

Varieties of healthcare reform: understanding EU leverage

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Introduction

In the wake of the financial crisis, EU Member States have enacted numerous cost-reducing healthcare reforms subject to varying degrees of supranational pressure. Cost-containment has been widespread: austerity measures have reduced access to care for the most vulnerable patients in many EU Member States (WHO 2014). However, a more nuanced examination reveals variation in the reform agendas of different country subgroups. At least three different approaches can be discerned. Countries such as the UK (England) and Sweden have used the recent crisis as an opportunity to tackle enduring structural problems. Reforms in countries like Greece or Ireland instead were mostly aimed at short-term savings. Immediate cost containment acquired priority over, or even prevented, the tackling of structural shortcomings. Most Continental countries stand somewhere in between, as they combined emergency and structural measures.

The explanation we suggest is that supranational advocacy is affecting domestic agendas through the filter of national policy legacies. Countries that had failed to enact efficiency-enhancing reforms before the crisis were more exposed to supranational influences, but countries with lower external constraints retained a greater ability to tailor past policy failures during the Great Recession. This chapter¹ tackles the main events and debates that occurred in relation to this policy area, comparing reform trends in ten representative case studies. Finally, it evaluates prospects and challenges for further policy change over the short and medium term. We suggest that the current emphasis on long-

1. An earlier and more detailed version of this chapter was published as an ETUI Report (Stamati and Baeten 2015).

term economic sustainability risks depriving European health systems of what they need to do: to provide citizens with effective and timely access to high quality medical services.

The chapter is organised as follows. Section 1 describes the leverage of the EU's economic surveillance system and its developments in 2014. Sections 2 and 3 present the reform agendas and paths followed in domestic healthcare systems across the EU. Section 4 endeavours to explain differences in national reform agendas. Section 5 offers concluding evaluations and discusses analytical steps needed to explain variation in reform agendas. Normatively, it suggests that supranational emphasis on fiscal concerns at the expense of substantive policy problems may threaten both access to and quality of care.

1. EU economic and fiscal surveillance of health systems

The economic crisis radically changed the way the EU engages in national health system reforms. The approach shifted from supporting voluntary cooperation between Member States to calling for curbs on spending and – sometimes major – spending cuts.

1.1 New instruments, increasing powers for the EU

In the wake of the crisis the EU institutions acquired unprecedented powers to supervise national healthcare policies.

The most comprehensive type of integrated EU surveillance applies to countries receiving financial assistance from the EU and the IMF. Financial assistance is linked to macroeconomic conditionality, which means that the countries involved have to commit to implementing the detailed policies included in a Memorandum of Understanding (MoU). The Eurozone countries Greece, Ireland, Cyprus, Portugal and also other countries outside the Eurozone (Latvia, Hungary and Romania) receive(d) financial assistance from the EU and the IMF after agreeing to engage in adjustment programmes defined in a MoU. The countries are subject to post-programme surveillance until at least 75% of the financial assistance received has been repaid.

Member States not in receipt of financial assistance are also increasingly encouraged to undertake reforms to their healthcare systems. Under the European Semester for Economic Policy Coordination (2011), the EU acquired new powers to supervise national budgetary and economic policies. The Semester aims to ensure coordinated action on key policy priorities at the EU level. It integrates, synchronises and reinforces the previously existing procedures of the Stability and Growth Pact (SGP) and Europe 2020 (the EU's growth strategy). It furthermore incorporates a new procedure, the Macroeconomic Imbalances Procedure (MIP). Since 2011, health system reform has been addressed under the Semester.

Country-Specific Recommendations (CSRs), adopted by the Council of the EU upon a proposal from the Commission, have a crucial role within the Semester cycle. CSRs provide tailored advice on structural reforms, which Member States have to consider in their national plans. To ensure CSRs implementation, stricter procedures for economic and fiscal surveillance were established between 2011 and 2013 by the Six Pack and the Two Pack of EU legislation (see Stamati and Baeten 2015). As a result, the CSRs concerning fiscal policy and macroeconomic imbalances became increasingly binding on Eurozone members. By contrast, CSRs based on the Europe 2020 strategy, which includes social objectives such as access to care, are not binding.

Furthermore, for the period 2014-20, funding from the European Structural and Investment Funds (ESIF) for several domains, including healthcare, is subject to the submission of a strategic plan for approval by the Commission. Implementation of the CSRs must be sufficiently reflected in the plan. Moreover, the Council, acting upon a proposal from the Commission, can suspend payments for the programme concerned if a Member State does not comply with past agreements and economic governance procedures (Council of the European Union, CEU 2013a).

1.2 Health system reform under EU economic and fiscal surveillance

The MoUs for Greece, Ireland, Cyprus, Portugal and Romania contain very detailed instructions for reforming the healthcare sector.

Each of the programmes focuses on a reduction in pharmaceutical spending, to be achieved through price reductions and wider generic drug usage. Other structural reforms include: the centralisation of procurement (Greece and Portugal); changes in supplier reimbursement rules (Greece and Portugal); e-health solutions and implementation of patient electronic medical records (all); the restructuring of hospitals and hospital payment systems (all); insurance fund mergers (Greece); streamlining of coverage (Greece and Portugal); and stronger budget control mechanisms (all). The establishment of a system for health-technology assessment is proposed in Cyprus and Romania. Most countries had to reduce the number of hospitals, hospital beds and publicly funded healthcare professionals (Greece, Ireland, Portugal and Romania).

The MoUs also include pure short-term cost reductions, such as higher user charges (all countries) or reductions in free access to care (Cyprus), reductions in hospital care (Ireland), and reductions in the scope of benefit packages (Greece, Cyprus, Romania). Greece and Ireland were asked to revise the payment system for physicians, cut wages, reduce staff, and extend working hours. Most likely to exacerbate financial barriers to health services are requests to cap public healthcare spending over GDP at levels below EU standards (Greece) during an economic recession. Measures to expand healthcare access were occasionally included, such as taking steps towards universal coverage (Cyprus) or a Health Voucher Programme for access to primary care for uninsured citizens (Greece).

The prescribed reforms are geared almost exclusively towards fiscal consolidation. Some of them may increase the long-term cost-effectiveness of the healthcare sector, but others risk jeopardising it. Shifting resources from inpatient to outpatient care can enhance efficiency if appropriate alternatives are made available. However, the MoUs either do not require the strengthening of primary care or fail to

provide the necessary resources (Petmesidou *et al.* 2014). Most short-term savings result from shifting costs to the private purse.

