to influence national reform processes (that we henceforth call “**EU leverage**”), domestic reform agendas, and policy legacies tracing back to the original health system regime (see Figure 1).¹

Figure 1 A conceptualisation of the health care reform process



Source: own elaboration by the authors

In a nutshell, we see policy changes in the three dimensions above as the result of active efforts by national and supranational policy-makers, who intervened in the institutional dynamics within the old policy regimes. Here we refer to the prominent neo-institutionalist approach to the study of welfare state genesis and reform, and in particular to its historical variant (Esping-Andersen 1990; Immergut 1992; Pierson 2000; Hacker 2004; Thelen and Streeck 2005; Bonoli and Natali 2012; on historical institutionalism see Steinmo 2008). Furthermore, we assume that the “EU leverage” and domestic agendas are mutually related, with no pre-determined causal direction. We owe this intuition to Börzel (2002) and Schmidt (2002) and, more generally, to a rich literature on the “Europeanisation” of domestic and social policies (Featherstone and Radaelli 2003; Ferrera 2005; Graziano and Vink 2007; Saari and Kvist 2007; Hemerijck 2013; on health care see Baeten *et al.* 2010). Finally, taking a longer-term perspective, we see that entwined processes at the EU and national level have affected health care policy trends since before the crisis.

1. Among the “remote” causes one should certainly include the structural, technological, cultural, and ideological changes mentioned in the introduction. However, since these fall out from the scope of this report, we have excluded them from the figure, focusing on “proximate” causes alone.

As Pierson (2004) and other historical neo-institutionalists recommend, we take institutional legacies as the strongest of the three causal drivers. Health care systems, we contend, do change and adapt over time, but routinely do so in a path-dependent, historically bound way. In our conceptualisation, path dependency stems from the great historical junctures in which the guiding principles and core architecture of national health systems were determined. Analytically, this is best understood as the health care “model” or “regime” that gained a foothold in each country between the late 1940s and the mid-1980s (the bold arrow in the above figure). Then, in a second step, the health systems’ path-dependent evolution continued through the pre-crisis reforms that, since the early 1990s and up to the crisis, updated or renewed the original models. While not the only contributing factors, past policy choices, achievements, and failures fundamentally constrained the fate and content of those reforms.

To be sure, the innovations adopted before the crisis were not a product of past choices alone. They rather resulted from domestic reform agendas and from the leverage acquired by the EU, for instance through monetary integration and the Social OMC (De la Porte and Pochet 2002; Saari and Kvist 2007; Marlier and Natali 2008). We account for the impact of the two levels of government, as shown by the scholarly debate on Europeanisation. First, we do not see domestic-EU relations as entirely bottom up or top down, but as reciprocal and entwined (Börzel 2002). The complexity and scope of EU processes, the presence of “fits and misfits” between national legacies and supranational requests, and the agency of domestic policy-makers – shifting the blame for unpopular reform onto Brussels, including those reforms they actually seek – all contribute to displacing more simplistic accounts. Secondly, we also acknowledge that the EU leverage on national policy-making was initially weaker than the effects of domestic politics. As argued by Schmidt, in fact, the influence of the EU is mediated by a number of national factors: policy legacies (the bold arrows in the scheme), features of the domestic agenda (preferences and the prevailing discourse), and, even more so, national levels of politico-institutional capacity and economic vulnerability (Schmidt 2002: 899).

Following Schmidt, we interpret the global crisis of 2008 as an exogenous shock, able to modify the three causal factors in their relative strengths. For heuristic purposes, we posit that the crisis has weakened path-dependency, widening the scope for more widespread and innovative transformations. This point will be empirically qualified in the conclusions. In the face of mounting problems and pressure, institutional constraints faltered, whereas the EU and the domestic agendas acquired greater and more equal sway. In particular, we stress that the reinforcement of EU economic governance and the mainstreaming of EU-MS interactions within the framework of the European Semester have greatly empowered the “EU leverage” factor. The comparative analysis will help to ascertain whether or not, due to these recent changes, the EU agenda is now as influential as national domestic agendas.

Following this line of reasoning, we proceed to present the three main components of our approach. First, we rely on the so-called “Rothgang-Wendt typology” (henceforth RW-typology) to conceptualise trends and outputs of

health care reform (Wendt *et al.* 2009; Rothgang *et al.* 2010; Böhm *et al.* 2012). In our view, the RW-typology is the most suitable for systematically assessing – and potentially measuring – fine-grained policy changes over a very short time span. As far as policy legacies are concerned, we will show that our selection of ten cases well represents the variability of health care models that characterizes the EU. Furthermore, as discussed above, our analysis will pay attention to the two decades before the crisis in order to characterise each country’s “pre-crisis” reform patterns. Finally, we will elaborate on the concept of “EU leverage” by means of a straightforward index capturing the EU’s efforts and chances to influence domestic dynamics.

Given the limits and the focus of the present exercise, we leave a whole set of domestic political variables as a country-specific “residual” to be disentangled by further research.

1.2. Assessing health reforms: the RW-typology

As suggested by Marmor and Wendt (2012), health care systems studies can be grouped along two axes: consideration of health outcomes and focus on the role of institutions and actors, or rather, the description of how health systems are organised. Our present attempt does not address outcomes directly, not least because of the novelty of the reforms under scrutiny. Concerning the second distinction, our characterisation of recent policy trends belongs to the first type of studies: since we look at the changing distribution of responsibilities within the health system, actor-centred frameworks such as the RW-typology (but see also Moran 1999) are ideally flexible and suitable for the task. Alternative or more refined approaches, such as in Joumard *et al.* (2010) and Paris *et al.* (2010), seemed instead too complex and in-progress to be used in the context of this report, especially looking at the quantitative side of their analytical framework.

The RW-typology (see the Appendix, sections A and B) focuses on which actors or mechanisms of coordination (**public actors/hierarchies; societal actors/collective negotiations; private actors/markets**) govern the functional dimensions upon which health care services rest: **regulation, financing, and provision**.² Based on earlier works by Moran (2000) and Rothgang *et al.* (2005), the RW-typology contributes to health care studies with a deductive taxonomy of 27 cases. This taxonomy enlists all the conceivable combinations ($3 \times 3 \times 3$) of the three actors/mechanisms and the three health care dimensions. Besides its theoretical merits, the RW-typology is useful to empirically assess the systemic impacts of seemingly minor reforms and even as a preliminary step for studying convergence, divergence, or clustering trends within the EU (Böhm *et al.* 2012; Hacker 2009). Likewise, it was employed in comparative (Schmid und Götze 2009; Schmid *et al.* 2010;

2. Following this line of reasoning, regulation – for instance – is classified as “societal” when the statutory system is self-administered by the social partners, as in Germany or Austria. For more examples and clarifications see the Appendix and the discussion in Böhm *et al.* 2012.

Cacace 2011; Rothgang *et al.* 2010) as well as single-case studies (Götze 2010 on the Netherlands; Frisina und Götze 2011 on Italy).

Applying the RW-typology to our ten country cases in the years before the crisis produces the outlook offered in Table 1. For each country, the table shows which sphere (**state**, **non-profit sector**, or **private sector**) exerts the greatest influence on each health care dimension. The assessment is based on three indicators, which serve as proxies for a more complex and heterogeneous reality.

Table 1 The 10 cases according to the RW-typology (before the crisis, ca. 2005)

Dimensions of health care	Regulation			Financing			Provision		
	Regulation index (Böhm <i>et al.</i> 2012; own calc.)			Share of total health spending (OECD)			Share of inpatient beds (OECD-Eurostat)		
Countries	State	Society	Private	State	Society	Private	State	Society	Private
France	70.0%	20.0%	10.0%	3.3%	74.4%	22.3%	65.4%	14.1%	20.5%
	State			Society			State	(Private)*	
Germany	11.2%	61.6%	27.2%	9.5%	67.1%	23.4%	43.4%	30.4%	26.2%
	Society			Society			State	(Private)*	
Greece*	34.0%	22.0%	44.0%	30.3%	29.8%	39.9%	69.6%	3.0%	27.4%
	Private			Private			State		
Ireland	100.0%	0.0%	0.0%	75.4%	0.5%	24.0%	72.6%	13.7%	13.7%
	State			State			State	(Private)*	
Italy	90.0%	0.0%	10.0%	77.8%	0.1%	22.1%	69.0%	2.9%	28.1%
	State			State			State	(Private)*	
Lithuania*	80.0%	0.0%	20.0%	9.4%	58.4%	32.2%	99.6%	0.0%	0.4%
	State			Society			State		
Netherlands	50.0%	40.0%	10.0%	5.1%	64.6%	30.3%	0.0%	100.0%	0.0%
	State			Society			Society	(Private)*	
Romania*	65.0%	10.0%	25.0%	12.8%	68.0%	19.2%	99.6%	0%	0.4%
	State			Society			State		
Sweden*	90.0%	0.0%	10.0%	81.2%	0.0%	18.8%	95.0%	0.0%	5.0%
	State			State			State		
UK-England	90.0%	0.0%	10.0%	80.9%	0.0%	19.1%	100%	0.0%	0.0%
	State			State			State		

* See the Appendix, Sect. B for indications on methodology and data sources

Sources: OECD data (Eurostat data for Lithuania and Romania); Böhm *et al.* 2012; elaboration by the authors.

On regulation estimates, see the Appendix, Sect. A and B

In the case of **financing**, we used the share of total health spending by financing agent: the government, the social funds, and private insurance providers as well as user charges. Our proxy for **provision** was instead the share of inpatient hospital beds per ownership type. While more encompassing indicators of provision have been suggested by the RW-typology literature (see again Böhm *et al.* 2012; Rothgang *et al.* 2010), we opted for simplicity

for issues of both data availability and substantive interest. Yet an exclusive focus on hospital inpatient care overestimates the overall role of public actors, potentially distorting the analysis. As an early warning for this caveat, we split the cell and included Böhm's more nuanced classification (Böhm *et al.* 2012) whenever our assessment contrasted with theirs. Regarding **regulation**, we drew once again on the results provided by Böhm *et al.* (2012: 33-69). In addition, we replicated their methodology on three cases not included in their sample: Greece, Lithuania, and Romania. As in the remainder of this report, we based our qualitative assessment on the information provided by the relevant HiT and ASISP country reports. More details on assumptions, data availability issues and calculations are provided in the Appendix, section B.

The table reveals considerable variation between European health systems. Regulation is the responsibility of the state in all but two countries: Germany, which features a mostly societal system of regulation, and Greece, where system fragmentation leaves private providers with considerable decisional leeway. The sample is almost equally split between systems in which financing is predominantly public and systems in which health funds and professional associations play a prominent role. Greece is once again the exception, since a relative majority of its health expenditure is financed through market based interactions. Finally, the provision of inpatient hospital care is public everywhere but the Netherlands, where it is totally non-profit. Table 1 provides a double classification for health provision in France, Germany, Italy, Ireland, and the Netherlands. This tackles a discrepancy arising from the fact that the provision indices most commonly found in the literature consider also the public or private status of pharmacists and dentists. When these providers are also accounted for, these five systems are classified as mostly private.

In sum, this first application of the RW-typology confirms that health systems across the EU vary considerably in their structure and organisation. Accepting the notion of "hierarchical dependence" between the three health dimensions proposed by Böhm and her co-authors (2012), the state-centred provision of inpatient services should be considered potentially dysfunctional in France, Germany, Lithuania, Romania (where financing is societal), and even more so Greece (where it is private).³ By tracing the most recent reforms and by comparing the figures in Table 1 with others meant to capture the post-crisis situation, we will be able to characterise the direction of change and give a tentative quantification of its magnitude. However, configurative system descriptions of this kind cannot on their own account for policy change. In particular, integrating them at face value into our perspective would either overemphasise institutional continuity (under the assumption of path-dependency), or lead us to expect greater transformations in the countries

3. In most countries, the authors suggest, the degree of socialisation of health care responsibilities does not increase when moving from regulation down to provision. This so-called "hierarchical dependence" entails a normative expectation of how well different health system configurations may function. Basically, public regulation is expected to sustain well either societal or private financing, whereas the opposite is not expected to work out. The same reasoning holds for public financing and societal or private provision.

with the least common configurations (in consideration of a “misfit” vis-à-vis a European norm). In order to put recent developments into perspective, we need to turn instead to the other two pieces of our framework: health system regimes and the factor that we termed “EU leverage”.

1.3. Reform drivers: health system regimes and the “EU leverage”

The degree of involvement of public, societal, and private actors in each health care dimension is neither self-evident nor self-explanatory. It depends instead on a set of political and institutional features, which also determine some more subtle aspects of power distribution (such as, within the public sphere, the role of the national, regional, and municipal levels of government). These differences matter for the way health systems work, experience problems, and introduce innovations. In order to take them into account, we refer to a different stream of typological studies (see again Marmor and Wendt 2012), less interested in the role of the actors (the “who”) and more concerned with the functioning of health systems (the “how”). Such studies share with the “welfare regimes” literature (Esping-Andersen 1990; Castles and Mitchell 1993) a fundamental theoretical interest in the political logic that underlies specific policy configurations.⁴

Although a fully coherent taxonomy is still missing (Wendt *et al.* 2009; Freeman and Frisina 2010), this scholarship largely supports the distinction between “Beveridgean” National Health Systems (NHS) and “Bismarckian” Social Health Insurance (SHI) in Western Europe (Frenk and Donabedian 1987; OECD 1987; Frenk 1994; Saltman and Dubois 2004; Burau and Blank 2006). The OECD (1987) seminally contributed to this approach by suggesting the existence of three general models: NHS, SHI, and the private health insurance (PHI) model (see also Immergut 1992; Tuohy 1999).⁵ Later, Borisova (2011) and Wendt (2009) have employed cluster analysis techniques in order to identify new health families among post-communist countries

4. And yet, variation in health systems is not easily mapped against existing “welfare state” regimes (Esping-Andersen 1990) or families (Castles and Mitchell 1993), whose study is mostly focused on monetary transfers (see Bambra 2005a;b for a discussion). While recent studies of continental health care systems acknowledge a demise of corporatism (Chinitz *et al.* 2004; Saltman and Dubois 2004; Hassenteufel and Palier 2007; Agartan *et al.* 2013) the EU’s Eastern enlargement of 2004 further complicated typological exercises (Kaminska 2013). Even from this perspective, EU countries do not seem directed towards a common model.
5. The analyses of funding and ownership have long characterised most taxonomic attempts since Anderson (1963). Field’s (1973) distinction between pluralist, health insurance, health service, and socialised health systems was based on the two dimensions of public ownership/control and autonomy of the medical profession. Terris (1978) looked at the main organisational unit of health systems all over the world in order to discriminate between pre-capitalist public assistance, capitalist health insurance, and socialist national health services (see also Roemer 1977; Elling 1994). Frenk and Donabedian (1987) studied instead the amount of state control and the basis for eligibility of the population (citizenship, contributions, or poverty), distinguishing 10 modalities of interventions that could feature – differently combined – in any given national system. More recently, a number of comparative studies reintroduced the “professional autonomy” and “the basis for coverage” dimensions, this time in a governance framework (see e.g. Marmor and Okma 1998; Moran 2000).

and inside the EU. Joumard *et al.* (2010) and Paris *et al.* (2010), instead, are two recent – and still rough – OECD contributions, trying to integrate the “regime” approach with insights from the RW-typology. Unfortunately, scholarly innovations of this sort invariably ended up with counter-intuitive country groupings and new hybrid cases.

Therefore, we simply decided to integrate a number of different perspectives and refinements of the more established **NHS/SHI dichotomy**, which can accommodate the entire population of European health systems. On the basis of this distinction, we propose a representative **10 country** sample of five NHS (Greece, Ireland, Italy, Sweden, and UK-England) and five SHI (France, Germany, Lithuania, the Netherlands, and Romania) cases. The sample encompasses small and large EU members, covering most of the EU28 population (more than 70%), both within and outside the euro area (OSE own calculations based on Eurostat data).

Table 2 The country sample – EU leverage by health system regime

Health regimes EU leverage	National Health Service Type (NHS)			Social Insurance Types (SHI)		
	“Nationally managed”	“Sub-nationally managed”	“Second Generation”	“Benefits in Kind”	“Reimbursement”	“Second Generation”
Weak	UK-England	Sweden				Lithuania
Moderate			Italy	Netherlands Germany	France	
Strong	Ireland		Greece			Romania

Source: own elaboration, based on Baeten *et al.* 2010; Bamba 2005a; Moran 2000; Kaminska 2013

As shown in Table 2 (columns), three sub-variants are distinguishable within each model. Among NHS systems, two distinctions are commonly drawn. The first is between the centralised organisation of the English (and Irish) system and the much greater powers of the municipalities in Scandinavian countries such as Sweden. The second is between systems that, like the three above, were consistent with the NHS model since their inception, and a South-European “Second Generation” that turned, like Italy and Greece, from SHI to NHS in the 1970-80s. Within the SHI type, a similar difference exists between the long-standing Bismarckian approach of SHI systems in Continental Europe and the experience of Eastern European counties such as Lithuania and Romania, which turned from the Soviet Semashko system to SHI after the fall of the Berlin Wall. Instead, among the traditional SHI systems, a last differentiation is posited between those that, like Germany and the Netherlands, tend to offer benefits in-kind, and systems like France, which focus on reimbursing patients for the costs of care.

In order to capture how much room exists for the EU to influence domestic health reforms in these countries, we devised a straightforward index that we called “**EU leverage**”. It can take three values: **weak**, **moderate**, and **strong**, which correspond to different rows in Table 2. A strong EU leverage

is assigned to countries that signed a Memorandum of Understanding. Otherwise, the index considers the number and content of Country-specific Recommendations given to each country, whether the country is a Eurozone member, and whether it received an Excessive Deficit Procedure or signed an Economic Partnership Programme. Then, it classifies each country as under either moderate or weak EU leverage. More details on how the index is calculated are given in the Appendix, Section C.⁶

Our ten-case sample is divided into three “EU leverage” groups. The first group contains the three MoU countries – Greece, Ireland, and Romania, which received very detailed EU guidance on health reforms – classified under strong “EU leverage”. The second group comprises countries under moderate “EU leverage”: the Netherlands, Germany, France, and Italy. Finally, the third group is composed of the three countries under weak “leverage”: the UK, Sweden, and Lithuania. Moving beyond the rough indicator, we can say that Lithuania, Sweden and the UK – and Italy and the Netherlands, if LTC is excluded – have not received strong EU guidance so far. Nonetheless, both Italy and Lithuania did announce important reforms in their 2013 NRPs, while the UK, Sweden, and the Netherlands enacted major changes even without a clear EU input (the last received a CSR on LTC for 3 consecutive years). France seems to have been put under EU scrutiny more recently, as it received health-related CSRs only in 2013. These very recent developments might make it challenging to discern its impact on national reforms.

In terms of comparative controls, the overall variation is nicely distributed. Both health families feature at least one case of weak and strong EU leverage. The four corners of the table stage a well-structured contrast between two countries with the same weak level of EU leverage (UK-England and Lithuania) and two MoU countries (Ireland and Romania). Yet the EU leverage varies much more among NHS than SHI systems. We did not suppose the two dimensions to be independent, but there is an arguable “Continental Europe effect” at work, squeezing all the countries within the two traditional SHI variants into the “moderate leverage” group. While this could be related to country features that reach beyond the limits of this report – for instance, features of their broader political economy and welfare state – it offers a major opportunity to assess regime effects within countries with a comparable EU leverage.⁷ Looking at the NHS family, the cases are well spread across the indicator’s scale. Moreover, the couple Italy-Greece (leverage values: 2.5 and “strong”) make it possible to test the effect of different degrees of EU leverage across one same health system regime.

6. Analytically, the index is best understood as an indication of how much national and supranational decision making, including EU economic governance, have been entwined in the 2008-2013 period. The index is time invariant and does not take into account the evolution of EU governance within the period. The analysis in Section 2 complements this simplifying assumption.

7. On the other hand, as shown in the Appendix, Section C, the French and German levels of EU leverage are almost at maximum distance (2 points out of the 2.5 in the range of the “moderate leverage” category).

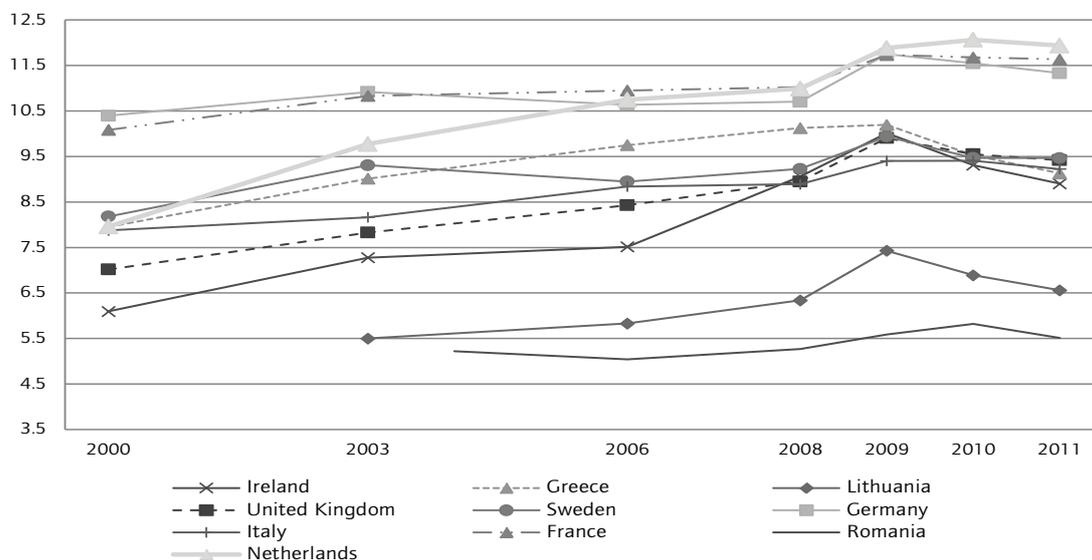
In sum, not all the European “families” of health systems have been equally addressed by EU-level initiatives. Yet it is possible to draw an analytical distinction within the same cluster, between countries that have been relatively more subject to EU governance tools and countries which have faced less pressure. As regards instead the general economic situation of the selected countries, it obviously correlates, to some extent, with the degree of EU influence. Nonetheless it still varies across the latter dimension. Countries such as Italy and the UK are low in the EU leverage scale, while having been severely hit by the crisis. In turn, Germany has been more incisively addressed by the EU, despite being economically successful.

1.4. Recent trends in health care spending, provision, and outcomes

In this last introductory section, we offer an essential backdrop to the main trends that have characterised health policies across the EU since the outbreak of the crisis. Our main interest is in verifying whether, in comparison with the previous policy direction, a deviation has occurred. We relied on the most recent OECD and Eurostat data, which in most cases stop at 2011 and only rarely and inconsistently include 2012.

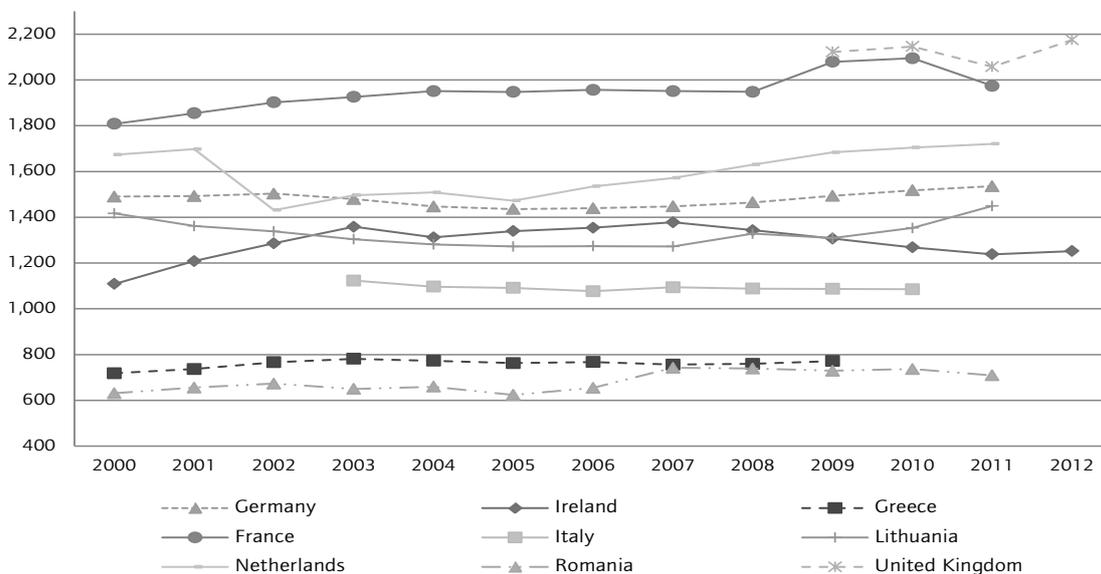
To begin with, Figure 2 shows how total health spending has evolved throughout the 2000s in the countries examined in this study. The trend-lines in the figure contrast a steady increase in total spending before the crisis with flat or decreasing trends from 2009 onwards. Between 2000 and 2008, in fact, Ireland, the Netherlands, Greece, and the UK all registered average annual spending growth rates equal to or higher than 3%. Over the decade, a mild process of convergence within change is apparent, with a visible reduction in the spread of spending levels within the EU15. And while health financing in Romania and Lithuania still remained far below Western European levels, the latter at least was catching up with all but the fastest-growing spenders. The crisis has dramatically changed this picture. After an immediate spending hike, due in most cases to the denominator effect of a contracting GDP, spending trends started to flatten. In 2011, only the Netherlands spent a greater share of its GDP on health than in 2009. Between 2008 and 2011, the growth rate of health spending over GDP turned negative in Ireland and Greece and was halved or almost halved in Lithuania, the UK, and the Netherlands. The slowdown was milder in Italy and Sweden, where spending, however, had also been growing more slowly. France, Romania, and especially Germany even managed to speed up their spending expansion.

