Original Article

Inside the black box: The EU's economic surveillance of national healthcare systems

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Abstract In the context of macro-economic surveillance, the European Union(EU) increasingly addresses national health system reform. Member States receiving financial assistance are required to implement detailed reforms stipulated in 'Memorandums of Understanding' (MoUs). But the health systems in other (non-MoU) countries are also scrutinised in the context of the 'European Semester': through this annual policy cycle, the EU has continuously strengthened the tools it uses to enforce compliance. This article aims to open the black box of the EU's economic surveillance of national healthcare systems by outlining the complex policy architecture of the EU's newly acquired role in this area. The story of how health has emerged on the European agenda illustrates how the Eurozone crisis created a policy 'window of opportunity' to push through fiscal surveillance of health systems as part of the solution to the crisis. The cognitive frameworks put forward by certain elites added up to the primacy of an economic perspective over health objectives. Finally, our analysis of the role of the actors involved in the elaboration of EU guidance in the field of health points to the dominance of 'economic' actors and relative absence of 'health' actors, in spite of increased attempts by the latter to gain influence.
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Introduction

Member States have always been very reluctant to cede powers to the European Union (EU) with regard to the organisation and funding of their national healthcare systems. They therefore explicitly limited the scope of EU intervention to supporting voluntary cooperation between national authorities (Vollaard and Martinsen, 2016, this issue).[1] Notwithstanding this limitation, important aspects of health systems are indirectly addressed in EU law, in particular in the context of the internal market (Mossialos *et al*, 2010).

The European sovereign debt crisis, which erupted around late 2009, provoked a radical change in the way the EU engages in national health system reforms. Indeed, as a result of the sense of urgency created by the Eurozone crisis – which ultimately threatened the European project as a whole – EU institutions acquired new powers to supervise national budgetary and economic policies. Within these policies healthcare is particularly targeted, mainly from a public finance perspective.

Member States receiving conditional financial assistance from the EU had to engage in Economic Adjustment Programmes containing detailed prescriptions for health system reforms. Other Member States, too, are increasingly receiving EU guidance on how to reform their health system, notably through enhanced coordination and surveillance of national macro-economic and fiscal policies as part of the 'European Semester'. This annual policy cycle places the European Commission at the heart of far-reaching healthcare reform enforcement.

But how have the EU institutions, over a very short time span, managed to find their way to the heart of national healthcare policies, despite major and enduring resistance from national health authorities to any significant EU involvement? The academic literature provides some initial insights. Thus it has become clear that a 'discursive transformation' (Helderman, 2014) of the European health policy framework in the last decade – in which public health expenditure is carefully labelled as 'growth friendly' as long as it is 'cost-effective' and 'efficient' – paved the way for a game change. Furthermore, since health systems account for significant shares of national budgets and are seen as having a great potential for 'efficiency gains', they are an obvious target for the EU fiscal governance frameworks (Fahy, 2012; Helderman, 2014). While these observations are important to an understanding of *why* healthcare has been targeted in the EU economic governance mechanism, they are not sufficient to explain *how* national resistance to EU interference in national health systems has been overcome so suddenly.

Earlier research demonstrated that the legal mechanism governing the EU's surveillance of health systems empowers finance actors at EU and national level over health actors (Greer *et al*, 2014). The content of health-care related EU guidance was formulated in terms of a discourse on sustainability of public finances rather than of social inclusion (Baeten and Thomson, 2012; Azzopardi-Muscat *et al*, 2015; Stamati and Baeten, 2015). Finally, it was demonstrated that the likelihood of obtaining a healthcare related Country-specific Recommendation (CSR) is strongly linked to the level of the general government debt (Azzopardi-Muscat *et al*, 2015). However, none of these studies unravelled the detailed process through which this new economic governance is being applied to healthcare by the European institutions.

This article aims to fill this gap, by opening up the 'black box' of the EU economic governance of health systems. It explains how this complex new EU machinery works in practice, traces how the content of the EU prescriptions is being shaped, and describes the power relations between the actors involved. We argue that the

sovereign debt crisis created a 'window of opportunity' for certain EU actors to break into the well-preserved domain of national healthcare policies. We also examine under which circumstances these new EU policies have the potential to guide – support or restrain – national health policies.

Our study does not provide an explanation of the EU's responses to the euro area financial crisis (see Verdun, 2015), nor does it assess the impact of the global financial crisis on welfare states in general (see Dolvik and Martin, 2015), or on health systems more particularly: the latter is subject of an increasing body of literature (see, for example, Stamati and Baeten, 2015; Thomson *et al*, 2015). Nor do we look into the actual impact of the EU on domestic reform policies. While extremely challenging in methodological terms, the latter has been analysed, for example, for France, Spain and Italy (Hassenteufel and Palier, 2015; Pavolini *et al*, 2015).

Our analysis is based on extensive analysis of published and unpublished EU documents. Given the limited transparency on the internal operation of the EU economic governance mechanism and the need to obtain the views of some of the 'policy entrepreneurs', we furthermore gathered key insights through interviews. Fifteen semi-structured interviews were conducted with high-level officials working in different Directorates General (DGs) of the European Commission, and 5 with Member State health officials, all carried out in the autumn of 2014. Our research therefore covers developments until the end of 2014.