For the period a country receives funding under a financial assistance mechanism, it does not participate in the European Semester process, unlike other Member States.

The number of Member States receiving CSRs to reform their health and/or long-term care (LTC) systems has steadily increased from three in 2011 to twenty in 2014. Only Lithuania, Hungary, Sweden, Denmark and the UK have so far escaped EU guidance on health and LTC reforms. Strikingly, three out of these five have deliberately stayed outside the Eurozone. This suggests that the Commission pushes the countries it can most easily influence. In terms of substance, most health-related CSRs remain generic and mainly interested in fiscal consolidation and cost-effectiveness. Whenever they are more specific, they urge reductions in pharmaceutical spending and institutional care costs through stronger outpatient and primary care and better coordinated care delivery. In 2013 and 2014, only three countries received CSRs mentioning care access and/or quality. Two of them are Romania and Spain, currently subject to strong austerity programmes in the healthcare sector. Notably, the recommendation for Romania to improve access to care is not reflected in its MoU, making its enforceability much weaker than its MoU commitments.

The 2014 round of CSRs presents some striking new features. For the first time there is a very detailed healthcare CSR (Ireland), which must be meticulously carried out, since the country in question is under reinforced post-programme surveillance. Explicit references to deadlines (France and Slovenia), spending reductions (France and Slovenia) or 'significant' improvements (France and the Czech Republic) increased pressure on some countries. The increased pressure on France and Slovenia is the result of the strengthened Excessive Deficit Procedure for Eurozone countries to which they are subject (SPC 2015). Finally, whereas the 2013 CSRs asked for the promotion of prevention, home care provision, rehabilitation and independent living, this did not happen in 2014. In particular in long-term care, the focus was directly on cost-effectiveness and sustainability.

Whereas no clear criteria were used to select the countries for the 2011 and 2012 CSRs a more systematic approach appears to have been implemented since 2013². This approach went public at the end of 2014, in a DG ECFIN document (European Commission 2014b). The process entails two stages. First, DG ECFIN identifies countries where there is a serious challenge to long-term fiscal sustainability, to which healthcare expenditure contributes to an important degree. This analysis is based on the projections provided in the Ageing Report (European Commission and EPC 2012) and the Fiscal Sustainability Report (European Commission 2012). In this way, twelve countries were flagged for a healthcare CSR in 2014, and out of these twelve, eleven effectively received such a CSR.

In the second stage of the selection process, the nature of the challenge is identified, which then feeds into the content of the CSRs. To this end, composite indicators covering the main dimensions of public expenditure on health have been created, i.e. on hospital care, ambulatory care, pharmaceuticals and administrative spending. An additional health status indicator is added which is supposed to capture the potential need for healthcare. If a country selected in the first stage performs below the median on one of these composite indicators, a particular challenge in the policy area is identified. As well as this quantitative comparative analysis, there is a country-specific analysis, which can lead to more specific or additional recommendations. The challenges are reflected in the CSRs and in the accompanying Staff Working Documents (SWD, since 2015 Country Reports), which have become increasingly detailed and are crucial to understanding the scope of the CSRs.³

Pressure to implement the CSRs also increased as a result of the conditionality linked to ESIF funding. Commission services urge the less economically developed Member States to use ESIF funding to

2. Private conversation with Commission officials.

3. Available at: http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index_en.htm (accessed on 5/11/2014).

fulfil the recommendations they received.⁴ Funding in the health sector is for many countries directed towards de-institutionalisation of care.⁵

1.3 The actors involved

Since the CSRs are to a large extent based on the Treaty articles governing the Stability and Growth Pact, the European Semester process is driven by the finance departments. The process of drafting the CSRs is coordinated by the European Commission's Secretariat General (SEC GEN), whilst the Directorate-General for Economic and Financial Affairs (DG ECFIN) holds the pen. Other DGs provide input. For healthcare-related CSRs, input comes in particular from the DGs for Employment, Social Affairs & Inclusion (EMPL), the Directorate-General for Health and Food Safety (SANTE) and the DG for Regional Policy (REGIO).

Before the CSRs are finally adopted by the finance ministers in the Council, Member States can propose amendments to the Commission proposals. Amendments to health and LTC CSRs are presented and discussed in the Social Protection Committee (SPC). Since 2014, the members of the Working Party on Public Health at Senior Level (WPPHSL) – a body which reports directly to the Health Council – are invited to the SPC when healthcare-related CSRs are discussed. The threshold for amending a CSR is very high and not a single substantial amendment has so far been adopted by the ECOFIN Council for health or LTC CSRs.⁶ This contrasts with other policy domains, such as pensions, where proposed CSRs are regularly and substantively amended (Zeitlin and Vanhercke 2014).

Strikingly, health ministers remain largely absent from the European Semester debates and remain extremely reluctant to discuss national

4. Interviews with Commission officials and Member State officials carried out in September/October 2014.

5. Available at: http://ec.europa.eu/contracts_grants/agreements/index_en.htm (consulted on 19/02/2015).

6. The time frame for proposing and agreeing on amendments is extremely tight: only two days in 2014. Amendments also face the reluctance of the Commission and reverse qualified majority voting in the Council.

reforms at the EU level. In June 2014, the Health Council invited Member States and the Commission to reinforce and improve cooperation between the Social Protection Committee and the WPPHSL so that Ministries of Health can actively contribute within the framework of the European Semester (CEU 2014a). Nonetheless, the addition of a specific headline target related to health in the EU 2020 strategy was not supported in the December 2014 Health Council meeting. Arguing in favour of an exclusive national competence, the Health Council proposed instead to exchange information and best practices (CEU 2014c).

To counterbalance the dominant position of the finance actors, health and social actors have striven to provide an objective and quantified approach to national challenges in access to and quality of care. Two developments are worth mentioning in this respect.

First, at the request of the Council, the Commission set up an expert group on health systems performance assessment (HSPA) in 2014, in which Member States participate on a voluntary basis. While Member States insist on the national level importance of this network, its voluntary nature and the exclusion of cross-country comparisons (CEU 2014b), Commission President Juncker stressed the importance of HSPA *'to inform policies at national and European level and to inform the work of the European Semester'* (Juncker 2014).

Second, the SPC is developing a tool to apply the methodology of the Joint Assessment Framework (JAF) to healthcare systems. This framework provides country profiles that give a detailed picture of the key challenges as well as particular good outcomes in each Member State, with a particular focus on health outcomes and access to and equity of healthcare.

Health authorities appear, however, to embrace such tools only reluctantly when they are meant to be used as part of the EU level surveillance mechanism of the Semester.

