

Health care policies: European debate and national reforms

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Introduction

Direct intervention in national health systems by multilateral organisations has until recently been the preserve of developing countries undergoing Structural Adjustment Programmes in return for World Bank and IMF loans. Following the economic crisis in the euro area, European Union (EU) countries have experienced something similar. In 2010 and 2011, the governments of Greece, Ireland and Portugal received financial assistance from the IMF, the European Commission and the European Central Bank (together known as the 'troika') after agreeing to engage in economic adjustment programmes. As part of these agreements they must take a wide range of actions in the health sector.

The troika's interventions are in line with other initiatives through which the EU is increasingly addressing health system reform (in all Member States) in the context of *macroeconomic policy*. To strengthen the governance of economic policy in the wake of the financial crisis triggered in 2007, economic actors in the EU have developed instruments that target national health care policies from a public finance perspective and stress the need for greater control over public spending on health.

These developments are remarkable given the vigour with which Member States have generally attempted to safeguard health care from

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EU interference. The dominant economic EU level approach has provoked national policy makers responsible for health to react through the Council and to stress the importance of investing in health care and the health system's contribution to achieving EU goals.

In this chapter we examine how these developments have come about, both in policy *approach* and *content*. We also review recent EU guidance on health care policy to see if there is a clear and consistent discourse on health system reform, and consider the extent to which this discourse has been reflected in national reform processes in the last two to three years. Finally, we discuss policy implications.

1. The EU's approach to health system reform: context and instruments

This section examines how guidance on health system reform has found its way into EU macroeconomic policies and outlines the response from health and social actors to this change in *approach*.

1.1 Health system reform embedded in EU economic governance

Controlling public expenditure on health has long been a theme in EU coordination of macroeconomic policies. The Broad Economic Policy Guidelines (BEPGs) issued by the Ecofin Council² (in the context of the Stability and Growth Pact adopted in 1997) have always encouraged Member States to review their health systems in the light of population ageing. The most recent guidelines (2010-2014) urge Member States to improve the sustainability of public finances, partly through reform of age-related public expenditure on pensions and health care, and also to ensure that this expenditure is financially viable, socially adequate and accessible (Council of the European Union, 2010a). Until recently, however, this type of EU guidance has been general and non-prescriptive.

The financial crisis exacerbated pressure on Member States' public finances, leading to renewed efforts to strengthen economic policy

2. Council configuration of EU ministers for economic and financial affairs.

coordination.³ These efforts include a new working method (the European Semester for economic policy coordination), the Euro Plus Pact, two legislative processes known as Six Pack and Two Pack, and the EU-IMF joint adjustment programmes in Greece, Ireland and Portugal.

Set up with effect from 2011, the European Semester for economic policy coordination aims to ensure coordinated action on key policy priorities at EU level. Under the Semester, 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. Where national governments fail to follow recommendations within the given timeframe, the EU can issue policy warnings and, ultimately, enforce compliance through incentives and sanctions.

The Semester incorporates existing procedures (such as the BEPGs) but has a stricter timeframe and process for follow up. It reviews Member States' budgetary and structural policies during a six-month annual cycle to detect inconsistencies and emerging imbalances. The cycle starts in January with 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 Council⁴ identifies the main economic challenges facing the EU and gives strategic advice on policies.

Contrary to expectation, given previous economic policy documents and the economic climate, the 2011 AGS did not deal with health care (European Commission, 2011a). At the end of 2010 the European Commission and the Economic Policy Committee (EPC)⁵ published a Joint Report on Health Systems (see below). It was issued in an attempt to push for the inclusion of health system reforms in 'Europe 2020' (the EU's growth strategy) and to submit reforms to macroeconomic surveillance⁶.

3. For a more comprehensive analysis of the new economic governance tools, see the chapter by Christophe Degryse and Philippe Pochet in this volume.

4. Composed of Heads of State or Government of the Member States.

5. 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.

