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Pursuing an overarching commodification script through country-specific interventions? The EU's New Economic Governance prescriptions in healthcare (2009–2019)

Sabina Stan [1] **and Roland Erne** [2,*]

[1]School of Nursing, Psychotherapy and Community Health, Dublin City University, Dublin, Ireland; [2]School of Business and Geary Institute for Public Policy, University College Dublin, Dublin, Ireland

*Corresponding author. School of Business, University College Dublin, Dublin, Ireland.
E-mail: Roland.Erne@ucd.ie

Abstract

After the 2008 financial crisis, the European Union (EU) introduced a New Economic Governance (NEG) regime, which enabled much more coercive interventions of EU executives in social policy areas hitherto shielded from them. This study assesses the policy orientation of their NEG prescriptions in healthcare for Germany, Ireland, Italy, and Romania from 2009 to 2019 and the potential for countervailing actions of labour movements. Acknowledging organized labour's contribution to the making of decommodified healthcare systems after 1945, we ask if the NEG prescriptions were informed by an overarching healthcare commodification script, as this is a necessary (albeit not sufficient) condition for transnational counter-movements. Our analysis reveals that the country-specific NEG prescriptions of the European Commission and the Council followed an overarching commodification script, which especially targeted the countries that lagged behind in health service commodification. NEG thus represents a case of *reversed* differentiated integration, which provided both opportunities and challenges to transnational counter-movements.

Key words: EU governance, differentiated integration, healthcare, Social Europe, European Semester, commodification, Covid-19 pandemic

JEL classification: I1 Health, G28 Government Policy and Regulation, O520 Economy-wide Country Studies: Europe

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1. Introduction

After 1945, national policymakers built welfare states that gave people access to health services based on their needs rather than their means. After the launch of the Economic and Monetary Union (EMU), however, the pursuit of market integration increasingly gave European Union (EU) institutions more room to intervene in the sector. Although some EU interventions promoted social rights, market-driven EU integration fostered mainly healthcare commodification (Greer 2014; Hervey and McHale 2015; de Ruijter 2019; Stan and Erne 2021). After the 2008 financial crisis, the EU established a New Economic Governance (NEG) regime that also allowed direct EU interventions in fields hitherto shielded from them (Copeland 2020; Jordan, Maccarrone, and Erne 2021). This happened despite literal readings of the Treaty suggesting that EU policymakers would not possess any powers in the field of healthcare (Art. 151–161; 168, TFEU). Even so, the EU's Court of Justice ruled that their coercive NEG interventions in social policy fields were justified to prevent the EU's disintegration (Kilpatrick 2017).

Institutionalist EU scholars have debated the extent to which the shift to NEG strengthened supranational or intergovernmental dynamics in EU policymaking (Bauer and Becker 2014; Bickerton, Hodson, and Puetter 2015). In this article, we pursue a complementary approach. By focusing on NEG interventions in healthcare, we assess the NEG regime's articulation with healthcare commodification and contentious labour politics. Concretely, we examine the policy orientation of NEG prescriptions that the Commission and Council of finance ministers (henceforth: EU executives) issued to Germany, Ireland, Italy, and Romania between 2009 and 2019 to see whether they pursue an overarching script in favour of healthcare commodification. This is important, as such a script is a necessary (albeit not sufficient) condition for transnational counter-movements that could alter the direction of EU healthcare governance.

The article starts by situating NEG healthcare prescriptions in the field of labour politics and the commodification of public services. We then outline the EU's pre-NEG healthcare governance and highlight NEG's much more coercive mechanisms. The next section describes our methods and details our case selection, which includes countries spanning different sizes, wealth, and healthcare financing modes. Our analysis shows that NEG prescriptions in healthcare were largely framed by an overarching commodification script that put healthcare workers and patients under pressure. We argue that commodification became a *script* not only because commodifying prescriptions were more numerous than decommodifying ones, but also because their uneven deployment across countries and years followed a common commodification *logic*. By targeting national health systems individually (through country-specific prescriptions), EU executives sought not so much to address these systems' specificities (e.g. in terms of healthcare financing) as to intensify commodification in countries that lagged in this respect. We thus argue that NEG represents a novel case of 'differentiated integration' (Bellamy and Kröger 2017; Schimmelfennig and Winzen 2020); namely *reversed* differentiated integration, which provides both opportunities and challenges to transnational counter-movements. We conclude by highlighting our study's contribution to current academic and policy debates and its implications for future research.