2. Domestic healthcare reform agenda(s)

According to the European Commission (2014a), European healthcare systems share a deep core of ‘European Social Model’ goals and values, and experienced similar transnational challenges due to the Great Recession. Accordingly, their reform agendas should be broadly similar or at least indicative of some degree of convergence. The question, then, is: do we really see EU Member States flocking together? And what does this tell us about the factors determining their reform agendas?

European health systems indisputably face common structural challenges. Over the last few decades, they have struggled to keep up with ever-changing needs and demands, while their basic principles have been put to the test by technological and socio-political transformations. The Great Recession and the ensuing politics of austerity have further restricted the room available to accommodate their multiple conflicting goals. National trends somehow shared a neo-liberal emphasis on decentralised decision-making, private provision, and patient choice. But the more complex systems that have resulted from this focus show little sign of convergence.

2.1 Scholarly debates and international advocacy

Health policies are complex and multifaceted, with different subfields addressed by various research streams. Recent studies cannot predict where healthcare is heading, but they offer telling snapshots of the international debate. The scholarship relevant to our topic comes in two main strands: classificatory studies of health system models and public health analyses interested in health regulation and management. Over the last five years, contributions have poured into both strands, occasionally proposing a more comprehensive approach (Pavolini and Guillén 2013).

Classificatory studies (see the discussion in Stamati and Baeten 2015) have long testified to the existence of profoundly different regimes and have ruled out even the latent existence of a ‘single’ healthcare model in Europe. There was a boom in ‘health regime’ literature in the early 2010s. Drawing on pioneering taxonomic studies such as Field (1973), Rothgang, Wendt and their co-authors advanced the so-called ‘RW-

typology' of health systems and health system change (Rothgang *et al.* 2010). The Organisation for Economic Co-operation and Development (OECD) attempted to combine this with the 'regime' approach, producing a much more complex taxonomy, with ambiguous and counter-intuitive results (Paris *et al.* 2010).

Sustained typological efforts only moderately influenced the international policy debate. Recent publications from the OECD (2010a) and the EU Commission (European Commission 2014a) explicitly acknowledge the significance of health system variation, but merely as a nuance in the formulation and implementation of generally applicable best practices. Since its 2000 *World Health Report*, the World Health Organisation (WHO) is much more inclined to take national diversity seriously. Yet this has not prompted regime-specific policy prescriptions.

Public health studies have had a greater impact. Here we focus on policy advocacy documents from international organisations. Over the last decade, OECD research has identified issues with health system performance, looking for best practices able to avert the incoming structural challenges. The original focus was on overuse of care (hospital utilisation), payment and recruiting systems, patient satisfaction, and the role of private insurance. EU documents addressed two topics. The first was how to strengthen primary and outpatient care and increase productivity and co-ordination (European Commission 2007). The second was a re-thinking of social and health services in the EU legal framework for services of general interest, recognising their specific goals and regulatory needs (European Commission 2003; Huber *et al.* 2006).

The global crisis stimulated sharper policy prescriptions, with a strong economic undertone (according to Walshe *et al.* 2013, only 4% of the Commission's funds for health research were spent on policy studies in 2011). The OECD and the EU jointly recognised the 'need for better value for money in health systems' (OECD 2009). The OECD (2009; 2010a; 2010b) suggested a focus on health market supply and demand dynamics, with an eye on long-term sustainability and the need for upfront investments. Care coordination, pharmaceutical pricing, and ICT could increase supply efficiency, while user charges could restrain the demand for care. 'Evidence-based medicine' and 'health technology assessment' would ensure constant policy updating. Overall estimates of efficiency gains were close to 2% of the OECD area's 2017 GDP.

The *EU Joint Report on Health Systems* (EPC and European Commission 2010) aimed to explain country differences by looking at national spending drivers. In order to enforce cost-effectiveness, the report recommended ensuring adequate funds, staff skills, and incentives, promoting primary over specialist care and a cost-effective use of medicines, improving governance and information flows, and strengthening health-technology assessment and prevention.

The WHO developed a genuine scepticism for prescriptions based on large international comparisons. It instead preferred to perform more detailed analyses of national political contexts, and to accompany these with more generic policy recommendations (WHO 2013a). Its reports have discussed the methodological and technical limitations of data collection and health indicator design (WHO 2012). Analysing the recent impact of crisis and austerity on health systems, the WHO (2013b; 2014) was much more critical of austerity than the OECD or the EU. Analytically, it is more attentive to the impact of the crisis in different countries and the responses taken to address it. It laments disinvestments in the health sector and limited progress in true efficiency-enhancing reforms. Normatively, the WHO has presented its *Health 2020* strategy, which is much more sensitive to the solidarity side of healthcare.

The 2014 WHO report highlighted country variations in health reform trends, traceable to differences in both contexts and policy choices (even in austerity). In this respect, the report lamented the potential long-term costs of arbitrary cuts and rushed implementation. Hidden costs do not only threaten access and quality levels, but may even jeopardise the policy consistency of some national systems. The study emphasised the concept of health system resilience in the face of various shocks, which comprises both economic and adequacy considerations. Recommendations supported the shift to a universalistic system of entitlement on the basis of residence.

Some of the WHO's perplexities filtered into the most recent publications by the OECD and the Commission. The OECD (2014) now explicitly relates geographical differences to health performance, focusing on 'unwarranted variation', which cannot be explained by demographic factors and patient preferences. The Commission documents *Investing in health* (European Commission 2013) and *Communication on effective,*

accessible and resilient health systems (European Commission 2014a) openly spoke of ‘system resilience’. Explicitly referenced was the need to ensure equality of access, corporate responsibility in the pharmaceutical field, and adequate financial resources for capital and technological investments. Caveats on direct comparisons of different systems and data reliability were also spelled out (SPC 2015). These analyses exemplify a savvy approach to health system assessment and policy advice.

2.2 Three reform agendas in the European Union?

The analysis presented in this chapter focuses on ten representative Member States within and outside the Eurozone: five National Health Services (NHS: Greece, Ireland, Italy, Sweden and UK-England) and five Social Health Insurance systems (SHI: France, Germany, Lithuania, the Netherlands and Romania). Looking at the most recent statistics and narrative accounts (Analytical Support on the Socio-Economic Impact of Social Protection Reforms - ASISP reports, waves: 2009-2013⁷ and the most recent Health Systems in Transition (HiT) reports⁸), historical reconstructions cover the period until late 2012, when the recommendations of the OECD and the EU were mostly directed towards cost containment, market efficiency, and cross-nationally applicable best practices. Our approach combines insights from the health regime and RW-typology literatures. In regard to the former, we acknowledge the importance of institutions and policy legacies; as for the latter, we assess policy changes against three healthcare dimensions (regulation, financing and provision) and three modes of governance (state control, societal self-administration, and market mechanisms).