6. Interview with the chair of the EPC, 4 August 2011.

The Ecofin Council's conclusions on the Joint Report invited the Member States and the Commission to 'factor these findings into its analysis and proposals in the framework of the Europe 2020 strategy', giving the Commission its desired mandate for action (Council of the European Union, 2010b). Health care was subsequently included in the 2012 AGS.

The European Semester also incorporates the National Reform Programmes (NRPs)⁷ and Stability and Convergence Programmes (SCPs)⁸ which Member States have had to draft annually in the context of the Stability and Growth Pact. Member States now send both of these documents to the European Commission in April each year. The Ecofin Council now issues its country-specific recommendations on the NRPs and SCPs in June or July. The Council also issues country-specific guidance to countries whose policies and budgets are out of line, before national budgets for the following year are finalised (Council of the European Union, 2010c).

In March 2011 euro area Heads of State or Government and six other Member States agreed on the Euro Plus Pact (European Council, 2011). This aims to strengthen further the economic pillar of monetary union and includes more ambitious and concrete commitments and actions, accompanied by a timetable for implementation. The commitments should be included in the NRPs and SCPs and are subject to the regular surveillance framework, with a strong central role for the Commission in monitoring implementation. Heads of State or Government will monitor progress towards common objectives on the basis of a series of indicators. Countries facing major challenges in any of these areas will be identified and will have to commit to addressing them in a given timeframe. Particular attention will be paid to enhancing the sustainability of public finances, indicated as being the most important aim and one that is to be addressed, in the first instance, by increasing the sustainability of pensions, health care and social benefits.

At the end of 2011, a new set of rules for economic and fiscal surveillance through a reinforced Stability and Growth Pact came into force. Based

7. NRPs contain national targets relating to broad EU-wide guidelines and set out what measures will be taken to meet them.

8. SCPs allow Member States to present their medium-term budgetary strategies and set out actions to strengthen their policies.

on this so-called *Six Pack* of EU legislation, financial sanctions will apply to euro area Member States that do not take adequate action. Member States in 'excessive deficit procedure' (EDP)⁹ (currently all Member States except Estonia, Finland, Luxembourg and Sweden), should comply with country-specific Council recommendations, issued by finance ministers, to correct their deficit. If a Member State fails to comply, the Council can impose financial sanctions, on the basis of a Commission recommendation, unless a qualified majority of Member States votes against it – a procedure which makes enforcement of the rules stricter and more automatic. These new surveillance tools will also be used within the framework of the European Semester.

Another set of regulations is likely to be adopted by the summer of 2012 and applies only to euro area Member States. According to this so-called *Two Pack*, the Commission will analyse whether a Member State's draft budgetary plan for the following year – to be submitted before 15 October – is in line with the recommendations from the European Semester that the country received in May/June of that year or requires a revision. For euro area Member States in EDP, a system of graduated monitoring will allow early detection of countries unlikely to correct their excessive deficit by the set deadline, and permit the EU to act accordingly. Member States experiencing or threatened with serious difficulties and those receiving certain types of precautionary financial assistance will be subject to enhanced surveillance¹⁰.

The most comprehensive type of integrated EU surveillance is the joint EU-IMF adjustment programme applied to Greece and Ireland since 2010 and Portugal since 2011. 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 by providing tailor-made, country-specific financial assistance. The EU provides two thirds of the programme funding and the IMF the remaining third. In return, the three countries have committed themselves to implement economic and social policies detailed in a Memorandum of Understanding (MoU) subject to quarterly review.

9. Under the Stability and Growth Pact, the EDP is triggered by a country's deficit breaching the 3% of GDP threshold established in the Treaty.

10. http://ec.europa.eu/economy_finance/articles/governance/2012-03-14_six_pack_en.htm.

Each MoU, in particular the ones for Greece and Portugal, contains detailed instructions for reforming the health care sector (European Commission, 2010c, 2010d, 2011b).

This analysis shows how an EU approach initially offering relatively general guidance on health sector issues in relation to macroeconomic policy has, in the last two years, turned into a systematic form of surveillance backed up by power to issue early warnings and apply sanctions. The macroeconomic surveillance implicitly includes health sector recommendations from the Commission. The EU-IMF adjustment programme goes further, explicitly involving instructions for national health system reform.

