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Healthcare reforms and the crisis

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Policy implications

In recent years and more particularly in the wake of the financial crisis, widespread cost-reducing healthcare reforms have been enacted in Europe at national level subject to varying degrees of pressure from the EU. In countries hardest hit by the crisis, these reforms have had detrimental effects on access to care. A strikingly contradictory feature of the current situation is that, whereas fiscal consolidation policies focus on stronger public controls, the EU internal market rules have a creeping deregulatory effect on health systems.
The need is for a more consistent healthcare agenda on the part of the EU and for more transparent and accountable procedures for its involvement in this field, taking due account of the basic objectives of healthcare systems.

Introduction

In this Policy Brief, we indicate how a new wave of healthcare reforms in Europe has affected pre-existing national models, and raise some questions concerning the role of the EU as an advocate of policy change in this field. We draw on findings and policy implications of our ETUI Report on recent healthcare reforms in ten EU member states: France, Germany, Greece, Ireland, Italy, Lithuania, the Netherlands, Romania, Sweden, and the UK (England) (Stamati and Baeten forthcoming 2015).

Since the crisis, the healthcare sector has become an obvious target for cost containment, due to its sheer size, its susceptibility to fiscal expansion – driven by factors such as technological progress, population ageing, and an adaptive demand for care – and its potential for improved cost-efficiency. While reforms are in many cases aimed at restoring the long-term financial viability of healthcare systems, they may also be ideologically driven. The crisis, furthermore, has radically altered the nature of EU intervention in domestic healthcare reforms. Whereas, traditionally, EU involvement in this policy area was limited to supporting voluntary cooperation between member states, at present the EU institutions are calling for major healthcare reforms as a means of consolidating public expenditure. Not only have the countries in receipt of financial assistance been required to implement the detailed list of reforms stipulated in their respective Memorandums of Understanding (MoU); other member states too have been encouraged to undertake reforms to their national healthcare systems. While initially the encouragement was issued in the form of 'recommendations', these have, under the most recent changes in European economic governance, become increasingly tantamount to 'instructions' insofar as, through the potential to issue sanctions for non- complying Eurozone member states under the so-called "Six Pack", "Two Pack" and the Macro-economic conditionality linked to the funding from the European Structural and Investment Funds, the 'recommendations' became increasingly binding.

The crisis has dramatically changed trends in total health spending (Figure 1). Steady increases during the earlier 2000s had led to a generalised catching-up, even for low spenders such as Romania and Lithuania, but between 2008 and 2011 health spending as a percentage of GDP began to decrease (Ireland and Greece) or to increase at only half its previous growth rate (Lithuania, the UK, and the Netherlands). The slowdown was milder in Italy and Sweden, where previous spending trends were also flatter. Accordingly, of the countries studied in our report, only France, Germany, and the Netherlands showed any sizeable (i.e. greater than 0.5 points) increase in health spending between 2008 and 2011.