Building on the analysis put forward in Stamati and Baeten (2015) we acknowledge the emergence across these countries of three broad agendas for healthcare reform during the Great Recession. The first agenda, *‘cost-containment and service privatisation’*, was identified in the three countries subject to EU-IMF financial assistance: Greece,

7. Available at: <http://socialprotection.eu/> (accessed on 3/9/2015)

8. Country HiTs available at: <http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits/full-list-of-country-hits> (accessed on 3/9/2015)

Ireland, and Romania. These countries achieved large health budget savings, shifting a substantial share of healthcare costs onto patients.

The second agenda, '*changing the healthcare mix*', was identified in the four Continental Eurozone countries in our sample: France, Germany, Italy and the Netherlands. Overall, these systems tried to continue with their pre-crisis reform agenda, consistent with nation-based problem solving and with international prescriptions.

The third agenda, '*systemic reorganisation*', occurred in Lithuania, Sweden, and the UK: three countries that do not belong to the Eurozone and were not involved in financial assistance programmes. These countries focused on their own long-standing structural challenges, with little common ground in terms of timing and content.

2.3 Research questions and hypotheses

Initially, we expected that the overall degree of change would be limited and that different health system regimes (NHS, SHI and their variants) would produce broadly similar reform agendas. With the partial exception of Greece, change in these countries was far from revolutionary. Reform agendas, however, did not match regime differences. We therefore ask the following research questions:

- Why did this variation in reform agendas occur in the first place? And why does it not follow traditional health regime divisions?
- Which factors, at the national and the supranational level, help explain these divergent reform agendas?

We formulate four working hypotheses, which are not mutually exclusive. The first two address our first question:

- H1: Cross-national variation in reform agendas was made possible by the external shock of the crisis, which weakened the constraining power of policy legacies ('*Aftershock*' hypothesis);

H2: Cross-national variation in reform agendas was a result of supranational pressures for cost-containment, in particular those coming from the EU (*'EU Leverage'* hypothesis);

The last two hypotheses address the second question:

H3: The timing and content of national reform agendas was determined by domestic political factors, such as majority changes in government (*'Domestic politics'* hypothesis);

H4: The timing and content of national reform agendas was determined by the enactment of efficiency enhancing reforms in the years before the crisis (*'Domestic vulnerability'* hypothesis);

In the following section we offer supporting evidence for the emergence of the three agendas.

3. Comparing healthcare reform trajectories

This section examines recent reform trends in our ten cases, grouped according to their health system family (NHS or SHI).

3.1 Reform patterns in National Health Services

All five countries with an NHS system – Greece, Ireland, Italy, Sweden and the UK-England – faced problems before the crisis and some were far from being success stories. We discuss them in turn.

3.1.1 Policy legacies and the impact of the crisis

Fragmentation of coverage and provision raised doubts on the very existence of a NHS in Ireland and Greece. Regional inequalities were traditionally strong in the other three countries, including the locally managed Swedish system. High (sometimes informal) user charges, inefficiencies and malpractices had delegitimised the Greek, Irish, Italian, and English systems. Health spending skyrocketed in Ireland

and increased everywhere but in Sweden, where cost containment had been successfully pursued in the 1990s.

Before the crisis, all countries had tried to reform their public/private healthcare mix and some of their regulatory mechanisms, including the allocation of competences between levels of governments. Faulty implementation (Greece, Italy), inconsistent choices or reform reversal (Ireland, Italy, and Sweden), and reform fatigue during the 2000s (Italy) prevented successful outcomes in most cases. Italian and Greek policymakers aimed to rationalise gatekeeping; English and Swedish ones to increase patient choice.

The fiscal impact of the crisis was highly diverse. Greece and Ireland had to apply for international financial assistance and commit to detailed reform programmes. Greece was asked to rationalise hospital services and governance (procurement and accounting rules), to adopt new norms for health professionals and pharmacists, and to promote the use of e-health tools and generic medicines. User charges were set to increase. Public health spending was capped. The entire plan was worth €2.7 billion savings. Initially, Ireland was asked to lift restrictions on GPs and pharmacists. Healthcare reforms were explicitly requested beginning in 2013. Italy and the UK were considerably affected as well. Italy entered a recession bordering on a sovereign debt crisis. Real spending trends in the healthcare sector turned negative on average between 2009 and 2012. The UK suffered a wide and costly banking crisis. No substantial response affecting the NHS was taken until the Conservatives won the 2010 elections, reviving long announced reform plans. Sweden was barely affected by the crisis. Its NHS did not experience major reform pressures, other than a revamped debate on regional health inequalities.

3.1.2 Reforms of health regulation

Recent regulatory reforms in NHS countries consisted of institutional reforms transferring powers to a different sphere or level of government, the adoption of stronger budgetary controls, the introduction of market or market-resembling mechanisms, and investments in access to and quality of care or e-health tools.

The agenda of institutional reforms varied, leading to nationally specific mixtures of decentralisation and re-centralisation. Greece and Ireland introduced new integrated care units with stronger gatekeeping functions at the local level. The Irish government pursued care coordination at the local level but re-centralised administrative and support services. Italy pursued a mix of centralisation and decentralisation, as the regions accepted more stringent budget rules in exchange for greater monitoring powers. ‘Recovery plans’ for insolvent regions introduced automatic increases in tax and charges, expanding central agenda-setting and sanctioning authority. ‘Health homes’ hosting several general practitioners were envisioned, but never financed. Sweden moved from a county-based to a regionalised system of health administration (with mixed results) and hospital management (with greater success). The English NHS was overhauled in 2012. Consortiums of general practitioners, subject to strong monitoring from the centre, replaced local health bodies and authorities.

(Potential) system-changing reforms were legislated only in Greece, Ireland and, to a lesser extent, Italy. Widespread mergers and consolidation of insurance funds, health and social welfare authorities, and even municipalities took place in Greece. Medical associations were authorised to issue licences, while EU-co-financed mental care NGOs expanded their service provision. Ireland announced a gradual shift towards universalism, financed through a mix of taxes, contributions and by applying a strict purchaser-provider split. Hospitals would be transformed into no-profit trusts, licensed by a new safety authority. Premium increases in private insurance plans would be subject to a ‘scheme of risk equalisation’. Italy expanded the role of complementary health insurance funds, covering dental care, rehabilitation, and long term-care (LTC). Membership of the funds increased in the 2010s, thanks to sustained government efforts.