Figure 2 Health spending trends in selected EU countries (total spending in % of GDP)



Source: OECD and Eurostat data

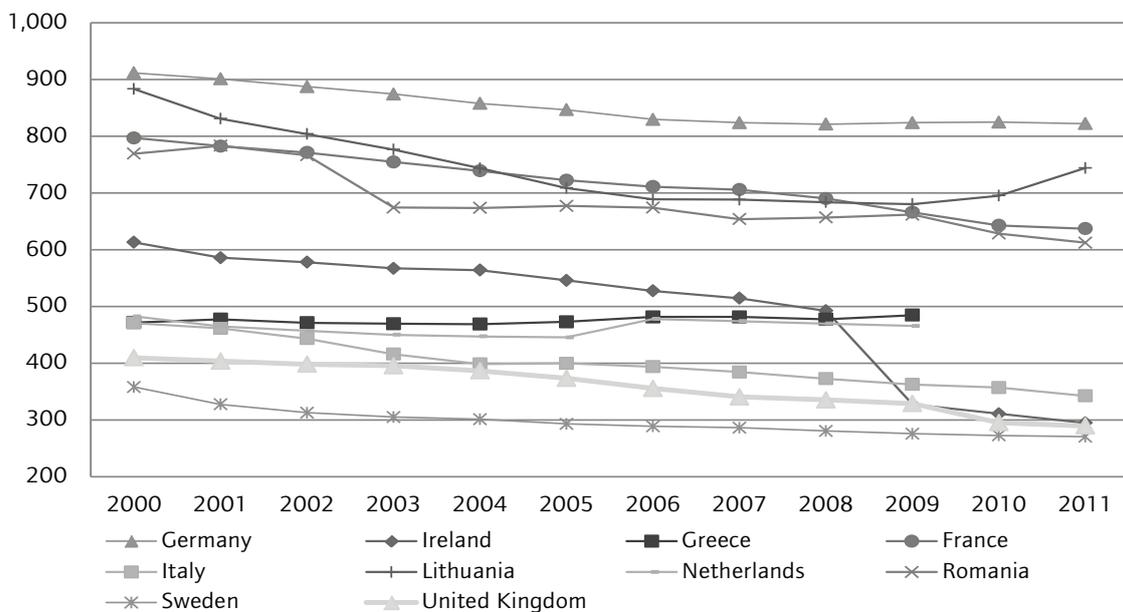
Figure 3 Total hospital employment density (head counts for 1,000 inhabitants) in selected EU countries



Source: OECD and Eurostat data

Figure 3 looks instead at the density of health professionals employed in hospitals per 1,000 inhabitants, a figure that is relevant for provision and employment trends. In this case, the situation is different. Employment levels were rather stable throughout the decade, except in the early 2000s, in Ireland (where there was a small increase) and the Netherlands (where the indicator registered a weak negative trend). Unfortunately, data for Greece stop in 2009 and do not allow for a real assessment of the most recent trends. Overall, Ireland and Romania registered the greatest contractions since 2008. Hospital employment density was almost stable in Italy and Greece and slowly increasing in France and the UK. It grew more markedly (between +1.6% and +2.9% over the previous period) in Germany, the Netherlands, and Lithuania.

Figure 4 Available beds in hospitals (per 100,000 inhabitants) in selected EU countries



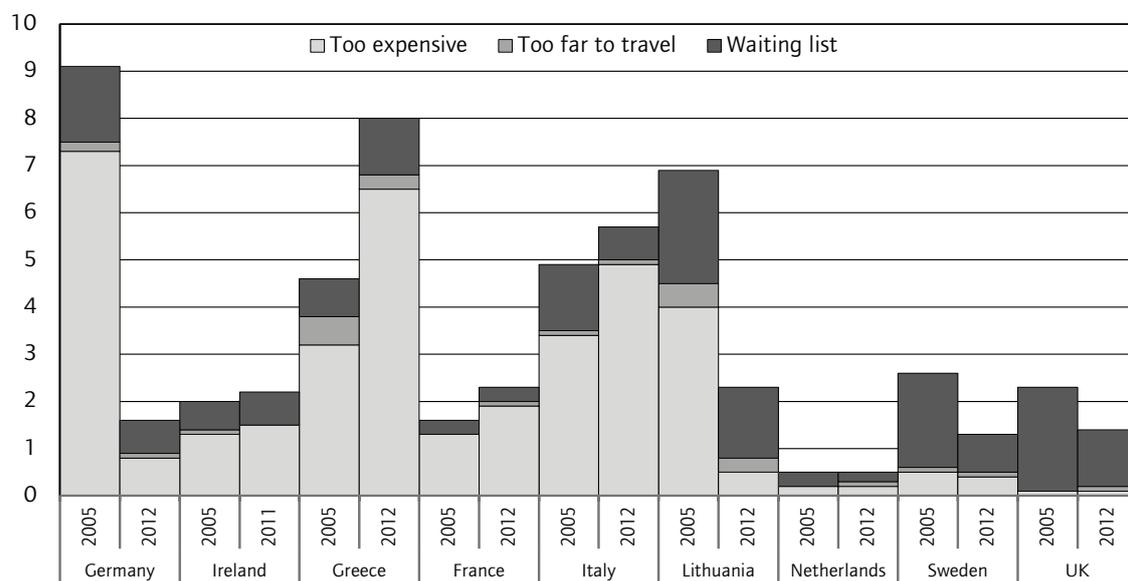
Source: Eurostat data

Figure 4 depicts trends in the density of available hospital beds per 100,000 inhabitants. In this case, two country groupings can be recognised: one with high density (Germany, Lithuania, Romania, and France) and one with a lower density (Greece, Ireland, Italy, UK, and Sweden). Both groups experienced a decreasing trend well before the crisis, so that the difference and spread among them have remained almost unchanged. All in all, the crisis seems to have mainly affected only two countries: Ireland, which basically halved its hospital inpatient sector (at least according to the face value of this figure) and Lithuania, which returned to the path of increasing bed density, after a decade of steady reductions.

Finally, we inquire whether the performances of these systems have been affected by the crisis. Figure 5 provides a graphical representation of self-reported unmet needs for medical examination for an average citizen

(aggregated over total income, sex, and age). The results are composite and reveal various country specificities. In fact, different countries managed to improve access by focusing on different sets of hurdles that used to prevent patients from meeting their medical needs. Germany and Lithuania, and to a lesser extent Sweden and the UK, succeeded in reducing the share of unmet medical needs notwithstanding the crisis. Some of the other countries, however, faced a worsening ability to effectively provide medical examinations. In Italy and Greece this was mainly due to increasing user charges.

Figure 5 Total self-reported unmet needs for medical examination (in %)



Source: Eurostat data

In sum, we can conclude our tentative exploration of recent trends in health financing, provision, and outcomes with a qualified judgement on the impact of the crisis. Most cases in our sample have experienced worsening trends in various aspects of their health systems. Nonetheless, a minority of countries has actually managed, at least in terms of some indicators, to improve its record. Such is the case of the Netherlands in total health spending and the UK and Lithuania in hospital employment and, respectively, waiting times and density of hospital beds. Certainly helped by its strong economic performance, Germany has managed to avoid most of the negative effects of the crisis and maintain high records in both financing and provision. And it did so while greatly improving the ability of its health system to meet the medical needs of the population. The analysis conducted in the following sections will help us to further test and qualify these preliminary findings, hopefully showing how they relate back to domestic policy legacies and the leverage of the EU level.

2. The role of the EU in health system reforms since the economic crisis

The economic and financial crisis triggered in 2008 provoked a radical change in the way the EU engages in national health system reforms. Member States have always been very reluctant to cede powers to the EU with regard to health care policies. As a result, the scope for EU intervention has been limited to supporting voluntary cooperation between national authorities.

In the wake of the crisis, especially in the Eurozone, the EU institutions acquired new powers to supervise national budgetary and economic policies. Within these policies, health systems are particularly targeted from a public finance perspective.

2.1. Health care reform under the European Semester for economic policy coordination

2.1.1. The instruments

The new EU policy instruments are embedded in the European Semester for economic policy coordination. Effective from 2011, the European Semester aims to ensure coordinated action on key policy priorities at EU level. The Semester mostly consists of the integration and synchronisation of existing procedures of the Stability and Growth Pact and the EU's growth strategy Europe 2020. Reinforced and new procedures, in particular the Macroeconomic Imbalances Procedure (MIP), have been incorporated through the Six Pack and Two Pack. The Semester reviews Member States' budgetary and structural policies during an annual cycle to detect inconsistencies and emerging imbalances. Governments must draw up budgets and other economic policies with agreed EU priorities in mind, and the EU can monitor national budgetary efforts and determine complementary action at EU level.

The cycle starts in November with the publication of the European Commission's Annual Growth Survey (AGS), which sets out EU priorities for boosting growth and job creation in the coming year. Following discussion of the AGS by the Council and the European Parliament, the Spring meeting of the European Council identifies the main economic challenges facing the EU and gives strategic advice on policies. Member States send their National Reform Programmes (NRPs), containing national economic plans relating to broad EU-wide guidelines and Stability/Convergence Programmes (SCPs) that outline their medium-term budget plans, to the European Commission in

April each year. Upon a proposal from the European Commission, the Ecofin Council issues Country-specific Recommendations (CSRs) on the NRPs and SCPs in June or July. The CSRs provide tailored advice on structural reforms in Member States. The subsequent SCPs and NRPs should be in line with all previous EU Recommendations.

To ensure the implementation of these CSRs, stricter procedures for economic and fiscal surveillance have been established based on the so-called Six Pack of EU legislation (which became law in December 2011) and the Two Pack (which entered into force in May 2013).

Through these new rules the Stability and Growth Pact (SGP) established in 1997 was reinforced. Under the SGP an Excessive Deficit Procedure (EDP), applied to Member States that breach either the deficit or debt criteria of the SGP.⁸ Henceforth, Member States in EDP are subject to extra monitoring and are set a deadline for correcting their deficit. They must submit regular progress reports on how they are correcting their deficits, and the Commission can request more information or recommend further action from those at risk of missing their deficit deadlines. Furthermore, based on the Two Pack, Euro area Member States with excessive deficits must submit Economic Partnership Programmes (EPPs), which contain plans for detailed fiscal-structural reforms aimed at correcting their deficits in a sustainable way. The Council can adopt an opinion or invite Member States to make adjustments to the plans. Where national governments fail to follow the recommendations within the given timeframe, the EU can issue policy warnings to be endorsed by the Council and ultimately enforce compliance through sanctions. Decisions on most sanctions under the EDP are taken by Reversed Qualified Majority Voting (RQMV), which means that fines are deemed to be approved by the Council unless a qualified majority of Member States overturns them – a procedure that makes enforcement of the rules stricter and more automatic and thus gives wide-ranging power to the Commission.

The Six Pack also extended multilateral surveillance to non-budgetary elements by establishing a mechanism to detect, prevent and correct macroeconomic imbalances (the Macroeconomic Imbalance Procedure-MIP). Here too sanctions apply for euro area member states in case of non-compliance with EU recommendations, thanks to ‘reverse qualified majority voting’ (RQMV).

As a result, the CSRs concerning fiscal policy and macroeconomic imbalances are binding for euro area members (De La Parra, 2013). By contrast, CSRs based on the Europe 2020 strategy, which includes the social policy objectives such as access to care, are not binding.

Finally, in December 2013, the Council adopted the cohesion policy package for 2014 - 2020. This package contains legislation concerning partnership

8. The EDP is triggered by a country’s deficit breaching the 3% of GDP and 60% of debt to GDP thresholds established in the Treaty.

agreements between the Commission and each Member State, whereby Member States undertake to use the funds towards the achievement of the Europe 2020 objectives. On the basis of these partnership agreements, funding from the structural and investment funds is also made subject to macro-economic conditionality. If a Member State does not sufficiently respect the conditions defined within the economic governance procedures, in particular under the MIP or EDP, the Commission can ask the Council to suspend a part of or all commitments or payments for the programmes concerned. A proposal to suspend commitments is deemed adopted unless it is rejected by the Council with a qualified majority. A proposal to suspend payments requires the support of a qualified majority of the Council (Council of the European Union, 2013a).

2.1.2. Involvement of the social and health actors in the processes

When EU economic actors target social protection, including health care, in the context of macroeconomic policy, social and health actors are typically provoked to react. The Open Method of Coordination (OMC) in the field of social protection emerged in 1999 in response to the EU's economic integration. It sought to add issues of quality and accessibility to the budgetary approach of the economic actors (see e.g. Vanhercke and Wegener, 2012). As a form of soft law, it aimed to spread best practice and achieve greater convergence towards key EU goals. Health care has been included in the process since 2004. Through this instrument, the ministers of Social Affairs in the EPSCO Council and DG Employment within the Commission had acquired a position as the counterpart of economic actors within the EU institutions.

Nevertheless, ministers for Social Affairs were largely excluded from the initial European Semester, since the CSRs are based on the Treaty articles governing the Stability and Growth Pact. Gradually the EPSCO Council, through its Social Protection Committee, regained some (limited) power to influence the content of the Country-specific Recommendations before their final adoption by the finance ministers in the Ecfm Council (Vanhercke 2013).

However, health ministers remain absent in the EU level debates on the CSRs. As a result, health-systems-related CSRs are adopted by the finance ministers, without being discussed by authorities responsible for the systems. In December 2013 the Health ministers adopted conclusions inviting Member States and the Commission to ensure the necessary coordination at both national and EU levels in order to adequately represent the health sector in the process of the European Semester (Council of the European Union, 2013b).

Social partners at European level have only been indirectly involved in the process of formulating CSRs, when they were invited to comment on the draft 2013 Annual Growth Survey (AGS), which serves as a basis for the subsequently formulated CSRs. However, they have no direct influence on this step of the process. In response the European social partners published a

declaration in which they called for greater latitude to allow them to comment and be consulted in a timely manner.⁹

2.1.3. Health care in the European Semester

Since 2012, health care is included in the AGS. The grounds for the inclusion of health care in 'Europe 2020' (the EU's growth strategy) and the submission of reforms to macroeconomic surveillance was prepared by a Joint Report on Health Systems published in 2010 by the European Commission (DG ECFIN) and the Economic Policy Committee (EPC)¹⁰ (European Commission 2010a). This report, the first EPC-EC publication on health systems, analyses the drivers of health expenditure across the Member States and a comprehensive annex identifies key challenges facing health systems in each of the 27 countries. The Council Conclusions on this Joint Report, issued by the Ecofin Council at the end of 2010, constituted the most detailed EU guidance on the content of health system reform until then and in such a way provided legitimacy to the finance actors (DG Ecfm and Ecofin Council) to include health care reform in the European Semester and to intervene in the content of health care policies (Baeten and Thomson, 2012).

Council Conclusions on the EPC-Commission Joint Report on Health Systems (Council of the European Union, 2010)

Key policy challenges that will need to be addressed by Member States:

- ensuring a sustainable financing basis, a high degree of pooling of funds and a good resource allocation that ensures equity of access;
- encouraging a cost-effective use of care through adequate incentives, including cost-sharing and provider payment schemes and as appropriate through the involvement of non-public providers, while ensuring the protection of those more vulnerable;
- encouraging the provision of and access to primary health care services to improve general health and reduce unnecessary use of specialist and hospital care;
- curbing supply-induced demand by considering the interaction between demand side factors and supply side factors, etc.;
- ensuring the cost-effective use of medicines through better information, pricing and reimbursement practices and effectiveness assessment;
- improving data collection and information channels and the use of available information to increase overall system performance;
- deploying health-technology assessment of the effectiveness, costs and broader impact of health care treatments more systematically in decision-making processes; and
- improving health promotion and disease prevention also outside the health sector.

⁹. http://ec.europa.eu/europe2020/pdf/2014/socjointcontrib_ags2014.pdf

¹⁰. The Economic Policy Committee (EPC) provides advice and contributes to the work of the Ecofin Council and the Commission by developing analysis and policy consensus.

Health care has subsequently been included in the Annual Growth Surveys since 2012. Overall, the AGSs insist on improving the cost-efficiency and sustainability of health systems while maintaining access to high quality care. To enhance competition, the AGSs also ask Member States to eliminate unjustified restrictions on business and professional services, including in the health sector.

As a result, the Council, acting on a proposal from the European Commission, is issuing an increasing number of CSRs on reforming health and long-term care (LTC) systems. Whereas only three Member States received a CSR on health care and LTC in 2011, a year later that number had increased to six, and it rose to 17 countries in 2013. These 17 countries are Austria, Belgium, Bulgaria, Czech Republic, Estonia, Finland, France, Germany, Italy, Luxemburg, Malta, the Netherlands, Poland, Romania, Slovakia, Slovenia and Spain.

Furthermore, the CSRs on health care have shown an increasing level of detail. Whereas the 2011 Recommendations generally called for an enhancement of the efficiency of public spending on health care and long-term care, the 2013 Recommendations deal with the content of health care policies.

There are some striking similarities in the 2013 CSRs addressed to the different countries. In order to enhance the cost-effectiveness of public spending, the CSRs urge a reduction of pharmaceutical spending and a reduction of costs in institutional care, both in homes for elderly people and in hospitals. This should be attained by measures such as developing out-patient care, strengthening public primary care provision and better coordinating and integrating care delivery. With regard to long-term care, CSRs focus on improving prevention, provision of home care, rehabilitation and independent living. For Bulgaria and Romania, CSRs included requests to improve access to health care and quality of care. It should be noted that the latter Recommendation for Romania is not repeated in the 2013 BoP adjustment programme (discussed below). This means that enforceability is much weaker than commitments made under the adjustment programme. France received a recommendation to remove unjustified restrictions in the access to and exercise of professional services. A similar recommendation had been addressed to Poland in 2012.

CSRs on long-term care are only addressed to Member States with well-developed systems for long-term care. The notable exception here is Italy, which received a CSR to improve its supply of LTC services in order to reduce financial disincentives for second earners to work.

The focus of these CSRs is thus mainly, but not exclusively, on fiscal consolidation. When looking at the content of the proposed reforms, they aim for structural reforms to improve cost-effectiveness in the system, meaning that they in principle only have a budgetary effect in the longer term.

There is little transparency on why a Member State receives a Country-specific Recommendation, how the content of these CSRs is defined, or on what evidence they are based. Overall, the content of the Country-specific Recommendations seems for all countries to be in line with the 2010 Council

Conclusions on the EPC-Commission Joint Report on Health Systems. Overall, they remain sufficiently generic not to be controversial.

Some of the Commission staff working documents assessing the SCP and NRP for each country and accompanying the proposal for a Country-specific Recommendation provide some hints on why countries receive a CSR. These documents often make a quantitative comparison of the country under assessment with the EU average with regard to the number of hospitals beds (eg Poland 2013), expected increase in public expenditure on health care (France 2013) or the rate of public spending on health care (Germany). In particular systems for long-term care are considered as a mere cost factor and it is argued that expenditure should be reduced in countries with above average expected expenditure increases.

Out of the 17 Member States having received a CSR in 2013, 5 Member States (Spain, France, Malta, the Netherlands and Slovenia) have so far submitted an Economic Partnership Programme as part of the enhanced surveillance of Eurozone Member States with an excessive deficit. These programmes were assessed by the European Commission, and the Council adopted conclusions, on the basis of a Commission proposal, on each of them. Each of these programmes contains a section referring to reforms in the health sector.¹¹

In addition to the 17 Member States, three other countries proposed extensive health care reforms in their 2013 National Reform Programmes (Hungary, Latvia and Lithuania).

2.2. Health care reform under the European financial assistance mechanisms

2.2.1. The instruments

The financial assistance mechanisms support EU Member States in difficulty and aim to preserve the financial stability of the EU and the euro area. Financial assistance is linked to macroeconomic conditionality. The countries involved have to commit to implementing the economic and social policies included in a Memorandum of Understanding (MoU). This is the most comprehensive type of integrated EU surveillance. Most MoUs entail very detailed health system reforms.

The mechanism is different for members of the Eurozone and countries that have not yet adopted the euro.

The Eurozone countries Greece, Ireland, Cyprus and Portugal received financial assistance from the IMF, the European Commission and the European Central Bank (known as the “troika”) after agreeing to engage in Economic Adjustment

11. http://ec.europa.eu/economy_finance/economic_governance/sgp/corrective_arm/index_en.htm

Programmes. This mechanism aims to guarantee the stability of the euro area and help Member States in financial difficulties or under serious pressure from financial markets. The EU provides two thirds of the programme funding and the IMF the remaining third.

Member States that have not yet adopted the euro can receive Balance-of-Payments (BoP) assistance, usually provided together with the IMF. Under this mechanism, the EU can provide mutual assistance when a Member State faces difficulties or when its balance of payments is seriously threatened. The Commission and the Member State concerned conclude a MoU and a Loan Agreement on the basis of a BoP assistance programme adopted by the Council. The MoU specifies economic policy conditions that are verified prior to a decision on the release of any further instalment. Latvia, Hungary and Romania received support under the BoP assistance.

Both types of financial assistance programmes are subject to regular review missions by the Commission, which may lead to sanctions for non-compliance and strict conditions in exchange for any financial assistance. The Member States concerned will undergo post-programme surveillance for as long as 75% of any financial assistance drawn down remains outstanding.

2.2.2. Health care under the financial assistance programmes

The BoP assistance programme for Romania and the Economic Adjustment Programmes for Greece, Ireland, Cyprus and Portugal are linked to MoUs containing very detailed instructions for reforming the health care sector. These programmes include several structural reforms, aiming to improve the cost-effectiveness of the systems. However, they also include reforms that could potentially affect the basic objectives of the health systems, ensuring universal access to high quality care.

Each of the programmes focuses on a reduction in pharmaceutical spending, which is in the first place to be achieved by price reductions on pharmaceuticals and increasing the share of generic drug usage. To this end several measures are put forward, such as compulsory prescription by International non-propriety name (INN), electronic prescribing and monitoring via (binding) prescribing guidelines, compulsory substitution and selective user charges to encourage greater use of generic drugs.

Other reforms also aim for a long-term structural effect and improving the cost-effectiveness of the system. These include: the centralization of procurement procedures for medicines and medical services (Greece and Portugal); changes in the reimbursement of pharmacies and wholesale pharmaceutical suppliers by third-party payers (Greece and Portugal); e-health solutions and implementation of patient electronic medical records (all); the restructuring of hospitals and reforms in the hospital payment systems (all); concentration of all health insurance funds (Greece) and streamlining of coverage (Greece and Portugal); and stronger budget control mechanisms (all). Furthermore,

the establishment of a system for health-technology assessment in Cyprus and Romania is proposed.

The reduction of the number of hospitals, hospital beds and health care professionals is potentially more controversial (Greece, Ireland, Portugal and Romania). For Romania this is linked to shifting resources from hospital-based care towards primary care and ambulatory care and to increasing the budget for primary care. For the other countries, it is much less clear whether the closure of hospital facilities is compensated by the deployment of alternative out-patient and primary care services. Shifting resources from inpatient to out-patient care can improve the cost-effectiveness of the system, provided that such reforms are based on an assessment of the population needs and accompanied by the development of appropriate alternative care services.

Some measures aim to redress access to care. Cyprus is committed to taking steps towards universal coverage, and Greece announced a Health Voucher Programme aiming to provide long-term uninsured citizens with access to primary health care services.

As opposed to the CSRs, the MoUs also include short-term cost savings that do not aim to improve the long-term cost-effectiveness of the system, but on the contrary risk hampering access to and quality of care. While all these countries had to increase user charges, some also committed to measures aimed at reducing the number of people with access to free public health care (Cyprus) or hospital care (Ireland), and to reduce the benefit package (Greece, Cyprus, Romania). A revision of the payment system for contracts with physicians and cuts in wages are part of the packages of Greece and Ireland. Additionally, commitments to reduce staff and extend working hours are formulated (Ireland). For Ireland, this is combined with the suggestion to recruit staff from other countries both inside and outside the EU.

Furthermore, policies to improve care integration, rehabilitation, health promotion and disease prevention are not part of these MoUs, as they are in the CSRs.

Potentially most damaging for ensuring access to and quality of care, however, is the attempt to cap public spending on health at a low level. For Greece this has been set “at or below 6% of GDP” – in other words, at pre-crisis levels. These levels were already low by EU standards, and an obvious consequence of setting the cap as a share of GDP at a time when real GDP is in substantial decline is a reduction in public spending, an effect highly likely to exacerbate financial barriers to health services.

2.3. Concluding reflections

Until recently, health systems had been addressed at EU level almost exclusively in the context of the internal market and patient mobility.

The economic and financial crisis triggered in 2008 provoked a radical change in the way the EU engages in national health system reforms. Not only did the EU acquire unprecedented powers to intervene in national health care policies, but our analysis also shows that reforming health systems is at the core of reforms put forward by the EU institutions to consolidate public expenditure. In 2013, 17 countries received one or more CSRs on health care and LTC. If we add to these the 5 Member States subject to financial assistance programmes, which include detailed instructions to reform the health sector, and 3 countries that themselves announced extensive health system reforms in their NRPs, only health care reforms in Denmark, Sweden and the UK are not targeted under the EU macro-economic surveillance mechanisms. The latter three countries explicitly opted out of the Eurozone, which means that the policy instruments are less forceful for them. There is little transparency on the selection of Member States to which a CSR has been assigned, but it could be argued that priority is given to countries where the EU can exert stronger influence. Pressure to adhere to the guidance was stepped up at the end of 2013 for 5 Eurozone Member States subject to an Excessive Deficit Procedure. They submitted Economic Partnership Programmes containing a section on reforms in the health sector.

When we look at the content of the EU guidance, we see that the focus of CSRs is mainly, but not exclusively, on fiscal consolidation. Overall, CSRs seem to be in line with the 2010 Council Conclusions on the EPC-Commission Joint Report on Health Systems. They aim for structural reforms to improve cost-effectiveness in the system. The reforms in the financial assistance programmes on the other hand do not only aim for more cost-effective use of the financial means, but also include measures to simply decrease costs in the short term, and could potentially affect access to and quality of care.

When trying to categorise the EU guidance under the different analysis axes of this report – regulation, provision and funding – the following picture materializes. First, regarding regulation, many reforms strengthen the governance role of the health authorities, thus extending their regulatory powers. The proposed measures to enhance competition in the health sector by removing restrictions on professional services are an exception to this finding. These are rather part of a liberalisation agenda that reduces the role of the state. With regard to regulation, there is no substantial difference in EU guidance between the CSRs and MoUs. The MoUs are nevertheless much more detailed and specific on these policies. Second, policies to shift financing sources are in particular part of the MoUs. These include policies to increase several user charges and to reduce the benefit packages covered by the statutory system. For Romania this is linked to the establishment of a framework for a private supplementary insurance market aimed at increasing the share of total private expenditure on health. No such measures are urged under the CSRs. Third, regarding health care provision, both MoUs and CSRs ask for policies to reduce hospital care. In some MoUs this is paired with instructions to reduce the number of health providers contracted with the statutory system. If more health care supply is removed from the statutory system than the population needs, such measures can lead to the privatisation of health care provision.