We first describe the analytical framework of our analysis, which helps us to understand how the Eurozone crisis created a policy 'window of opportunity' to push forward fiscal surveillance of health systems as part of the solution to the crisis. The next section describes the institutional setting that allows key actors to take their place in the decision-making process. The subsequent section then explains how health became part and parcel of the EU's economic governance and discusses how this policy area has been dealt with, substantively. The section after that analyses the role of the key actors involved in the EU's economic governance of health systems. The following section describes how the implementation of EU guidance in health is monitored, and asks whether EU governance in health actually works. The final section discusses our main findings.

Analytical Framework: Windows and Opportunities

To understand how the sovereign debt crisis allowed the EU institutions to enter the heart of national health systems, we draw on the framework elaborated by Kingdon (1995), who distinguishes three important streams of the policy formation process that must be aligned for a matter to be dealt with in the public policy arena: first, *problem recognition* (why do certain problems capture the attention of policymakers while others do not); second, the *political stream* (creating the ability and willingness

to pursue a policy change) and third, the *policy stream* (whether or not certain ideas or policy alternatives take hold and grow). At some critical junctures the three streams join, and the greatest policy changes grow out of that coupling. At such moments, a 'window of opportunity' opens and policymakers are able to push through their pet solution for the problem. Kingdon's framework helps us to understand how the Eurozone crisis created a policy 'window of opportunity' to push forward fiscal surveillance of health systems as part of the solution (see also Greer and Löblová, 2016, this issue).

The policy agenda is first determined by *problem recognition.* For policy change to happen, 'conditions' should come to be defined as 'problems'. For Kingdon, a crisis can be seen as a 'focusing event', which reveals underlying problems in the affected policy area. Following Kingdon, we will show that the Eurozone crisis played a role in selectively bringing financial sustainability problems in the field of healthcare to the attention of policymakers through:

- the *use of indicators* and comparisons between countries to assess the magnitude and changing dimension of the fiscal sustainability challenges in health systems;
- the *repackaging* of the issue of the financial sustainability of healthcare into new categories, in particular into those related to the threat to the stability of the Euro.
- *feedback* on the operation of existing programmes, which includes systematic monitoring, evaluation and studies on particular topics.

Second, ability and willingness to pursue a policy change are required: these are determined by the *political stream* of the policy-making process. The Eurozone crisis clearly had an impact on certain aspects of this stream: we will see how important precedents in terms of political practice were set in the MoUs with the countries needing financial assistance in 2010, and how this created spill-overs into adjacent policy arenas, in particular within the European Semester. Also, the political practice of providing specific guidance in the field of pensions, well before the crisis, created spill-overs into the field of healthcare. We will furthermore demonstrate how actors, in particular the finance ministers and Commission services responsible for fiscal sustainability, have been empowered to seize a place at the negotiation table.

Kingdons' *policy stream*, finally, focuses on *the generation of policy alternatives*. This stream enables us to understand why certain ideas survive, while others do not. Kingdon considers that 'policy entrepreneurs', who broker people and ideas, are more important than inventors. 'New' policy alternatives may in fact be familiar ideas that simply never made it onto the decision-agenda, but which for some reason are seriously re-considered by decision makers. We argue that EU guidance on the content of the reform of health systems progressively became seen as part of the solution to the problems of the stability of the Eurozone. This occurred through mechanisms such as the gradual accumulation of knowledge and ideas; the recombination of already familiar elements by credible actors (the finance actors in our case), and finally 'softening up' activities. The latter mean that through

persuasion and diffusion, for instance through expert groups and EU reflection processes, an idea gradually culminates in a 'tipping' phenomenon, as a result of which it becomes accepted as a valid policy alternative.

In sum, this theoretical framework shows how the sovereign debt crisis helped to create the conditions for a coupling of the problems, politics and policy streams by political entrepreneurs who: (i) played a key role in the decision-making process and; (ii) were familiar with the instruments and practices of EU economic policy coordination before the beginning of the crisis. The next section explains the broad institutional setting which influences each of the streams of the political process.

The EU's Economic Governance: Institutional Setting

Controlling public expenditure on health has, for a long time, been a theme in the EU coordination of macro-economic policies, notably in the context of the Stability and Growth Pact (SGP) (European Council, 1997). In force since 1999, the Pact aims to facilitate and maintain the stability of the Economic and Monetary Union (EMU). The Council periodically issues Broad Economic Policy Guidelines (BEPGs) which set out policies to ensure the sustainability of public finances and reduce macro-economic imbalances. If a Member State breaches the thresholds for government deficit of 3 per cent of GDP or for debt exceeding 60 per cent of GDP, the Council can decide to activate an Excessive Deficit Procedure (EDP), under which a Member State can ultimately be issued financial sanctions. The framework for coordinating national macro-economic and fiscal policies based on the SGP was gradually complemented with a 'soft' governance framework for employment and social policies.

The sovereign debt crisis exacerbated pressure on Member States' public finances, leading to efforts to further strengthen economic policy coordination. As a result, Member States provided the EU institutions with unprecedented powers – especially in the Eurozone countries – to supervise national fiscal and economic policies.