Various market-based or market-like mechanisms were adopted in all countries. Greece, Ireland and Sweden lifted restrictions on pharmacies. Ireland also liberalised rules on general practitioners and medical advertising and created ‘hubs’ connecting hospitals and pharmaceutical firms. Italy re-regulated private practice in public facilities. England enacted the transformation of all hospitals into foundations, with lighter rules on private funding but increased transparency requirements. The choice of family doctors was partially liberalised. The ‘Any

Qualified Provider' approach was gradually adopted for medical procurement and contracts. Greece started introducing pay for performance criteria in the remuneration of medical professionals. Similar initiatives were also discussed in the UK.

Stronger cost and drug price controls played a large part in the Greek reform agenda. Greece centralised hospital procurement, mandated periodic reporting on drug spending and procurement, and repriced fees and reimbursements. Positive drug lists, generic prescribing targets, accounting based on diagnosis-related-groups, as well as clawback mechanisms and 'international reference pricing' for pharmaceuticals were all adopted. Ireland also promoted generic drug substitution and 'reference pricing' mechanisms. Italy introduced new monitoring tools for LTC as well as new guidelines on drug purchasing and prescribing, meant to increase competition. It also embarked on a reorganization of hospital care and pharmaceutical spending. New national standard costs were imposed through a 'benchmark mechanism', supported by a 'redistribution fund'. Finally, some Swedish counties called into question and occasionally re-regulated their systems of purchaser-provider split.

New investments in healthcare mainly addressed e-health developments. Greece and Ireland expanded their e-health facilities as a means for cost control. International e-auctions, e-prescribing (intended to eradicate non-compliance with new prescription rules) and e-referrals became mandatory in Greece. As requested by its creditors, Ireland developed a new e-health strategy in 2013. Health identifiers for patients and professionals would prompt an e-prescription system based on a 'Money Follows the Patient' funding model.

Improving access to and quality of care was also featured in the Irish and, prominently, UK (English) agenda. Ireland redirected some of its health savings to the establishment of home-based nursing services. In 2012, waiting times were set to be reduced except for specialist visits, where the longest queues existed. In England, NHS prescription charges were frozen for 2010-2011. After a number of misconduct scandals, the British government pledged to reduce inequalities and improve LTC standards across the four nations. LTC reforms ensued between 2012 and 2014. Regulatory and surveillance authorities were

strengthened, but not without major implementation problems. Prevention initiatives were also revamped all over the UK.

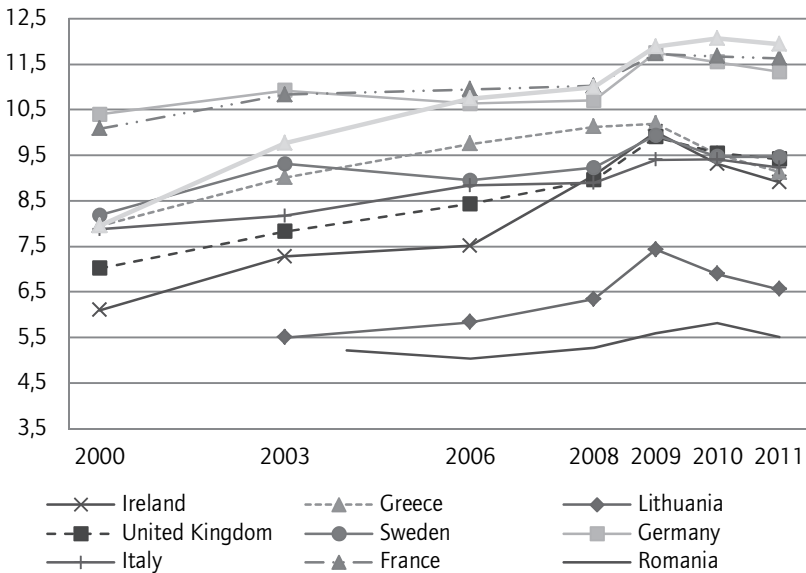
3.1.3 Reforms of financing and provision

Financing reforms mainly dealt with general spending and hospital budget cuts, increases in taxes and user charges. Changes in service provision resulted from measures taken in financing and regulation.

Spending cuts were particularly severe in Greece, Ireland and Italy. Public health spending in Greece (about 10% of GDP in 2009) has fallen by about €5 billion. The government mandated a 20% haircut of the social funds' debt with medical providers. On drugs, the haircut was 8% plus the clawback tax. The cost per patient in public hospitals fell from €3,500 in 2009 to €2,500 in 2011. Drug spending was reduced by about €2 billion in 2011-2012. The Irish health budget was cut by about 20% (€3 billion) between 2010 and 2012, thanks to major reductions in health sector wages and employment. The Irish budget for 2012 included a planned reduction of hospital beds and wards and a 4-5% cut in inpatient services. Italy cut NHS state subsidies by about €8 billion in 2012-14 and planned a further 0.4% GDP cut by 2017. Almost 10,000 hospital beds have been lost since 2009. Small hospitals and facilities were closed or clustered. Funding for disability assistance was discontinued between 2009 and 2013. Reductions in medical wages and hiring were scheduled in 2011-2018. Figure 1 provides a visual illustration of the main public spending trends up to 2011.

Tax financing of healthcare grew in Ireland and Sweden. Ireland levied a special health levy (2% on earnings up to €100,000 a year, 2.5% above that sum, with exemptions for the lowest incomes) in 2008. In 2012 it was increased to 4% (€75,000/year) and 5% above that sum. As a response to rising health costs, Swedish county councils and municipalities raised taxes in 2012-13. Stronger-than-expected recovery provided local health budgets with extra tax money.

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



Source: Data retrieved from OECD (stats.oecd.org) and Eurostat (epp.eurostat.ec.europa.eu). Data for Greece are up to 2009 only.

Greece, Ireland, and Italy increased user charges. Greece increased user charges and reduced exceptions for drugs and clinical care. Hospitals issued a €5 ‘entrance ticket’ for outpatient care as well as an afternoon shift with extra and partly non-reimbursable fees. A €25 fee on admission and an extra €1 fee (on top of a 25% co-payment) on prescriptions were imposed in 2014. Reimbursements for general practitioners were limited to 150-200 visits per month, which implied extra fees for patients in excess of this. Extra co-payments and a ceiling on consumables were introduced in 2012. The Irish budget for 2010 imposed a 50% charge on drug use (up to a family maximum of €10/month), increased from €100 to €120 the monthly threshold for drug reimbursements and raised by 21% the price of private beds in public hospitals. Out of pocket payments increased from €120 to €132 for 60% of the population in 2012. The Italian State and regions agreed to increase user charges by more than €2.5 billion overall. Further increases were announced but not legislated.