Finally, policies to enhance statutory care provision are substantially more present in the CSRs than in the MoUs. This includes policies to improve primary care, rehabilitation, health promotion and disease prevention.

A final reflection can be made on the (lack of) coherence between EU policy guidance for health system reform under the European Semester and macro-economic surveillance on the one hand and the application of the EU internal market rules to health care on the other hand. Whereas the proposed measures aiming for cost-effectiveness and fiscal consolidation push for a stronger governance role for health authorities, the internal market rules enshrined in the Treaty on the Functioning of the European Union (TFEU) require Member States to remove unjustified restrictions on competition and free movement of health services and products (Mossialos *et al.* 2010). The resulting potential deregulatory dynamic contrasts with the need for strong governance (Gekiere *et al.* 2010).

The application of the “free movement of services” principle to health services has recently been specified in the Directive on patients’ rights in cross-border health care (European Parliament and Council of the European Union 2011). The Directive clarifies the rights of patients to seek health care in another EU Member State. According to the Directive, the Member State that covers a patient must ensure that the costs incurred for treatment in another Member State are reimbursed if the treatment in question is part of the domestic health benefit basket. The costs have to be reimbursed up to the level of costs that would have been paid had the treatment been provided domestically. The reimbursement can be made subject to the same conditions as would be imposed if this health care were provided domestically. Member States have to establish transparent cost calculation mechanisms for the reimbursement of cross-border health.

This Directive implies increased consumer choice, and for many Member States it requires a revision of the benefits basket or adaptation of the payment system. In particular, the obligation to cover health services delivered by all providers abroad –including private and non-contracted providers– can put pressure on statutory purchasers of care to also domestically reimburse care from non-contracted providers. This contrasts with the measures urged under the economic governance mechanism, in particular in the countries under a MoU, where there is a strong emphasis on limiting the number of health care facilities – particularly hospitals – and providers offering statutorily covered care. Furthermore, the Directive could be used by actors to further their own agendas, in particular to exit the statutory system, to create more competition in the system or to question applicable rules (Baeten 2011).

Overall, we can conclude that EU guidance on health system reforms primarily focuses on improving the cost-effectiveness of the systems by strengthening the governance role of health authorities. For countries subject to a financial assistance programme, this is combined with policies generating short term savings that shift part of the financial burden from the public to the private purse. These policies risk affecting the access to and quality of publicly covered care.

3. Health system reforms

This Section provides an in-depth illustration of the main trends affecting the financing, regulation, and provision of health care in our country sample. We rely on the classification proposed in Section 1 in order to divide our ten cases into groups, according to their degree of “EU leverage”: strong (Greece, Ireland, Romania), moderate (France, Germany, Italy, and the Netherlands) and weak (Lithuania, Sweden, and the UK). Domestic policy processes have been mostly identified by referring to the various waves of ASISP reports (2009-2013) and HiT reports. We relied on information made available by the OECD (2013) and the WHO (2011). For some cases, background information was found in Guillén and Pavolini 2013. We employ the RW-typology approach to trace development trends and present reform measures for each of the three health care dimensions: regulation, financing, and provision. Although some categorisations will remain blurry, we hope that the general result will be a clearer indication of where and how the new measures can introduce innovation within the existing systems.

3.1. Member States under strong EU leverage

During the economic crisis, Greece, Ireland, and Romania signed MoUs with the European Council, the ECB, and the IMF. MoUs have empowered supranational influences on these countries’ domestic health agendas, and their effects are very likely to grow even stronger in the future. At the same time, their policy legacies were, for different reasons, unfavourable, as the traditional system was inefficient and had lost legitimacy. The public health budget registered large savings, whereas health risks have been increasingly shifted onto individuals.

The **Greek** NHS (ESY), adopted in the early 1980s but never truly implemented, was riddled with inequalities and occupational fragmentation, falling far short of satisfactory outcomes. Mounting expenditure (tax-financed and out-of-pocket), chronic resource shortages (especially concerning LTC, mostly provided informally) and ineffective prevention policies had already prompted several reforms by Karamanlis’ centre-right government since 2004. Local ESY agencies (RMHCA) were reduced, private-public partnerships stimulated, and new regulatory mechanisms (centralised procurement, e-health, double-entry bookkeeping) introduced. Faulty and incomplete implementation, within a context of endemic corruption, nullified most of the

new provisions. With little success, the EU in 2007 recommended enhancing and integrating public health care.

As the debt crisis unfolded in the Eurozone, two MoUs were signed under the troika's aegis in 2010 and March 2012. Both were updated several times. The "rescue packages" also required health system reforms, including improvements in governance (such as hospital procurements and accounting), new rules for health professionals and pharmacists, as well as reinforced cost control through electronic prescriptions/referrals and the promotion of generic medicines. Hospital services and the number of providers were to be reduced, while user charges were set to increase. In the light of previous domestic attempts, the EU-led health reform agenda was unprecedented particularly in its cost-cutting ambitions, capping public health spending at 6% GDP, but with the aim of not reducing access. The overall fiscal impact was estimated at around €2.7 billion for the period 2009-15.

The **Irish** system contained an opaque mix of public (tax-based) financing and private provision, especially inside public hospitals. Regional administration, in place since the 1970s, was deemed a source of waste and resistance to efficiency-enhancing coordination and merging. Discrimination between patients of private and public doctors, misconduct scandals, and geographical inequalities were widespread. GP density (56 per 100,000 patients) was low and entitlement rules opaque. In the first half of the 2000s, the NTPF was established to provide care for long-waiting patients in the public system, while the national (but regionally administered) HSE took responsibility for the health budget, replacing the decentralised system. Repeatedly re-reformed, the HSE failed to strengthen provision (especially primary and LTC) and improve coverage. It proved unable to simplify and streamline provision or to achieve real coordination between public services and an ever wider for-profit sector. In 2007, a new authority (HIQA) began to oversee health and social care standards and an "integrated directorate" (ISD) was created to improve service coordination in 2008.

Net of capital assets, public health spending doubled in real terms between 2000 and 2009. When the crisis of 2008 shut down the Irish banking system, the government doubled Ireland's public debt in a major bank bailout. Unrecoverable fiscal expansion ultimately led to the MoU signed with the Troika (December 2010) and revised ten times until autumn 2013. The resulting financing package (€85 billion for the period 2010-13) steadily required hard fiscal austerity, which translated as €25 billion in cuts between 2008 and 2012. Concerning health care, initially the only request was to lift restrictions on GPs and pharmacists. Although health care reform is extensively discussed in the Economic Adjustment Programme reviews from mid-2011 onwards, these were only included in the MoU updates from early 2013 onwards. Thus, the health budget remained unscathed until 2010. Irish bonds returned to the market in July 2012.

Having replaced 19 health ministers in less than 25 years, the **Romanian** health system never managed to abandon its socialist legacies, notwithstanding the adoption of EU legislation. Spending levels and health outcomes remained

at the bottom of EU rankings. Political clientelism and, more recently, unemployment have narrowed the contribution bill of the mandatory SHI. Due to the quasi-universalist ambitions of the system, this also led to a huge financial overdraft. Extremely low medical wages and systematic shortages of drugs and supplies made corruption endemic and even legitimate in the eyes of the users. Corruption also inflates user charges (40% of pharmaceutical costs) and worsens inequality in health care access. The domestic health reform agenda envisaged stronger financing and coordination between central regulators (CNAS and NHIF) and county level insurance funds in order to improve efficiency and access. However, the rationale of administrative reforms, including decentralisation efforts financed by the EU Social Fund, remained chaotic and inconclusive. A clear trend emerged instead towards the privatisation of financing and provision (private clinics and insurance plans) and the individualisation of health risks.

The recession of 2009-10 brought the Romanian economy down to levels unseen since the heyday of the post-socialist transition. In 2009 a first Balance-of-Payments Assistance Programme was adopted, including a Memorandum of Understanding between the European Community and Romania. This was updated four times in 2010 and 2011. The government reacted in 2010 with a mix of spending increases and public sector cuts to fuel the economy. This paved the way to the adoption of a MoU for a €1.4 billion “precautionary loan” from the EU and the World Bank in 2011. Regarding health reforms, the MoU subjected the shaky hospital budget to the surveillance of the Ministry of Finance. Increasing financial needs and shrinking contributions moved the CNAS budget from surplus in 2006 to increasing deficits since 2008. Overall liabilities totalled about €1 billion between 2009 and 2012, while huge arrears to suppliers (€1.3 billion in March 2013) led many pharmacies to refuse drugs to patients or hospitals covered by the national fund. In November 2013 a third Balance-of-Payments Assistance Programme (2013-2015) was adopted, based on a third Memorandum of Understanding.

3.1.1. Regulation reforms and trends

Besides crude cost containment measures, Greece tried to liberalise the pharmaceutical and medical profession markets. Ireland and Romania studied two more complex and encompassing proposals.

In **Greece**, Law 4025/2011 transferred to the Medical Associations the authority to issue licences. EU co-financed mental care NGOs were authorised to provide assessment, medical, and monitoring services. At the same time, restrictions on pharmacies were lifted: opening hours were liberalised and their guaranteed profit margins lowered. Steps were taken to introduce P4P criteria (such as capitation fees, volume of services, and preventive activities) for the remuneration of medical professionals. In **Ireland**, several measures to liberalize the health sector have been requested in the Memorandum. To this end, legislative changes to remove restrictions in the pharmaceutical professions and medical services were published in 2011, restrictions on the number of general practitioners (GPs) qualifying have been eliminated

and the Government has submitted legislation to make it easier for general practitioner doctors to obtain contracts under the General Medical Services Scheme. Restrictions on medical advertising have also been eased.

A bipartisan consensus emerged among **Irish** policymakers, favouring the shift toward a universalistic system. In 2012, the government announced its intention to replace the HSE with the gradual introduction of a universal, single-tier system by 2016 by returning key powers to the Health Ministry and transforming hospitals into no-profit trusts. The new programme, structured around two funds (a Primary Care Fund and a Universal Insurance Fund), is meant to reduce waiting time and lists, strengthen community mental health services, and grant free access to GPs by 2015. The latter would rely on a strict distinction between purchasers and providers and be financed through a mix of taxes and social contributions. All hospitals, public and private, would be licensed by a new Patient Safety Authority. Social and community care would be separate and remain tax funded. Several documents were published in recent years: “Future Health” and “Healthy Ireland”, two reports on the role of public and non-profit hospitals, and one policy paper on the creation of a patient-centred funding model (MFtP). “Future Health” illustrated future health reforms, care integration and organisational changes in primary care, but also the new system meant to replace the HSE. The second document focused on wellbeing and prevention, envisaging the creation of a dedicated agency. The two reports detailed the setting up of seven main hospital groups with integrated budgetary responsibilities for both kinds of hospitals. The MFtP model seeks to reduce treatment complexity, incentivising out-patient care. The government also announced a reform of private insurance plans, based on a permanent “scheme of risk equalisation”, to regulate premium increases, as well as a reform of disability services and of the “Fair Deal” scheme to strengthen community-based and home-based LTC. A Programme Management Office inside the Health Ministry would mainstream the reform process from the centre.

After two years of negotiations with domestic and international stakeholders, a draft for a major liberalisation of the health sector was advanced in **Romania** in December 2011. The proposal was quickly abandoned during the frantic political phase that led the government to resign in February. Victorious in the 2012 elections, the former minority recovered much of the aborted proposals in its draft Health Care Law 2012. The new plan provided for replacing county directorates with eight regional structures (with a loss of 4000 jobs and savings worth €50 million/year), splitting the CNAS into up to ten non-profit companies (to be funded by a new National Authority with very similar tasks). It planned to reorganise hospitals as autonomous non-budgetary institutions with performance-based remunerations, and to create two national agencies (for EU-financed health projects and hospital accreditation). Beneficiaries earning more than two times the gross minimum wage would pay 5.5% of the minimum wage as a contribution for their dependants. Medical services would be provided in different packages: a tax-financed social package for low income earners, a state-financed minimum package, an insurance-financed “basic package”, and a privately financed optional package. Finally, the law envisaged free choice between public and private insurers.

As is often the case when major health reforms are discussed, the reallocation of administrative competences and the consolidation of facilities and resources have been a top priority. By harmonising benefits and rules across different groups of beneficiaries, rationalisation and merging could also end up reinforcing universalism.

In **Greece**, the major health insurance funds, partly harmonised and made financially independent with the 2010 pension reform, were merged into a single national fund: the EOPYY (including the IKA and the OAEE). A broader merger of the EOPYY with all ESY primary providers and some local health authorities is almost completed. Law 4025/2011 reorganised welfare authorities, merging a number of childcare and LTC facilities, incorporating several rehabilitation centres in the ESY, and establishing private day case surgery/treatment units. Law 3852/2010 (the so-called “Kallikratis plan”) included health care within an administrative overhaul of the Greek state. Local and regional Health and Social Care Committees were established to oversee spending trends, empowering planning and evaluation. From January 2011, 1,034 municipalities were reduced to 370 through amalgamations. They will be responsible for social service delivery, and social welfare tasks undertaken by prefectures are transferred to the newly created local authorities.

Both **Greece** and **Ireland** have been studying how to reorganise care provision by creating a decentralised network of financially autonomous units for primary (GPs) and specialist (pathologists, paediatricians, and gynaecologists) care. Family doctors would act as gatekeepers and administrative coordinators. The **Irish** National Recovery Plan for 2010 transferred competences from hospital to community-based services, while centralising administrative tasks such as payroll, procurement, purchasing, as well as ITC and personnel services. Clinical care programmes, based on the successes of the 2008-10 cancer control programme, were launched in 2010 and confirmed in 2012 under the responsibility of a newly established Special Delivery Unit (SDU) in the Health Ministry. The government announced for 2014 the creation of a national Health Innovation HUB meant to connect hospitals with pharmaceutical MNCs.

In November 2008, the **Romanian** government proposed the full decentralisation of (non-emergency) hospitals and the creation of new agencies responsible for public health, medical assistance, health programmes, and hospital equipment. The programme was temporarily abandoned after the 2008 elections and replaced by a mild organisational reform of the Health Ministry (Decision 1718/2008). In 2009, the administration of 373 (out of 435) hospitals was decentralised. On the agenda since 1996, hospital accreditation by a dedicated Commission (NCHA) was finally introduced in order to enforce national standards and withdraw NHIF money from non-compliant hospitals. Local authorities would appoint managers and finance administrative expenditures. Appointment criteria and funding levels, however, remained unregulated. Between 2011 and 2013, all Romanian hospitals were set to be re-classified within five “competence” categories (from regional centres to specialised facilities). The procedure was repeatedly postponed until the end of 2013, as most centres were expected to fail the quality requirements. By

2013, savings from closing hospitals were much smaller than planned and only 14 out of 67 had become residential facilities. 28 hospitals achieved the “regional” status, whereas a large majority (201) only obtained limited or very limited competences. Failed centres were downgraded to “hospital branches”, with no clear implications for their operations.

While regulation and enforcement of uniform performance standards in Greece is still lacking, Romania and Ireland tried to update their standards. In early 2008, the **Irish** HIA approved new national standards for residential care with effect from 2009, while a NHSS Bill was passed in October, providing for a new income-support scheme for home-based nursing LTC. In January 2012, a new target required that no one would wait more than 9 months for treatment or 6 hours from arrival to discharge or getting a bed in an Emergency Department. However, waiting times for specialist visits requested by a GP, normally the longest, were not included. In **Romania**, higher standards were adopted in disability care facilities, although staff shortages prevented similar improvements in mental health centres. Finally, a government ordinance was issued in April 2010 to combat fraud in medical certificates; tighter rules and penalties resulted in €34 million of savings and €400,000 worth of fines. The 2013 Romanian MoU endeavoured to define the publicly-reimbursable basic benefits package based on objective and verifiable criteria. To this end, the basic benefits package for medical services and products was redesigned.

Greece and Romania exerted direct and sustained efforts to keep hospital and clinical costs under control, as promised in their respective MoUs. In **Greece**, health units were obliged to justify procurement requests in their annual plans and hospitals to report quarterly on drug spending. Centralized procurement reached a 25% level of hospital coverage. Costing mechanisms, fees, and *per diem* refunds were re-priced in 2011, for an estimated 30% increase in hospital revenues. A first attempt to introduce DRG cost-accounting try-outs led to a hike in reimbursement bills, so the attempt had to be halted to avoid putting health insurance funds at financial risk. A new attempt, this time including personnel costs, is currently on the agenda. It will rely on a dedicated DRG Management Institute and the assistance of foreign expertise. Finally – while at work on alternative measures – the government introduced a temporary clawback mechanism in 2013, similar to that imposed on drug providers, which will target private clinics and diagnostic health units. The EOPYY will not reimburse amounts exceeding an annual target. The greatest risk is that the resulting extra costs will be passed onto the patients. Also **Romania** started to implement a centralized procurement system for pharmaceuticals and medical devices for hospitals. It furthermore reduced new cost standards for LTC by 8%, and cut by 3% the resources available to disabled and elderly patients from January 2010.

Controlling drug prices became a shared top priority for the 3 MoUs countries. In **Greece**, cost savings in pharmaceuticals spending make up some 2/3 of the overall reductions in health care, amounting to about EUR 1.0 billion (0.6% of GDP) over 2013-14. Positive drug lists,

abolished by Karamanlis in 2006, reappeared in early 2010. In May 2010, pharmaceutical prices were cut by 20% and the EOF issued a negative list of non-reimbursable prescription drugs. For hospitals to achieve a generic prescribing rate close to 30%, the cost of generics was kept below 70% of the original drug's price. Also, the "positive list" of drugs was meant to be revised periodically. In February 2011, the Ministry of Health acquired drug pricing authority. From May, a national "price observatory" was tasked with four-month "international reference pricing" (IRP) revisions, keeping Greek prices in line with the lowest three across the EU. Finally, a ban on pharmaceutical exports was announced by the EOF in October 2012, to avoid drug shortages due to price differentials with Western European markets. E-prescriptions (see below) and prescriptions by active substance were made compulsory. About 800 new generic medicines have been priced since February 2013. The OTC list has been enlarged and the previously fixed mark-up of 35% has been transformed into a maximum mark-up to increase competition in the OTC sector. The positive list has been updated and a clawback system is active. In 2010, the **Irish** Health Minister announced the government's intention to provide for generic drug substitution and "reference pricing" (to compare the therapeutic effectiveness of different drugs) starting in 2011. These measures were adopted in 2013. Reference pricing is expected to deliver at least €50 million savings in 2014. The Health (Pricing and Supply of Medical Goods) Act 2013 also includes a process for the review of existing prices outside of reference pricing. With Emergency Ordinance 104/2009, **Romania** introduced a clawback tax on the sale of reimbursable and hospital drugs. Producers had to pay from 5% to 11% of total sales to cover gaps between NHIF allocations and effective drug consumption. Increasing pharmaceutical use, however, inflated the clawback tax: the tax rate was lowered from 30% to 20% in 2012, although other measures attenuated this reduction. At the end of the year, the government agreed with drug producers on a mechanism for reducing hospital arrears and a new clawback formula.

As a last cost-containment mechanism, e-health tools were introduced in Greece and Romania. In Greece, hospitals have been obliged to use international e-auctions to maximize procurement value. In October 2010, the OAEE fund launched an e-prescriptions pilot programme, later to be extended to IKA and other funds. Significant savings have also been achieved with the introduction of e-prescribing and e-referral systems, progressively made compulsory throughout the system. E-prescription now covers more than 90% of all out-patient pharmaceutical prescriptions under EOPYY and a system that allows for the e-registration of manual prescriptions has been implemented. An automatic blockage mechanism, activated when branded prescriptions reach 15%, is in place. Branded prescriptions now only make up about 1% of total out-patient prescriptions. Full e-prescription coverage was set to be achieved by autumn 2013. The next planned step would be the introduction of "compulsory prescription protocols" for some therapeutic groups, enforcing the adoption of ICD-10 coding. Both **Romania** and **Greece** implemented IT-based patient recording (respectively in 2010 and 2011). Registrations with Romanian family doctors fell from 27 million (5 million more than the entire Romanian population) to 17.9 million patients.

The insured population fell from 20 to 18.7 million. Estimated gains for the health administration total €39 million. As requested in the updated MoU, **Ireland** developed a new e-Health strategy in 2013, with emphasis on the establishment of health identifiers for patients and professionals. Identifiers should enable the creation of an e-prescription system and a Money Follows the Patient hospital funding model. The publication of the Health Identifiers Bill was expected before the end of 2013.

3.1.2. Financing reforms and trends

Recent reforms have increased the share of health care financing shouldered by individual patients. Starting conditions varied widely. In the mid-2000s, the **Greek** tax system financed only 20% of total health spending (mostly through indirect taxes), against 46% from user charges and 34% paid by social insurance. Direct costs to users were also inflated by poor administrative coordination between private providers and GPs operating under the funds. In mid-2011 the budget of 210 mental health and rehabilitation centres was cut by 45%, while chronically ill or disabled retirees in residential care were required to contribute up to 80% of their pension income. In **Ireland**, 80% of health spending was tax-financed, including health-related LTC and even privately provided services. In **Romania**, financing was based on social contributions, supplemented by systematic subsidies from the general revenues. EU funds are increasingly used to finance residential care and reforms involving sub-national levels of government. The EU Social Fund financed 85% of the costs of decentralisation in Romania.

Increasing co-payments was a key driver of health financing privatisation. In Greece, co-payments (for pharmaceuticals, diagnostic tests and use of private clinics) increased and exemptions were drastically reduced. An “entrance ticket” was introduced in September 2010 for all regular visits to out-patient hospital departments. In the second half of 2011, user charges for hospital access increased to €14 million and to €100 million for afternoon visits. Moreover, each GP is reimbursed only up to 150-200 visits per month: patients beyond this limit must pay an extra fee of €10 to €20. Since the EOPYY had to operate with €2 billion less than initially planned, co-payments (15% for clinical tests, 25% for certain prosthetic, orthopaedic, and respiratory devices) and a ceiling on consumables were introduced in January 2012. At the same time, existing exemptions from user charges for some groups were lifted (e.g. for the chronically ill exemptions are strictly related to their chronic illness, even though some of their ailments maybe an “indirect” consequence of their health conditions). A €25 fee on hospital admission and an extra €1 fee (on top of a 25% co-payment) on prescription have been imposed in 2014. User charges for treatment in private clinics (if required) have also increased (the rates differ among major health insurance funds, ranging from 15% to 50% in the case of farmers). At the same time, however, €46 million worth of vouchers were introduced in 2013-14 to restore primary care access (for only 4 months and up to 3 visits) for 100,000 people among those who lost their SHI coverage.

The **Irish** budget for 2010 contained a new charge on medicines equal to 50% per item (up to a family maximum of €10/month), an increase from €100 to €120 in the monthly threshold for the Drugs Payment Scheme, and a 21% cost increase for private beds in public hospitals. Legislation to charge all private patients in public hospitals is envisaged to take effect in 2014. OoP payments increase from €120 to €132 for 60% of the population in 2012. Private insurance coverage grew in Greece and Romania but remained stable in Ireland, even though personal plans increased premiums (up to 40% more costly) while decreasing medical scope.

In line with what was agreed in the MoU, from 2009 **Romania** provided for a new “health ticket” that expanded co-payments on the basis of income and service type, for all but the most vulnerable. The health ticket came into force in April 2011. In November 2011, after more than one year of delay, the Parliament introduced co-payment of medical services, including hospitalisation, starting on January 1st 2012 (Law 220/2011). Rather than apply means-testing as originally agreed in the MoU, the new norm excluded the weaker 40% of the Romanian population. Also, it did not apply to emergency care, family doctors and medical laboratories. Unlike the 2010 draft, the law allowed co-payments through private plans and defined for each patient an income-proportional, rather than fixed, annual co-payment ceiling. Co-payments replaced the 2009 clawback tax, with an estimated gain of more than €80 million. One year after their introduction, however, financial effects were insignificant, as access through emergency services saw a suspect increase.

The reforms brought together spending cuts and tax increases. Public health spending in **Greece** fell by €2.9 billion between 2009 and 2012, with €2 billion more planned in 2013-14. This €5 billion cut, unfolding in just 5 years, far exceeds the 2% GDP (about €1 billion) that the OECD estimated as the margin for efficiency gain in the decade 2007-17. Greek health insurance funds spent €10.2 billion (including pharmaceuticals) in 2009, reduced by €850 million in 2010, €1.4 billion in 2011, and €3.5 billion in 2012. The national budget covered deficits from funds and hospitals, most of which were in severe fiscal straits.¹² The **Irish** health budget, €16.3 billion in 2010, was cut down to €13.3 billion by 2012 (by €1.1 billion, of which €660 million from public sector wage cuts, in 2010, by €727 million in 2011, and by €750 million in 2012). Wages, procurement, outsourcing, and the capital and drug budgets bore the brunt of the reductions. In 2010, the Health Minister announced a further (non pay) cut of €106 million, a 40% price cut on 300 of the most common off-patent drugs. The National Recovery Plan of November 2010, published just before the signing of the MoU, acknowledged the need to protect the health sector but mandated another €1 billion cut, and 6,000 more redundancies. Cuts to the NTPF were enacted between 2010 and 2011. The 2012 budget envisaged €800 million additional cuts for 2014 and

¹². For instance, the sickness insurance of IKA, one of the biggest funds, was about €2 billion in 2008. By the end of 2013, the Greek EOPYY still faced €1.6 billion arrears and a €1.2 billion deficit. The transformation of EOPYY into a funding organisation responsible for both primary and secondary care is currently being studied.

implemented an extra cut worth €300 million and 3,500 jobs in December. Savings were partly redirected to more pressing needs: €97 million to support the new Fair Deal programme for home-based nursing care, €10 million to expand the coverage of HCP, €230 million to expand the coverage of the medical card and to improve access to GPs. €50 million extra were allocated to the NHSS, which had been suspended for overdraft in 2011, whereas a €360 million supplementary budget was activated to bail out the HSE in 2012. In **Romania**, the health budget was relatively sheltered from cost-containment measures and “only” fell by 12% between 2008 and 2011. Short of funding for the last term of 2009, the government financed it with credits from the 2010 budget.