The most comprehensive type of EU surveillance applies to countries receiving financial assistance from the EU and the International Monetary Fund (IMF). Financial assistance is linked to macro-economic conditionality, which means that the countries involved have to commit to reforms in economic and social policies included in a MoU agreed with the European Commission, in liaison where appropriate with the European Central Bank (ECB) and the IMF (formerly known as the 'Troika'). Each aMoU provides detailed prescriptions to reform the healthcare system. The programmes are subject to regular review missions by the lenders, which may lead to sanctions for non-compliance and strict conditions in exchange for any further financial assistance.

For all other (non-MoU) Member States, new EU policy instruments have been embedded in the 'European Semester' for economic policy coordination.

The European Semester integrates, synchronises and reinforces previously existing frameworks to coordinate national macro-economic and fiscal policies, based on the SGP on the one hand, and Europe 2020, the EU's growth strategy that incorporates the 'soft' governance framework for employment and social policies on the other hand (Zeitlin and Vanhercke, 2015). The yearly cycle of the Semester starts in November with the publication of the European Commission's Annual Growth Survey (AGS), which sets out EU priorities for boosting growth and job creation in the coming year. On the basis of Guidelines issued by the Council, Member States prepare annual National Reform Programmes (NRPs). The NRPs are reviewed by the Commission and followed by CSRs from the Council upon a proposal by the Commission. The CSRs provide tailored advice on structural reforms in Member States, including in the health sector.

To ensure implementation of the EU guidance within the Semester, stricter procedures for economic and fiscal surveillance have been established through the so-called Six-pack of EU legislation[2] (that became law in December 2011), the Two-pack (that entered into force in May 2013)[3] and the Treaty on Stability, Coordination and Governance in the Economic and Monetary Union[4]. As a result, Eurozone Member States in the Excessive Deficit Procedure are subject to enhanced monitoring. If they fail to follow the recommendations within the given timeframe, moreover, the EU can issue policy warnings to be endorsed by the Council and ultimately enforce compliance through financial sanctions. The Six-pack also extended multilateral surveillance to non-budgetary elements, by establishing a mechanism to detect, prevent and correct macro-economic imbalances through a dedicated procedure. Here too sanctions apply for euro area Member States in case of non-compliance with EU recommendations.

As a result of these reinforced frameworks, the tools to enforce compliance with CSRs concerning fiscal and macro-economic policies – that include recommendations urging countries to improve the cost-effectiveness of healthcare – have been seriously strengthened, in particular for euro area Member States. By contrast, CSRs based on the Europe 2020 strategy – that include social policies such as improving access to care – remain 'soft' governance instruments with comparatively weaker surveillance and enforcement (see also de la Porte and Heins, 2015). At the same time, the latter have developed real 'bite' in the last few years, notably through multilateral surveillance, peer reviews and *ex ante* reviews (Zeitlin and Vanhercke, 2015)

A final instrument to strengthen the enforceability of economic governance was added to the EU's toolbox in the form of the funding rules of the 2014–2020 European Structural and Investment Funds (ESIF).[5] These rules state that the Commission may request a country to redirect part of the funding to meet the priorities defined in the CSRs (Council of the European Union, 2013).

The Emergence of Healthcare in EU Economic Governance

Already since the 1990s, the Broad Economic Policy Guidelines (BEPG) have consistently urged Member States to improve the sustainability of public finances, in particular through reform of age-related public expenditure on pensions and health and long-term care. The EU's Employment Guidelines ask Member States to reform their health systems to ensure that they provide adequate services and social cohesion. Whereas, the BEPG in the field of pensions have gradually been specified in EU level policy debates (Natali, 2010), the same has not happened for healthcare.

The year 2010 was clearly a turning point, when healthcare was incorporated into the EU's economic governance mechanism. In April 2010, the Eurozone crisis culminated in a decline of the euro currency, when Greece's debt rating was reduced to BB+ (a 'junk' status). Starting with the Greek MoU in April 2010, all MoUs – concluded with Portugal, Romania, Ireland and Cyprus – now contain detailed instructions for reforming the healthcare sector. This contrasts with the MoUs that were concluded before the Eurozone crisis – with Hungary (2008), Latvia (2009) and Romania (2009) – in which healthcare was not addressed, while they all included detailed prescriptions on reforming the pension system. The Greek MoU thus allowed for a 'repacking' of issues relating to the financial sustainability of healthcare systems, which were now seen in the context of the Eurozone crisis. It furthermore created a precedent in terms of political practice, which spilled over into the other MoUs, and later into the European Semester.

The inclusion of healthcare within the European Semester indeed followed 1 year later. In the first AGS, published in the autumn of 2010, extensive attention was paid to reforming pension systems, but healthcare was not even mentioned. That year, the European Commission's DG for Economic and Financial Affairs (ECFIN), which is in charge of stable public finances and financial stability, and the Economic Policy Committee (EPC) published a Joint Report on Health Systems (European Commission and EPC, 2010).[6] This report, the first publication published jointly by these two institutions that specifically deals with health systems, analyses the drivers of health expenditure and identifies key challenges facing each national health system in the EU. It thereby played a vital role in the acceptance of the financial sustainability of healthcare as a 'problem' (rather than a mere condition) by policymakers. In December 2010, the Economic and Financial Affairs Council (ECOFIN) adopted Conclusions on this Joint Report (Council of the European Union, 2010), that constituted the most detailed EU guidance on the content of health system reform until then. These Council Conclusions thereby provided essential legitimacy to the finance actors at EU level (DG ECFIN and ECOFIN Council), enabling them to intervene with regard to the content of healthcare policies and to include healthcare reform in the European Semester (Baeten and Thomson, 2012). As a result, healthcare has been addressed every year in the AGSs since 2011.