The scope for private service provision increased in Greece, Ireland, and Sweden. Hospital reorganisations reduced the number of publicly provided beds in Greece by more than 10%. About 25% of intensive care beds suffered from staff shortages. Greece's reformed partnership regime expanded for-profit financing for the hospital infrastructure. In Ireland, contracting of out-of-home care expanded during the 2000s due to greater state financing and declining informal care. However, career benefits and allowances were cut from 12.6 million hours in 2008 to 9.8 in 2012. In Sweden, recent liberalisations increased the volume of private provision. About €4 million were spent in 2012-2014 on initiatives to increase patient choice, with mixed effects on access to care.

Policymakers in all countries strived to preserve current access levels, but succeeded in varying degrees. The reform of the Greek health insurance funds left unemployed workers and some professionals with no or reduced coverage. In response, €46 million worth of vouchers were introduced in 2013-2014 to restore baseline access to primary care for some of these groups. Litigations between providers and insurance funds over arrears repayments occasionally disrupted hospital services. Waiting lists began to increase again in 2012, due to decreased hospital capacity. In April 2009, Greece agreed to a progressive de-institutionalisation of mentally ill patients. Confronting similar problems, Ireland granted the long-term ill free access to general practitioners. In 2009, Italy earmarked €1.4 billion, partly coming from EU funds, for a new round of regional projects on primary and long-term care. In Sweden, about €110 million have been paid since 2009 to reward county councils meeting national waiting time standards. In the UK, waiting times – reduced by the large investments of the 2000s – have started to increase again since 2010. Delayed referrals for routine surgery were reported in England.

3.2 Reform patterns in Social Health Insurance systems

Five countries in our sample have a Social Health Insurance system: France, Germany, Lithuania, the Netherlands and Romania.

3.2.1 Policy legacies and the impact of the crisis

France, Germany and the Netherlands all combine public insurance with voluntary supplementary schemes. Comparatively generous, their health and long-term care are effective and demand low user charges, but face risks of insufficient care coordination and polarization between social and private actors. The Netherlands, and more recently France, also saw health spending soar during the 2000s. Lithuania and Romania had a difficult transition out of the soviet Semashko system. Lithuania adopted new framework legislation in the mid-1990s but failed to fully develop a modern health system. Romania never managed to properly complete the transition, confronting endless financial, public health and corruption problems. High tax-financed subsidies remained unavoidable.

From the 1980s and until the crisis, France continued with the decentralisation and managerialisation of its health system. A major reform in 2004 adopted the so-called *Tarifification à l'Activité* (a sort of Diagnosis-Related-Group mechanism), increased patient choice of primary care, incentivised hospital performance and allowed higher charges for un-referred patients. In 2006 and 2007 the Netherlands and Germany adopted two similar reforms, seeking convergence between social and private health insurance. Both reforms increased coverage and reduced costs, but required further consolidation in the years of the crisis. Lithuania harmonized standards and recentralised regulatory competences in the 2000s, but remained dependent on hospitalisation and on a mix of subsidies and high user charges. Romanian reforms envisaged sounder financing and more coordination between government levels, but remained inconclusive. The system increasingly privatised financing, provision, and risks.

Germany and, to a lesser extent, France fared comparatively well through the crisis, while Dutch growth and employment trends were badly influenced. Their health budgets were not affected, keeping the reform debate focused on pre-crisis priorities. After years of sustained growth, the crisis drew Lithuania into a heavy recession. Existing health budget reserves were able to absorb the financial shortage. The health agenda remained in line with pre-crisis priorities: empowering equality in access and patient choice while combating corruption. Romania entered a deep recession in 2009-2010 and had to apply for a Balance-of-Payments Assistance Programme. Shrinking contributions turned a

surplus in 2006 into spiralling deficits. Huge arrears (€1.3 billion in March 2013) led to frequent service disruptions.

3.2.2 Reforms of health regulation

As in NHS countries, in SHI systems regulatory reforms addressed institutional settings, cost controls, marketisation and investments.

National trajectories of institutional reform varied within our selection of SHI countries. France reorganised health planning, empowering the regional level. Germany and the Netherlands adopted a mix of centralisation and decentralisation. From 2009, the German federal level acquired the authority to set health contribution rates (15.5% in 2013). A reform in 2012 then reinforced or further decentralised state competences. In the Netherlands, LTC tariffs have been centrally determined since 2010. Lithuania opted for recentralisation. County councils were abolished and authority over regional hospitals shifted to other government levels. Three strategic objectives were set in 2010: reorganising the health funds and the hospital network, reforming the pharmaceutical market, and maintaining pre-crisis access levels. Conversely, Romania decentralised hospital administration, licensing excluded. Local authorities would appoint managers and finance administration in a rather unregulated environment. The reclassification of hospitals, however, was hard to implement and produced fewer savings than expected. A new bill was enacted in 2013, aiming at a reallocation of administrative competences towards regional – but centrally supervised – companies and structures.

All countries, especially Romania, adopted new cost control measures. In France, the scope of *Tarifification à l'Activité* in public hospitals was extended to more medical expenses. Stricter yearly growth norms were scheduled for the Dutch health budget over the period 2012-2017. Lithuania implemented Diagnosis-Related-Group funding beginning in 2012. In Romania, basic benefit packages of medical services and products were redesigned, consistent with the MoU's calls for more transparent rules on reimbursement. The Memorandum also subjected hospital budgeting to the surveillance of the Ministry of Finance. Since 2012, high income earners were asked to pay extra contributions for their dependants. Medical services were offered in different packages:

minimum, basic, and with private supplements. Romania also introduced a centralised procurement system for pharmaceuticals and medical devices for hospitals. A 2010 ordinance tackled medical certification fraud; tighter rules and penalties resulted in €34 million savings and €400,000 worth of fines.

Germany, Lithuania and Romania re-regulated their pharmaceutical markets. The German market was reformed in 2010, increasing mandatory discounts on certain drugs and introducing a stricter formula for price updates. In 2009, Lithuania resolutely acted to stop medical price inflation, ruling a price freeze and higher VAT taxes on drugs. The pharmaceutical sector was entirely re-regulated in 2010, expanding generic use and cutting their prices. Romania introduced a clawback tax on pharmaceuticals in 2009, but design flaws inflated the tax rate so much, so that a new formula was needed as early as 2013.