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2. Accumulation by dispossession and the commodification of public health services

Several scholars have argued that NEG prescriptions became more 'social' during Junker's term as Commission President, namely, through the increasing participation of 'social' policymakers in the drafting of NEG prescriptions, and their increasingly 'social' (as opposed to economic) orientation (Zeitlin and Vanhercke 2018). Others criticized this socialization thesis, given the pre-eminence of fiscal and economic aims but also the ambiguous formulation and weak coercive power of potentially decommodifying prescriptions in social policy areas (Copeland and Daly 2018; Dawson 2018; Crespy and Vanheuverzwijn 2019; Copeland 2020). Still others adopted a third stance and argued that social policymakers may have not socialized the Semester, but managed at least to undermine the efficacy of its fiscal agenda (Greer and Brooks 2021). This article assesses the NEG regime's policy orientation by focusing most specifically on its prescriptions in healthcare. In doing this, we diverge in several respects from the approaches adopted in the socialization debate outlined above.

First, most studies in the field have followed institutionalist approaches in European integration and social policy studies and focussed on the role of national and EU institutions in NEG policymaking (Azzopardi *et al.* 2015; Greer, Jarman, and Baeten 2016; Baeten and Vankercke 2017; Greer and Brooks 2021). We argue that such a focus on these institutional actors glosses over the central role that interest politics (most notably, labour movements) has played in the making of decommodified healthcare systems after the Second World War. In response to organized labour's demands for better working and living conditions after 1945, policymakers across Europe created welfare states and decommodified health services, which played a pivotal role in the accumulation regime of Fordist capitalism and fostered citizens' social rights (Marshall 1950; Esping-Andersen 1990). They also protected healthcare workers' labour rights and contributed to the social reproduction of all workers in and outside the workplace (Copeland 2020). In the 1970s, however, the crisis of the accumulation regime of embedded liberalism led to a new phase of capitalist expansion centred on what Harvey (2004) called accumulation by dispossession. This included attacks on the commons of public services, leading to their increasing recommodification.

In this article, we focus on the articulation between NEG and labour politics, which we see as revolving around healthcare workers' and users' interest in promoting decommodified health services and in resisting their commodification. In so doing, we seek to complement the institutionalist focus of social policy and EU integration studies by shifting the question of NEG's orientation from a consideration of *national–supranational* institutional dynamics to a consideration of *interest politics* dynamics that transcend borders. Whereas a few unions have at times pursued agendas that accommodated the commodification of public services (Stan and Erne 2016), on the whole European trade unions consistently opposed healthcare commodification (Erne *et al.* 2024). Accordingly, NEG prescriptions that call for a commodification of healthcare services provide a necessary (albeit non-sufficient) condition for the emergence of *transnational* counter-movements. After all, most socioeconomic protests *across* European borders since 1997 occurred in response to commodifying EU interventions (Erne and Nowak 2022).

Second, we argue that adopting a contentious labour politics perspective allows us to select the commodification–decommodification axis as the most relevant one for assessing the orientation of the NEG prescriptions in this sector. This allows us to avoid the

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methodological pitfalls of typologies used earlier; namely, Crespy and Vanheuverzwijn's (2019) distinction between social retrenchment and social investment agendas; Copeland and Daly's (2018) market-making, market-correcting, and mixed policy orientations; or Daly's (2012) liberal, Third Way, and traditional socio-democratic paradigms. For example, the Third Way paradigm and social investment measures promoted welfare along individualist lines that restricted solidarity (Lynch and Kalaitzake 2020) and assigned 'a strong role for the market in delivering welfare' (Daly 2012: 282).