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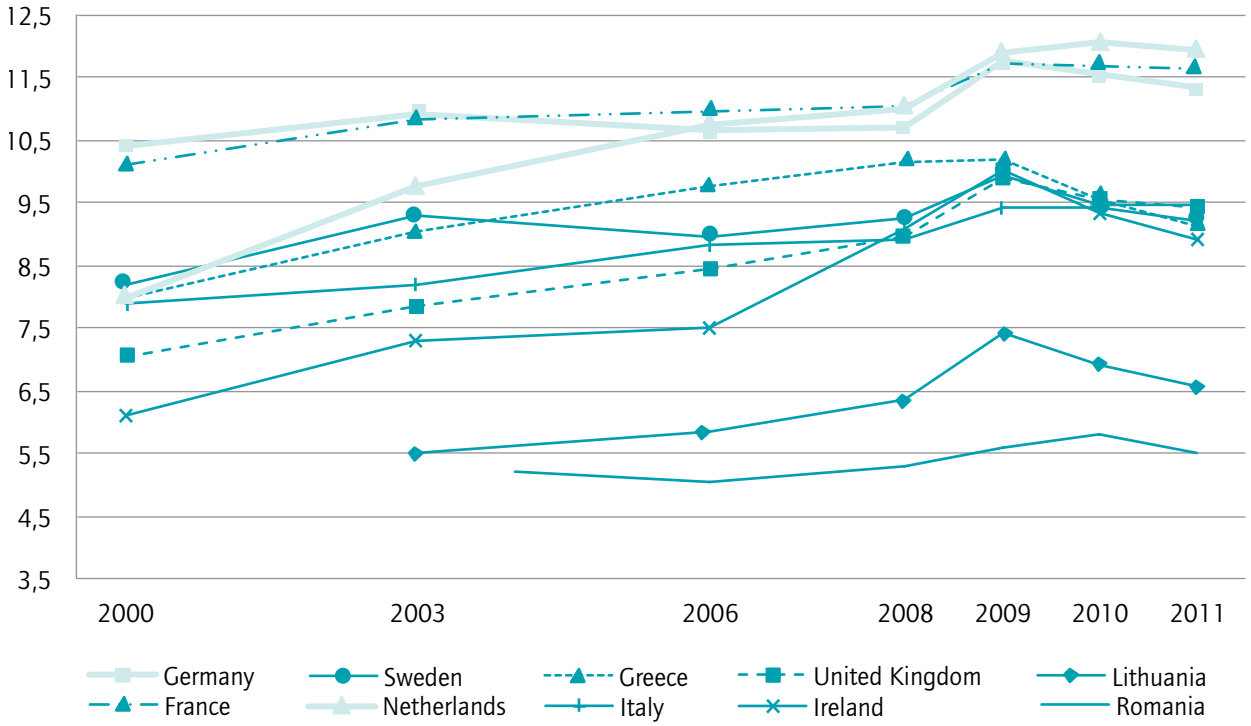
Figure 1 **Health spending trends in selected EU countries (total spending as a % of GDP)**



Source: OECD and Eurostat data. Data for Greece are up to 2009 only.

Figure 2 **Total self-reported unmet needs for medical examinations (in %)**

Source: Eurostat data

Looking at trends in access levels (measured by self-reported unmet needs for medical examinations), Figure 2 reveals marked national differences. Germany and Lithuania, and to a lesser extent Sweden and the UK, succeeded in reducing the share of unmet medical needs even after the crisis. Other countries, however, experienced worsening trends. In Italy and Greece this was mainly due to increasing user charges.

2. EU economic governance and healthcare reforms

In the wake of the crisis the EU institutions acquired unprecedented powers – especially in the Eurozone countries – to supervise national budgetary and economic policies. Within this context, healthcare systems represent a particular target.

Member states in receipt of financial assistance from the EU and the IMF (i.e. Greece, Ireland, Cyprus, Portugal, and Romania) had to commit to implementing – subject to a quarterly review – the reforms enumerated in a Memorandum of Understanding (MoU); these included detailed specifications for healthcare system reforms. Other member states too received, under the European Semester for Economic Policy Coordination, an increasing number of Country-Specific Recommendations (CSRs) on health- and long-term care; these became increasingly binding, in particular for Eurozone countries. In 2013, 17 EU members received one or more CSRs on health- and/or long-term care.

Examination of the content of the EU 'guidance' reveals that the focus of CSRs is mainly, but not exclusively, on fiscal consolidation; the call is for long-term structural reforms aimed at improving cost-effectiveness. The reforms stipulated under the MoUs, on the other hand, are not exclusively aimed at a more cost-effective use of financial resources but include also measures designed simply to decrease costs in the short term.

While there is little transparency as to the criteria that determine to which member states a healthcare-related CSR should be addressed, there are indications of priority being given to countries over which the EU can exert stronger influence. Pressure to adhere to the 'guidance' increased at the end of 2013 for five Eurozone members – Spain, France, Malta, the Netherlands and Slovenia – subject to an Excessive Deficit Procedure. These countries submitted Economic Partnership Programmes containing a section on reforms in the healthcare sector. Only healthcare reforms in Denmark, Sweden and the UK, which had explicitly opted out of the Eurozone, are so far not targeted under the EU economic governance mechanisms.