Table 1: Overview of countries having received a healthcare related CSR 2011–2015[a]

	2011	*2012*	*2013*	*2014*	*2015*
Austria	**x**	**x**	**x**	**x**	**x**
Belgium	—	**x**	—	—	—
Bulgaria	—	**x**	**x**	**x**	**x**
Croatia[b]	—	—	—	**x**	**x**
Cyprus[c]	**x**	**x**	*	*	*
Czech Republic	—	—	**x**	**x**	**x**
Denmark	—	—	—	—	—
Estonia	—	—	—	—	—
Finland	—	—	**x**	**x**	**x**
France	—	—	**x**	**x**	**x**
Germany	**x**	**x**	**x**	**x**	—
Greece[c]	*	*	*	*	*
Hungary	—	—	—	—	—
Ireland[c]	*	*	*	**x**	**x**
Italy	—	—	—	—	**x**
Latvia	—	—	—	**x**	**x**
Lithuania	—	—	—	—	**x**
Luxembourg	—	—	—	—	—
Malta	—	—	**x**	**x**	—
The Netherlands	—	—	—	—	—
Poland	—	—	**x**	**x**	—
Portugal[c]	*	*	*	**x**	—
Romania[c]	*	*	**x**/*	**x**/*	**x**/*
Slovakia	—	—	**x**	**x**	**x**
Slovenia	—	—	—	**x**	**x**
Spain	—	—	**x**	**x**	**x**
Sweden	—	—	—	—	—
United Kingdom	—	—	—	—	—
TOTAL	**3**	**5**	**11**	**16**	**14**

[a]A healthcare related CSR was counted when a recommendation or recital mentioned 'health' 'hospital(s)', 'outpatient care', 'primary care', 'doctor(s)', 'pharma', or 'medicine'.
[b]EU accession in July 2013.
[c]Country under a MoU during the years marked with an asterix.
Source: own elaboration, based on European Commission, http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index_en.htm, accessed 28 August 2015.

Overall, the AGS insist on improving the cost-efficiency and sustainability of health systems while maintaining access to high quality care. Drawing on these AGS, the Council, on the basis of proposals from the European Commission, has been issuing an increasing number of CSRs on reforming health systems. The number rose from healthcare related CSRs addressed to 3 Member States in 2011, to 6 in 2012; 11 in 2013 (plus seven on long-term care) and 16 in 2014 (plus eight on long-term care). For 2015, the overall Commission approach was to issue fewer but more targeted Recommendations, which led to health related CSRs for 14 countries. For a detailed overview, see Table 1.

The main focus of EU guidance, both in the MoUs and in the CSRs, is on improving fiscal sustainability to control public expenditure. Note that the health related CSRs are formulated in fairly generic terms, calling on Member States to improve the cost-effectiveness of health systems. Such CSRs largely outnumber recommendations focusing on improving access to and quality of care. The reforms in the MoUs, on the other hand, do not only aim for increased cost-effectiveness, but also include short term savings, shifting costs from the public system to patients and workers, through measures such as increasing user charges, the reduction of benefit packages and cuts in wages.

In the 2014 health related CSRs, as compared with the CSRs of the previous years, two developments stand out. First, for the first time there was a very detailed CSR, given to Ireland. As an ex-MoU country, Ireland is still subject to post-programme surveillance and is expected to implement the detailed reforms required. Second, two of the 2014 CSRs mention – for the first time – a deadline and ask explicitly for 'savings' and 'reducing spending' (France and Slovenia). The increased pressure on these two countries is the result of the strengthened Excessive Deficit Procedure for Eurozone countries, to which they are subject (SPC, 2015). The 2015 CSRs are again more generic, although the recitals remain detailed and are in a similar vein to previous years.

The Commission Staff Working Documents (SWD, included in the 'Country Reports' since the 2015 cycle), published along with the CSRs, are important to help us fully understand the scope of the EU guidance (available at www.ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index_en.htm, accessed 2 June 2015). Over the years, the content of the SWDs has become increasingly detailed and country-specific. They have referred, for instance, to desired reforms with regard to public procurement, capital investment planning, contracting policies, hospital and financial management, clinical guidelines, and informal payments. They reflect the quantitative approach of the assessment framework used to underpin the CSRs, by pointing for instance to an above average number of hospital beds and pharmaceutical expenditure or a below average number of general practitioners and nurses.

The Making of the EU Guidance: Opening the Black Box

Unravelling the negotiation processes with the 'Memorandum countries' is an uphill battle. Opaqueness and informality have characterised these negotiations. The MoU on Specific Economic Policy Conditionality is signed by the Commission on behalf of the EU lenders, and approved by the Eurogroup, the informal meetings of the finance ministers of the Eurozone. Conditionality is mainly defined at staff-level negotiations, and only a small number of domestic actors are involved, mainly Ministers and some key advisors (Ioannidis, 2014). In the case of non-euro area

memorandum countries, the Commission has an even more central role, as it is not acting on behalf of the Eurozone Member States as lenders, and the ECB is not involved.