Liberalisations were documented in all countries except France. German social funds were allowed to merge and enter into ‘selective contracts’ with health providers in a trend towards increasing liberalisation. The Netherlands expanded the scope of free pricing in the hospital sector, reduced risk pooling among health funds, announced a partial lifting of the traditional ban on for-profit hospital care, and reduced the limits put on referrals to medical specialists. Lithuanian health centres were given more autonomy in planning and utilization, albeit still in a heavily state-regulated environment. In Romania, the 2012 reform also envisioned the transformation of hospitals into autonomous non-budgetary institutions and free patient choice between public and private insurers.

France and Germany reformed doctors’ remuneration rules. Germany adopted a daily lump sum regime, mandatory since 2015, to remunerate psychiatric treatment. In 2009, France introduced more flexibility in medical remuneration and incentives to provide services in disadvantaged areas. The Workers’ Sickness Fund also established a successful ‘pay for performance’ scheme: general practitioners can receive up to €7 extra per patient if they comply with national targets and demands. A reform in 2012 restated some of the rights and prerogatives of professionals in health centres. In October 2012, the social partners agreed to a new voluntary contract that contains incentives to limit the amount of over-billing for specialist visits.

Also in SHI countries, new investments addressed access to care and e-health tools. The assisted use of social media for LTC therapies has been enacted in Germany (2013) and the Netherlands (2012). Lithuania's efforts to improve national public health records continued with success after the crisis. Disease-specific programmes and e-health records were activated to improve the general effectiveness and coordination of health and LTC services. Romania implemented IT-based patient recording in 2010. Millions of erroneous registrations with family doctors were erased, resulting in €39 million savings. Romania also adopted higher standards in disability care facilities. Staff shortages prevented similar improvements in mental health centres.

3.2.3 Reforms of financing and provision

Reforms combined cuts and refinancing with higher user charges. There was an expansion in private provision of specialist care in Romania.

Some countries, especially Germany, had fiscal leeway to refinance short-term deficits with extra subsidies. The German social funds remained solvent with about €28 billion worth of reserves. Healthcare contribution rates decreased to 7.0% (employers) and 7.9% (employees) in 2009, before rising to 7.3% (in 2010) and 8.2% (in 2011). LTC contributions increased to 1.95% in 2008 and 2.05% in 2013. The federal subsidy to the health budget was increased by €7.2 billion for 2009 and €15.7 billion for 2010. In 2009, an interest free loan equal to 50% of the costs of the recession was made available to strengthen the new national health fund, which eventually experienced a €4.4 billion surplus at repayment time (2011). The surplus was used to correct some design flaws in the 2007 reform of health funds, to reduce doctor shortages in rural areas, and to bring the federal health subsidy below 20%. In 2011, France allocated an extra €1.9 billion to its health budget. Lithuania adopted a major reform of healthcare financing in 2009. 75% of the insurance system was to be financed through mandatory social contributions, with wider coverage, stricter controls and fines, and higher state-financed premiums. The Romanian health budget was spared from the cuts and, in 2009, even received advanced funding from the 2010 budget. Nonetheless it fell by 12% between 2008 and 2011. In 2011, Romanian pensioners were required to pay health contributions (5.5%) up to a minimum income floor, in order to increase revenues.

Spending cuts featured prominently in the Netherlands and Lithuania. In the Netherlands, healthcare spending was expected to grow by €6 billion by 2016 as stagnation persisted. €5.4 billion cuts were scheduled for 2013-17: €1.4 in healthcare and €4 in LTC, which meant reducing residential and inpatient care and slashing health insurance benefit packages. In 2009, Lithuania froze the health budget at its 2008 nominal level, revoking a 6.7% planned increase and 6.2% of the 'point cost' of most treatments. A wide range of minor measures achieved an extra 8.7% savings in 2010. In Germany, social insurance administrative costs were temporarily frozen at their 2010 level. Liquidity constraints caused major disruptions in the activity of Romanian hospitals and pharmacies. In April 2013, the entire cost of stomatology care services was shifted onto patients. Public reimbursements to private providers were capped at 5% of total county allocations in 2013 and 2014.

Germany and Lithuania invested in hospital equipment and staff. Romania invested in a more decentralised hospital structure before austerity kicked in. German hospitals were entitled to €1.3 billion of investments over the period 2009-11. In 2009, representatives of hospitals and insurers signed an agreement on wage increases. As a result, hospitals received an extra €1.1 billion funding and a further €1.1 billion in 2013-14. Lithuania spared most outpatient and short-term inpatient services from the cuts. Spending increased on municipal nursing and long-term care. Geriatric services were expanded and more effectively coordinated from 2010. Revised working schedules kept waiting times for consultations under control, while access levels to most outpatient services increased. Inpatient services were reorganised and liberalised. Savings were used, together with EU funds, to strengthen local outpatient units in both primary and secondary care (+30% since 2005). EU funds were prominently and increasingly used to decentralise residential services, which led to the elimination of 9,200 beds, reducing hospitalization costs.

User charges were increased in France, Romania and the Netherlands. France raised hospital and consultation fees and lowered reimbursements on medicines for less severe illnesses and medical devices. In the Netherlands, user charges increased from 4% to 8% for wealthier than average patients. Germany managed to reduce co-payments on outpatient services. In 2009, Romania, as prescribed by the MoU, introduced a new 'health ticket' that increased user charges on the basis

of income and service type. Further co-payments on medical services took effect in 2012. Instead of being means-tested as agreed in the MoU, the new charges were progressive and did not apply to emergency care and family doctors. This resulted in lower savings than expected. Additional charges made up for revisions in the clawback tax, with an estimated gain of more than €80 million.

Private provision substantially increased in Romania. Romania agreed to leave a share of service provision to the private sector. Private clinics, which apply EU15 clinical and wage standards, rapidly expanded in the dental and maternity sector, stimulated by access granted by private insurance plans. Preference for private clinics is growing rapidly, especially among young, highly educated and well-off citizens, and in major cities.

4. Explaining differences in national reform agendas

4.1 Reforms in a nutshell: path breaking or regime breaking?

The examination of country trajectories revealed great within-regime variation in the reform agenda. The clearest difference that maps on regime boundaries is the larger room for external refinancing available in SHI systems, which are contribution-based. Potentially path-breaking reforms in the post-crisis period were limited to the Memorandum countries, which also saw a greater expansion of private provision. (De)centralisation trends revealed a will to experiment and 'refresh' policy networks rather than convergence towards a new model of governance. Other interventions are broadly consistent with the recommendations of the international debate reviewed in Section 2.1. Measures for liberalisation and marketisation were highly context-dependent. Pharmaceutical market reforms were enacted everywhere, but with comparable variation in technical details. E-health tools were mostly adopted as a means to strengthen monitoring and enforcement.