In contrast, this article examines if NEG prescriptions called for a further commodification of health services (i.e. making them like commodities to be traded in the market, Polanyi 2001[1944]), or, alternatively, a strengthening of their solidaristic and public character (decommodification). As full commodification or decommodification are rarely achieved, it makes little sense to assign prescriptions to either of these two poles. We, therefore, assess NEG healthcare prescriptions in terms of their potential for increasing or decreasing the degree of health-service commodification in relation to the status quo.

We operationalize the concept of commodification by considering how attacks on welfare redistribution and resulting pressures on state budgets led many governments to seek to diminish the state's role in the funding, provision, and management of health services, while also making them more market-like. Some measures aimed to *curtail* resources for public health services directly. Others sought to do so more indirectly through *marketizing* public healthcare by adopting business-like (new public management) models of service organization (managerialization), opening the sector to private players (liberalization), or giving a bigger role to private provision, funding, and management of services (privatization) (Mercille and Murphy 2017). Often, governments implemented marketizing measures also as an indirect means to contain public spending (Stamati and Baeten 2015); in turn, both the curtailment and the marketization of public services made more space for private accumulation. The marketization of health services and the retreat of the state from their funding, management, and provision thus constitute the two sides of the same commodification coin (Mercille and Murphy 2017; Stan and Toma 2019).

Healthcare commodification measures have a direct impact on *healthcare workers*. Privatizing measures, such as the outsourcing of ancillary services, lead to the segmentation of wages and employment conditions. Measures such as the introduction of performance-based pay replace collective wage-setting arrangements with individualistic market-like ones (Stan and Erne 2016; Jordan, Maccarrone, and Erne 2021). Other measures affect labour rights indirectly. For example, bed reductions and employment caps in hospitals lead to increased workloads and worsening working conditions (Armstrong *et al.* 2000). Measures such as hospital financing based on Diagnostic-Related Groups (DRG) and corresponding e-health systems quantify health services to contain costs, with detrimental effects for healthcare workers' working conditions (Schulten 2006; Kunkel 2021).

Healthcare commodification has a direct impact also on *users*' rights to access health services. For example, the introduction of basic service packages entails a reduction in services covered by public schemes. The rising importance of co-payments and private insurance to pay for services makes access to them dependent on users' private means, to the detriment of disadvantaged groups (Math 2017). Other measures impact users' rights indirectly, as fewer beds and healthcare workers in public hospitals lead to a lower quantity and quality of health services (Armstrong *et al.* 2000). Likewise, performance-based payments (Friedberg *et al.* 2010) and the DRG financing method leads to hospitals cherry-picking

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lucrative patients (Krachler, Greer, and Umney 2022), a lower quality care, and less access to care for vulnerable populations (Mihailovic, Kocic, and Jakovljevic 2016).

Thus, the commodification of public health services results in an erosion of both worker and user rights. Moreover, even when healthcare commodification allegedly promotes individual rights (e.g. in the form of performance-based wage schemes or patient choice), it leads to intensified competition among workers and users. This fundamentally unsettles their collective social rights.

To understand NEG interventions in healthcare policy, we therefore need to situate them not only in the institutional, intergovernmental, or supranational dynamics of EU politics but also in the transversal dynamics of (*transnational*) social class conflicts, which centre on the commodification of labour and social rights. Given private businesses' incessant need to secure new areas for growth and private accumulation, healthcare commodification is very much in their interest. Given the centrality of decent employment conditions and healthcare services for healthcare workers' and users' social reproduction, commodification also fundamentally affects their interests (Copeland 2020). By asking whether NEG prescriptions follow an overarching commodifying script in healthcare, we therefore also ask whether they have the *potential* to trigger transnational counter-movements, and thus whether a future change in NEG's orientation is possible. Before answering this question, we need nonetheless to first sketch the mechanisms of EU healthcare governance before and after the establishment of NEG.