Tax increases were especially important in the **Irish** case. A universal social charge was levied on all taxpayers in 2008, whereas unplanned emergency measures were taken in early 2009. The special Health Levy (2% on earnings up to €100,000 a year, 2.5% above that sum, with exemptions for the lowest incomes, as well as for medical card holders, survivors and single parents) was increased to 4% up to €75,000 a year and 5% above that sum. The health levy was increased in 2012. To increase the contribution bill, **Romanian** pensioners were also subjected to health contributions (5.5%) up to a minimum benefit floor from January 2011.

Keeping the hospital budget under control was a common priority.

In line with obligations in the MoU, **Greece** pursued cost-containment in the hospital sector by redrawing the hospital map and by rationalising both administration and resource management. Laws 3868/2010 and 3918/2011 provided for an afternoon shift in hospitals and health centres with extra (and partly non-reimbursable) fees and introduced a €5 co-payment for out-patient services. At the same time they also granted full reimbursement for diagnostic tests run in public hospitals. Costs of medical supplies were reduced by 12.3% between 2010 and 2011. The government met with the representatives of medical industries, negotiating an option to pay part of current hospital debts with “zero-coupon” bonds entailing a 20% loss for the creditor. Cost per patient in public hospitals fell from €3,500 in 2009 to €3,000 in 2010 and €2,500 in 2011. Drug spending was reduced by about €2 billion in 2011-12. Also, in January 2013 the government decided a “haircut” of 20% on EOPYY debts to hospitals, pharmacies and suppliers (on drugs the haircut was 8% plus the clawback tax). DRGs payment is being progressively implemented. From January 2014, hospital services will be purchased directly by EOPYY through prospective budgets based on KEN-DRGs costing procedure. Centralised procurement has been initiated and in 2013 covered about 25% of all hospital buys. The **Irish** budget for 2012 included a planned reduction of hospital beds and wards and a 4-5% cut in services (mostly inpatient, but also emergency and homecare) and a price increase for private beds in public hospitals, but also free GP access for the long-term ill. Romania reduced the number of contractible hospital beds while planning the introduction of further mechanisms to reduce hospitalization periods and to increase the use of ambulatory services. In April 2013, the **Romanian** CNAS stopped funding stomatology care and emergency services, shifting the entire cost onto patients,

despite widespread dental problems in Romania. Public reimbursements to private providers (including the most efficient) were also capped at 5% of total county allocations in 2013 and 2014.

3.1.3. Provision reforms and trends

As a general trend, recent reforms have reduced the scope of public provision while fostering the development of private alternatives.

As an exception, in 2008 **Romania** invested in hospital equipment and expanded financing for ambulance services, as well as for oncologic, diabetic, and maternity programmes. On the contrary, the **Greek** SDIT partnership system increased health care infrastructure investments by €800 billion by expanding the role of for-profit actors.

Access to health provisions was eroded in Greece and Romania. In **Greece**, unemployed persons and members of professional funds that did not join the EOPYY lost their insurance coverage. In addition, harmonisation across the funds meant a reduction in the lowest common standards. Finally, delays in the implementation of measures to repay arrears led suppliers to boycott the ESY, further disrupting hospital services. Instead, **Romania** agreed with the World Bank on a restriction in the scope of social insurance, leaving some services to the private sector. Private clinics, which follow West European clinical and wage standards, experienced two-digit growth rates in 2009 and 2010. They mostly operate laboratory diagnostics and dental and gynaecology/maternity services. Private insurance plans typically provide access to basic services with top-up options. Preference for private clinics is growing rapidly, especially among young, highly educated, and well-off citizens, and in the major cities.

Hospital reorganisations reduced the number of publicly provided beds. In **Greece**, the network of insurance and primary care providers was reconsolidated after lengthy political confrontations. The contextual redrawing of the hospital map left 83 out of 137 centres and 32,000 out of 36,000 beds (550 for private practice). Moreover, about 25% of the intensive care beds were not used due to staff shortages. Decreased hospital capacity led to a reversal of the progress made on waiting lists in 2012, introduced to increase access to home-help assistance, publicly or privately provided, and with a possibility of extension to other disability services. Decentralisation in **Romania** led to the elimination of 9,200 beds and to a marked (up to 20%) reduction of hospitalised patients and relative costs. Moreover, hundreds of pharmacies were closed due to NHIF arrears, while many hospitals limited their activities to major interventions, waiting for financial assistance from the CNAS.

The trend towards privatisation of provision is particularly evident in health-related LTC. In April 2009, the Greek Health Minister agreed with the EC a progressive de-institutionalisation of mentally ill patients. Even the large “Home Help” programme (assisting about 120,000 elderly and disabled persons) was at risk of closure. In Ireland, home care packages

are a combination of home help, public health nursing and other allied professionals. HSE directly provides 75% of home care, although contracting out to private providers is expanding. In the mid-2000s, private home care providers increased from less than 10 to more than 200 as a result of the decline in informal care (mostly provided by religious organisations and the non-profit sector) and of HSE expanding its allocations for externally provided services. Due to the crisis, carers' benefits and allowances were cut from 12.6 million hours in 2008 to 9.8 in 2012. The HSE funded 23,611 places in the NHSS in 2012.

3.2. Member States under moderate EU leverage

France, Germany, Italy, and the Netherlands can be classified as countries subject to a moderate EU influence. Official EU documents, including CSRs, often referred to their health and LTC systems as too costly, inefficient, or otherwise in need of reform. At the same time, governments in these countries already defined and pursued ambitious reform agendas. In most cases, what we see in this subgroup during the crisis is an intensification or acceleration of previous reform trends and goals, or at least attempts in that direction. In particular, we see that countries that adopted major regulatory reforms before the crisis (Germany and the Netherlands) show a smoother reform process during the crisis as well. Italy, which failed to enact reforms between 1999 and 2008, instead rushed considerable cuts over the last years, a pattern more similar to the Greek one, although Italian health spending over GDP is rather low. France stands in between the Italian and the Dutch-German cases with respect to both reform timing and content. External pressures, jointly brought about by the EU and the aftermath of the crisis, have arguably led to a wider scope for cost-cutting interventions. Reforms to make provision and regulation more market-oriented are also common.

The **French** health system combines traits of both the SHI and the NHS model. It provides for universal public insurance, together with greater public control and voluntary supplementary schemes (VHIs). The individual share of costs for SHI+VHI insurees is 9%. Provision also relies on a public/private mix whereby primary and ambulatory care are mostly provided privately, while hospitals and hospital services are mostly public. This separation sometimes leads to weak coordination and other inconsistencies. Consistent with the health regime to which France belongs, SHI funds reimburse health care costs ex post. Overall, the system keeps user charges low while granting broad access and high care utilization.

Decentralisation, privatisation, and managerialisation trends have been apparent in the French system since the 1980s. SHI coverage and benefit scope were reduced, shifting health responsibilities towards the VHI. Hospital managerialisation started in the early 1990s. Facing a series of health deficits in the vicinity of €10 billion between 2003 and 2005, French policymakers enacted a major reform in 2004. A new top regulator, the HAS, was introduced into the system. Hospital acute care was set to be paid through

a T2A system, a DRG-like mechanism. The best performing hospitals could be rewarded with additional funds, and it became possible to close down the least efficient. Patients were asked to select a family GP, to whom they would address any medical necessity. At the same time, specialists were allowed to ask patients not referred by a GP for higher fees. After many years of rapid growth, health spending reached 11% of GDP, or €208 billion, in 2007. Further cost-containment mechanisms had already appeared before the crisis. Economic growth trends in France (-2.7% in 2009) were less affected by the Great Recession than in the rest of the EU. Still, estimates suggest that the crisis contributed to up to 75% of the health deficit in 2009 and 2010, adding to the system's long-term challenges. Major shortcomings include lack of coordination, high costs, and the strong influence of the medical profession over policy-making.

Formerly considered the prototype of the SHI model, the **German** health system is actually a SHI/PHI hybrid. SHI schemes cover about 70 million people and PHI plans about 9 million, while about 3 million Germans benefit from public employees' schemes. Health and LTC spending increased from 9.6% of GDP in the early 1990s to 10.5% in the late 2000s (about €300 billion). The SHI system is contribution-financed (until July 2009, employers paid 7.3% of gross wages and employees 8.2%) and offers standardised statutory benefit packages that pool individual health risks. Contributions are equally split between employers and employees, while dependent family members are automatically co-insured. Competition for insurees among the SFs began with the HCSA reform of 1993, which led to a wave of mergers and a significant reduction in the number of SFs (from almost 1,000 to 134 between 1995 and 2013). PHI plans are instead based on detailed individual contracts, whose premiums are determined on the basis of individual risks.

The GKV-WSG Reform of 2007 started a convergence of the SHI and PHI systems. Every German citizen was given the right and duty to hold a health insurance policy. SFs were granted more purchasing power and the possibility of offering market-like contracts; while private companies were required to offer SHI-like services and premiums, including a cheap entry option (Basistarif) meant to guarantee broad access. A new general health fund (Gesundheitsfonds) reallocates revenues among individual funds, pooling their risks with an adjusted capitation formula. Whenever the fund is unable to cover 95% of SHI spending, the government has to increase the contribution rate. SHIs can charge flat-rate extra premiums to cover extra costs or refund net contributors among their members. Extra premiums in SFs were capped at 1% of personal income. This let the insurers pay for cost differentials and thus incentivised very tough competition for high-income insurees (indirectly contributing to market segmentation), at least until the revision of the GKV-WSG reform in 2009. As of 2007, the number of uninsured people was 196,000, but the figure is shrinking within the new hybrid system. As Germany fared comparably well during the Great Recession, the reform process remained framed by the pre-crisis agenda. Since economic slowdown only occurred in 2009 and employment effects were limited in time and intensity, unemployment insurance schemes could step in and pay health

contributions. Thus, the health and LTC budgets were only mildly affected. As a result, the long-term challenges of ageing, regional heterogeneity in care provision, and a decreasing medical workforce remained more of a threat than short-term budgetary stress.

The **Italian** case well represents some of the defining traits of 2nd generation NHS regimes. When the NHS system replaced Italy's old mutuality model in 1978, the state assumed an unprecedented role, within a policy field long dominated by voluntarism and societal players. The new system, managed from the centre through a network of local authorities (USLs), soon experienced financial and governance problems. Most of its weaknesses were the result of an unclear attribution of competences between the central and the regional levels. As suggested by Pavolini (2013), the evolution of the system followed three main directions: privatisation, managerialisation, and decentralisation. Decentralisation unfolded within a broader process of administrative and legislative revisions of the Italian state structures. Managed competition and "quasi-markets" were introduced by the 1992 reform, which also transformed the USLs into independent regional agencies (ASLs) and provided for the transformation of public hospitals into hospital trusts (AOs). With the introduction of the National Health Plan 1998-2000 and the reform of 1999, the processes of managerialisation and regionalisation were partly reversed. With the "federal" reform of 2001, health care became a shared competence between the state and the regions, with the state tasked with the definition of minimum standards (LEAs). During the rest of the 2000s, incremental transformations unfolded in the absence of major reforms. As the crisis struck, Italian financial markets fared comparatively well, but Italy's GDP and public finances were severely hit. Italy particularly suffered from the debt crisis of the euro area, but recent health care reforms did not invert previous policy trends. Nonetheless, cuts in health care public expenditure were clearly visible in the period of 2009-2012: the annual growth rate of expenditure in public health care in real terms was on average -0.7% between 2009 and 2012 (OECD 2013).

The **Dutch** SHI system has historically relied on well-developed societal and private insurance institutions, able to guarantee high levels of access (e.g. the so-called Treek norms on acceptable waiting times), solidarity, and equality. Contributions and tax funding cover almost 90% of total health spending, with a 6% to 8% share for private payments. By law, hospitals and nursing centres operate on a strictly non-profit basis. Family doctors operate in private practice and gate-keep access to reimbursable specialist care. LTC services, publicly funded and provided by non-profit actors, are fully integrated into the Dutch health system. Over the last decades, however, the system has suffered from an uncontrollable fiscal expansion, by 4.4% a year in the 2000s and up to 13.2% of GDP in 2010 (with estimates for 2040 ranging from 22% to 31%). Expansion paved the way for the 2006 reform (HIA). With this major reform, previously distinct SHI and PHI schemes were integrated into a single mandatory scheme for the entire population. Providers and insurers operate within a framework of regulated competition, which still upholds social solidarity: no subscription can be rejected, the state pays premiums for the under-18s, and risk- and experience-rating are forbidden.

Under the HIA, each citizen must purchase a basic health plan (covering family medicine, maternity care, pharmaceuticals and hospitalisation) and pay a 7.75% payroll tax. Services to non-residents are provided privately and only covered by the HIA as a last resort. Enrolment is open and mobility among competing providers guaranteed on a yearly basis. A tax credit system ensures that nobody pays premiums higher than 5% of their income. Risks are pooled among the insurers by a complex risk equalisation formula. As they compete among themselves on service quality and cost, insurers negotiate prices, volumes, and quality of care with individual hospitals, GPs, and pharmacies. In the pharmaceutical sector, insurers managed to limit reimbursements to the lowest-priced generic drugs, leading to an above 80% cost reduction between 2006 and 2012. High consumer mobility, financial surpluses, and robust solvency rates among the insurers testify to the success of this reform. While most health provision is governed by non-market arrangements, competition among providers has increased. On a negative note, the insurance market is highly concentrated, with 4 insurers' groups controlling 93% of the market. Moreover, although the number of uninsured citizens has steadily decreased, the number of insurees unable to pay their premiums over the medium term (defaulters) is on the rise.

3.2.1. Regulation reforms and trends

Measures dealing with the allocation and reallocation of health responsibilities and administrative powers were undertaken also in countries under a moderate EU influence. They featured more prominently in Italy and France, but less so in the Netherlands. In **France**, the HPST reform, passed in July 2009, introduced regional plans (PRSS) in order to streamline planning across various types of care. As of April 2010, it replaced local health bodies with 26 regional ARSs in charge of coordinating and improving prevention activities, the territorial distribution of health professionals, and the provision of ambulatory and hospital care. Tasked with controlling and monitoring quality of care, the ARSs also supervise capital investments and the acquisition of advanced equipment.

In accordance with its historical evolution, the reallocation of responsibilities and mergers was repeatedly enacted in the **Italian** NHS. In 2009, a reform of public administration reduced the number of associations entitled to participate in collective agreements. Later in the year, the SRA 2010-2012 was finally agreed. It contained a mix of centralisation and decentralisation. The regions obtained a more equal footing in the area of monitoring functions. In exchange, they accepted more stringent requirements and penalties (including automatic tax increases and the threat of compulsory administration). "Recovery plans", negotiated in 10 regions since 2010, introduced automatic tax and copayment increases and nationally guided reforms in exchange for more funding. This renewed form of centralisation proved very effective, as the Italian Court of Auditors confirmed in 2011 a 28% deficit reduction in one year (from €3.2 billion to 2.3 in 2010). In early 2011, the NHP 2011-13 was adopted. In September 2011, L.149/2011 redefined incentives for virtuous

regions and sanctions for Governors and NHS managers non-compliant with recovery plans. Implementing the NHP 2011-13, the Balduzzi Reform of 2012 reorganised primary care and envisioned the creation of “health homes” where several GPs could work jointly. However, it failed to provide for their financing.

A mix of centralisation and decentralisation also characterised the less important reforms undertaken in the other two countries. In **Germany**, since 2009 health contribution rates (15.5% in 2013) have been set by the federal government, no longer by each SHI fund independently. The GKV-VStG reform of 2012 revised instead some of the responsibilities of the municipalities and Länder, taking further steps towards decentralisation. In the **Netherlands**, LTC tariffs have been centrally determined by the NHA since 2010, unless the regional care offices strike a better deal with the providers.

Privatisations and liberalisations were considered in all countries, France excluded. In Germany and the Netherlands, they mainly constituted a completion of the 2007 and 2006 reforms. In Italy, they implied increasing references to the principle of “selective universalism”. In **Germany**, mergers between different types of SFs have been allowed since 2008. On 1 January 2009, the merger of the Techniker Krankenkasse and the IKK-Direkt made gave rise to Germany’s largest fund. From 2009, “selective contracting” between SFs and health care providers was permitted under limited circumstances. It was further liberalised by the GKV-FinG (2010) and the GKV-VStG (2012) reforms. Later on, ways to further increase mobility between SHI and PHI funds were still discussed. In January 2013, the government introduced a long-debated LTC reform (PNG). Among the debated but not legislated measures was the introduction of an independent regulator for LTC providers, in place of the current self-regulation regime. By 2011, the scope of free pricing in **Dutch** hospitals had reached 70%, while ex-post risk equalization mechanisms were abolished. In 2011, the government announced its intention to lift the country’s traditional ban on for-profit hospital care under certain (strict) conditions. In **Italy**, a 2009 ministerial decree introduced new rules on complementary health insurance funds (FISs), covering dental care, rehabilitation, and LTC. FISs seem to have taken off in the 2010s. In November 2012, the government had expressed interest in strengthening their role, while making the NHS more “selective” and focused on “real needs” (“selective universalism”). In its September 2013 note to the DEF document, the government addressed the concept again.

Mechanisms of cost control for hospital/clinical and pharmaceutical costs have been a top priority in all of the four countries. From 2008, French policymakers extended T2A funding for public hospitals from acute care to all kinds of medical expenses. In **Germany**, the GKV-ÄndG and the AMNOG reforms were enacted in 2010 to reduce drug and hospital costs. The former increased from 6% to 16% the mandatory discount imposed on a number of pharmaceuticals. Further price increases were forbidden until December 2013. The latter contained some technical revisions of the 1989 PRS: pharmaceutical companies seeking to sell innovative drugs at full price would need the G-BA to acknowledge their therapeutic added value and (then) the

GKV-Spitzenverband to agree on a discounted price within the following 12 months, or have the price set by arbitration. In the hospital sector, AMNOG lowered to about 1% the yearly price updates of 2011 and 2012. A recently debated topic was how to reform the current DRG system, which incentivises hospitals to treat an excessive number of patients for purely financial reasons.

In the **Netherlands**, the scope of free pricing in hospital care incrementally reached 70% by 2011. In 2011, the Health Minister agreed with representatives from hospitals and insurers on a framework of responsibilities meant to keep hospital care growing at an average of 2.5% a year between 2012 and 2015. The agreement was revised and extended in July 2013, lowering the growth norm of the health sector (excluding family doctors) to 1.4% for 2014 and to 1% a year from 2015 to 2017. GPs and hospitals face lower limits for referrals to medical specialists, while providers were asked to be more prudent in their recourse to top clinical care. The **Italian** approach was maybe less organic, but no less resolute. In December 2008 the government announced new monitoring tools for LTC, while the Budget Law of July 2011 determined new drug purchasing rules. In November, The Monti government tried to introduce more price competition in the pharmaceutical sector with new prescribing guidelines. The DEF 2013 envisaged, among other measures, a reorganization of hospital and out-patient care and stricter rules for pharmaceutical spending. Finally, the Budget Law of October 2013 confirmed a number of cuts to health care employment. However, these cuts would not be implemented should the “Health Pact” currently under consideration eventually be signed. This Health Pact contains a more ambitious set of regulations, ranging from new LEAs and standards to the reorganisation of hospital care and inpatient acute care.

Regarding other regulatory issues, in each of these countries investing in **prevention** is, rather vaguely, identified as a possible avenue to increase the efficiency and efficacy of the health system. Finally, **e-health** measures meant to introduce the assisted use of social media into LTC therapies have been enacted in both **Germany** (2013) and the **Netherlands** (2012).

3.2.2. Financing reforms and trends

Financing reforms in all of the four countries consisted of a combination of cuts, refinancing (which includes increasing taxation), and increasing co-payments. However, the incidence of each dimension varied among them. In **Germany** and the **Netherlands**, cost containment has not led to dramatic retrenchment of the health system. During the *Great Recession*, the **German** SHI system stabilized its health financing share. Public subsidies supporting the national funds and the other SFs allowed it to remain solvent and with about €28 billion worth of reserves. As a result, no SFs charged extra premiums in 2013. In the **Netherlands**, notwithstanding the austerity course taken by the latest governments, health care spending is still expected to increase by €6 billion between 2012 and 2016.

Pure and simple cuts to health spending items featured prominently in Italy and marginally in the Netherlands. France almost exclusively relied on co-payments, while Germany depended on more complex refinancing strategies. In the **Netherlands**, the Lib-Lab government appointed in October 2012 announced €5.4 billion of extra cuts for the 2013-2017 period: €1.4 in health care and €4 in LTC. The former included a €1 billion reduction in the scope of HIA benefit packages, which met formidable opposition and was cancelled. The latter will be attained by abolishing day care and personal counselling, reducing Wmo household services, and excluding less severe cases from residential care. Only the main goals of the actual reform were presented to the Parliament. Inpatient services within AWBZ will be replaced by a new system (called LICA), which only focuses on the most severe cases. The other AWBZ services (worth €2 billion) will be merged with HIA home nursing and be provided as out-patient services. Publicly funded benefit packages will be reduced, while co-payments will increase from 4% to 8% for patients wealthier than a nationally defined amount. A tri-partite agreement signed in the care sector in April 2013 softened some of the most severe cuts planned for the Wmo.

Italy repeatedly relied on spending cuts. In 2008, no new funds were allocated to the NDF for the period 2009-2013. Moreover, while the 2010 national contract renewal for health professionals had promised increases in medical wages, the wages were frozen as soon as the crisis escalated in the summer of 2011, together with new job openings. In addition, the “Budget Law” of July 2011 determined, for the period 2012-14, about €8 billion in cuts, boiling down to a 7.5% reduction of the 2012 state subsidy to the NHS budget. By February 2012, however, the State and the Regions agreed on the following cuts schedule: none in 2012 and €2 billion in 2013 (mainly on drugs and goods and the acquisition of services). The DEF 2013 also set public health spending on a downwards path, lowering it to 7.1% of GDP in 2014 and to 6.7% in 2017. Finally, consultations with stakeholders and social partners tried to redefine the conditions to be met for entitlement to the companion allowance (CA), which basically constitute Italy’s LTC policy. In its first version, the Budget Law determined that all claimants with a yearly income above €60,000 (or couples above €80,000) would be excluded from the CA. Moreover, CA values were to be reduced proportionally for incomes below the threshold. These measures were withdrawn during the Parliamentary proceedings.

As indicated above, co-payments were increased most in France and Italy, whereas Germany got rid of one of its fees. Given the surplus of the general health fund in 2013, the **German** government abolished the so-called *Praxisgebühr*, a €10 co-payment periodically paid by patients undertaking out-patient specialist visits. In the **Netherlands**, the “mandatory deductible amount”, a form of co-payment introduced in 2008 and not applied to primary and family care, was doubled between 2008 and 2013 (from €170 to €350 per person). The abovementioned Lib-lab reform proposal of 2012 also included increasing LTC co-payments from 4% to 8% for patients wealthier than a nationally defined amount. In **Italy**, the Budget Law of July 2011 enacted new user charges. By February 2012, the State and the

Regions agreed on 5 billion of cuts in 2014, of which more than 50% collected through increased co-payments. A new co-payment system on pharmaceutical goods and health care services, worth €2 billion with effect since 2014, was announced in 2012 but repealed in October 2013. In **France**, hospital fees were once again increased in 2010, up to €18 per day. Later in the year, the LFSS law of 2010 increased co-payments by lowering reimbursements on medicines for less severe illnesses (from 35% to 30%) and medical devices (from 65% to 60%), while further increasing hospital fees for hospital treatments above €120. Finally, an increase in consultation fees from €22 to €23 has taken place since January 2011.

Tax increases, subsidies and other refinancing tools characterised the German reform process. At the same time, they were also present among the rather heterogeneous packages of the Italian governments. As part of a stimulus package, **German** hospitals were entitled to €1.3 billion of investments over the period 2009-11. Contribution rates decreased to 7.0% (employers) and 7.9% (employees) from July 2009 to 2010. Although not unanimously, Merkel's centre-right majority proposed to keep the lower contribution rate for employers, replacing it with a flat capitation fee. The PFWG for 2008 increased the contribution rate to 1.95% (2.20% for insureds without children): employers and employees each pay 50% of the contribution/premium, while pensioners pay the whole of it. In 2009, hospital financing was reformed (KHRG). Representatives of hospitals and insurers signed an agreement concerning the financing of wage increases in 2009. As a result, hospitals received an extra €1.1 billion funding increase. In 2013 and 2014, German hospitals received another €1.1 billion extra subsidy to cover medical staff expenditures. In March 2009, in **Italy**, €1.4 billion were deployed for a new round of regional projects on primary care and LTC (partly financed by EU funds). When the abovementioned SRA 2010-2012 was agreed, the regions obtained a €6 billion funding increase as a compensation for the more stringent regulatory requirements. In May 2011, L. 68/2011 introduced new "standard costs" and defined LEA-costs through a "benchmark mechanism" that was supported by a "Redistributive fund". In 2011, the **French** government made available to the health budget an extra €1.9 billion, gathered through minor revisions in the functioning and contribution rates of other social schemes.

The emphasis on refinancing has been a defining feature of the German case. In 2009, an interest free loan equal to 50% of the costs of the recession was granted by the government to GKV-WSG's new national health fund, sheltering its introduction from short term pressures. Loan repayment, set for the end of 2010, was later postponed to 2011. The federal subsidy to the health budget was contextually increased by €7.2 billion for 2009 and €15.7 billion for 2010. The 2010 GKV-WSG reform reduced some financial shortfalls in the SHI system. GKV-FinG then readjusted the contribution rates to 8.2% for employees and 7.3% (which was also set as the maximum ceiling) for employers, leaving to the insureds the whole cost of future adjustments. Also, it froze SHI administrative costs at their 2010-level. Finally, it put in place a new mechanism (*Sozialausgleich*), financed by the general health

fund and by the general revenues, in order to compensate SHI insurees for whom the national average “extra premium” would exceed 2% of their wage. The new norm, inspired by the Dutch 2006 reform, was meant to redress the competitive distortions introduced with the (discontinued) 1% limit to extra premiums. At the same time, it made financing less dependent on labour income. The national health fund experienced a €4.4 billion surplus at the end of 2011. Finally, in 2013, the KVBeitrSchG reform lowered the interest rate faced by defaulters on their outstanding premiums, which had led many even deeper into the red. In early 2012, a debate started on whether and where to invest the health fund surplus of 2011. The 2012 reform (GKV-VStG) will use some of it to reduce physicians’ shortages in rural areas. Given the surplus of the general health fund, tax subsidies to the SHI system have been reduced by slightly more than 20% in 2013. Moreover, in January 2013, the government introduced a long-debated LTC reform (PNG). The law increased SLTCI contributions by a further 0.1%; while also introducing tax-favoured (up to €60/year), funded PLTCI plans.