1.2 National health authorities want to weigh in on the process

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. Recent developments are no exception.

In the past decade, social actors such as the EPSCO Council and DG Employment within the Commission have acquired a position as the counterpart of economic actors. 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 aims to spread best practice and achieve greater convergence towards key EU goals. Health care has been included in the process since 2004 (see Box 1).

In a similar vein, this time relating to the European Semester, in June 2011 health ministers called through the Council for a process of reflection 'with a view to listing effective ways of investing in health, so as to implement modern and sustainable health systems that are capable of adapting to changing needs' (Council of the European Union, 2011). Aware of the challenge to health systems posed by the economic crisis, they understood the need to take the lead in debates: 'If we don't

do that, then somebody else will'¹¹. One of the health ministers' main concerns was to ensure that measures introduced to make health systems more financially sustainable would not only focus on cost containment (Council of the European Union, 2011). Health ministers also highlighted the contribution of health to economic growth. The Council therefore called for the health sector to 'play an adequate role in the implementation of the Europe 2020 Strategy' and underlined 'the leading role of Ministers of Health in developing and pursuing effective, health policy-driven approaches in order to adequately address macroeconomic, health and societal challenges' (Council of the European Union, 2011).

Box 1 The Social OMC

Every two or three years Member States outline progress made towards common objectives in National Strategic Reports (NSR), which have a section on health care¹². These are assessed in a Joint Report on Social Protection and Social Inclusion which sets out key priorities, identifies good practice and is adopted by the Commission and the EPSCO Council to be submitted to the Spring session of the European Council.

The 2010 Report stresses that the challenge for health systems is to improve efficiency while ensuring universal access to quality health care (European Commission, 2010a). A supporting document includes possible strategies for improving health system effectiveness and efficiency (European Commission, 2010b).

Under the Europe 2020 Strategy, the role of the Social OMC, including health care, seems to have been weakened. It is feared that the NSR will be replaced by succinct national reporting and that social assessment through the annual (Joint) Reports will be downgraded and its impact will be reduced (Vanhercke and Lelie, 2012).

The reflection process will be held under the auspices of the Working Party on Public Health at Senior Level, a body created by the Council and reporting directly to it. By hosting the reflection process in a Working

11. Interview with the health attaché of a National Permanent Representation to the EU, 1 August 2011.

12. See <http://ec.europa.eu/social/keyDocuments.jsp?type=3&policyArea=0&subCategory=0&country=0&year=0&advSearchKey=nsr+spsi&mode=advancedSubmit&langId=en>.

Party, Member States wanted keep control over it rather than hand the lead to the European Commission: The real discussion must remain with the Member States¹³. The Working Party should be in regular dialogue with the Economic Policy Committee (EPC) and the Social Protection Committee (SPC) to ensure that health actors are involved in ongoing debates on health systems by economic and social actors at EU level¹⁴.

Four sub-groups have been set up to deal with the following topics (European Commission, 2011c):

- enhancing health representation in the Europe 2020 Strategy and the European Semester;
- identifying success factors for effective use of Structural Funds for health investments;
- providing adequate responses to society's growing and changing health needs and efficient and effective design for health sector investment; and
- measuring and monitoring the effectiveness of health investments.

Two points are worth noting. First, in what seems to be a recurrent (and therefore potentially predictable) pattern (see e.g. Baeten, 2005), health ministers, who have traditionally been reluctant to allow the EU to interfere in what is seen as a national responsibility, have been forced to react to developments initiated by economic actors. It is plausible to suggest that the Commission deliberately put debate on health systems on the EU political agenda via economic actors first, to ensure its attempt would be successful and knowing full well that the health actors would respond. Second, in spite of Member State efforts to keep control over the reflection process through the Working Party on Public Health at Senior Level, the Commission has managed to position itself in the driving

13. Interview with the health attaché of a Permanent Representation of a Member State to the EU, 1 August, 2011.

14. Interview with the health attaché of a Permanent Representation of a Member State to the EU, 1 August 2011.

seat of the most important sub-group dealing with health representation in the Europe 2020 Strategy and the European Semester¹⁵. Furthermore, since the Commission acts as a single entity, the voice of DG ECFIN may be strong in these debates (also behind the scenes).