3. Healthcare policy change: legacies and patterns

Healthcare policy analysts typically characterise health systems as consisting of three dimensions – regulation, financing, and provision – each subject to three possible spheres/modes of governance: 1) state/public control, 2) society/self-regulation, and 3) individuals/market mechanisms (Rothgang *et al.* 2010; Böhm *et al.* 2012).[1]

When analysing trends within each dimension, an overall picture of stability emerges. In the mid-2000s (Table 1 in the Appendix), *regulation* was predominantly governed by the state in all but two countries: Germany, which featured a mostly self-administered – or 'societal' – system of regulation, and Greece, where system fragmentation left private healthcare providers with considerable decisional leeway. Countries were almost equally split between systems in which *financing* is predominantly public and systems in which health funds and professional associations played a prominent role. Greece was the exception, as most of its health spending was financed through market mechanisms. Finally, the *provision* of inpatient hospital care was public everywhere but in the Netherlands where it was totally private non-profit (i.e. 'societal'). By the early 2010s (Table 2 in the Appendix), the sphere/mode of governance predominantly in control of each dimension had not changed, except in the single case of Greece where financing had become increasingly societal and less private. Taking into account a greater sensitivity of Greece's fragmented system to moderate changes, a general impression of stability emerges. However, caveats should be expressed with regard to data constraints since changes having occurred later than 2011 are not yet in the figures.

A closer comparison of the pre- and post-crisis scenarios indicates nonetheless a number of trends taking place across groupings of European national healthcare systems.

For the purposes of such a comparison, and as a preliminary to analysing trends within each dimension, countries were grouped according to the level of EU influence exerted on their healthcare policy.

The three *Memorandum countries*, which were subject to the strongest EU influence, namely, Greece, Romania and Ireland, enacted the most stringent reforms in terms of spending levels, financing structure, and public/private mix of provision. In the dimension of regulation no common trend was apparent, mainly because of different starting conditions. In the financing dimension, various forms of reorganisation are apparent in different country-specific directions: massively towards the societal sphere in Greece, moderately away from it in Romania, and strongly from the state and towards the private sector in Ireland. Greece underwent the greatest change, shifting its financing dimension from mostly private to mostly societal as the result of a rationalisation effort according to which numerous separate health insurance funds were merged into a single national fund. Despite this change, the Greek system remains hybrid. In terms of provision, meanwhile, a mild trend towards privatisation seems to be underway, with a probable lag in the case of Greece.

Italy, Germany, the Netherlands and France, countries that experienced a rather *moderate EU influence* on their healthcare policymaking (e.g. as Eurozone members subject to an Excessive Deficit Procedure), display some similar changes in the area of regulation. Generally speaking, in these countries the role of both the market and the state was reinforced, at the expense of societal self-administration. The relative share of regulatory powers in the hands of societal actors fell in these countries (except Italy, where societal actors have no role in regulation). In France and Germany, the powers forfeited were taken up mostly by the state, reinforcing state authority over cost and financing choices. In Germany, the shift away from the societal sphere is driven mainly by the progressive merging of the self-administered and the private health insurance systems, which has reinforced

1 For more details on the methodological and conceptual underpinnings of this categorisation, the reader is referred to the full report.

both market and state, combining liberalisation with tighter cost controls. In the reorganisation of healthcare financing, by contrast, no common trend has appeared because of the high level of societal financing in the Netherlands. Mild privatisation took place in the provision dimension, to the benefit of private (France and Germany) or non-profit (Italy) providers. In the Netherlands provision remained 100% non-profit.

Lithuania, Sweden, and the UK (England), where *EU leverage* was *low*, emerged as the most autonomous nations in terms of healthcare policymaking. These countries are characterised, in other words, by highly country-specific reform agendas. Both Sweden and England have shifted a great deal of regulatory authority from state decisions to market mechanisms; in Lithuania no major change is apparent in this respect, most likely because a regulatory mix similar to that recently introduced in Sweden and the UK (England) was brought in much earlier during the reforms of the 1990s. Financing, on the contrary, is in this group of countries characterised by a mild trend towards renationalisation. An apparent lack of change in provision – stemming to some extent from data issues – is a last shared feature within the group.