3.2.3. Provision reforms and trends

Reforms that produced effects on health provision were mostly regulatory reforms dealing with professional incentives to reinforce access and coverage in certain sectors or depressed areas. This is especially the case of **Italy** and **France**. In consideration of their substantive content, and in order to facilitate comparison, we resolved to present them in this section.

Since 1 January 2009, physicians in **Germany** have received fixed Euro-cent values per service. Prior to this reform, physicians did not know the actual equivalent of their work. The doctor’s fee was subject to a complex distribution scheme. In 2010, the Health Minister Rösler suggested the introduction of a quota for country doctors (*Landarztquote*). In January 2013, the PsychEntgG adopted a daily lump sum regime to remunerate treatments of psychiatric and psychosomatic cases. The new system starts with a budget-neutral introduction period (2013-2017) with voluntary participation of the psychiatric facilities in 2013 and 2014. From 2015, participation will be compulsory for all facilities. In 2017, a five-year convergence period will start. In June 2009, the **French** CNAMTS established a P4P contract (CAPI) soon adopted by one third of the interested doctors. GPs can receive up to €7 extra per patient if they comply with targets and requests formulated by the HAS. In July, the HPST reform made certain aspects of medical education and remuneration more flexible, stimulating medical provision in disadvantaged areas. In 2011, the Loi Fourcade, a reform of HPST, strengthened the legislative framework of the Health centres (*Maison de Santé*) and restated some rights and prerogatives of the medical profession. Finally, under the auspices of the new socialist government, representatives of SHI funds and of the medical profession signed an agreement in October 2012, which provided for a new voluntary contract for “sector 2” doctors, offering incentives to limit the amount of overbilling.

In **Italy**, the terms for exercising the medical profession within public facilities were further reregulated in 2009. The abovementioned “Budget Law” of July 2011 also determined staff hiring restrictions in the NHS. On the contrary, the Budget law of November 2011 focused on expanding employment in the health sector (around 4,000 to 5,000 new pharmacies and about 15,000-20,000 new employees in this sector). Finally, the Budget Law of October 2013 enacted a “freeze” of salary increases in the whole public sector and a total stop of “turn-over” in 2014. The stop will be lowered to 40% in 2015 and fully abandoned in 2018. However, these cuts would not be implemented should the Health Pact eventually be signed. As mentioned above, the Health Pact contains a more ambitious set of regulatory reforms. Among the other reforms, in September 2009 the government launched a major pardon for illegal migrants, mostly directed to the needs of informal care workers (indirectly strengthening outpatient LTC). The agreement on the SRA 2010-2012 in December 2009 also imposed on the regions the elimination of 9,812 hospital beds (95% of which were in the South). Regarding provision-related measures in the NHP 2011-2013, it envisaged the closure of small hospitals and delivering facilities or their transformation into integrated structures.

3.3. Member States under weak EU leverage

Lithuania, Sweden, and the UK all underwent major reforms of their health system. The main driver behind these innovations seems to be the formulation of a domestic reform agenda. As a result, policy change mainly followed from the attempt to solve long-lasting or salient policy challenges. Maybe not surprisingly, this group is the most heterogeneous in terms of reform timing and substantive content. Health administration and the allocation of health responsibilities have featured as prominent issues. Organisational aspects dealing with health care provision and regulation have thus been crucial, within a shared effort to move away from some of each country’s defining policy legacies.

Lithuania is still struggling to develop a modern health system. A series of laws and regulations since the 1994 Health System Law (HSL) redefined the architecture and main goals of the Lithuanian health system. Legislative harmonisation and reconsolidation followed during the 2000s, when the Ministry of Health also started to recentralise competences, for instance over regulatory standards (including licensing and certification), capital investments, and supervision. The resulting system relies on mandatory health insurance and individual user charges. Private health insurance is mostly provided by MNCs to their employees. In 2011, health spending totalled 6.9% of GDP, 73% of which was financed by the National Health Insurance Fund (NHIF), partly through social contributions and partly with tax allocations. The remainder is covered by private spending, including user charges (2% of GDP). Subsidies from the budget play a major role, contributing for more than half of the insured population and making coverage nearly universal. Co-payments are required for rehabilitation services and pharmaceuticals (covered by the NHIF up to 50%, 80%, 90% or 100% based on patients’

category and disease). Patients are free to register with their preferred primary provider, who then receives an annual capitation fee from the NHIF. Although funding allocation seeks to compensate regional inequalities, the fact that NHIF fees are set nationally may lead private providers to make patients pay the difference. Services not included in NHIF coverage are defined by a “price list”. Provision is mostly public or non-profit and highly reliant on hospitalisation. Private providers, in turn, offer high quality care (very often through public facilities) but only a few specialist services, such as dental care or cosmetic surgery. Residential care services were offered since before the transition. LTC is centrally regulated and also financed by NHIF money and patient fees, other than by municipalities. It absorbs 1.2% of Lithuania’s GDP, and about 40% goes to nursing services. Frequently mentioned in the policy debate, community-based care remained limited. Residential accommodation is mostly provided by the state or NGOs, but the great majority of residents live in large-scale public structures.

After several years of sustained growth, the crisis brought Lithuania into a heavy recession (-15% GDP growth in 2009) until 2011. Existing NHIF reserves (about €100 million) absorbed most short term budget pressures so that policy-makers could focus on the timely restructuring of public health care. In 2008, a change in government shifted the Ministry of Health into the hands of the liberals, who immediately took on an austerity course. The post-crisis health agenda remained in line with the priorities of the National Public Health Strategy 2006-2013: adopting a cross-policy approach to health promotion (inclusive of criminal and fiscal measures), reducing regional and socio-economic inequalities in health and access, shortening waiting times (especially in oncological centres), and combating corruption and bribes. Also, 450 new agreements with the private sector were expected to empower provider choice rights.

The **Swedish** system is the prototype of a sub-nationally managed NHS. The regional and local levels retain most political as well as the financial authority. Both the county councils and the municipalities are rather independent from the national Government. The basic local health care idea is an integration of a local hospital with primary health care and municipal health services, in order to provide integrated and accessible health services for the basic needs of the population. Total health care expenditure in percentage of GDP in Sweden has decreased since the 1990s and stabilised during the past two decades at 9.2% of GDP, in line with other EU countries. This stabilization is a result of cost containment measures taken by the county councils and regions. In 2010 about 82% of the total expenditure of the county and regional councils, and 30% of the total municipal expenditure, was related to health care. Financing mainly comes from public sources. Private providers are gaining importance in primary health care, financed by the county councils and regions. There are also private practitioners who are financed by private out-of-pocket payments or private health insurance. The most important law is the Health and Medical Services Act from 1982, where the responsibility of the county councils and regions for the provision of health care is established. The law affirms the independent positions of the county councils and the regions regarding the organisation of the health services. As part of an increasing focus on cost control, a number of

New Public Management (NPM) reforms were implemented in the early 1990s, including a purchaser-provider split. However, many county councils have returned to a traditional mode of planning and control (The Health Systems and Policy Monitor). Since 2005, there is a national care guarantee concerning acceptable waiting times. The 2008 system of free choice for patients in primary health care is also expected to improve this situation by increasing the number of private practices.

Sweden was among the EU countries least affected by the economic crisis. According to the European Commission, the Swedish economy does not appear to face any kind of sustainability challenge. Its deficit was only briefly negative in 2009 and its public debt (38.4% of GDP, expected to drop further over the short term) is much below the Treaty threshold. As a result, the Swedish health system did not experience major pressures for change related to past failures or due to the crisis. The only exception is that recently, the large regional differences in the quality and efficiency of health care have been more and more heatedly debated.

Health and LTC services in **the UK** are funded, regulated, and provided by four publicly funded NHSs. They were created in 1948 and health care competences were further decentralised after the devolution of legislative and administrative powers to Scotland, Wales, and Northern Ireland in 1999. A shift towards a managerial approach has taken place since the implementation of the Griffith Report in 1983. Since 1997, Labour governments have tried to improve access, quality, and satisfaction levels, with substantial investments and new hiring but also through several market-friendly reforms meant to improve efficiency. Health care in the UK is universal and free at the point of use for legal residents. In the last years before their abolition, the English NHS has distributed more than 80% of financing among 152 Primary Care Trusts (PCTs), on the basis of their population and risk profile. PCTs used to commission services either within the NHS or by contracting out to private providers (non-profit and for-profit) and local authorities. Between January 2006 and April 2008, the scope for patients choosing GPs increased, thanks to an electronic booking system. Patient choice concerning hospitals for referral was similarly extended to the entire NHS network, plus numerous private centres. The level of unmet medical needs is comparatively low in the UK, and patients are increasingly involved in the governance of the system. Just before the crisis, evaluations of doctor practices and of the financial status of NHS organisations across the four nations testified, on average, to an improving trend. The result was a fragmented system where different municipalities could face widely diverse cost structures. Even though the private health sector is growing, mainly due to the desire to avoid long NHS waiting times, private spending has remained around 1.5% of GDP throughout the 2000s. User charges finance a negligible part of health spending, and the coverage rate of private insurance plans before the crisis was only about 12.5%. Nonetheless, unlike in Scotland and Wales, patients in England who are not eligible for an exemption must pay a share of their drug costs. Available medicines may also vary among the four nations and, for drugs awaiting national approval, among English municipalities (a problem also known as “postcode lottery”).

More than 80% of the British health spending is tax financed. In comparative terms, the UK is not a big health spender; nonetheless total expenditure has substantially increased since the end of the 1990s (by almost 7% a year in real terms) and grew further from 8.4% of GDP in 2007 to 9.8% in 2009 and 9.4% in 2011. During the 2000s, per capita spending (equal to €2,636 in 2010) grew by 4.9% in real terms, with sizeable regional variation (up to 18% between England and Northern Ireland). As a result, performance indicators such as waiting times (18 weeks) improved, while patient choice and satisfaction increased. And yet, inequalities between England and the poorest areas of the other regions (especially Scotland and Wales) persisted and even worsened. Moreover, access to emergency care and outcomes such as cancer or premature mortality remain below international standards. Regarding LTC, 4% of the English elderly live in care homes. About one in three is a privately funded resident. In addition, depending on the type of the residential institution, patients pay between 39% and 49% of their care's full cost. Provision is almost entirely non-public, as 92% of residential and nursing homes are either voluntary or for-profit. The quality of residential care can be very low in some municipalities, and several scandals (such as Castlebeck's and Mid-Staffordshire's) and official investigations have revealed situations where patients' human rights were breached.

The UK was severely affected by the financial crisis of 2007-08. The British banking system had to be bailed out and partly nationalised. The costs of a large stimulus package, combined with falling tax revenues, impacted various years of deficit spending, as the Labour government invested in education and health care. The public deficit turned two-digit and the ratio of public debt to GDP doubled. Real GDP growth turned negative in 2008, fell to -5.2% in 2009, and has remained below 2% since then, while unemployment increased from about 5.5% in the mid 2000s to about 8% since 2011. Direct effects on health spending mainly occurred in the private sector, where the coverage of private medical insurance fell to 11.1% of the population in 2011. After an early stage of cautious adjustments, the government agenda took a decisive turn towards austerity, as soon as the Conservatives and Liberal Democrats won the elections of May 2010. Notwithstanding the high popularity of NHS in the UK, the initial strategy of parametric efficiency-enhancing initiatives revealed its limits. Health spending received wide media attention, and the debate insisted on the implementation of long announced reforms of health care and LTC.

3.3.1. Regulation reforms and trends

All of these countries experienced an important electoral shift in favour of the political centre-right, which fostered the opening of a new political phase. This increased the scope and ambitions of the most recent reforms, which looked for real changes in the allocation of health care competences. In Lithuania, the recentralisation of powers once delegated to independent agencies has sped up since 2008. Seven public health institutions were also reorganised or merged in 2009. The new trend

consolidated with the abolition of county councils in 2010; whereas the Board of the Regions acquired wider managerial powers, the administration of Regional hospitals was transferred either to the national or the local level for about €10 million worth of savings. In 2010, health funds also entered a third stage of administrative reform. Although mental health programmes ceased to be implemented, investments in most nationally coordinated care and prevention programs continued. About €300,000 were invested in a new cancer prevention programme. At the same time, initiatives taken since 2008 have achieved huge reductions in the illness and mortality consequences of alcohol intoxication. Moreover since 2010, the “Mother and child health programme”, supported by the Swiss government, has greatly improved the quality of natal care and infant mortality rates. The Lithuanian Health Programme 2020, conceived within the framework of EU2020, adopted an inter-sector approach, involving other sectors and policies in health promotion and prevention activities. The Parliament declared 2013 the Year of Health Promotion.

In **Sweden**, proposals to rationalise financing and provisions followed from a reconsideration of purchaser-provider splits, which came to be considered a source of increasing costs. As a result, more and more county councils abandoned or re-regulated their market models, whereas, in 2007, the Parliament’s Responsibility Committee suggested moving beyond the county-based model. Sweden would instead be divided into 6-9 regional councils in order to provide a better financial base and a more sustainable organisation on the regional level. The regional councils were supposed to be established through mergers between neighbouring county councils. In 2011, regional councils were established in Halland and on the island of Gotland, and more county councils began negotiations for merging. The results, however, are mixed: it seems instead that many county councils are just changing their names to regional councils.

In **England**, the Social Care Act 2012 completely overhauled the structure of the NHS, reforming the commissioning and provision of care as well as the role of local and national regulators. The Department of Health will oversee both health and social care, with direct responsibility on public health and the effective functioning of the system, but without administrative authority over NHS organisations and service providers. Every budget year, the Department of Health (DoH) must elaborate a “mandate” setting the official medium-short term goals for the NHS. Accountable to NHS England, Clinical commissioning groups (CCGs) will replace both PCTs and SHAs from April 2013, combining their tasks with powers formerly exercised by the DoH. They contract general practitioners and can purchase services from any provider, public or private, that meets the national standards (“Any Qualified Provider” approach). Since April 2012, the new approach has become mandatory for a minimum of three services. As the law provides for the future abolition of NHS trusts, all hospitals and NHS trusts are expected to turn into Foundation Trusts anytime soon. FTs must increase the transparency of their accounts and board meetings. They can now expand up to 49% the share of income they derive from providing care privately, provided that they can testify to the beneficial effects on their NHS functions. Local Health and Wellbeing Boards (HWBs) will promote

inter-sector coordination between public health, health, and social care. Municipal HealthWatch bodies (HWs), nationally supported by HealthWatch England from within the CQC, will replace Local Involvement Networks as a point of contact between civil society and the care system. Both HWBs and HWs will be accountable to municipal Overview and Scrutiny Committees. Monitor and CQC will provide integrated regulation and supervision of the entire system, including a joint licensing regime. Monitor was also given powers to deter anti-competitive behaviours and, in cooperation with NHS England, it will set national tariffs for NHS services. NICE, now the National Institute for Health and Care Excellence, became a non-departmental public body and also acquired authority on social care. Public Health England (PHE) was established to provide expert services in support of public health.

Domestic problem solving has been a crucial driver of reform in this group of countries. Therefore, new standards and strategic objectives featured prominently among the new measures. In **Lithuania**, a “Programme for the third stage of the restructuring of health care institutions and services” was approved in December 2009 and three strategic objectives were set in 2010: reorganising the health funds and the hospital network, reforming the supply and pricing of pharmaceuticals, and maintaining pre-crisis levels of access and funding. Disease-specific programmes and e-health records were activated to improve the general effectiveness and coordination of health and LTC services: the strategy also provided for large-scale mental health and child immunization programmes, although the former were never implemented. Two rounds of public discussion (December 2011 and November 2012) addressed some long-standing shortcomings of Lithuanian health. Issues of health inequality were also debated during the Baltic Health Policy Dialogue of November 2011. Since June 2013, illegal residents in **Sweden** will be given the same access conditions as asylum seekers. Standard improvements were considered all over the **UK**. Since 2010, **English** hospitals providing treatments in mixed-sex accommodation would receive no public compensation for their services. To deter abuses and malpractices, in 2013 the Chief Inspector of Hospitals announced a new regime of inspections: visits could be unannounced and occur at evening or in weekends. The Scottish Action Plan for 2007 focused on patient participation, improved access, and health inequalities, paving the way for a governance reform in June 2008. The 2008 “Equally Well” report detailed a preventive approach to health inequalities across the nation. The Welsh government put out a similar plan to promote a preventive and cross-policy approach to care. In addition, between 2008 and 2009, it took the first steps towards a reform to recentralise NHS Wales. Also in Northern Ireland the government proposed a major reform of health and social care, meant to tackle both governance and inequality issues. Unlike Wales, Scotland and Northern Ireland proposed waiting time targets in line with England’s 18 weeks.

Improving access, especially in LTC, was another key reform goal in the UK. The English Secretary of State published in 2008 a recommendation intended to harmonise access to services across the four nations in consideration of patients’ residence. In the same year, the Health and Social

Care Act re-established the CHI as the Care Quality Commission (CQC), tasked with assuring patient safety and the quality of health and social care. The new organ had a very troubled start and experienced major problems in establishing itself. In 2008, the Review led by the Health Minister Lord Darzi produced its final report, “High Quality Care for All”. The report suggested the adoption of P4P compensation for hospitals and family doctors, the adoption of a new set of indicators, and greater information to stimulate competition on medical outcomes among providers. Some of the report’s proposals were implemented by the Health Act 2009, which was introduced by a “Constitution for the NHS” redefining patients’ rights and responsibilities. A 5-year strategy for the NHS was put out in December 2009, announcing measures to reinforce the link between hospital income and patient satisfaction, and to liberalise the choice of family doctors. In July 2010, the new government published the White Paper “Equity and excellence: Liberating the NHS”, proposing the abolition of PCTs and their replacement with consortiums of GPs. NHS prescription charges were frozen for 2010 and 2011, and their abolition was also considered in Northern Ireland. As regards LTC, the Personal Care at Home Act of 2010 provided free home care to between 280,000 and 400,000 needy persons. In 2011, the reports of the Dilnot Commission on Funding of Care and Support and of the Law Commission outlined several criticalities in the financing, provision, governance, and outcomes of the LTC system. In the same year, Southern Cross, the largest private provider of social care, went bankrupt. In April 2012, the English government published a White Paper proposing new steps towards the creation of a new National Care Service. New standards and additional care entitlement were planned since 2014, paving the way for the universalistic provision of full personal care for free. England eventually enacted a new Care Bill in May 2013, reforming LTC services starting in January 2016.

Pharmaceutical spending was reformed and re-regulated in Lithuania and Sweden. As soon as the crisis struck, **Lithuania** suspended new programmes and other initiatives with expansive effects on pharmaceutical spending. Between 2009 and 2011, the average price of prescription decreased by about 13% and the relative co-payment by 31%. NHIF savings on drugs and medical devices totalled about €19 million on reimbursements and about €17.4 on co-payments. Since January 2009 (July as regards the public system), VAT on pharmaceuticals increased from 5% to 19%, although reimbursable drugs were excluded until January 2011. Whereas spending for medicines and medical devices had nearly doubled between 2004 and the first half of 2009, later in the year the new rules brought it considerably below its 2008 level. In July 2010, a reform of the accessibility and prices of pharmaceutical products reregulated every aspect of drug sales and consumption, from production and authorisations to dispensation and reimbursement. This included grouping drugs by therapeutic effect, more permissive conditions for parallel import, pricing rules based on the cost of generics from more than three producers, longer prescription storage obligations, and new guidelines for pharmacists. The price of generic alternatives was cut by 30% and 20 generics were included among reimbursable drugs, for an estimated €1.25 million worth of savings. Pharmaceutical prices fell by 10%, NHIF was reduced by 8.3% over

the previous year, and co-payments by 23%. The government also agreed with medical producers to limit drug sales, facilitating the timely repayment of pharmacies and health funds. However, health funds had to abandon the “advance payment model”. Pharmaceutical information available to clients was improved, also through a “client monitor” on drug prices. In 2010, new measures provided for the introduction of DRG-funding in hospitals (since 2012) and for reducing drug spending and hospitalisation rates. In 2009, the **Swedish** pharmacy market was re-regulated by allowing private owners to operate pharmacies. At the same time, non-prescription drugs were authorized for sale outside of pharmacies. A recent evaluation of the reform has shown that the number of pharmacies has increased by about 40% and that total cost for drugs with generic alternatives has decreased by 10%. New brands have been established for non-prescription drugs, which cost 15-75 % less than the previous ones.

Hospital reorganisations were implemented in both Lithuania and Sweden. Since 2010, **Lithuanian** hospitals were reorganised in a three-level scale, according to the type and volume of services provided. During the third stage, merging was the most common way to reduce legal entities and reallocate the provision of specialist services. About 2.8% of all hospital beds, mostly at the district level, were eliminated. Health centres were given more autonomy in planning and utilisation. However, this occurred within a heavily state-regulated environment, which kept prices for health services 20% to 40% below their actual value. Every year, hospital care will be publicly ranked according to a new list of quality and performance indicators, which includes patient satisfaction. Overall, however, patients were dissatisfied by the changes and an official evaluation of this reform was planned for 2012. Hospital mergers, with the creation of “hospital groups” under a joint management, were implemented successfully in **Sweden**, starting to redraw the Swedish hospital map.

3.3.2. Financing reforms and trends

In all three countries, financial resources have been redirected within the health system, with a mix of refinancing and spending cuts. **Lithuania** adopted a major financing reform. Until 2008 public health spending was financed by one third of the general income tax, state budget contributions for the unemployed, pensioners, and children, and a 3% payroll tax. Since January 2009, the insurance system has been 75% financed by social contributions, 6% paid by the employee (9% for the self-employed) and 3% paid by the employer; in addition, state-financed premiums have increased. The range of health contributors has expanded and stricter controls have been established. State financed premiums were increased by 75% by 2010. In November 2010 fines were imposed on individuals unable to pay their mandatory contributions, producing large positive effects on both coverage and financial stability. A 6.7% planned budget increase for the NHIF was revoked, freezing spending at its 2008 nominal level. Health service programmes and personal health services were the most severely cut items.

The NHIF budget was cut by 6.2% by means of an 11% reduction in the “point cost” for treatments (except for primary care and disease prevention, as well as disadvantaged areas and GPs performance rewards). In 2010, the NHIF budget was further stabilised with a wide range of minor interventions and reduced by an extra 8.7% in 2010.

In **Sweden**, a large majority of all county councils and municipalities reported positive results in 2012, and income from taxes are expected to increase, due to both employment growth and tax increases. Although budgets have been tightened, expenditure for both health care and long-term care continued to increase. As a response to the economic crisis, the government contributed with extra state funding in 2011, and county councils and municipalities generally raised taxes both in 2012 and 2013.¹³ According to the latest estimates, the tax revenues are increasing more than previously expected due to a strong recovery in the economy, and health care expenditure is expected to rise as a result of the ageing population, so it may be difficult to balance the budgets. At the same time, about €0.5 billion were invested to improve coordination and pharmacological treatments in LTC provision, together with palliative, preventative, and dementia care, as well as mental health since 2013. Since 2009, about €110 million has been paid as a performance reward – the so-called “Queue billion” (of Swedish Crowns) - to county councils that comply with the national guarantee on waiting times. The incentive proved successful, although it can result in new patients being prioritised over more problematic or chronic cases. Between 2012 and 2014, about €4 million were spent in initiatives to increase freedom of choice among health providers.

In **England**, as a further demand stimulus, the Labour government decided to bring forward £3 billion worth of capital investments from 2010-11 to 2008-10. Part of these funds was directed to the NHS. At the same time, NHS England’s budget for 2010-11 grew by approximately £4 billion, although the planned amount was cut by £2.3 down to £102.3 billion. Cuts were meant to be absorbed by efficiency savings: those from reducing waste in inpatient hospital care were estimated at £500 million per year. PCTs reported a surplus of £1.5 billion (about 1.5% of the NHS budget) as a result of tariff reductions, a pay freeze in the public sector, and 2% of their budgets being earmarked for non-recurring expenditures. Overall, the NHS received a £20 billion reduction target to meet by 2014-15, which NHS managers received with great scepticism. Although real health spending growth has ranged between +4% and +7% a year in the past decades, the Spending Review for 2010-14 only expected an annual 0.1% increase. This figure results from the combined effects of the following trends: +1.3% in the resource budget, -17% in capital spending, and -33% in administrative expenses. Over the long-term, the NHS

¹³. About 70% of the county council’s total costs are financed through taxes, 16 % by state grants and 4% are financed through patient fees. Each county council takes its own decisions on the tax rate and how to allocate tax revenues. Spending trends are closely monitored by the different county and regional councils and also by the different municipalities, as well as by the Swedish Association of Local Communities and Regions, which is in charge of reporting on them.

is expected to accumulate a £30 billion funding gap in the absence of further structural reforms, endangering the principle of free provision at the point of use. Recent estimates of real health budget cuts for 2014-15 indicate -2.7% in Northern Ireland (which also includes social care), -0.25% in England, -7.9% in Wales (for 2013-14) and -2.9% in Scotland (for 2013). As proposed by the Dilnot Commission (although on much less generous terms) a cap on individual care costs worth about £61,000 (2011 prices) will be introduced, with the state financing exceeding costs. Lower caps are foreseen for young and disabled patients. Individuals with property value and savings up to £100,000 will receive a proportional subsidy on their residential care costs.

3.3.3. Provision reforms and trends

Concerning the provision dimension, changes unfolded rather differently across the three countries.

In Lithuania, the effects of investments and service rationalisation improved the record of some services. Most out-patient and day/short-term inpatient services were spared from the cuts. Provision, in fact, increased in inpatient day/short-term services and surgery, as well as out-patient specialist care. Reliance on inpatient rehabilitation was discouraged, favouring out-patient alternatives.¹⁴ Since 2010, NHIF-funded, municipal level, home nursing services started to be provided to patients with “special needs” by teaming family doctors with nurses and social care professionals. Inpatient services have not been privatised, but rather reorganised and liberalised (especially with the “third wave” of restructuring in 2010) and savings used to strengthen out-patient alternatives in both primary and secondary care. Thanks to changes in health professionals’ working schedule, about 90% of health care centres kept waiting times for consultation below 10 working days, with increased accessibility to most out-patient services. Passed in January 2011, the “Outline of further health system development until 2015” announced the creation of an integrated system of diagnostic, health care, and social services for the elderly, covering also surgical operations and dental care. The impossibility of discharging existing patients meant little change occurred in LTC. In the attempt to reduce reliance on hospitalisation, policymakers prevented GPs from referring patients to inpatient rehab services and increased investments (partly financed by the EU Structural Funds) in establishing local out-patient units (+30% since 2005). Municipal level spending on nursing and long-term care increased during the crisis, and more geriatric services for the elderly population were introduced in 2010. Guidelines for deinstitutionalisation programmes in disability and childcare were issued in late 2012.