Negotiations between the Commission, the IMF and the ECB on the one hand and the national authorities on the other are held jointly, and agreements on the conditions for assistance are reached simultaneously with the representatives of the three institutions (Pisani-Ferry *et al*, 2013). The lenders' representatives have significant bargaining power in EU conditionality negotiations. Formally speaking, the European Commission is the senior partner of the Troika, both in the preparation and monitoring of EU conditionality (Pisani-Ferry *et al*, 2013). Between the Commission and the ECB there is a hierarchy, since the European Commission operates 'in liaison with the ECB'. The role of the IMF as a minority lender is less certain (Ioannidis, 2014).

On the basis of the limited information available with regard to the negotiations on healthcare, the following picture emerges. Although there are indications that the IMF played a key role in insisting on reducing public expenditure in healthcare (Reeves *et al*, 2014; e-mail exchange with Mamas Theodorou, expert in the Cyprus European Social Policy Network country team), there are strong indications that the Commission's DG ECFIN had the lead in the negotiations on the detail and content of the healthcare reforms, and that the ECB was not really interested in this matter. Policy ideas can be put on the table by both the country representatives and the Troika partners, while the Troika defines the required budgetary efforts (see also Theodoropoulou, 2015). Initially, MoU negotiations on healthcare reform were mainly prepared by the horizontal country desks within DG ECFIN. Gradually, DG ECFIN recruited experts on the healthcare systems of (some of the) Memorandum countries. Other DGs could feed their policy ideas into the process through the inter-service consultation within the Commission.

Turning to the European Semester process, here too the European Commission is clearly in the driver's seat at every stage of the process: preparing, drafting and monitoring the implementation of the CSRs. Furthermore, since the EU recommendations are, to a large extent, based on the Treaty articles governing the Stability and Growth Pact, the European Semester process is primarily driven by the finance actors. A new group of actors have thus managed to seize a place at the negotiation table, thereby changing the political stream.

It is unclear how countries were selected for the 2011 and 2012 healthcare related CSRs. However, since 2013 a more systematic approach has been taken, which was made public for the first time at the end of 2014 by DG ECFIN (European Commission, 2014). This approach entails the following three stages.

DG ECFIN *first* assesses for each country whether there is a medium or high risk of a fiscal sustainability gap. For countries with such a challenge, the *second* stage consists of an examination of to what extent expected expenditure trends in the specific field of healthcare (and long-term care and pensions) contribute to this

sustainability gap. Countries are selected for a CSR when the trends in healthcare expenditure are found to contribute above median (that is, half of the countries) to the fiscal sustainability gap. On the basis of this assessment framework, 13 countries were flagged by DG ECFIN for a healthcare CSR in 2014, and out of these, 12 effectively received a health CSR: Austria, the Czech Republic, Finland, France, Germany, Ireland, Malta, Poland, Portugal, Slovenia, Slovakia and Spain.

Once the countries are selected, the *third* step involves defining the nature of the challenge. This provides the input for determining the content of the CSRs. To this end, composite indicators are used that cover the main dimensions of public expenditure on health: 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 performs below the median on one of these composite indicators, a particular challenge in the policy area is identified (European Commission, 2014).

This framework, and the important match between the countries thus flagged for a CSR and the countries actually having received a CSR, indicates the dominance of the quantitative, fiscal approach in the selection of countries. This is true despite the fact that many Commission interviewees pointed to the very weak assumptions on which the assessment framework is based: 'comparing apples with oranges', as one of our interviewees put it. Many were surprised that there has been little or no reaction from Member States to the assessment framework.

This quantitative comparative analysis is accompanied by a country-specific analysis, which can lead to more specific or additional recommendations. All the thematic Commission DGs are involved in this exercise, through country team meetings – organised about 10 times a year and coordinated by SECGEN. While DG ECFIN holds the pen, several other DGs provide important input to the process. For healthcare related CSRs, the DGs mostly contributing are the DG for Employment, Social Affairs & Inclusion (EMPL), the DG for Health and Food Safety (SANTE) and the DG for Regional Policy (REGIO). Whereas, country desk officers from most DGs are generalists, and thus not specialised in healthcare, DG SANTE has recently been expanding its expertise on health systems, although it does not have enough staff to specialise in real depth on each country. Furthermore, in-depth thematic sessions, involving the thematic DGs and external experts – in particular from international organisations – are organised to analyse specific challenges in individual Member States. For 2014, such sessions were organised on healthcare for 7 countries, which is more than for any other field of fiscal policies. Most of these thematic sessions were led by DG SANTE. Since DG ECFINs' expertise is concerned with macro-fiscal policy, it relies on these other actors to provide input concerning the content of the specific challenges faced by healthcare systems, and to draft concrete proposals at the micro level. The thematic DGs also provide input on other than fiscal challenges, in particular on challenges relating to access to healthcare and quality of services.

This resulted for instance in 2014 in CSRs for Bulgaria, Croatia, Latvia and Romania (European Commission, 2014).