In a next step, countries were grouped according to the traditional healthcare regime family to which they belong. From the standpoint of these policy legacies, the most significant changes took place in 'nationally managed' National Health Systems (NHS) and in 'benefits-in-kind' Social Health Insurance (SHI) systems (the Netherlands and Germany). The countries with an NHS system – Greece, Italy, Ireland, UK (England) and Sweden – show divergence in terms of financing but fairly similar reform outputs in terms of regulation. State authority over regulation decreased in all these countries (except Ireland, due to stricter control imposed by the MoU), and in the provision dimension small adjustments without any clear common trend took place. SHI systems in our sample included France, the Netherlands, Germany, Romania and Lithuania. In the western European countries of the SHI family a withering of the social sphere of regulation is apparent. In terms of financing, some readjustment of spending shares took place in most countries, with the exception of the already mentioned increase in societal financing in the Netherlands. Finally, across SHI countries there is evidence of a slight move towards privatisation in the provision of hospital beds.

What observations can be made concerning the respective roles of the EU and of national policy legacies in structuring these reform trends? Opposite reform outcomes often occurred in countries with similar institutions. Not even Greece and Italy – two NHS systems hard hit by the crisis – show a similar pattern of reform. Germany and the Netherlands, on the other hand, pursued similar reforms and reform patterns, and yet achieved opposite results. Lithuania and Romania, meanwhile, display some shared trends that are different from, or at least less marked than, those in the other SHI countries; even so, a more subtle influence of policy legacies is apparent. Whereas Italy and Greece share the legacy of a failed decentralisation, which also contributed to delays in their reform patterns, England and Sweden are trying, respectively, to regionalise a centralised and an extremely decentralised system. Such instances may suggest that regime-specific legacies are still determinant for several crucial details of the new reforms.

In sum, whilst there were some significant shifts in terms of all three dimensions, no paradigmatic or regime shifts were found. Greece underwent the greatest change, shifting its financing dimension from mostly private to mostly societal, but it remains a hybrid case. Our analysis also suggests that policy legacies may interact with EU leverage to affect national reform patterns. Countries subject to strong EU leverage may have become so exposed to the imperatives of the EU because, among other reasons, they had failed to enact efficiency-enhancing reforms, in healthcare as in other sectors, before the crisis struck. With the partial exception of Italy, countries subject to moderate EU leverage did in fact enact major health reforms in the mid-2000s (2006 in the Netherlands, 2004 in France, 2007 in Germany) and sought to implement them even after the crisis had hit, increasing their fiscal prudence in order to escape the attention of EU-level policymakers. Finally, countries subject to weak EU leverage were those that retained the capacity to design and enact reforms specifically tailored to addressing their past policy failures. In these countries, major shifts in attitude towards the governance of domestic health systems were in some cases determined by changes in national government.

Conclusions

Widespread subtractive healthcare reforms have been enacted in European countries, under stronger EU surveillance, since the onset of the global crisis. While healthcare-related CSRs have grown in number, scope, and detail, the EU remains simultaneously unable and unwilling to promote a consistent well-defined healthcare agenda, be it oriented to convergence or to the co-existence of different models. Predominantly, the EU addresses issues of macro-economic coordination and cost-effectiveness via an indirect approach characterised by scant awareness of the specificities of national health systems. For policy-formation purposes, supranational agency is not yet on an equal footing with domestic drivers and processes, and may well serve to complicate country-level responses. While EU pressures may occasionally provide 'enabling constraints' for subtractive reforms, they have contributed little to the development of a new healthcare model for the 21st century.

Moreover, the process behind the issuing of healthcare-related CSRs is opaque and difficult to understand. Most CSRs are generic, almost interchangeable and uncontroversial. It could well be that the EU institutions' aim is to provoke a reaction from the national level, before examining the finer details. States having fallen into dire fiscal straits are targeted by the EU, from the outset, with more detailed prescriptions. It might accordingly be that more transparent and accountable procedures for CSR formulation, selection, and issuance would increase both the effectiveness and the legitimacy of the requests put forward by the EU level.

From a substantive perspective, EU 'guidance' addresses the dimensions of regulation, financing, and provision in different ways. Both CSRs and MoUs recommend strengthening the regulatory powers of public authorities and differ only in their level of detail. Measures affecting the respective roles of different financing sources (e.g. higher user charges or caps on public spending)

appear in MoUs, but not in CSRs. Regarding provision, MoUs and CSRs both call for a reduction in hospital care. Some MoUs even require reductions in the numbers of providers contracted by the statutory system. Policies designed to enhance statutory care provision (e.g. primary care and rehabilitation) are substantially more present in the CSRs than in the MoUs.