14. However, specialist out-patient care has been increasingly contracted out to private providers: since May 2008, the NHIF started to pay a share of home care services, up to €231 per patient (with patients and municipalities paying the remaining costs), for an estimated total spending of €6.66 million per year.

In Sweden, recent efforts to liberalise the health market have increased the volume of private provision. Access outcomes are yet to be ascertained: for instance, the reduction of places available for institutional care has increased waiting times for inpatient residential services. As part of a generalised mainstreaming of “health pathways”, services are becoming more and more integrated at the local level. Some hospitals have not been closed, but rather included in so-called “*närsjukvård*” (hospital mergers, see above), which integrate local hospitals with primary and municipal social care within an open organisational model. Health, social, and employment services cooperate with social insurance in coordinating professional rehabilitation. Overall, privatisation of hospitals has been limited.

No major change occurred in England regarding the provision dimension. Evidence suggests, however, that recent reforms might be interfering with the delivery of care. Waiting times, successfully reduced since the mid-2000s, have begun to increase again since summer 2010. Delays in referrals for routine surgery, such as hip and knee replacements, were reported in several parts of England as a result of relentless cost containment. Taking a prospective look, the current agenda of administrative reform looks very ambitious if one considers the strict efficiency targets already imposed on the system and the hostile reactions of the health stakeholders. Commentators expect access levels and waiting times to be negatively affected by the transition.

Comparative conclusions

We started this report with two main questions. We asked which trends have emerged since 2008 in the field of health care and health care reforms and which effects they have produced on European health regimes. More specifically, we asked how the challenges posed by the crisis have been addressed and how the influence of the EU had conditioned health reform processes at the national level. In addition, we inquired about transformations in the role assumed within these systems by the state, societal actors, and the market.

In the course of the analysis, we traced the recent evolution of both EU and domestic processes. In line with our initial conjecture and theoretical expectations, we concluded that EU guidance has become stronger since the crisis. The number, scope, and detail of its Country-specific Recommendations have grown. In most countries, however, the “EU leverage” is not yet as influential as that of domestic reform agendas and remains limited to the coordination of macroeconomic policies within the EU. As a result, the incidence of the supranational level is mainly indirect. It is related to aspects of financial sustainability and cost-effectiveness, with little interest in or awareness of the specific goals and specificities of each national system. In countries that entered financial assistance programs (MoUs), such an emphasis on the health budget was complemented by real “imperatives” concerning short-term cost-containment and budget cuts. This implied shifting onto the private sector, and ultimately onto patients, an increasing share of the costs. Even in this case, however, evidence does not allow us to conclude that these countries received, from the top down, a fully developed and consistent new health care agenda.

Apart from its focus on the budgetary side of health policies and its reference to non-divisive policy goals – such as increasing efficiency or promoting prevention – our process tracing exercise has identified no new health care paradigm that was supra-nationally defined and imposed from the top down. There are also no indications that the EU is promoting national convergence towards a unique model. And it is equally difficult to say whether supranational actors such as the Commission or the Troika are ready to accept – or maybe willing to promote – different health care models in different countries, tailored on their economic performance and socio-economic prospects. As pointed out in Section 2, the entire process of formulating and issuing Country-specific Recommendations (CSRs) is rather blurry. Most healthcare related CSRs are rather generic and almost mutually interchangeable. At this moment it looks as if the most important message from the EU institutions through a CSR is to reform the system to make it more financially viable,

without a strong recommendation for a specific reform. It could well be that the EU institutions try through the CSRs to provoke a reaction from Member States, to then be able to go into more detail in future documents. However, there are no indications of strong involvement in or reaction from Member States to their health CSRs nor of an interaction between EU institutions and Member States. Disentangling the causal processes inside this “black box” would require further primary research on the criteria and procedures behind the formulation, selection, and issuance of CSRs.

A plausible assumption we posited in this report is that the EU to some extent concentrates its indications on those states it can more easily influence. This would especially be the case for Eurozone members and countries under (or at risk of) an Excessive Deficit Procedure. More simply, it could be that some governments simply want to remain off the EU’s radar screen, fearing the political or economic costs of European “naming and shaming”. Finally, it could also be the case that EU policy-makers are willing to reach beyond the specific target of any given CSR and speak to the governments of the entire Union. The evidence gathered in Sections 2 and 3 did not challenge our choice to model the role of the EU as “leverage” on domestic processes, rather than as an alternative reform agenda imposed from the top-down.

Moving on to the empirical findings of our study, we can first of all conclude that European health systems are experiencing a great deal of transformation and change. While most of these changes are interpreted by the RW-typology as parametric or “sub-dimensional”, the actual scope and depth of these reforms is revealed by the qualitative approach. As we hypothesised in Section 1, reform patterns and processes that were slowed down or stalled due to political and institutional rigidities at the national level were revamped (or definitively cast aside) under the new scenario opened by the crisis. Not surprisingly, then, the resulting reform patterns stand out as a mix of policy innovation and stability, defined in continuity with – or opposition to – previous policy choices and challenges. While we are not able to fully comment on the longstanding reform patterns of these countries, we developed a framework of analysis (Appendix, Section B) for dealing with the topic.

Table 3 gives an initial glance at the changes taking place in our ten cases. Looking at the defining categories of the RW-typology, very little has changed: most of what happened remained confined to the sub-dimensional level, with the sole exception of health care financing in Greece, shifting from relatively more private to relatively more societal (see below). Two sets of reasons can be advanced in response to this lack of more intriguing findings. First of all, data constraints limited our ability to measure the full effects of the changes that have taken place. Using 2011 as a cut-off point clearly is a suboptimal choice given the timing of the crisis and of the austerity packages that followed it. Unfortunately, this is a shortcoming that can only be corrected when more recent data are published in comparative datasets. Second, cases of great fragmentation, such as Greece’s hybrid system, more easily shift from one configuration to another. Even a moderate percentage change in one dimension can in fact tilt the balance towards a different sphere. A more

careful qualitative assessment is then required, to avoid overestimating the real effects of numbers dancing around a threshold.

Table 3 The 10 cases according to the RW-typology (after the crisis)

Dimensions of health care	Regulation			Financing			Provision		
	Regulation index (Böhm <i>et al.</i> 2012; own elab.)			Share of total health spending (OECD)			Share of inpatient beds (OECD-Eurostat)		
Countries	State	Society	Private	State	Society	Private	State	Society	Private
France	75.0%	15.0%	10.0%	3.6%	73.1%	23.2%	62.2%	14.1%	23.7%
	State			Society			State	(Private)*	
Germany	18.4%	50.6%	31.0%	8.6%	67.9%	23.5%	40.6%	29.6%	29.8%
	Society			Society			State	(Private)*	
Greece**	29.0%	27.0%	44.0%	23.4%	41.6%	33.4%	69.7%	2.7%	27.6%
	Private			Society			State		
Ireland	100.0%	0.0%	0.0%	66.8%	0.2%	33.0%	67.5%	16.2%	16.2%
	State			State			State	(Private)*	
Italy	85.0%	0.0%	15.0%	77.6%	0.3%	22.2%	68.5%	3.6%	27.9%
	State			State			State	(Private)*	
Lithuania**	80.0%	0.0%	20.0%	10.6%	60.8%	28.7%	99.5%	0.0%	0.5%
	State			Society			State		
Netherlands	47.5%	37.5%	15.0%	8.1%	77.5%	14.4%	0.0%	100.0%	0.0%
	State			Society			Society	(Private)*	
Romania**	70.0%	10.0%	20.0%	13.7%	65.4%	20.9%	97.1%	0.2%	2.8%
	State			Society			State		
Sweden	75.0%	0.0%	25.0%	81.6%	0.0%	18.4%	95.0%#	0.0%#	5.0%#
	State			State			State		
UK-England	80.0%	0.0%	20.0%	82.8%	0.0%	17.2%	100%	0.0%	0.0%
	State			State			State		

Data from Hermann and Flecker 2010 (no change assumed)

* Characterisation of the overall dimension by Böhm *et al.* 2012; Sweden: 2008

** All characterisations and regulation estimates have been determined by the authors in line with Böhm *et al.* 2012's methodology, on information by ASISP and HiT reports

Sources: OECD data (Eurostat data for Lithuania and Romania); Elaboration by the authors. Data are for 2011 except where indicated. For details on Regulation estimates, see Appendix, Section A and B

Our conceptualisation of the reform process (Figure 1 above) led us to focus on two main drivers of policy change: the EU leverage and national policy legacies. As we more closely compare the changes between the pre-crisis (Table 1) and the post-crisis (Table 3) scenarios, we can also check which variable best grasps the overall direction of the reforms. In accordance with the structure of Section 3, Table 4 looks at differences in the indicators by EU leverage country group. The goal of Table 4 is to integrate the comparative policy change narratives of the previous Section with the examination of available statistical evidence on reform outputs. This is especially the case

of the financing and provision dimensions, where qualitative and statistical examinations give fully consistent results. Due to the lack of any dedicated statistical source, the Regulation Index works a bit differently. As explained in the Appendix, Regulation Index values in Tables 3 and 4 are best understood as “quantifications” of the combined effect of all the shifts in actors’ roles and responsibilities previously illustrated in Section 3.

Table 4 Change 2005-11 in the three health care dimensions, by EU leverage group

Dimensions of health care	Regulation Regulation index (Böhm <i>et. al.</i> 2012; own elab.)			Financing Share of total health spending (OECD)			Provision Share of inpatient beds (OECD-Eurostat)		
	State	Society	Private	State	Society	Private	State	Society	Private
Countries under strong EU leverage									
Greece	-5.0%	+5.0%	0.0%	-6.9%	+11.8%	-6.5%	+0.1%	-0.3%	+0.2%
Ireland	0.0%	0.0%	0.0%	-8.6%	-0.3%	+9.0%	-5.0%	+2.5%	+2.5%
Romania	+5.0%	0.0%	-5.0%	+0.9%	-2.6%	+1.7%	-2.5%	+0.2%	+2.3%
Common trend?	No common trend			Reorganisation			Mild privatisation		
Countries under moderate EU leverage									
France	+5.0%	-5.0%	0.0%	+0.3%	-1.3%	+0.9%	-3.2%	0.0%	+3.2%
Germany	+7.2%	-11.0%	+3.8%	-0.9%	+0.8%	+0.1%	-2.8%	-0.8%	+3.6%
Italy	-5.0%	0.0%	+5.0%	-0.2%	+0.2%	+0.1%	-0.5%	+0.8%	-0.2%
Netherlands	-2.5%	-2.5%	+5.0%	+3.0%	+12.9%	-15.9%	0.0%	0.0%	0.0%
Common trend?	Weakening societal sphere			No common trend			Partly mild privatisation		
Countries under weak EU leverage									
Lithuania	0.0%	0.0%	0.0%	+1.1%	+2.4%	-3.5%	-0.1%	0.0%	+0.1%
Sweden*	-15.0%	0.0%	+15.0%	+0.4%	0.0%	-0.4%	-	-	-
UK-England	-10.0%	0.0%	+10.0%	+1.9%	0.0%	-1.9%	0.0%	0.0%	0.0%
Common trend?	Liberalisation			Mild renationalisation			No change		

* No updated data for provision

Sources: calculations using the data in Table 1 and Table 3

Obviously, the Memorandum countries – which we classified as “under strong EU leverage” – have enacted the most consequential reforms in terms of spending levels, financing structure, and the public/private mix of provision. As we mentioned, **Greece** is the only country that, in our account, underwent a **dimensional change**, shifting its financing dimension from prevalently private to mostly societal. We pointed out that this change may be more of a change in names than a real transformation of how money flows within the Greek system. And yet, it indicates that the financing dimension has been rationalised and its fragmentation within the Greek system reduced. On the other hand, Greece still remains a hybrid case with major holes in its regulatory framework. To make things worse, its shift towards more societal financing (and also regulation) is at odds with its current self-identification as an NHS. This starkly contrasts with the Lithuanian and the Dutch case, where increasing societal financing is to be considered fundamentally synergic with their broader SHI setup.

Looking at the broader picture, we do not see a common trend in how our three **Memorandum countries** have reformed health care **regulation**. Although they agreed to enact similar reforms, differences in specific measures (such as stricter standards and inspections in Romania, as opposed to the delegation of powers to societal actors in Greece) and in their starting conditions implied that no common trend emerged. The story is different as far as financing and provision are concerned. In the first case we see similar changes, although in different directions: we can speak of a **reorganisation of financing** pushing in country specific directions: momentarily towards the societal sphere in Greece, moderately away from it in Romania, and strongly from the state and towards the private sector in Ireland. The **provision** of inpatient services instead seems to be something along the lines of a **mild privatisation**, although too small to be fully confirmed as in the Greek case.

As we move on to countries under a **moderate EU leverage**, we see first of all a similarity in the regulation dimension. In three out of four cases (the exception being Italy, where societal actors have no role in regulation) we calculated a decrease in the relative share of regulatory powers in the hands of societal actors (a **withering societal sphere**). In France and Germany, these powers were, totally or mostly, taken up by the state, mainly in the form of more efficient cost-control tools, or through a reinforcement of state authority over choices mainstreaming the system of financing. In Germany, the shift away from the societal sphere is mainly driven by the progressive merging of the self-administered and the private systems. The new regulations have expanded the authority of the state on fiscal matters (which include pooling risks and setting contribution rates) while liberalising some organisational features of the system: fund mergers, benefit package rules, and the functioning of the pharmaceutical sector. Instead, we do **not** see a **common trend** regarding the reorganisation of health care **financing**, given especially the strong increase in the Dutch share of societal financing. Looking at **provision** instead, we see again a trend of mild privatisation at work, with a decreasing share of publicly provided beds being compensated by private (France and Germany) or non-profit (Italy) providers. Provision remained 100% non-profit in the Netherlands.

If we finally focus on the **weak EU leverage** group – which we recognised as the most autonomous and country specific in putting out its reform agendas – we see a more definite set of emerging trends. Regarding regulation, both Sweden and England shifted a great deal of authority from state decisions to market mechanisms in the subfields of market access (rules governing competition among providers and the contracting out of services), access to care (weakening or getting rid of gate-keeping), and remuneration of providers (more price-based criteria).¹⁵ While we did not register any meaningful change

¹⁵ The large shift measured in the Swedish case results from three sets of changes: the expansion of the free choice systems for primary care patients, major liberalisations enacted in the pharmaceutical sector, and the new “open organisational model” adopted for hospital mergers. In England, the value of the indicator results from measures liberalising the choice of family doctors and reinforcing pay for performance criteria in the remuneration system, from the

of direction in Lithuania, it must be stressed that the Baltic country underwent very similar reforms in the late 1990s, reaching in fact a similar regulatory mix to post-crisis England and Sweden. Very different is the situation with funding, where we seem to recognize an increase of state prerogatives across these systems, almost a **mild renationalisation of health financing**. Finally, we did see a last common factor in the absence of change regarding provision (but this partly results from data issues as well).

Table 5 Change 2005-11 in the three health care dimensions, by Regime Family

Dimensions of health care	Regulation			Financing			Provision		
	Regulation index (Böhm <i>et. al.</i> 2012; own elab.)			Share of total health spending (OECD)			Share of inpatient beds (OECD-Eurostat)		
Countries	State	Society	Private	State	Society	Private	State	Society	Private
National Health Systems									
Greece	-5.0%	+5.0%	0.0%	-6.9%	+11.8%	-6.5%	+0.1%	-0.3%	+0.2%
Italy	-5.0%	0.0%	+5.0%	-0.2%	+0.2%	+0.1%	-0.5%	+0.8%	-0.2%
Ireland	0.0%	0.0%	0.0%	-8.6%	-0.3%	+9.0%	-5.0%	+2.5%	+2.5%
UK-England	-10.0%	0.0%	+10.0%	+1.9%	0.0%	-1.9%	0.0%	0.0%	0.0%
Sweden*	-15.0%	0.0%	+15.0%	+0.4%	0.0%	-0.4%	-	-	-
Common trend?	Decrease in state authority			No common trend			Small readjustment		
Social Health Insurance									
France	+5.0%	-5.0%	0.0%	+0.3%	-1.3%	+0.9%	-3.2%	0.0%	+3.2%
Germany	+7.2%	-11.0%	+3.8%	-0.9%	+0.8%	+0.1%	-2.8%	-0.8%	+3.6%
Netherlands	-2.5%	-2.5%	+5.0%	+3.0%	+12.9%	-15.9%	0.0%	0.0%	0.0%
Lithuania	0.0%	0.0%	0.0%	+1.1%	+2.4%	-3.5%	-0.1%	0.0%	+0.1%
Romania	+5.0%	0.0%	-5.0%	+0.9%	-2.6%	+1.7%	-2.5%	+0.2%	+2.3%
Common trend?	Withering societal sphere			Mostly readjustment			Mild privatisation		

* No updated data for provision

Sources: calculations using the data in Table 1 and Table 3

If we replicate this comparative exercise by controlling for health care regimes, we can divide the sample into its SHI and NHS sub-samples, grouping countries on the basis of their regime. From this perspective, we first of all see that most of the largest shifts calculated in the table took place in the “nationally managed” NHS and in the “benefits-in-kind” SHI. Looking within each family, **NHS systems have diverged in financing**, but have had similar reform outputs with respect to the other two dimensions. Concerning **regulation**, we see a **decrease in state authority** everywhere but in Ireland, where the “exception” occurred as a result of a combination of liberalising and cost-control measures. **Small adjustments** without a clear common trend took place in the **provision** dimension, where one could still argue that a slow privatisation might be unfolding. In **SHI systems**, instead we confirmed our impression of a **withering social sphere of regulation** in Western Europe, which does not seem to be the case in the former Semashko systems of Romania and Lithuania.

adoption of the “Any Qualified Provider” approach, and from the expansion and liberalisation of Foundation Trusts. The English value is lowered instead by the increasing role of the government and of independent regulators in setting standards and ensuring compliance.

In terms of **financing**, we see mostly a **readjustment** of spending shares against which the Dutch exception once again stands out. Finally, there is an evident case of **mild privatisation** going on in the **provision** of hospital beds.

A very interesting finding is that, as we compare countries by health regime, we see almost opposite reform outcomes, with the partial exception of Lithuania and Romania. Not even Greece and Italy – which are two second-generation NHS regimes and were among the losers in the global crisis – show commonalities in their reform patterns. The point is confirmed by the fact that Germany and the Netherlands, whose reforms and reform patterns have a lot in common, actually produced quite opposite results.

In a different respect, the more fine-grained regime dimension still had an impact on the reforms in more conventional terms of policy legacies and failure-induced learning. The centralisation and decentralisation trends that fuelled many reforms within the NHS family are only conceivable against the administrative legacies of each country. So, for instance, Italy and Greece share the legacy of a failed decentralisation, which also contributed to delaying their reform record until the very last moment. At the same time, England is currently trying to redesign health and social care, integrating them at a lower level of government. Sweden, on the contrary, has long acknowledged the shortcomings of an extremely locality-centred system, and is currently trying to solve at least some of them through a perhaps ill-fated process of regionalisation. This may suggest that regime-specific legacies, while weakened by the crisis just as we expected, are less able to determine broad tendencies but are still relevant for the more fine-grained aspects of the reforms.

Finally, we can also hypothesise that health care families/regimes and EU leverage produce, in their interaction, a structuring effect on national reform patterns. So, for instance, countries under strong EU leverage became highly exposed to the imperatives of the EU because, among other reasons, they failed to enact a number of efficiency-enhancing reforms before the crisis struck. At the same time, with the partial exception of Italy, countries under moderate EU leverage did in fact enact a major health reform in the mid-2000s (2006 in the Netherlands, 2004 in France, 2007 in Germany) and tried to maintain its enactment and implementation in the stormy waters of the crisis. In so doing, they had to be more fiscally prudent than they would have otherwise been – partially to avoid the attention of EU-level policymakers. Finally, countries under weak EU leverage are also those who remained free (and able) to design and finally enact reforms that look for very specific solutions addressing past policy failures. In these three countries more than in any other, changes in government really meant a shift in the overall approach to the governance of the domestic health system. This is an interesting structuration of the patterns we traced when working on Section 3, which definitely deserves to be tested in further research.

Regardless of regime differences, a broad view of European health systems suggests a twofold and at first sight conflicting trend. On the one hand, there is growing reliance on market-based actors and mechanisms, due to fiscal

pressures on the public health budget as well as to the deliberate choice of conservatively minded policy makers. On the other, whenever budgetary issues have become alarming, governments have turned to centralised regulation and/or increased public control on decentralised spending patterns. While national regulations and decision concerning financing and provision have varied across countries, such a trend holds across regimes and levels of “EU leverage”. Its final outcome might be interpreted in two ways. First, the trend could entail a major step towards a neo-liberal state of health care, where market mechanisms are combined with very strict public budget discipline. This could be a way of depicting what has taken place in the Memorandum countries. Alternatively, such a mix of market expansion and stronger public controls could lead one to ask whether policymakers are currently following an inconsistent health care agenda. On the one hand, the dominant principles of economic and public management recommend shifting costs and responsibilities to the private sector. On the other, privatisation and liberalisation often lead to market failures (such as hidden economic and information costs) which require strong regulatory powers if cost-effectiveness is to be preserved. Governments newly expand their control, or create new bureaucracies, standards, and procedures, in order to restore efficiency within – allegedly unregulated – health markets. Here the role of the public authorities is not limited to enforcing tough budget constraints, as would be the case in a pure neo-liberal agenda. The result is the progressive emergence of country specific “hybrids”, combining market mechanisms and public regulation. These national hybrids, however, are certainly far from identifying a new policy paradigm, which would provide market expansion and public regulation with clearly defined and synergic roles. Recent policy changes which have occurred in Germany, France, and especially England would be consistent with this interpretation.

To conclude, we now consider the contributions and limitations of the present piece of research. No doubt, it is a first step towards an ambitious goal: understanding and classifying health reform patterns within the EU, while also acknowledging their effect on the traditional health system families and regimes. We believe, indeed, that this first step has been taken. We have provided a straightforward analytical framework where the effects of the EU, the impact of national legacies, the shock of the crisis, and domestic processes can easily and properly be accommodated. Furthermore, we have managed to take the best from the various typological attempts in the literature, accounting for both political-institutional typologies such as those inspired by the work of Esping-Andersen, and health-specific descriptive taxonomies such as the RW-typology. Empirically, we have traced developments in 10 EU Member States (plus the EU level itself) up to and including the most recent quantitative data and qualitative accounts. Moreover, we have built on top of the RW-typology a graphic/quantitative framework that has the potential to become, in the future, a fully-fledged tool for measuring health reform types and trends.

At the same time, we acknowledge that data limitations have been a major hurdle for our quantitative analysis. We were forced to stop in 2011, so could not appreciate most of the consequences of the austerity packages in a structured

and comparative manner. Considering options for further research, it would be interesting to deal with the domestic factor. We can safely conclude that domestic reform agendas played a key role in all the countries in our sample, and especially when the EU role was weak. However, we were forced to treat them as a residual factor. A qualitative follow up to this research, studying domestic variables within a small-N setting, could be a useful complement to the present report.

References

- Agartan T.I., Kaminska M. E. and Wendt C. (2013) Social health insurance without corporate actors: changes in self-regulation in Germany, Poland and Turkey, *Social Science and Medicine*, 86, 88-95.
- Anderson O. W. (1963) Medical care: its social and organizational aspects. Health services systems in the United States and other countries, *New England Journal of Medicine*, 269, 839-843.
- Baeten R. (2013) Evolutions récentes dans l'UE ayant un impact sur les systèmes nationaux de soins de santé, Paper Series. Briefing Paper 9, Bruxelles, OSE.
- Baeten R. (2012) Europeanization of national health systems: national impact and EU codification of the patient mobility case law, Brussels, EPSU and OSE.
- Baeten R. (2011) Past impacts of cross-border health care, in Wismar M. et al. (eds.) *Cross-border health care in the European Union: mapping and analysing practices and policies*, Observatory Study Series 22, Brussels, European Observatory on Health Systems and Policies, 255-287.
- Baeten R. and Thomson S. (2012) Health care policies: European debate and national reforms, in Natali D. and Vanhercke B. (eds.) *Social developments in the European Union 2011*, Brussels, OSE and ETUI, 187-212.
- Baeten R., Vanhercke B. and Coucheir M. (2010) The Europeanisation of national health care systems: creative adaptation in the shadow of patient mobility case law, Paper Series. Research Paper 3, Brussels, OSE.
- Baeten R. and Jorens Y. (2006) The impact of EU law and policy, in Dubois C.-A., McKee M. and Nolte E. (eds.) *Human resources for health in Europe*, European Observatory on Health Systems and Policies Series, Berkshire, Open University Press, 214-234. http://www.euro.who.int/document/e87923_13.pdf
- Bambra C. (2005a) Cash versus services: 'worlds of welfare' and the decommodification of cash benefits and health care services, *Journal of Social Policy*, 34 (2), 195-213.
- Bambra C. (2005b) Worlds of welfare and the health care discrepancy, *Social Policy and Society*, 4 (1), 31-41.
- Böhm K., Schmid A., Götze R., Landwehr C. and Rothgang H. (2012) Classifying OECD healthcare systems: a deductive approach, *TranState Working Papers* 165, Bremen, Sfb 597 'Staatlichkeit im Wandel'.
- Bonoli G. and Natali D. (eds.) (2012) *The politics of the new welfare state*, Oxford, Oxford University Press.
- Bonoli G. and Palier B. (2007) When past reforms open new opportunities: comparing old-age insurance reforms in Bismarckian welfare systems, *Social Policy & Administration*, 41 (6), 555-573.
- Borisova L.V. (2011) Health care systems as determinants of health outcomes in transition countries: developing classification, *Social Theory and Health*, 9 (4), 326-354.