2. Health system reform: a coherent EU discourse?

This section looks in more detail at the *content* of the EU's policy guidance on health system reform, to see if it is possible to identify a clear and consistent discourse. It reviews objectives set out in the Social OMC in 2006, the Ecofin Council's conclusions on the 2010 *Joint Report on Health Systems*, health sector recommendations included in the 2011 NRPs, and the MoUs for Greece, Ireland and Portugal.

Before 2010, guiding principles for health system reform had only been adopted by social affairs ministers in the EPSCO Council, and these were presented as common objectives within the Social OMC (see Box 2). Not only are these objectives broadly defined, the very fact of their being objectives (as opposed to specific policy measures or tools) means that they are unlikely to be controversial and therefore likely to command widespread support. Any measures mentioned are given in the most general terms (e.g. 'developing quality standards reflecting best international practice' or 'appropriate incentives for users and providers'). In content, the objectives closely resemble the health system goals set out by the World Health Organization: universal financial protection, equity of access to health services of good quality, efficient use of health care resources, responsiveness and equity in improved health outcomes (WHO, 2000).

At the end of 2010, the Ecofin Council adopted conclusions on the *Joint Report on Health Systems* drafted by the EPC and the European Commission (DG ECFIN) (European Commission and EPC, 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

15. The other subgroups are chaired by Member States.

each of the 27 countries (European Commission and EPC, 2010b). The conclusions (see Box 3) are noteworthy in three ways. First, they constitute the most detailed EU guidance on health system reform to date. Second, they move away from a near exclusive focus on objectives and include a range of policy tools, immediately increasing the likelihood of their being controversial. Third, the inclusion of policy tools makes it all the more remarkable that the conclusions were adopted by finance ministers rather than social affairs or health ministers.

Box 2 Common objectives for health and long-term care in the Social OMC (SPC and EPC, 2006)

Member States should provide accessible, high-quality and sustainable health care and long-term care by ensuring:

- access for all to adequate health and long-term care; that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed;
- quality in health and long-term care, and the adaptation of care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients; and
- that adequate and high-quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active lifestyles and good human resources for the care sector.

The proposed policy tools seem relatively uncontroversial, however. Several elements correspond to objectives agreed in the Social OMC. Additionally, the focus is not so much on public expenditure control through crude cost containment as on enhancing efficiency (value for money) through ‘a high degree of pooling of funds’, improved resource allocation (e.g. better access to primary care and reducing unnecessary use of specialist care) and a focus on cost-effectiveness (e.g. cost-effective use of medicines and other services underpinned by systematic use of health technology assessment).

Two aspects of the conclusions could be seen as controversial: the inclusion of ‘cost sharing’ (user charges) and the recommendation for health care to be provided ‘as appropriate through the involvement of non-public providers’. The latter point, the only part of the conclusions that was not in the Joint Report, is reflected in the 2012 AGS, which recommends enhancing competition by removing unjustified restrictions on business and professional services in the health sector (European Commission, 2011d), and again in the Irish MoU (see below).

Box 3 Council conclusions on the EPC-Commission Joint Report on Health Systems (Council of the European Union, 2010b)

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 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.

In both cases, however, the use of careful wording (e.g. 'as appropriate') lessens the potential for controversy. Listing user charges as an incentive to encourage 'cost-effective use of care' could be interpreted as a 'value-based approach' in which user charges are removed from cost-effective services and patterns of use or selectively applied to non-cost-effective services and usage (Chernew *et al.*, 2007; Fendrick and Chernew, 2006). Such an approach is not without its own challenges (Thomson *et al.*, 2010), but it is better than non-evidence-based advocacy of user charges to contain costs. The user charges recommendation is also accompanied by an exhortation to ensure 'the protection of those more vulnerable', which is in line with international evidence (Habicht *et al.*, 2006; Swartz, 2010).