The quantitative analysis, together with the country-specific analysis, feeds into the Commission SWDs. Interviewees stressed that country knowledge, thematic expertise and quantitative data are decisive in the ability to influence the SWD formulation, but only in so far as thematic DGs are able to come up with 'strong ideas' that are 'formulated in a way that appeals to macro-economists' and 'fit into DG ECFIN's agenda'. Thematic DGs (notably EMPL and SANTE) made it clear that they have been able to co-shape the discourse: 'It is this overall political message of getting more coordination and integration (of care); for some countries, try to rely less on inpatient hospital infrastructure'. In other words: the finance actors thus acted as successful policy entrepreneurs, presenting health system reform as part of the answer to the Eurocrisis, notably through the gradual accumulation of knowledge and ideas.

Drawing on the analysis in the SWD, and on input from all DGs, CSRs are primarily drafted by the Secretariat General (SECGEN) and discussed with the four 'Core DGs' (SECGEN, ECFIN, EMPL and TAXUD). Finally, they are submitted to the College of Commissioners for adoption. This is the most political part of the exercise and where final changes to the drafts are made. This process implies political trade-offs between priorities in different policy domains for a country. Respondents made it clear that the specific content of a CSR 'really has to do with whether the political environment of that Member State would be receptive here and now'. In this process, the wording of the CSR is often tempered, which underscores the importance of the SWD for understanding the messages addressed to the Member States.

Before the CSRs are formally adopted by the finance ministers in the ECOFIN Council, Member States can amend the Commission proposals by a reinforced qualified majority. Amendments are prepared by advisory committees of the ECOFIN Council and the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council. These committees are, respectively, the Economic Policy Committee (EPC), the Economic and Financial Committee (EFC), the Employment Committee (EMCO) the Social Protection Committee (SPC). Contrary to the other committees, the SPC does not have a Treaty-based role in the Semester, which weakens its position. In spite of this, the Committee contributed to a slow but certain 'socialization' of the Semester process in the period 2011–2014 (Zeitlin and Vanhercke, 2015).

The threshold for amending a CSR proposed by the European Commission is very high. Amendments are only acceptable by the Commission if they do not reduce the effort to be made by a Member State. In addition, the timeframe during which amendments can be proposed and agreed between the different committees is very tight (merely a few days in 2014). Commission respondents stressed that the more the Commission improves the evidence base for the CSRs, the more difficult it will become for Member States to argue against them.

Quite remarkably, in view of the increased EU surveillance described above, national health authorities remain extremely reluctant to engage in the debates and continue to consider the organization and financing of healthcare as an exclusively national responsibility. As long as CSRs are non-specific, health authorities prefer to remain 'low profile'. As one interviewee explained: 'they've been vacillating between Comical Ali, saying "there is no Europe in health, there are no tanks in Baghdad", and Calimero: "there is too much Europe in health" '. Most national health authorities acknowledge that systems may face fiscal sustainability challenges, but insist on being able to define at national level the specific measures to improve the cost-effectiveness of their system. However, many of them do not want the EU to intervene at all in issues going beyond fiscal sustainability, in particular in the quality and accessibility of healthcare. It would be stating the obvious to say that finance ministers in the Council and their representatives in the EPC do not seem to be burdened by such sensitivity with regard to subsidiarity in the field of healthcare.

Unsurprisingly in view of the above, health authorities have so far had barely any impact on the EU debates. Up until 2013, health ministers were not at all involved in the process. Since 2014, the SPC invites the members of the Working Party on Public Health at Senior Level (WPPHSL, commonly called 'the Seniors') to participate in the discussions when healthcare related CSRs are discussed. The WPPHSL is made up of the senior officials of the national health ministries and reports directly to the Health Council. Members of the WPPHSL, however, have kept a very low profile in the discussions. Furthermore, at the national level, the position of health ministers is usually not strong enough to convince their finance colleague. As a result, no substantial amendments to health CSRs have yet been approved by the Council.

Does it Really Work? Monitoring Implementation and Efficacy

One key element of the EU's renewed economic governance is its increased emphasis on monitoring of implementation. For the 'Memorandum' countries, the Troika carries out quarterly reviews, and, based on this, updates the documents presenting the diagnosis and the strategy with the list of policy measures deemed appropriate. The Commission conducts this assessment in liaison with the ECB, and then makes a recommendation to the Eurogroup to approve the disbursement.

Post-programme surveillance (PPS) applies until at least 75 per cent of the financial assistance received has been repaid. Under PPS, the Commission, in liaison with the ECB, conducts regular review missions in the Member State to assess its economic, fiscal and financial situation and to determine whether corrective measures are needed.

Implementation of the CSRs within the European Semester is monitored both by the European Commission and the Council. With regard to the Commission, DG ECFIN has a bilateral meeting twice a year with each of the national finance

ministries. Thematic DGs carry out country visits to monitor progress and to detect and explore challenges. For countries under the macro-economic imbalances procedure, progress is assessed through In Depth Review (IDR) missions.