- Börzel T. (2002) Member State responses to Europeanization, *Journal of Common Market Studies*, 40 (2), 193-214.
- Burau V. and Blank R.H. (2006) Comparing health policy: an assessment of typologies of health systems, *Journal of Comparative Policy Analysis*, 8 (1), 63-76.
- Cacace M. (2011) *Das Gesundheitssystem der USA: Governance-Strukturen staatlicher und privater Akteure*, Frankfurt am Main, Campus-Verl.
- Castles F.G. and Mitchell D. (1993) Worlds of welfare and families of nations, in Castles F.G. (ed.) *Families of nations: patterns of public policy in Western democracies*, Aldershot, Dartmouth, 93-128.
- Chinitz D., Wisma M. and Le Pen C. (2004) Governance and (self-)regulation in social health insurance systems, in Saltman R.B, Busse R. and Figueras J. (eds.) *Social health insurance systems in Western Europe*, Maidenhead, Open University Press, 155-169.
- Council of the European Union (2010) Council conclusions on the EPC-Commission Joint Report on health systems in the EU, 3054th Economic and Financial Affairs Council Meeting, Brussels, 7 December 2010. http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/ecofin/118273.pdf
- Council of the European Union (2013a) Council adopts cohesion policy package for 2014-2020, Press release 17826/13, 16 December 2013. http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/EN/genaff/140106.pdf
- Council of the European Union (2013b) Council conclusions on the 'Reflection process on modern, responsive and sustainable health systems', Employment, Social Policy, Health and Consumers Affairs Council meeting, Brussels, 10 December 2013. http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/140004.pdf
- Cylus J. et al. (2012) Is there a statistical relationship between economic crises and changes in government health expenditure growth? An analysis of twenty-four European countries, *Health Services Research*, 47 (6), 2204-2224.
- De la Parra S. (2013) *The two pack on economic governance: an initial analysis, Background Analysis 2013.03*, Brussels, ETUI.
- De la Porte C. and Pochet P. (2012) Why and how (still) study the Open Method of Co-ordination (OMC)?, *Journal of European Social Policy*, 22 (3), 336-349.
- Degryse C., Jepsen M. and Pochet P. (2013) *The Euro crisis and its impact on national and European social policies, Working Paper 2013.05*, Brussels, ETUI.
- Duckett S.J. (2004) *The Australian health care system*, Melbourne, Oxford University Press.
- Elling R.H. (1994) Theory and method for the cross-national study of health systems, *International Journal of Health Services*, 24 (2), 285-309.
- Esping-Andersen G. (1990) *The Three worlds of welfare capitalism*, Cambridge, Polity Press.
- European Commission (2010a) Joint report on health systems, Occasional Papers 74, Brussels, European Commission and Economic Policy Committee (AWG). http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp74_en.pdf
- European Commission (2010b) Commission staff working document, Joint Report on Social Protection and Social Inclusion, accompanying document to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. Proposal for the Joint Report on Social Protection and Social Inclusion 2010, Supporting document, SEC (2010) 98 final, 5 February 2010. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SEC:2010:0098:FIN:EN:PDF>

- European Commission (2011) The social impact of the economic crisis and ongoing fiscal consolidation. Third report of the Social Protection Committee, Luxembourg, Publications Office of the European Union.
- European Commission (2013) Social policy reforms for growth and cohesion: review of recent structural reforms 2013. Report of the Social Protection Committee, Luxembourg, Publications Office of the European Union.
- European Parliament and Council of the European Union (2011) Directive 2011/24/EU of 9 March 2011 on the application of patients' rights in cross-border healthcare, Official Journal of the European Union, L 88, 4 April 2011.
- Featherstone K. and Radaelli C. (2003) The politics of Europeanization, Oxford, Oxford University Press.
- Ferrera M. (2005) The boundaries of welfare: European integration and the new spatial politics of social protection, Oxford, Oxford University Press.
- Field M.G. (1973) The concept of the 'health system' at the macrosociological level, *Social Science & Medicine*, 7 (10), 763-785.
- Freeman R. (2000) The politics of health in Europe, Manchester, Manchester University Press.
- Freeman R. and Frisina L. (2010) Health care systems and the problem of classification, *Journal of Comparative Policy Analysis: Research and Practice*, 12 (1-2), 163-178.
- Frenk J. (1994) Dimensions of health system reform, *Health Policy*, 27 (1), 19-34.
- Frenk J. and Donabedian A. (1987) State intervention in medical care: types, trends and variables, *Health Policy and Planning*, 2 (1), 17-31.
- Frisina L. and Götze R. (2011) The changing role of the state in the Italian healthcare system, TranState Working Papers 150, Bremen, Sfb 597 'Staatlichkeit im Wandel'.
- Gekiere W., Baeten R. and Palm W. (2010) Free movement of services in the EU and health care, in Mossialos E., Permannand G., Baeten R. and Hervey T. (eds.) *Health systems governance in Europe: the role of European Union law and policy*, Cambridge, Cambridge University Press, 461-508.
- Giaimo S. and Manow P. (1999) Adapting the welfare state: the case of health care reform in Britain, Germany, and the United States, *Comparative Political Studies*, 32 (8), 967-1000.
- Gilardi F., Füglistner K., Luyet S. (2009) Learning from others: the diffusion of hospital financing reforms in OECD countries, *Comparative Political Studies*, 42 (4), 549-573.
- Glassner V. and Galgóczi B. (2009) Plant-level responses to the economic crisis in Europe, WP 2009.01, Brussels, ETUI. <http://www.etui.org/Publications2/Working-Papers/Plant-level-responses-to-the-economic-crisis-in-Europe>
- Götze R. (2010) The changing role of the state in the Dutch healthcare system, TranState Working Papers 141, Bremen, Sfb 597 'Staatlichkeit im Wandel'.
- Graziano P. and Vink M. (eds.) (2007) *Europeanization: new research agendas*, Basingstoke, Palgrave Macmillan.
- Hacker B. (2009) Hybridization instead of clustering: transformation processes of welfare policies in Central and Eastern Europe, *Social Policy & Administration*, 43 (2), 152-169.
- Hacker J. (2004) Privatizing risk without privatizing the welfare state: the hidden politics of social policy retrenchment in the united states, *American Political Science Review*, 98 (2), 243-260.
- Hall P. (1993) Policy paradigms, social learning, and the state: the case of economic policymaking in Britain, *Comparative Politics*, 25 (3), 275-296.

- Hassenteufel P. and Palier B. (2007) Towards neo-Bismarckian health care states? Comparing health insurance reforms in Bismarckian welfare systems, *Social Policy & Administration*, 41 (6), 574-596.
- Hemerijck A. (2013) *Changing welfare states*, Oxford, Oxford University Press.
- Hermann C. and Flecker J. (eds.) (2010) *Privatization of public services: impacts for employment, working conditions, and service quality in Europe*, New York, Routledge.
- HOPE (2011) *The crisis, hospitals and healthcare*, HOPE Report April 2011, Brussels, European Hospital and Healthcare Federation.
- Immergut E.M. (1992) *Health politics: interests and institutions in Western Europe*, Cambridge, Cambridge University Press.
- Joumard I., André C. and Nicq C. (2010) *Health care systems: efficiency and institutions*, OECD Economics Department Working Papers 769, Paris, OECD Publishing.
- Kaminska M.E. (2013) The missing dimension: a comparative analysis of healthcare governance in Central and Eastern Europe, *Journal of Comparative Policy Analysis: Research and Practice*, 15 (1), 68-86.
- Karanikolos M. et al. (2013) Financial crisis, austerity, and health in Europe, *The Lancet*, 381 (9874), 1323-1331.
- Marlier E. and Natali D. (eds.) (2008) *Europe 2020: towards a more social EU?*, Brussels, P.I.E. Peter Lang.
- Marmor T.R. and Okma K.G.H. (1998) Cautionary lessons from the west: what (not) to learn from other countries' experiences in the financing and delivery of health care, in Flora P., De Jong P.R., Le Grand J. and Kim J.Y. (eds.) *The state of social welfare: international studies on social insurance and retirement, employment, family policy and health care*, Aldershot, Ashgate.
- Mladovsky P. et al. (2012a) Health policy in the financial crisis, *Eurohealth*, 18 (1), 3-6.
- Mladovsky P. et al. (2012b) *Health policy responses to the financial crisis and other health system shocks in Europe*, Copenhagen, WHO Regional Office for Europe.
- Montanari I. and Nelson K. (2013) Social service decline and convergence: how does healthcare fare?, *Journal of European Social Policy*, 23 (1), 102-116.
- Moran M. (1999) *Governing the health care state: a comparative study of the United Kingdom, the United States and Germany*, Manchester, Manchester University Press.
- Moran M. (2000) Understanding the welfare state: the case of health care, *British Journal of Politics and International Relations*, 2 (2), 135-160.
- Mossialos E., Permanand G., Baeten R. and Hervey T. (eds.) (2010) *Health systems governance in Europe: the role of European Union law and policy*, Cambridge, Cambridge University Press.
- OECD (1987) *Financing and delivering health care: a comparative analysis of OECD Countries*, OECD Social Policy Studies 4, Paris, Organisation for Economic Co-operation and Development.
- OECD (1992) *Reform of health care: a comparative analysis of seven OECD countries*, Paris, Organisation for Economic Co-operation and Development.
- OECD (2010) *Value for money in health spending*, Paris, Organisation for Economic Co-operation and Development.
- OECD (2012) *Health at a glance: Europe 2012*, Paris, Organisation for Economic Co-operation and Development.
- Okma K.G.H. et al. (2010) Six countries, six health reform models? Health care reform in Chile, Israel, Singapore, Switzerland, Taiwan and the Netherlands, *Journal of Comparative Policy Analysis: Research and Practice*, 12 (1-2), 75-113.

- Pavolini E. and Guillén A.M. (eds.) (2013) *Health care systems in Europe under austerity: institutional reforms and performance*, Basingstoke, Palgrave Macmillan.
- Pavolini E., Palier B. and Guillén A.M. (2013) The health care policy quadrilemma and comparative institutional reforms, in Pavolini E. and Guillén A.M. (eds.) *Health care systems in Europe under austerity: institutional reforms and performance*, Basingstoke, Palgrave Macmillan, 193-221.
- Pierson P. (2000) *The new politics of the welfare state*, Oxford, Oxford University Press.
- Pierson P. (2004) *Politics in time: history, institutions, and social analysis*, Princeton, Princeton University Press.
- Rico A., Saltman R. and Boerma W.G.W. (2003) Organizational restructuring in European health systems: the role of primary care, *Social Policy & Administration*, 37 (6), 592-608.
- Roemer M. (1977) *Comparative national policies on health care*, New York, M. Dekker.
- Rothgang H. et al. (2010) *The state and healthcare: comparing OECD countries*, Basingstoke, Palgrave Macmillan.
- Rothgang H., Cacace M., Grimmeisen S. and Wendt C. (2005) The changing role of the state in healthcare systems, *European Review*, 13 (S1), 187-212.
- Saari J. and Kvist J. (eds.) (2007) *The Europeanisation of social protection*, Bristol, Policy Press.
- Saltman R.B. and Dubois H.F.W. (2004) Individual incentive schemes in social health insurance systems, *Eurohealth*, 10 (2), 21-25.
- Schmid A., Cacace M., Götze R. and Rothgang H. (2010) Explaining health care system change: problem pressure and the emergence of 'hybrid' health care systems, *Journal of Health, Policy, Politics and Law*, 35 (4), 455-486.
- Schmid A. and Götze R. (2009) Cross-national policy learning in health system reform: the case of diagnosis related groups, *International Social Security Review*, 62 (4), 21-40.
- Schmidt V. (2002) Europeanization and the mechanics of economic policy adjustment, *Journal of European Public Policy*, 9 (6), 894-912.
- Swartz K. (2010) *Cost-sharing: effects on spending and outcomes*, Research Synthesis Report 20, Princeton, Robert Wood Johnson Foundation.
- Terris M. (1978) The three world systems of medical care: trends and prospects, *American Journal of Public Health*, 68 (11), 1125-1131.
- Thelen K. and Streeck W. (eds.) (2005) *Beyond continuity: institutional change in advanced political economies*, Oxford, Oxford University Press.
- Thomson S., Foubister T. and Mossialos E. (2010) Can user charges make health care more efficient?, *British Medical Journal*, 341, 3759.
- Tuohy C.H. (1999) *Accidental logics: the dynamics of change in the health care arena in the United States, Britain, and Canada*, New York, Oxford University Press.
- Tuohy C.H. (2003) Agency, contract, and governance: shifting shapes of accountability in the health care arena, *Journal of Health Politics, Policy and Law*, 28 (2-3), 195-215.
- Vanhercke B. (2013) Under the radar? EU social policy in times of austerity, in Natali D. and Vanhercke B. (eds.) *Social developments in the European Union 2012*, Brussels, OSE and ETUI, 91-120.
- Vanhercke B. and Wegener L. (2012) Beyond the open method of coordination: towards hybrid governance of health care in the EU, in Cantillon B., Verschueren H. and Ploscar P. (eds.) *Social inclusion and social protection in the EU: interactions between law and politics*, Antwerpen, Intersentia.

- Wendt C. (2009) Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare, *Journal of European Social Policy*, 19 (5), 432-445.
- Wendt C. and Thompson T. (2004) Social austerity versus structural reform in European health systems: a four-country comparison of health reforms, *International Journal of Health Services*, 34 (3), 415-433.
- Wendt C., Frisina L. and Rothgang H. (2009) Healthcare system types: a conceptual framework for comparison, *Social Policy & Administration*, 43 (1), 70-90.
- WHO (2000) *The world health report 2000 - Health systems: improving performance*, Geneva, World Health Organisation.
- WHO (2013) *The world health report 2013 - Research for universal health coverage*, Geneva, World Health Organisation.

Analytical Support on the Socio-Economic Impact of the Social Protection Reforms (ASISP) reports

- Anderson K. and Backhans M. (2013) *Pensions, health and long-term care: Sweden, Country Document 2013*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Augurzky B., Schmähl W. and Tauchmann H. (2011) *Pensions, health and long-term care: Germany, Annual National Report 2011*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Axelsson R., Wadensjö E. and Baroni E. (2010) *Pensions, health and long-term care: Sweden, Annual National Report 2010*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Baroni E. and Axelsson R. (2011) *Pensions, health and long-term care: Sweden, Annual National Report 2011*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Baroni E. and Axelsson R. (2012) *Pensions, health and long-term care: Sweden, Annual National Report 2012*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Burke S. and Considine M. (2011) *Pensions, health and long-term care: Ireland, Annual National Report 2011*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Considine M. and Burke S. (2012) *Pensions, health and long-term care: Ireland, Annual National Report 2012*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Considine M. and Burke S. (2013) *Pensions, health and long-term care: Ireland, Country Document 2013*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- De Deken J. and Maarse H. (2013) *Pensions, health and long-term care: Netherlands, Country Document 2013*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Donders P. and Maarse H. (2011) *Pensions, health and long-term care: Netherlands, Annual National Report 2011*, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.

- Donders P. and Maarse H. (2012) Pensions, health and long-term care: Netherlands, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Donders P. and Van Riel S. (2010) Pensions, health and long-term care: Netherlands, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Fargion V. (2009) Pensions, health and long-term care: Italy, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Fargion V. (2010) Pensions, health and long-term care: Italy, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Gross P. (2009) Pensions, health and long-term care: Lithuania, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jankauskienė D. and Medaiskis T. (2010) Pensions, health and long-term care: Lithuania, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jankauskienė D. and Medaiskis T. (2011) Pensions, health and long-term care: Lithuania, Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jankauskienė D. and Medaiskis T. (2012) Pensions, health and long-term care: Lithuania, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jankauskienė D. and Medaiskis T. (2013) Pensions, health and long-term care: Lithuania, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jessoula M. and Pavolini E. (2011) Pensions, health and long-term care: Italy, Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jessoula M. and Pavolini E. (2012) Pensions, health and long-term care: Italy, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Jessoula M. and Pavolini E. (2013) Pensions, health and long-term care: Italy, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Morel N., Naczyk M. and Palier B. (2009) Pensions, health and long-term care: France, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Morel N., Naczyk M. and Palier B. (2012) Pensions, health and long-term care: France, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Naczyk M., Morel N. and Palier B. (2013) Pensions, health and long-term care: France, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Ó Cinnéide S. (2009) Pensions, health and long-term care: Ireland, Annual National Report 2009, Asisp

- Ó Cinnéide S. and Considine M. (2010) Pensions, health and long-term care: Ireland, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Palier B., Naczyk M. and Morel N. (2010) Pensions, health and long-term care: France, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Palier B., Naczyk M. and Morel N. (2011) Pensions, health and long-term care: France, Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Petmesidou M. (2009) Greece: Pensions, health and long-term care, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Petmesidou M. (2010) Greece: Pensions, health and long-term care, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Petmesidou M. (2011) Greece: Pensions, health and long-term care, Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Petmesidou M. (2012) Greece: Pensions, health and long-term care, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Petmesidou M. (2013) Greece: Pensions, health and long-term care, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Schmähl W., Augurzky B. and Mennicken R. (2012) Germany: Pensions, health and long-term care, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Schmähl W., Augurzky B. and Mennicken R. (2013) Germany: Pensions, health and long-term care, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Schmähl W., Wille E. and Erdmann D. (2009) Germany: Pensions, health and long-term care, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Schmähl W., Wille E. and Erdmann D. (2010) Germany: Pensions, health and long-term care, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Seeleib-Kaiser M. (2009) United Kingdom: Pensions, health and long-term care, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Seeleib-Kaiser M. (2010) United Kingdom: Pensions, health and long-term care, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Seeleib-Kaiser M. (2011) United Kingdom: Pensions, health and long-term care Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Seeleib-Kaiser M. (2012) United Kingdom: Pensions, health and long-term care, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.

- Seeleib-Kaiser M. (2013) United Kingdom: Pensions, health and long-term care, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Wadensjö E. and Axelsson R. (2009) Sweden: Pensions, health and long-term care, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Zaman C. (2009) Romania: Pensions, health and long-term care, Annual National Report 2009, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Zaman C. (2010) Romania: Pensions, health and long-term care, Annual National Report 2010, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Zaman C. (2011) Romania: Pensions, health and long-term care, Annual National Report 2011, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Zaman C. (2012) Romania: Pensions, health and long-term care, Annual National Report 2012, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.
- Zaman C. (2013) Romania: Pensions, health and long-term care, Country Document 2013, Cologne, Analytical Support on the Socio-Economic Impact of the Social Protection Reforms.

Health Systems in Transition (HiT) series - Reports

- Anell A., Glengård A.H. and Merkur S. (2012) Sweden: health system review, Health Systems in Transition, 14 (5), 1-159.
- Boyle S. (2011) United Kingdom (England): health system review, Health Systems in Transition, 13 (1), 1-514.
- Busse R. and Riesberg A. (2005) Gesundheitssysteme im Wandel: Deutschland, Kopenhagen, WHO Regionalbüro für Europa im Auftrag des Europäischen Observatoriums für Gesundheitssysteme und Gesundheitspolitik.
- Economou C. (2010) Greece: health system review, Health Systems in Transition, 12 (7), 1-204.
- Chevreul K., Durand-Zaleski I., Bahrami S., Hernández-Quevedo C. and Mladovsky P. (2010) France: health system review, Health Systems in Transition, 12 (6), 1-326.
- Lo Scalzo A., Donatini A., Orzella L., Cicchetti A., Profili S. and Maresso A. (2009) Italy: health system review, Health Systems in Transition, 11 (6), 1-243.
- McDaid D., Wiley M., Maresso A. and Mossialos E. (2009) Ireland: health system review, Health Systems in Transition, 11 (4), 1-298.
- Murauskiene L., Janoniene R., Veniute M., van Ginneken E. and Karanikolos M. (2013) Lithuania: health system review, Health Systems in Transition, 15 (2), 1-179.
- Schäfer W., Kroneman M., Boerma W., van den Berg M., Westert G. and Devillé W. (2010) The Netherlands: health system review, Health Systems in Transition, 12 (1), 1-267.
- Vladescu C., Scîntee G. and Olsavszky V. (2008) Romania: health system review, Health Systems in Transition, 10 (3), 1-206.

All links were checked on 4 November 2014.

Appendix

A. The RW typology and policy change

Table 6 Deductive classification of health care systems, according to the RW-typology

Health System Type	Regulation	Financing	Provision
National Health Service	State	State	State
Non-profit National Health System	State	State	Societal
National Health Insurance	State	State	Private
State based mixed-type III	State	Societal	State
State based mixed-type IV	State	Private	State
State based mixed-type V	Societal	State	State
State based mixed-type VI	Private	State	State
Social Health System	Societal	Societal	Societal
Etatist Social Health System	State	Societal	Societal
Social Health Insurance	Societal	Societal	Private
Societal-based mixed-type IV	Societal	State	Societal
Societal-based mixed-type V	Societal	Societal	State
Societal-based mixed-type VI	Societal	Private	Societal
Societal-based mixed-type VII	Private	Societal	Societal
Private Health care Idealtyp	Private	Private	Private
Etatist Private Health System	State	Private	Private
Corporatist Private Health System	Societal	Private	Private
Private-based mixed-type VI	Private	State	Private
Private-based mixed-type V	Private	Private	State
Private-based mixed-type VI	Private	Societal	Private
Private-based mixed-type VII	Private	Private	Societal
Etatist Social Health Insurance	State	Societal	Private
Pure mixed-type II	State	Private	Societal
Pure mixed-type III	Private	State	Societal
Pure mixed-type IV	Private	Societal	State
Pure mixed-type V	Societal	State	Private
Pure mixed-type VI	Societal	Private	State

Source: adapted from Böhm, *et al.* 2012: 8; 12

The proponents of the RW-typology have derived from previous studies the intuition that health systems are developed along three dimensions: regulation, financing and provision. Their multi-dimensional approach, combined with a “who-does-what” actor-centred perspective, accounts well for several types of policy change. We illustrate this point by showing how Peter Hall’s influential distinction between first-, second- and third-order

types of *change* (Hall 1993) can be accommodated by the model. Such an exercise can serve as a clarification of how we interpret some of the country trajectories under analysis.

To begin with, Table 6 shows the 27-case deductive taxonomy originally proposed in Rothgang *et al.* 2009, integrated with the theoretical refinements suggested in Böhm *et al.* 2012, which called into question the empirical plausibility of most hybrid system types. Among the “plausible” systems in the refined typology, we find three ideal-typical setups, where all dimensions share the same value: a prototypical NHS or socialist system (state-state-state); an idealised social insurance system (societal-societal-societal); and a fully deregulated private insurance system (private-private-private). In addition, an idealtypical hybrid system (state-societal-private) appears in the lowest part of the table. Each idealtype comes together with a group of health systems that share its same “preference” for either the state, society, or the market, which result dominant in two out of three dimensions. The hybrid idealtype individuates instead a group of similarly heterogeneous systems. The majority of these configurations, most notably all the other “pure-mixed” types, are theoretically expected to be unsustainable: only two variants in each of the first three groups are deemed stable.¹⁶

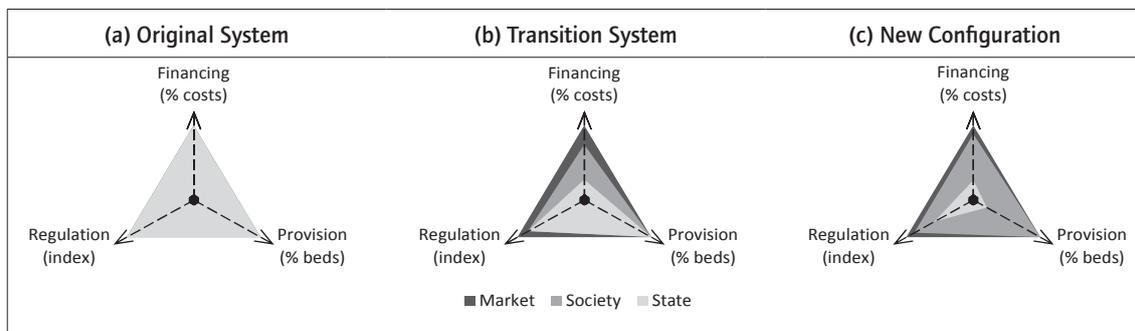
Here, we are not interested in how well these deductive types fit real world systems, but in the way the structure of the table can be used to describe different sorts of policy change. That is why we refer to Peter Hall (1993). A case of first-order – or **paradigmatic** – change would be captured by the RW-typology as a shift between rows of different shades of gray. Such a major change would most likely stem from a sum of changes in various dimensions (e.g.: a socialist system that is undergoing a transition to the market economy). A second-order – or **instrumental** – change would instead appear as a shift among rows of the same colour (or, if you prefer, quarter). Such a change would in most cases be limited to a single dimension. On the contrary, a third-order – or **parametric** – change would unfold as a sub-dimensional alteration, unable to affect how the overall dimension is governed and thus to produce a row-shift in the table. Finally, the recently introduced distinction between “plausible” and “implausible” systems adds a new perspective to the approach. To the extent that real-world changes, paradigmatic or instrumental, can turn well configured systems into “implausible” ones, the political sustainability of the reforms can become an object of normative analysis.

¹⁶ These are systems in which the collective management of health responsibilities is not deemed incompatible with the hierarchical relation between regulation, financing, and provision. Whereas the original RW-typology was not interested in the empirical likelihood of any “type”, Böhm and her co-authors contend that “mixed types” can only exist in practice if their “level of collectivisation” (state > society > private) respects the “hierarchical interdependence” between health dimensions (regulation > financing > provision). Health system types, so the argument goes, are “plausible” if and only if their level of collectivisation falls or stays the same when moving down from a superior to a subordinate dimension. While the state can easily regulate societal/private financing agencies/providers, market-based regulation can hardly govern tax-financing or administer non-profit hospitals. See Böhm *et al.* 2012: 11-13.

Graphing the typology

We now provide a graphical representation of how health systems are conceptualised by the RW-typology. Systems are portrayed as triangular areas, unfolding along the three axes of regulation, financing, and provision, ranging from 0% to 100%. The light gray area represents the role of state actors, the medium gray one that of societal actors, and the heavy gray one that of private ones. The vertices of each triangle show on the relative axis the pertinent shares of regulation, financing, and provision. For a graphical convention, the light gray area spreads from the origin, while the others are added to it, acting as a supplement and a top-up. Figure 6 uses this methodology to stage a fictitious example, which may help to clarify how we use the RW-typology in this report.

Figure 6 A fictitious policy trajectory



Source: elaboration by the authors

In its original state – panel (a) – this fictitious case was akin to an *ideal-typical NHS* or, alternatively, to a socialist Semashko system: the state was in full control of regulation, financing, and provision. This corresponds to the first row of Table 6. With the passing of time, the original system underwent an important reform – panel (b). New legislation brought about a second-order change and financing mostly became societal and partly private. In addition, a liberalisation of the old gate-keeping system also introduced a sub-dimensional change in regulation. The system has become a *State based mixed-type III* and moved to the fourth row of Table 6. Normatively speaking, such a configuration entailed a risk of instability/fragmentation. It could thus be expected to experience coordination problems between financing and provision, and/or undergo further changes.