It can be concluded that while reforms have not been path-breaking, they have resulted from a complex adaptive process. And if they have not been regime-breaking, they have shown how similar legacies can be pushed in different directions. The crisis has indeed weakened their constraining power. The role of austerity, however, is difficult to

disentangle. In some countries, reforms actually accelerated after a change in government (Romania, the Netherlands and more particularly Lithuania, Sweden, and the UK), especially when the political right came to power. In others, most notably France and Italy, changes in government did not imply major alterations in the ongoing policy direction. Our final hypothesis – domestic vulnerability – can help to explain the reform content in countries that did not suffer from strong structural or external pressures (Germany, Sweden, and the UK-England).

4.2 The role of ‘EU leverage’

What is still missing from the picture is a clearer understanding of how the EU has influenced national trajectories, beyond the Memorandums (MoUs) and the use of EU funds for local-level initiatives. As a first step in this direction, we developed a simple indicator of ‘EU leverage’ (see Stamati and Baeten 2015 for the methodology), which is intended to indicate the extent to which national and supranational decision-making have been entwined in the 2008-2013 period. We classified leverage as strong in MoU countries (Greece, Ireland, and Romania), moderate in France, Germany, Italy, and the Netherlands, and weak in Lithuania, Sweden, and the UK (England).

Greece, Ireland, and Romania followed the ‘*cost-containment and service privatisation*’ agenda, which implied large health budget savings and a shifting of risk towards patients. Regulation was reorganised, reinforcing the role of the state in Romania and that of social insurance funds in Greece. Financing was rationalised in Greece, with a greater role for insurance contributions vis-à-vis the state and market actors, and was privatised in Ireland. Evidence of privatisation of inpatient service provision started to appear in Ireland and Romania. In this case, domestic systems that had lost credibility were particularly vulnerable to the strong supranational pressures coming with EU-IMF assistance.

France, Germany, Italy and the Netherlands followed the ‘*changing healthcare mix*’ agenda, combining nation-based problem solving with supranational indications. Engaged in ambitious liberalisations of their public/private mix since at least the mid-2000s, these systems received

allegations of reform-sluggishness. This clearly holds for Italy and, to a lesser extent, France. Regulatory reforms mainly shifted control powers from insurance funds towards the state (France, Germany) or the market (Italy and the Netherlands). Some indications of privatisation were evident in service provisions, with a small share of publicly provided hospital beds being taken up by private (France and Germany) or non-profit (Italy) actors. Their overall strategy is consistent with the intermediate level of EU leverage they experienced.

Lithuania, Sweden, and the UK followed a '*systemic reorganisation*' agenda. Sweden and England both shifted a great deal of state authority on competition, gatekeeping, provider remuneration, and contracting out rules to market mechanisms. Lithuania took a similar policy direction back in the late 1990s and then focused on raising its standards. State prerogatives increased in healthcare financing, while provision remained largely unchanged. These countries experienced lower domestic and supranational pressures for cost containment, which reflects their non-membership of the Eurozone. Domestic politics and partisan policy agendas had a greater influence on reform outputs.

Concluding remarks

In this chapter we have provided evidence of the emergence of three European health reform agendas that do not follow traditional lines of demarcation between health regimes. We have also shown that recent reforms in a representative group of EU Member States have been influenced by international health research and supranational advocacy, leaving some degree of policymaking autonomy. In order to make sense of this varying degree of autonomy, we devised a straightforward indicator of EU leverage on domestic reform processes. The indicator is not able to fully explain variations within and between country groups, but does fit well with broad distinctions in their health agendas.

Looking at the broader picture and ignoring the persistence of national specificities, the clearest trend is that reforms largely reflecting the neo-liberal paradigm were legislated in rather different scenarios. In no country was the government free enough from external pressures and

sceptical enough of neo-liberal receipts to counter the general tendency towards marketisation and austerity.

Going back to our hypotheses in Section 2, we may conclude that the 'EU leverage hypothesis' is that which best fits our empirical observations, clearly ahead of its rival 'Aftershock hypothesis'. The utility of the 'Domestic politics' and 'Domestic vulnerability' hypotheses is dubious, as their causal leverage is mixed. A way to reconcile these findings is to assume that EU leverage tends, in fact, to be greater in reform-sluggish countries, reacting to an accumulation of pressure from domestic (fiscal) problems. When levels of EU leverage are high, however, the role of domestic politics is much more restricted. Conversely, national political dynamics enjoy more leeway – and a greater ability to address short-term challenges – when EU leverage is low, even in countries that lack a recent record of reforms.

Neither the impact of the crisis (which varied according to national legacies), nor supranational pressures (which varied with the degree of national economic vulnerability) are alone able to account for this general neo-liberal trend. And yet, our analysis of recent developments in international debates and advocacy showed that neo-liberal ideas were indeed dominant, but also far from being universally accepted or settled once and for all. Finally, the importance of domestic politics alone cannot explain the timing of the reforms, which suggests that short term factors played at least some role. The contingent but varying success of neo-liberal solutions is more a result of the overall configuration of these factors than of their isolated effect.

The causal linkages we suggested can and should be spelled out more clearly. Strengthening the quantitative framework of our analysis would also help us to be fairer when comparing the EU leverage hypotheses with its alternatives. Domestic dynamics and the (changing) preferences of national governments need to be observed much more closely, before a general argument can be advanced on the impact of partisanship and ideology on healthcare reforms. A closer focus of our qualitative reconstruction on high-interest cases such as Greece, Germany and the UK-England, would surely strengthen our causal account.

Our findings, however, already allow us to make a point on the evolution of the EU health agenda. The economic and fiscal orientation of EU leverage means that countries unable to undertake the necessary healthcare reforms receive supranational pressures to do so only if they fall short on economic, rather than social, goals and indicators. This trend introduces a major bias in policymaking, which does not serve the public health ambitions of the European Social Model well. An apparent contradiction in the current EU agenda is that while fiscal consolidation policies focus on stronger public controls, EU internal market rules have a creeping deregulatory effect on health systems. What is needed is more consistency and more transparency in the way health policymaking and European governance are entwined, taking greater account, for instance, of the WHO's criticisms and observations.

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