3. EU healthcare governance pre- and post-NEG

In the 1990s, the EU market and monetary integration placed constraints on public expenditure and unit labour costs in its Member States. The EU accession criteria exerted similar pressures on Central and Eastern European countries. In response, both old and new Member States sought to curtail health expenditure and/or payroll taxes for sickness funds by adopting healthcare commodification measures (France, Taroni, and Donatini 2005; Schulten 2006; Ferre *et al.* 2014). Commodification, however, advanced at an uneven pace, as fiscal pressures affected states unevenly. The reforms led to pockets of commodification in various healthcare systems, which were then drawn into a cycle of further commodification triggered by EU market integration (Hervey and McHale 2015). The latter put states under pressure to liberalize health services further, given the EU laws on cross-border care and on the procurement and concessions of public services. These laws and new tools such as the European Health Insurance Card also promoted the individual rights to cross-border care of single market-oriented consumer citizens (Stan and Erne 2021).

In the 2000s, labour flexibility became a key component of economic policymaking (Daly 2012; Heimberger, Huber, and Kapeller 2020). Attacks on labour rights became possible even in coordinated economies such as Germany. In contrast, user rights to healthcare continued to be politically sensitive. Chancellor Schröder's healthcare reforms of 2003, for example, did not formally question people's rights to access healthcare but contained payroll-tax contributions to sickness funds to make German enterprises more competitive internationally (Schulten 2006).

After 2008, however, EU leaders realized that market and monetary integration had generated macroeconomic imbalances that threatened to break up the EU. Without much ado, the EU leaders shook off the institutional gridlocks that had hitherto prevented *coercive* EU

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interventions in social policy fields and empowered its executives to prescribe, monitor, and enforce policy changes (Erne *et al.* 2024). Since 2008, the EU has concluded ten sovereign debt loan programmes, which obliged partaking Member States to implement NEG prescriptions outlined in the Memoranda of Understanding (MoU). In 2011 and 2013, the EU adopted two packages of laws that gave the EU executives the right to issue coercive country-specific recommendations (CSRs) for all EU countries. CSRs' coercive power was underpinned by a reinforced Excessive Deficit Procedure (EDP) of the Stability and Growth Pact (SGP) and the introduction of a new Macroeconomic Imbalance Procedure (MIP), which enables the Commission and Council to request the correction of national policies that undermine or risk undermining the 'proper functioning of the economy' (Art. 2, Regulation 1176/2011). The two procedures include financial *sanctions* for non-complying Eurozone countries: fines of up to 0.2 per cent of GDP for failure to redress excessive deficits and 0.1 per cent for failure to redress excessive imbalances. Moreover, since 2014, European Structural and Investment funding to *all* Member States is *conditional* on 'sound economic governance', meaning the implementation of *corrective* MoU, SGP, and MIP prescriptions (Art. 23, Regulation 1303/2013). Since 2011, all EU states must participate in an annual cycle of CSRs, surveillance, and enforcement: the European Semester. The Semester integrates CSRs legally based on different procedures (MoU, SGP, MIP, Europe 2020) into one document, the Council Recommendations on national reform programmes, which are drafted by the Commission and then amended and approved by the Council of EU finance ministers. The Commission then monitors the implementation of CSRs by each state and assesses its progression in Country Reports, which thereafter inform the next yearly round of CSRs. Table 1 summarizes the different strands of the NEG enforcement regime and their *coercive* power.

In sum, the EU's shift to NEG added new multilateral surveillance mechanisms, which were much more *coercive* than what was attempted in the 2000s through the then toothless SGP or the 'soft law' methods of EU policy coordination. NEG enhanced the coercive power of EU policy prescriptions and subordinated social policy to the aims of fiscal discipline and macroeconomic stability (Pochet and Degryse 2013; Erne 2015; Bekker 2021). Certainly, NEG pressures did not preclude national governments from playing two-level games to justify reforms to their national constituencies; nonetheless, these governments were also bound to demonstrate implementation to the Commission, facing the threat of sanctions in case they would fail to do so (Erne *et al.* 2024). While not denying the importance of national–supranational dynamics, this article turns to labour politics to ask whether NEG prescriptions in healthcare follow a common commodification script and thus have the potential to trigger transnational labour counter-reactions.