In fact, another second order change took place, further reinforcing the role of the societal sphere in the system. Public hospitals were privatised, but the ban on for-profit providers was not lifted. As a result, the sickness funds momentarily entered in the dimension of service provision, further restricting the role of the state. At the same time, the funds also acquired a greater say on patient access to specialist care and, say, on the fixation of part of the payroll tax. While the state remained the most influential regulator, the funds claimed a share of the regulatory space that had been momentarily left to the markets. The system thus reached its final configuration as an *Etatist Social*

Health System (ninth row in Table 6), finding new institutional consistency. In other words, two consistent second-order changes in a row cumulatively produced a paradigmatic transformation. At the same time, two opposing parametric changes fell just a bit short of producing a deeper change of regulatory instruments. In sum, each sphere found a dimension of health care to cultivate and the outlook for private health plans is positive. Should their role in financing unexpectedly grow, for instance due to a change in employers' preferences, than the system could suffer again from inconsistencies between financing and provision. The risk, however, seems fairly low.

In conclusion, it must be stated that a similar reform trajectory is an extremely rare occurrence in the path dependent world of health care systems. Nonetheless, the RW-typology helped us to trace, understand, and synthetically present a complex set of multi-dimensional changes of different magnitude, taking into account their incremental or disruptive relation and their effect on the overall consistency of the health system. The second part of the Appendix will further elaborate on which data and operational choice are needed to enrich the RW-typology with a graphical dimension.

B. The RW-typology: operationalisation and measurement

Within the RW-typology, **regulation** is defined as the set of relations that exists between “financing agencies, providers, and (potential) beneficiaries” (Rothgang *et al.* 2005). Six sub-dimensions or “objects of regulation” are then distinguished within regulation (Figure 7). For each “object”, the typology asks and qualitatively discerns what actor/sphere is responsible for regulation and control and/or whether the relation is governed through hierarchies, networks, or markets. **Financing** and **provision** are self-explanatorily defined as the offering of health goods and services and the collection of funds necessary to fuel these activities.

Figure 7 Objects of regulation

<p>Relations between (potential) beneficiaries and financing agencies:</p> <ol style="list-style-type: none"> 1. <i>Coverage</i>: the inclusion of (parts of) the population in public and/or private health care systems 2. <i>System of financing</i>: the financing of health care by public and/or private sources
<p>Relations between financing agencies and service providers:</p> <ol style="list-style-type: none"> 3. <i>Remuneration of service providers</i>: the specific system of provider compensation 4. <i>Access of (potential) providers to health care markets</i>: access to financing agencies
<p>Relations between service providers and (potential) beneficiaries:</p> <ol style="list-style-type: none"> 5. <i>Access of patients to service providers</i>: the specific delivery of care to patients 6. <i>Benefit package</i>: the content and range of services offered to patients

Source: Rothgang *et al.* 2010:14; Böhm *et al.* 2012: 9

Indications in the literature

When assessing the public, societal, and private involvement in **regulation**, Böhm and her co-authors decided to exclude “coverage”, which they considered as an exclusive competence of the highest levels of government. Having qualitatively attributed to the state, society, or the private sector the other five sub-dimensions, they created an **index of regulation** by giving each sphere one point for each “object” it fully governs, or a fraction of point (half or one third) in case of concurrent values. They then attributed the whole dimension to the actor with the highest score.

For the qualitative assessment, they employed the following methodology. They dealt with “system of financing” as they would have done with the financing dimension (see below), but considered in addition whether social contribution tax rates were autonomously determined by the health funds, or by executive or legislative bodies. Only in the first case did they acknowledge it as societal. Similarly, they assigned the “remuneration of service providers” to the actor in charge of negotiating prices with the providers. Most notably, they evaluated the inpatient and out-patient sector separately, occasionally assigning two concurrent values. For “access of potential providers to health care markets”, they similarly distinguished between the inpatient and out-patient sector. They attributed market access regulation: to the state, in presence of an explicit planning system; to society, in cases of autonomous decisions by the insurance funds or negotiations with providers’ associations; and to the private sector, in case of unrestricted access. As regards patient access, once again distinguishing between inpatient and out-patient services, they classified it as: state, in case of no free choice (or of strong incentives to forgo it); societal, if similar restrictions are imposed by social insurance funds; state/market, when a public *gatekeeping* system is in place, but the choice of general practitioners is free; and private, if no restrictions exist. Finally, they classified “benefit package” as: state, when the scope of services is, *de jure* or *de facto*, in the hands of public authorities; societal, when social funds or societal actors autonomously contribute to defining the package; and private, when there is no mandatory package and private insurance/service providers compete on benefit scope.

Now we turn to the other two dimensions. State financing consists of general or earmarked taxes which do not constitute a direct entitlement to health care. The societal sphere features, instead, earnings-related contributions, which give access to health insurance within a non-public quasi-fiscal system where individual risks are pooled together. Private insurance contributions calculated on the basis of individual risk profiles, as well as the various sorts of user charges, all represent the private sector of this dimension. The public, societal, or private nature of service provision depends instead on the provider’s ownership status: public, non-profit, or for profit. For dealing with the issue, Rothgang and his co-authors (2010: 57-59) developed three “service provision indexes”. To calculate them, one must look at the quota occupied by each sphere in four health sectors: on one side, inpatient care, measured by the number of inpatient beds by hospital ownership; on the other, out-patient

care, dental care, and the pharmaceutical sector, measured as the density, by employment status, of physicians, dentists, and pharmacists. Averaging the respective quotas, weighted by the share of health spending paid to each sector, suffices to produce the indexes.

How we proceeded

We followed the indications above to produce the information shown in Table 1 and Table 3. To gain a better understanding of the long-term trajectories taken by our 10 countries, we also replicated our analysis using the earliest data available in the OECD and Eurostat datasets. In so doing, we could compare countries over time throughout three periods: the earliest data available, meant to capture the legacy of the health care “model” or “regime”; the mid-2000s, corresponding to the pre-crisis wave of reforms; and the early 2010s, the current post-crisis scenario. We also attempted a graphical representation of these three snapshots, using so-called radar charts, or spidergrams (Table 7). So, for each country, panel (a) represents the legacy of the original health “regime”, panel (b) the pre-crisis scenario of Table 1, and panel (c) the post-crisis situation of Table 3. What follows is an account of the elaborations, assumptions, and conventions we adopted to maximise the validity of the analysis, under the existing data and time constraints.

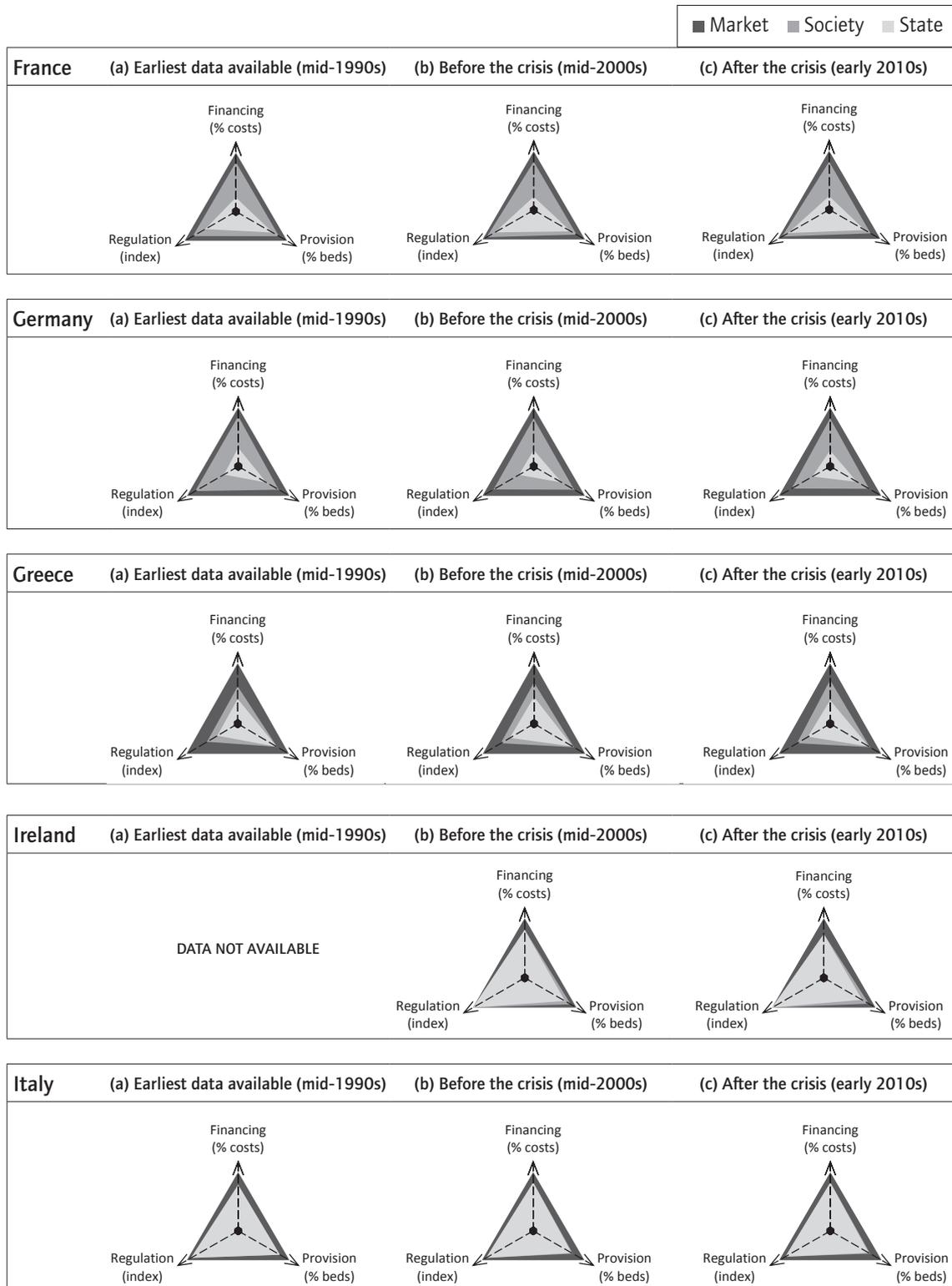
In the case of **financing**, following the guidelines was straightforward. We calculated the public, societal, and private shares of total spending for almost all countries with OECD and Eurostat data. We only faced missing values when collecting data for the first graphs, meant to capture the legacy of the regimes. In the Dutch care, data availability issues forced us to use, all along, current rather than total expenditure figures (which, however, amount to more than 92% of total spending). In general, we used 1995 data as the earliest available, but made an exception with Lithuania and Romania: to them, we assigned 100% to the state in every dimension in order to represent the socialist Semashko model. In the Greek case, we had to estimate the relative shares of public and societal financing and we did so by applying the ratio we found in the earliest disaggregated figures available.

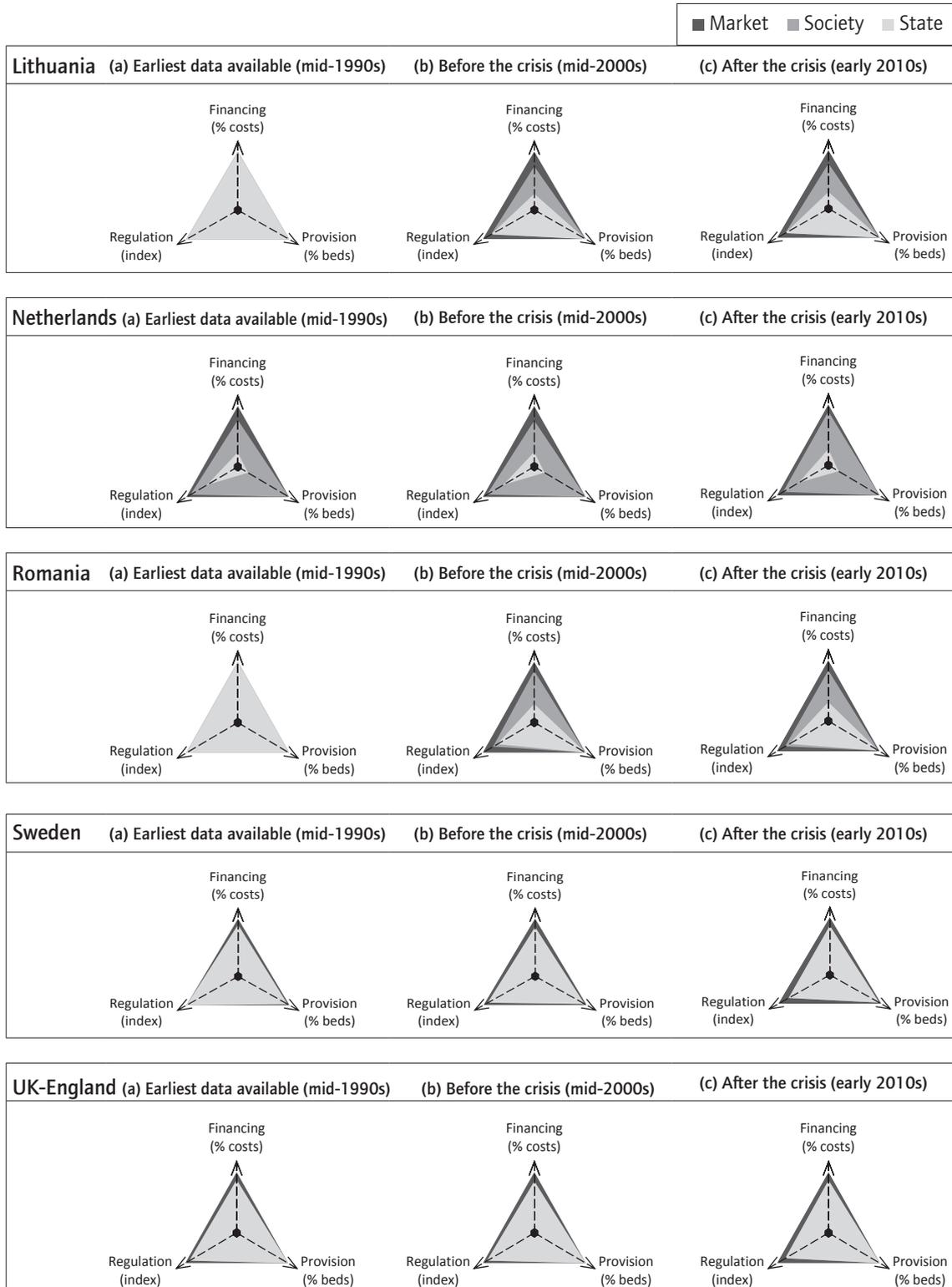
Data issues were more pressing with **provision** and prevented us calculating overall “provision indexes” for a satisfactory number of countries. Therefore, we resolved to circumscribe the analysis to the inpatient sector, which is the most relevant for the present report and typically absorbs the greatest share of a country’s health spending. Even by looking at the inpatient sector alone, we encountered missing data. We had to rely on 1997 data (2000 data for UK-England) for graphs (a). For Sweden, we referred to Hermann and Flecker (2012: 94), reporting data for 2007. In order to be able to graphically represent these cases, we assumed no change occurred: a bold but not implausible assumption, considering the reform record of the two countries. In a similar fashion, in the German case we used the same data in both panels (a) and (b). In the Italian case, data on provision for the first graph came from Pavolini and Guillén (2013: 219) and refer to 1990. Data for the Dutch graph (c) and

the Dutch values in Table 3 refer to 2009, instead of 2011. For Ireland, we did not draw any panel (a), since we could not come up with reliable estimates to impute. Irish data in Table 1 and panels (b) were taken from Brick *et al.* 2010 and HSE 2008 and refer to 2007. Confronted with the typical erratic trends in Irish bed availability, we calculated 2011 figures for Table 3 and panels (c) as follows. First, we accessed public hospital beds data on the HSE website. The figures for 2007 did not correspond to what was reported, with a greater level of clarity and precision, in HSE 2008. So, we used the website data only to calculate the 2007-2011 difference (-883 beds), and then subtracted it from the 2007 value in HSE 2008. Second, we distributed in equal shares between the non-profit and for-profit sector a planned increase of 770 beds reported in our sources. Even against the risk of overestimating the increase of non-public provision, this choice seemed the most in line with available evidence.

In dealing with **regulation**, we followed the results in Böhm and her co-authors (2012: 33-69), which we acknowledge as an accurate description of the latest pre-crisis scenario. Following their indications, we replicated the analysis on Greece, Lithuania, and Romania using the latest HiT reports available from WHO. The most puzzling “objects of regulation” in Greece’s fragmented system were “system financing” and “benefit package”. To classify these sub-dimensions, we scored points on the regulatory index in proportion to the public, societal, and private financing shares. Finally, we rescaled the three resulting scores as percentages, in order to make them consistent with the values for financing and provision. Having achieved a complete set of figures for Table 1 and panels (b), we moved on to characterising the preceding snapshot for panels (a). We did so by purging the pre-crisis scenario from the effects of the regulatory reforms of the 1990s. Once again, in Lithuania’s and Romania’s past Semashko systems, we considered regulation to be fully governed by the state. As we reran the analysis on the post-crisis scenario (panels (c)), we opted for a more forward-looking perspective, necessary to cope with the early stage and/or unclear effects of many reforms. Putting more emphasis on the direction of change, rather than its effects, we slightly revised the scoring system, making it more sensitive to sub-dimensional changes. For each new provision that redistributed regulatory powers relevant for any of the five “objects of regulation”, we also shifted 5% (10% for more encompassing reforms) from the sphere whose authority have been restrained to that which has been empowered.

Table 7 Graphic representations of health care system trajectories in selected EU countries





Source: see above; See Table 1 and Table 3

C. The “EU leverage index”

Table 8 The “EU leverage index”: calculations and results

Country	Criteria MoUs	Country-specific Recommendations			€-zone Member	EDP/ EPP	Final Index Score	EU leverage*
		2011	2012	2013				
France	-	-	-	+1	+1	+1	3	Moderate
Germany	-	+1	+1	+1	+1	+1	5	Moderate
Greece	Y	-----NOT RELEVANT-----						Strong
Ireland	Y	-----NOT RELEVANT-----						Strong
Italy	-	-	-	+0.5	+1	+1	2.5	Moderate
Lithuania	-	-	-	-	-	+1	1	Weak
Netherlands	-	+0.5	+0.5	+0.5	+1	+1	3.5	Moderate
Romania	Y	-----NOT RELEVANT-----						Strong
Sweden	-	-	-	-	-	-	0	Weak
UK-England	-	-	-	-	-	+1	1	Weak

Calculation of the index:

- a) If one or more MoUs were signed by the country, we considered it sufficient to indicate a strong EU leverage;
- b) If no MoU was signed, we distinguished between **weak** and **moderate** EU leverage. We assigned:
 - b.1) +1 point for each year it received a Country-specific Recommendation (+0.5 if the recommendation only dealt with LTC);
 - b.2) +1 point for Euro-zone member countries;
 - b.3) +1 point for countries under EDP/EPP for one or more years.

* Value range: 0-5. Values ≥ 2.5 are classified as **Moderate**, values < 2.5 as **Weak**

Source: elaboration by the authors

The index is calculated as a simple sum, as shown in Table 8. As explained in footnote 4, it is best understood analytically as an indication of how much national and supranational decision making have been entwined in the 2008-2013 period. It takes into account whether EU pressures directly address the health system (Memorandums and CSRs) or not (Eurozone membership and Excessive Deficit Procedures or Partnership Programmes) and whether they come with explicit sanctioning mechanisms (Memorandums and Excessive Deficit Procedures) or not (CSRs and euro-membership). It is time invariant and not meant to capture the evolution of EU governance in the years under scrutiny, which is the topic of Section 2. So, here we sum together CSRs put forward in different years, interpreting them as multiple observations on one same ongoing phenomenon.

List of acronyms and abbreviations

AGS	Annual Growth Survey (EU governance)
AMNOG (Germany)	Gesetz zur Neuordnung des Arzneimittelmarktes (Law Reorganising the Pharmaceutical Market)
ANAES (France)	National Agency for Accreditation and Evaluation in Health
AO(s) (Italy)	Aziende Ospitaliere (Hospital Trusts)
ARH(s)	Agences Régionales d'Hospitalisation (Regional Hospital Agencies)
ARS(s)	Agences Régionales de Santé (Regional Health Agencies)
ASL(s)	Aziende Sanitarie Locali (Local Health care Agencies)
AWBZ (Netherlands)	Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act)
CAPI	Contract for Improvement of Individual Practices
CMU (France)	Universal Sickness Coverage (schema)
CNAM (France)	Caisse Nationale d'Assurance Maladie (National Sickness Insurance)
CNAMTS (France)	Caisse nationale de l'assurance maladie des travailleurs salariés (National Sickness Insurance Fund for the Salaried Workers)
CNAS (Romania)	National House for Health Insurance
CNSA (France)	Caisse nationale de solidarité pour l'autonomie
CSG (France)	Contribution sociale généralisée
CSR(s):	Country-specific Recommendation(s)
DEF	Document of Economy and Finance
DRG(s)	Diagnosis Related Group(s) (cost control mechanism)
EC	European Commission
ECB	European Central Bank
EDP	Excessive Deficit Procedure (EU governance)
EOF (Greece)	National Organisation of Medicines (regulator)
EOPYY (Greece)	National Health Services Organisation (national SHI fund)
ESY (Greece)	The Greek "NHS"
EU	European Union

F4S	Fee-for-service
FPFZG (Germany)	Familienpflegezeitgesetz (Family Care Law)
FSI(s) (Italy)	Fondi Sanitari Integrativi (Supplementary Health Funds)
G-BA (Germany)	Gemeinsamer Bundesausschuss (Federal Joint Committee, regulator)
GDP	Gross Domestic Product
GKV(s)	German for SHI(s)
GKV-ÄndG (Germany)	GKV-Änderungsgesetz (Law on the Change of the SHI)
GKV-FinG (Germany)	GKV-Finanzierungsgesetz (Law on Financing the SHI)
GKV-Spitzenverband (Germany)	National Association of SHI Funds
GKV-VStG (Germany)	GKV-Versorgungsstrukturgesetz (Law on the Change of the SHI)
GKV-WSG (Germany)	GKV-Wettbewerbsstärkungsgesetz: (Law to reinforce competition among SHIs)
GP(s)	General Practitioner(s) (health professional)
HAS (France)	Haute Autorité en Santé (regulator)
HCP (Ireland)	Home Care Packages (LTC provisions financed by the HSE)
HCSA (Germany)	Health Care Structure Act (reform law)
HIA (Ireland)	Health Information Authority (regulator)
HIA (Netherlands)	Health Insurance Act (Zorgverzekeringswet)
HIQA (Ireland)	Health Information and Quality Authority
HPST (France)	Loi Hôpital, Patients, Santé, Territories (reform law)
HSE (Ireland)	Health Service Executive (public service)
HTA	Health Technological Assessment
IKA (Greece)	Social Insurance Fund for Private Employees
IMF	International Monetary Fund
IQWiG (Germany)	Institute for Quality and Efficiency of Care
IRP	International Reference Pricing (cost control mechanism)
ISD (Ireland)	Integrated Service Directorate
ISP (Italy)	Internal Stability Pact (National economic governance)
KHRG (Germany)	Krankenhausfinanzierungsreformgesetz (Hospital Financing Reform Act)
KVBeitrSchG (Germany)	Gesetz zur Beseitigung sozialer Überforderung bei Beitragsschulden in der Krankenversicherung (Law for the removal of excessive demands for outstanding health insurance premiums)
LEA(s) (Italy)	Essential Level(s) of Assistance (standards)
LFSS (France)	Loi de Financement de la Sécurité sociale (Social Security Financing Law)

LICA (Netherlands)	Long-term Intensive Care Act (Wet LIZ)
LTC	Long-term care (health-related)
MDK (Germany)	Medical Review Board of the SHI funds (regulator)
MFtP (Ireland)	Money Follows the Patient (funding model)
MNC(s)	Multinational Corporation(s) (stakeholder)
MoU(s)	Memorandum(s) of Understanding
NCHA (Romania)	National Commission for Hospital Accreditation (regulator)
NDF (Italy)	Fondo Nazionale per la Non-Autosufficienza (National Dependency Fund)
NHA (Netherlands)	Netherlands Healthcare Authority (regulator)
NHCI (Netherlands)	National Health Care Institute (Zorginstituut Nederland)
NHIF (Romania)	National Health Insurance Fund
NHP(s) (Italy)	Piano Sanitario Nazionale (National Health Plan)
NHS	National Health System (model) / National Health Service (UK: public service)
NHSS (Ireland)	Nursing Home Support Scheme
NRP(s)	National Reform Programme(s)
NTPF (Ireland)	National Treatment Purchase Fund (occupational SI fund)
OAEE (Greece)	Social Insurance Fund for Private Sector Pensioners (occupational SI fund)
OMC	Open Method of Coordination (EU Governance)
OoP	Out-of-pocket (payment/spending)
P4P	Pay for Performance (criteria)
PCT(s) (UK)	Primary Care Trust(s)
PfWG (Germany)	Pflegeweiterentwicklungsgesetz (LTC reform law)
PHI	Private Health Insurance (model; Germany: private insurance plan)
PNG	Pflege-Neuausrichtungsgesetz (LTC Renewal Law)
PRS	Plan Stratégique Régional de Santé
PST	Pacte santé territoire (Territory Health Pact)
RMHCA (Greece)	Regional Management Health Care Agencies
SCP(s)	Stability and Convergence Programme(s)
SDIT (Greece)	Private Finance Initiatives (partnership)
SF(s) (Germany)	Sickness Fund(s)
SI	Social Insurance (model)
SHI	Social Health Insurance (model)

SHIF (Lithuania)	State Health Insurance Fund
SPC	Social Protection Committee (European Commission)
SPF (Lithuania)	State Patient Fund
SRA(s) (Italy)	State-regions Agreements (National economic governance)
T2A (France)	Tarification à l'Activité
UK	United Kingdom
USL(s) (Italy)	Unità Sanitarie Locali (Local Health care Authorities)
YPE	Health Region Administrations (local government)
WB	World Bank
Wmo (Netherlands)	Social Support Act