A range of health system reforms were included in the 2011 NRPs of 13 Member States (Bulgaria, the Czech Republic, Germany, Greece, Ireland, Italy, Lithuania, Poland, Portugal, Romania, Slovakia and Slovenia), but on instruction from the Commission, the Ecofin Council provided country-specific recommendations for health system reform in only three countries. This time the Council's recommendations are very general, suggesting Austria should 'further strengthen the national budgetary framework' by aligning responsibilities across different levels of government, particularly in the health sector; Cyprus should 'accelerate implementation of the national health insurance system' (a reform that has been postponed numerous times since it was first mooted); and Germany should further enhance 'the efficiency of public spending on health care and long-term care'¹⁶.

The EU-IMF MoUs signed with Greece, Ireland and Portugal go beyond objectives, guidance or recommendations to take the form of detailed instructions for health system reform that are subject to quarterly review and sanctions for non-compliance (see Box 4). The programme for Greece is the most extensive, followed by the programme for Portugal. The Irish programme, in contrast, contains very few health sector-specific instructions.

16. http://ec.europa.eu/economy_finance/economic_governance/sgp/convergence/programmes/2011_en.htm.

Box 4 Health system reforms set out in the MoUs**Greece¹⁷**

A key element of the MoU is that public spending on health should not exceed 6% of GDP (European Commission, 2010c). Within this rigid parameter, the IMF proposed reforms to improve management, procurement, accounting and pricing systems, combined with the establishment of operational oversight by the Minister of Finance, while the Commission focused on creating the prerequisites for greater efficiency and transparency.

Short-term measures include (European Commission, 2010e):

- an effective monitoring and information system with regular auditing, data reporting and assessment;
- the centralisation of procurement procedures for medicines and medical services;
- changes in the reimbursement (price-volume agreements, rebates and discounts) of pharmacies and wholesale pharmaceutical suppliers by third-party payers;
- generic electronic prescribing and monitoring via prescribing guidelines for physicians;
- enforcement of and increase in user charges for outpatient care in public hospitals and health centres (from €3 to €5 per visit), extends user charges for unwarranted emergency visits and changes to prescription drug charges to encourage greater use of generic drugs.

Medium-term (two years) measures include:

- better pooling of funds to purchase health services;
- stronger primary care services and a shift in use from hospital services to primary care;
- implementation of patient electronic medical records;
- improvement of hospital costing and budgeting systems; and
- improvement of physician and hospital reimbursement systems.

Longer-term measures include streamlining of responsibilities across agents and stronger health system governance.

17. This section draws on a background briefing prepared by Dimitris Gouglas.
<http://www.imf.org/external/np/loi/2010/grc/120810.pdf>.

Portugal¹⁸

The MoU focuses on measures to reduce public spending on pharmaceuticals and hospital care, including the following measures:

- increased user charges via stricter means testing and ensuring charges are higher for outpatient specialist visits than for primary care visits;
- cuts in tax relief for private spending on health;
- streamlining of coverage for civil servants;

- changes in the reimbursement (price-volume agreements, rebates and discounts) of pharmacies and wholesale pharmaceutical suppliers by third-party payers;
- compulsory generic and electronic prescribing and monitoring via prescribing guidelines for physicians;
- the centralisation of procurement procedures for medicines and medical services;
- increase competition among private providers and reduce NHS spending on private diagnostics;
- strengthening primary care, including through performance-based payment of providers and aiming for a better distribution of family physicians across the country, and a shift in use from hospital services to primary care;
- improvement of hospital costing and budgeting systems, IT use and governance and rationalisation of the hospital network; and
- implementation of patient electronic medical records.

Ireland

The Irish MoU requires the government to remove barriers to trade and competition in health care by abolishing restrictions on the number of GPs qualifying, restrictions on GPs wishing to treat public patients and restrictions on GP advertising (European Commission, 2010d).