Multilateral surveillance between Member States happens both at the level of the ECOFIN Council -prepared by the EFC and EPC- and of the EPSCO Council, prepared in a joint meeting of the SPC with 'the Seniors' (WPPHSL). The ECOFIN Council deals with the fiscal aspects and the EPSCO Council with the content of the health reforms, with a focus on access. Respondents stressed that the SPC multilateral surveillance has become progressively more critical, more focused and more evidence based. The findings of the monitoring process feed into the discussion on the amendments to CSRs. Some national health officials were sceptical as to the multilateral surveillance in the SPC and perceived it as a forum to inform the Commission, rather than an exchange between Member States. Through persuasion and diffusion the SPC thus helps to create general pressure for 'reform', while promoting certain policy alternatives. In this way, the review and monitoring conducted by the SPC can be considered as a key 'softening up' activity in the policy stream.

Given the strong focus of the finance actors on quantitative data to assess challenges in health systems, the health and social actors also stepped up efforts to objectivise and quantify challenges in access to and quality of care. Two developments are worth mentioning in this respect. First, an expert group on health systems performance assessment , in which Member States participate on a voluntary basis, was set up (Council of the European Union, 2014). Second, the SPC is working on the application of the 'Joint Assessment Framework' (JAF) to healthcare systems (SPC, 2015). This framework provides country profiles that look into the key challenges as well as good outcomes in each Member State. National level interviewees were critical towards the JAF on health, which is still in a 'pilot' phase. Some questioned the validity and comparability of the data, while others raised doubts about its usefulness 'if in the end DG ECFIN only assesses the financial impact of the reforms'. This may explain why in February 2015, the decision was taken to develop the JAF health further but to not yet use it in the European Semester (SPC, 2015). Despite this, DG ECFIN already uses the health pilot JAF in the Semester, with the support of the EPC.

When assessing the efficacy of the European Semester, interviewees estimated that, as long as CSRs remain generic, Member States will always be able to claim compliance, since health systems are under permanent reform. Where CSRs become more detailed, the likelihood that domestic actors react to the CSRs and use them to further their own agenda increases.

The strengthened tools of the ESIF are a potential lever for implementation of the CSRs. Although macro-economic conditionality will in principle only apply if the Commission 'has a strong case', funding of health related projects is now also one of the domains subject to so-called '*ex ante* conditionality'; this implies that Member

States that choose to finance health must submit a 'health strategy' for approval by the competent Commission services. For countries with a health related CSR, the Commission can ramp up pressure to include implementation in their strategic plan. It was mentioned several times that EU guidance and funding could push for a shift from institutional care to outpatient care. However, Commission officials also made it clear that 'once the operations are running, the *ex-ante* conditionalities disappear from the radar'.

Furthermore, pressure increased for some Eurozone Member States under the EDP. Interviewees expected that if enforceability and the risk of sanctions increase, more importance will be attached to the recommendations. Others found that the strengthened EDP (in France, Spain and Italy) did have a strong impact on control over healthcare spending, and that EU influence was largely responsible for severe cuts, while the Member State maintained some flexibility on the timing and content of the reforms (Hassenteufel and Palier, 2015; Pavolini *et al*, 2015).

It goes without saying that the EU prescriptions for memorandum countries have the most far-reaching impact. Member States under post-programme surveillance sit somewhere between the EDP countries and the 'Memorandum' countries. As one respondent formulated it 'the more you need from Brussels, the more weight the CSRs carry'.

Figure 1 below shows how the EU leverage on domestic healthcare reforms can be considered as a continuum, with, at the one end, MS without a healthcare CSR and not under an EDP and, at the other end, the 'Memorandum' countries. It brings together a wide range of EU governance instruments with different legal bases and sanctioning authority. When considering the different levels of potential impact of the EU guidance on health system reform, our findings suggest that, the stronger the enforceability, the higher the impact, and the more Member States engage in discussing the guidance with 'Brussels'.

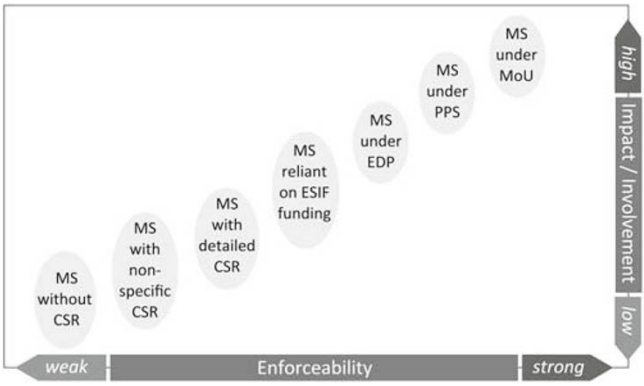

Figure 1: EU leverage on health care reform.

Discussion and Conclusions

Health system reform is now at the core of European economic governance. Not only has the EU acquired far-reaching powers to intervene in national healthcare policies, but reforming health systems has become a centrepiece of the policies put forward by the EU institutions to consolidate public expenditure. In this way the European Commission is penetrating into the heart of the national health systems, in an issue area that is, formally speaking, out of bounds.