A further contradiction stems from the fact that fiscal consolidation pushes for stronger public controls, while the application of the EU internal market rules to healthcare services and products has a creeping deregulatory effect on healthcare systems.

All of the above results in a twofold conflicting development: growing reliance on market-based actors and mechanisms meets increasing public control on spending patterns. The final outcome might be interpreted either as a neo-liberal healthcare agenda, where market mechanisms are complemented by very strict public budgetary discipline, or as the emergence of new 'hybrid models' with market mechanisms and public regulation coexisting in the absence of any synergy. In either case, part of the financial burden will be shifted to patients, so as to realise short-term savings. If populations' health needs do not decrease accordingly in the future – and there is no reason to believe they will – this trend will threaten both access to and quality of public care.

Up to now, the EU has exerted influence on healthcare system reforms at the national level either directly – through the Memorandums and to a lesser extent through CSRs – or indirectly, by hardening public budget constraints within the Eurozone and through EDPs and other economic governance tools. In both cases the main underlying rationale of EU intervention has been economic and financial; yet its policy indications have become ever more specific, and in some cases astonishingly detailed. This approach is potentially disruptive for national health systems, threatening national institutions and their politics but without advancing any workable alternative model.

While neo-liberal turns in European healthcare agendas are not to be blamed on the EU exclusively, its institutions are currently in the worst position to advance proposals aimed beyond the 'austerity course'. Healthcare expenditure savings cannot and should not be the main focus of EU involvement. Improved cost-effectiveness must be an instrument in the service of preservation of the mission of healthcare systems to ensure universal access to high-quality healthcare.

The EU is, nonetheless, in a position to support member states in their national reform agendas aimed at responding to structural challenges that will affect the delivery and quality of healthcare services. To this end, there is a need to redress the imbalance between the fiscal/economic objectives of the European Semester and its social objectives. The impact of healthcare system reforms on access to and quality of care should be monitored in a manner similar to fiscal trends, with pressure being stepped up when member states perform poorly on the relevant indicators. The EU should sharpen and clarify its overall approach to healthcare system reform, making it both more transparent and more accessible.

National authorities remain responsible and accountable for their healthcare policies. The EU's policy agency should be attentive to the specific configuration of each system, in particular to the administrative and financial resources needed to fulfil the goals defined by each national legislative and constitutional framework. Furthermore, EU guidance should be evidence-based. This means that the European Commission needs more research and consultation before formulating its recommendations. The EU could, furthermore, elaborate instruments that would allow member states to assess performance of their systems.

Last but not least, the EU should ensure that its policies in other fields, in particular those of pharmaceuticals and medical devices, are supportive for healthcare system reform rather than aimed at serving the interests of the industries in question. The recent controversy on the shift of powers in these fields between DG Sanco and DG Enterprise illustrates the tensions in the related EU policies.

More ambitiously, the EU may be willing to embark on the path of greater coordination of healthcare systems and to aim for the development of a common view on the general direction to be taken by healthcare system reforms. National authorities are in great need of economically and socially sound reform agendas. More efforts to reinforce the 'constructive side' of EU interventionism are both necessary and desirable.

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Table 1 **The 10 cases before the crisis (mid 2000s)**

Dimensions of health care / Countries	Regulation Regulation index (Böhm *et. al.* 2012; own calc.)			Financing Share of total health spending (OECD)			Provision Share of inpatient beds (OECD-Eurostat)		
	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		

Source: Stamati and Baeten 2014. *In the literature, that also considers the ownership status of pharmacists and dentists.

Table 2 **The 10 cases since the crisis**

Dimensions of health care / Countries	Regulation Regulation index (Böhm *et. al.* 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**
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		

Source: Stamati and Baeten 2014. *In the literature, that also considers the ownership status of pharmacists and dentists.
Figures calculated on the most recent data available (ca. 2013 for Regulation, ca. 2011 for Financing and provision).