In contrast to the Council conclusions on the Joint Report and the NRP recommendations, some of the MoU requirements are more controversial, notably the increase in user charges and the cap on public spending on health in Greece. The higher user charges required in the Portuguese

18. <http://www.imf.org/external/np/loi/2011/prt/051711.pdf>.

MoU are subject to means testing and reflect, to some extent, a value-based approach. But in Greece the value-based approach is absent where user charges for outpatient care (including primary care) are concerned and more muted for other services (limited to imposing higher user charges for 'unwarranted' emergency visits and lower charges for cheaper generic drugs).

Potentially much more damaging, however, is the attempt to cap public spending on health 'at or below 6% of GDP' – in other words, at current 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 (-3.5% in 2010, -6.9% in 2011 and -4.4 in 2012)¹⁹ is a reduction in public spending – an effect highly likely to exacerbate financial barriers to accessing health services.

One other striking aspect of the MoUs for Greece and Portugal is the promotion of e-health (such as e-prescriptions, interoperable IT systems in hospitals and electronic medical records), which may reflect the influence of the EU's Digital Agenda. This contains an important role for e-health and is intended to boost economic growth. It may also reflect a broader health system trend to enhance e-health, particularly through the development of electronic patient records. E-prescribing can contribute to more efficient and better quality care (McKibbin *et al.*, 2011), but national e-health programmes are neither cheap nor straightforward to implement (see e.g. Greenhalgh *et al.*, 2011). It is therefore questionable whether investment in large-scale e-health projects should be a priority for health systems facing serious financial problems.

A number of trends emerge from this brief overview of EU guidance on health system reform. First, the *nature* of the guidance has changed, moving from the statement of broad objectives (the Social OMC) to recommendations that include specific policy tools (the conclusions on the *Joint Report*), and from there to detailed instructions (the MoUs). Second, the *content* of the guidance has become more controversial. This is not surprising, given the increasingly prescriptive nature of the guidance.

19. <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&plugin=1&language=en&pcode=tsieb020>.

Third, the range of stated objectives for health system reform has grown and the tensions between different objectives are more evident.

Two objectives are explicitly spelled out in almost all of the different policy documents reviewed so far, including the MoU with Greece: ensuring the sustainability of public finances through greater cost efficiency and ensuring access to high quality care. The objective of boosting employment by creating jobs in the health sector is mentioned in the broader policy documents (e.g. the 2012 AGS), but is not taken up in the more concrete guidance (the *Joint Report* conclusions or the MoUs). Neither is the argument (made in the 2010 *Joint Report on Social Protection and Social Inclusion*) that countries with poor health indicators will need to spend more (and more effectively) on health care in future. However, the objective of enhancing competition in the health sector is reflected in the 2012 AGS (European Commission, 2011d), the NRP recommendations for Denmark (further liberalisation of pharmacies) and the Irish MoU (European Commission, 2010d and 2011e). Although these particular recommendations are not contested, question marks could be applied to blanket calls to open up health care delivery to competition between public and private providers.

As the EU's guidance has become more prescriptive, the tensions between some of these goals have become increasingly clear. In Greece, for example, it is difficult to see how large cuts in public spending on health can be reconciled with the objective of 'maintaining universal access and improving the quality of care delivery'²⁰, unless policy makers can achieve substantial efficiency gains very rapidly. However, their ability to do so is called into question by recent reports of growing access problems and worsening health status in Greece (Kentikelenis *et al.*, 2011). Sustained efficiency gains in health care rarely come at a low cost, and this is especially so once relatively easy targets (such as cuts in pharmaceutical prices) have been achieved.

20. Page 35 of the 8 December 2010 MoU letter, <http://www.imf.org/external/np/loi/2010/grc/120810.pdf>.

3. EU discourse and national health system reforms

This section briefly considers whether the EU discourse summarised in the previous section has been reflected in national reform processes in the last two to three years. Since it is difficult to establish the extent of the EU's role in stimulating national reforms without significant research, the analysis is tentative and not intended to be systematic.