Although several tools already existed before the sovereign debt crisis and shaped the debate on pension reforms, there was no political will to apply such frameworks to health systems. The year 2010 was a game changer. Following Kingdon, we have shown how the crisis created a window of opportunity that was skilfully used by economic actors to apply their solutions to healthcare. The Greek MoU in 2010 created a precedent in terms of political practice. The template was then further elaborated in the other Memorandum countries, following a 'learning by doing' approach. This then created spill-overs into the European Semester. A Commission publication identifying key challenges facing each national health system helped to show the financial sustainability of health systems as a problem. The Council Conclusions on this Report provided essential further legitimacy to the finance actors at EU level, enabling them to intervene in the content of healthcare policies.

Through our analysis we gained substantial insight into how different actors are involved in the process. The finance actors are in the driving seat of the EU's involvement in health. This comes as no surprise, since EU intervention in this field is largely based on the Treaty articles governing the Stability and Growth Pact. The European Commission is firmly in control of the whole process. Although there is an important difference between the Memorandum countries and the others, the room for Member States to co-shape the EU guidelines are, in all cases, limited.

The health authorities are only marginally involved and remain reluctant to engage in EU level debates, especially with respect to access to or quality of care. The result thereof is that the Semester primarily deals with the fiscal issues, without taking into account the consequences of the fiscal policies on quality and accessibility of care.

And yet the Commission can hardly be considered as an 'agent on the run': its authority (including new legal frameworks) is bolstered by the Member States. Some of our interviewees were very clear about what was at stake: some of the richer Member States, net contributors to the EU, are closely watching to see whether the process is well implemented by the 'agent' – the European Commission. As formulated by a Commission official 'for them (Ministers) it is a lot more important that other Member States are doing their reform' (see also Schmidt, 2015).

In this way we have shown how the crisis of the Eurozone created the conditions for a coupling of the problems, politics and policy streams by political entrepreneurs (the finance actors) who played a key role in the decision-making process and were

familiar with the instruments and practices of EU economic policy coordination before the outbreak of the crisis.

We have shown how the EU institutional actors in the EU economic governance of healthcare initially focused almost exclusively on reinforcing the restrictive 'throughput' (governance processes), as defined by Schmidt (2015), by producing numbers, and that they gradually made some efforts to improve the *throughput* quality by creating more transparency, by acquiring more micro-level expertise on specific health systems and making the guidance increasingly evidence-based. In this way they have reverted to the longstanding approach in which the EU institutional players seek to counter claims about the poverty of the EU's *input* legitimacy (responsiveness to citizens) and to reinforce claims to its *output* (performance of EU policies) legitimacy through the quality of the governance processes (Schmidt, 2015).

Regarding the million dollar question of whether the EU's economic surveillance of healthcare systems really works, and whether guidelines are taken into account by Member States, the answer thus is 'it depends'; the potential domestic impact of EU guidance must be seen on a continuum and increases with the enforceability of the applied instruments.

All in all, EU economic governance on health systems illustrates the asymmetry between weak EU level powers on social policies and strong powers in the economic field, aiming for market and monetary integration. National welfare states are legally and economically constrained by European rules of economic integration, whereas efforts to adopt European social policies are politically impeded by the diversity of national welfare states (Scharpf, 2002). Or as elaborated by Greer (2014), to market compliance the EU has now added fiscal compliance.

This finding also provides a preliminary answer to the question that runs through this special issue, that is, whether the EU economic governance of health systems contributes to the making of a European healthcare Union. Our analysis has made it crystal clear that the process is very much dominated by the objectives of fiscal sustainability. Nevertheless, some recent initiatives seem to suggest a prudent move towards the creation of a European healthcare union. These include the setting up of a working group on health systems performance assessment; the elaboration of a joint assessment framework for healthcare; the important investments in knowledge building on the detailed micro-level challenges facing health systems and the shift in the discourse within the EU governance mechanism to pay more attention to coordination of care and to rely less on hospital infrastructure. If national health actors want the health system objectives of providing universal access to high quality care to be moved to the front-stage of the EU agenda, it seems high time that they try to get into the black box themselves.

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Notes

1 Article 168,7° of the Treaty on the Functioning of the European Union.
2 Council Regulation (EC) 1466/97; Council Regulation (EC) 1467/97; Council Regulation (EC) 479/2009; Regulation (EU) No 1173/2011 and Directive 2011/85/EU.
3 Regulation (EU) No 472/2013 and Regulation (EU) No 473/2013.
4 Treaty on Stability, Coordination and Governance in the Economic and Monetary Union, between the Kingdom of Belgium, the Republic of Bulgaria, the Kingdom of Denmark, the Federal Republic of Germany, the Republic of Estonia, Ireland, the Hellenic Republic, the Kingdom of Spain, the French Republic, the Italian Republic, the Republic of Cyprus, the Republic of Latvia, the Republic of Lithuania, the Grand Duchy of Luxembourg, Hungary, Malta, the Kingdom of the Netherlands, the Republic of Austria, the Republic of Poland, the Portuguese Republic, Romania, the Republic of Slovenia, the Slovak Republic, the Republic of Finland and the Kindom of Sweden, Brussels, 2 March 2012.
5 The European Structural and Investment Funds are: European Regional Development Fund (ERDF), European Social Fund (ESF), Cohesion Fund (CF), European Agricultural Fund for Rural Development (EAFRD) and the European Maritime and Fisheries Fund.
6 The EPC contributes to the work of the Economic and Financial Affairs (ECOFIN) Council and the Commission by developing analysis and policy consensus.

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