The EU's influence is most obviously seen in the three countries subject to EU-IMF adjustment programmes. Here, concrete instructions for reform must be implemented in return for financial assistance. However, there are differences in the quantity of prescriptions provided for Greece and Portugal on one hand, and Ireland on the other. These may reflect the fact that Ireland had already initiated a major programme of health system reform. In early 2011, the newly elected coalition government issued a programme for reform²¹ which included plans to move towards 'universal health insurance' by 2016. These plans comprise wide-ranging reforms to the structure of health financing and health care delivery and are intended to promote universal access to health care and enhance efficiency in the use of resources.

There are also differences across the three countries in the speed and extent of reform implementation. The Irish parliament has already passed legislation acting on the MoU's instructions regarding restrictions on GPs' ability to treat public patients.²² Significant reforms have also been introduced in Greece, but while many of the Commission's short-term targets have been partially met, this is not the case with the medium and longer-term targets. Some delays can be attributed to technical complexities; others are regarded as due to opposition from interest groups (European Commission, 2011e).

Other countries have engaged in reform of the health system in the last two to three years. These have largely been nationally initiated processes, often in response to the fiscal constraints imposed by the financial crisis. A comprehensive survey carried out by the European

21. <http://per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf>.

22. <http://www.irishtimes.com/newspaper/ireland/2012/0312/1224313153908.html>.

Observatory on Health Systems and Policies identifies a wide range of health system responses from 2008 onwards and the following paragraphs summarise those reported to have continued in 2011, including in Greece, Ireland and Portugal (Mladovsky *et al.*, 2012).

Several countries reported continuing cuts to public spending on health care (Austria, Greece, Ireland, Italy, Portugal, Romania, the Catalonia region of Spain and the United Kingdom), increasing tax or contribution rates to sustain collective funding (Italy, Greece, Portugal) or delaying or slowing investment in capital projects such as hospital infrastructure (Bulgaria, France, the United Kingdom). Some countries have opted to protect the health budget, to avoid shifting costs to households (Belgium, Denmark, Sweden).

Countries also report making changes that affect levels of statutory coverage. Greece and the Czech Republic reduced entitlement to health care for foreign residents and Catalonia introduced a scheme to obtain compensation for treating patients from other regions. Cyprus once again decided to postpone the implementation of its new National Health Insurance system, which would have extended coverage to the whole population. Greece introduced a uniform benefits package across all health insurance funds, while Portugal removed a range of services from the special system of coverage for public sector workers (ADSE) in 2011, including occupational injury and ill health, unconventional therapies and cosmetic surgery, and made membership of this scheme voluntary.

Pharmaceuticals continued to be a key area of policy focus. Following on from quite widespread efforts to negotiate lower drug prices with manufacturers in several countries in 2009 and 2010, a handful of countries introduced positive lists of reimbursable drugs (the Czech Republic, Greece) or medical devices (Bulgaria). The Czech Republic, Greece, Portugal and Romania increased user charges (in Portugal to create incentives for people to use primary care or outpatient services before accessing inpatient or emergency care), while others (Belgium, Italy) have tried to strengthen access to health care by removing some user charges or extending entitlement to exemption from user charges. The UK government decided not to extend the range of chronic conditions exempt from outpatient prescription charges.

Changes introduced in 2011 to lower health care costs included new procedures for procurement for medical devices (centralisation in Bulgaria, Greece and Portugal and auctions in the Czech Republic); cuts in the price statutory purchasers pay for drugs (Greece, Portugal, Romania), health care supplies (Portugal) or health services (Estonia); cuts in provider salaries or profit margins (France, Greece, Ireland); smaller than usual increases in provider fees (Denmark, the United Kingdom) or slowing down retention and recruitment of staff (Greece, Ireland); and cuts to or caps on administrative budgets (Ireland, the United Kingdom). Hospital reconfiguration continued in Greece.

Health system responses to the financial crisis show considerable overlap with EU guidance, especially in terms of controls on public spending on health and particularly in the area of pharmaceuticals – the ‘low-hanging fruit’ we noted above. Nevertheless, two of the most extensive programmes of national reform proposed since 2010 – in Ireland and in England – do not seem to have been influenced by EU guidance. Rather, they reflect national political processes and domestic policy agendas. In both countries, new governments were made up of political parties who had been out of power for a long time and therefore seized the opportunity to introduce major changes.

The content of reforms has in general involved efforts to lower public spending on health care, although very few countries have done this by explicitly reducing benefits or increasing user charges. Rather, several countries have focused on trying to enhance efficiency by lowering the cost of pharmaceuticals to third-party payers and patients, making more effort to promote rational use of drugs and addressing excess capacity in the hospital sector.

Discussion and conclusions

This chapter has outlined recent developments in health system reform at EU and national levels.

At EU level the policy setting and content have developed rapidly in the last two years. Until recently, health systems had been addressed almost exclusively in the context of the internal market and patient mobility. But at the end of 2010, EU finance ministers adopted Council

conclusions setting out policy guidelines for the health sector. Not only were these conclusions the most detailed EU guidance on the health sector then available, they also gave the European Commission a mandate to address health system reform in the context of macroeconomic surveillance.

De Ruijter and Hervey (forthcoming) argue that the Commission is using economic actors and institutional mechanisms (such as the Ecofin Council), where EU competence is less contested, to communicate and progress its policies on health care, an area in which it does not have competence. They also argue that this is because when health care is presented as a social issue, the actors involved do not have enough traction to get policy documents through to the Council.

At first glance, it may seem as though the EU's shift in policy approach and content is a response to the financial crisis and the crisis in the euro area. But some actors argue that this is not the case: the conclusions to the Joint Report 'would have been drafted even without the crisis'²³. Rather, the financial crisis created a window of opportunity for the EU to claim greater legitimacy to influence this domain of national competency – something that had been on the Commission's political agenda for a long time.

The chapter has also shown how the nature and content of the EU's policy guidance on health system reforms has changed, moving from objectives, which can command widespread support; to still relatively general policy tools, which could be controversial, but are couched in appropriately nuanced terms; to specific prescriptions, some of which are much more controversial. This development has several implications. First, it brings to the fore tensions between different EU objectives for health system reform: ensuring the sustainability of public finances through greater cost efficiency; ensuring access to high quality care; boosting employment by creating jobs; boosting economic growth; and enhancing competition in the health sector. In particular, it questions the ability of Member States to promote universal access to high quality services at a time when they are required by the EU to cut public spending on health. Evidence from Greece suggests that these objectives

23. Interview with the chair of the EPC, 4 August 2011.

cannot always be reconciled and the consequences include declining access to health care and lower health status.

Second, and perhaps more significantly, there is now a precedent for the EU to intervene directly in national health policy, severely constraining the ability of Member States to determine national priorities for policy objectives and tools. While Greece, Portugal and Ireland are extreme examples of this intervention, the development may spread to other countries. The Six Pack (and the forthcoming Two Pack) legislative processes substantially strengthen the EU's powers of macroeconomic surveillance by introducing the possibility of sanctions. Member States with 'excessive deficits' (currently all except Estonia, Finland, Luxembourg and Sweden) will from now on be obliged to comply with country-specific recommendations issued by finance ministers in the Ecofin Council. Since the 2012 AGS included health care, future recommendations also seem likely to do so.

As others have noted, the health sector may be an attractive target in comparison to other areas of public spending (such as pensions and education), not least due to its size, but also due to its potential for improved productivity and other efficiency gains (Fahy, 2012). The recent trend in national reform processes gives credence to this view, with many countries focusing on obtaining better value for money in health care, rather than simply cutting benefits across the board.

Now more than ever, however, it is vital that those accountable for health care policy take part in EU debates and decision-making processes so that EU-driven policy guidance is evidence based, informed by social objectives and understands the importance of national context.

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