As health services account for a significant part of public expenditure (15% on average across the EU in 2019, Eurostat [gov_10a_exp]), it is not surprising that NEG prescriptions targeted them. This happened not only indirectly through prescriptions on public spending or employment relations (Greer, Jarman, and Baeten 2016; Jordan, Maccarrone, and Erne 2021; Miro 2021) but also directly (Azzopardi *et al.* 2015; Stamati and Baeten 2015). Between 2013 and 2017 for example, 5 per cent of all CSRs dealt with health services (Efstathiou and Wolff 2018). Healthcare services thus became 'part and parcel of the EU's economic governance' (Baeten and Vanhercke 2017: 3).

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Table 1. Coercive power of NEG prescriptions.

Legal basis of NEG prescription	Enforcement mechanisms	Coercive power
MoU strand: Prescriptions related to MoU and Precautionary-MoU	Withdrawal of financial assistance Withdrawal of EU structural funding Financial fines Naming and shaming	Very significant
Corrective SGP/MIP strand: SGP- and MIP-related prescriptions for states with excessive deficits or excessive macroeconomic imbalances	Withdrawal of EU structural funding Financial fines Naming and shaming	Significant
Preventive SGP/MIP strand: SGP- and MIP-related prescriptions for states with no excessive deficits or excessive macroeconomic imbalances **Europe 2020 strand:** Prescriptions related to the 'Europe 2020' strategy	Naming and shaming	Weak

Source: Adapted from Jordan *et al.* (2021) and Erne *et al.* (2024).

4. How to analyse the meaning of NEG healthcare prescriptions?

To assess whether NEG prescriptions are framed by a common commodification script across countries and years, we analysed prescriptions issued for states located in different positions in the uneven EU political economy and NEG regime across time. We selected Germany, Italy, Ireland, and Romania, as proxies for the relative power of larger/smaller and richer/poorer states within the EU governance regime. The four locations also feature different modes of healthcare financing, that is, primarily through government budgets (Italy and Ireland) or payroll-tax contributions (Germany and Romania). Finally, these are also locations where the reorganization of the hospital sector along market lines before NEG was more (Germany and Italy) or less (Romania and Ireland) advanced (Supplementary Appendix Tables A1 and A2).

We define NEG prescriptions as the shortest policy statements in MoU and CSRs that make sense from a semantic point of view. NEG prescriptions are subparts of MoU and CSRs (Efstathiou and Wolff 2018) rather than CSRs in their entirety (Copeland and Daly 2018). Concretely, we analysed NEG prescriptions that explicitly refer to health services issued from 2009 to 2019. Our observation period thus starts with the first MoU issued in 2009 for Romania and ends in March 2020, when the Council suspended the SGP in response to the Covid-19 pandemic.

We consider that the existence of a commodification script depends not solely on the presence of a significant number of commodifying prescriptions, but also on the degree of their coercive power, and on the logic of their deployment across countries and years in relation to previous commodifying reforms. Moreover, in analysing NEG prescriptions, we consider that their meaning is not immediately accessible to the reader but is given by their communicative, policy, and semantic contexts (Erne *et al.* 2024).

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First, we see the production of NEG documents as a communicative process, whereby actors variously situated in the uneven social field (Bourdieu 1991) of the EU's NEG regime struggle over the legitimate naming of reality. Scholars in the socialization debate have pointed to the divergence between officials from the economic and social Commission departments and Council committees (Daly 2012; Zeitlin and Vanhercke 2018). The share and the relative importance in NEG documents of commodifying or decommodifying policy content are an outcome of these struggles.

Following Bakhtin (1988), we also acknowledge that the unevenness of the NEG's social field mirrors the uneven power relations between NEG prescriptions' addressers (Commission and Council) and addressees (Member States). Power differentials between states, and between them and EU institutions, are key in NEG's enhanced surveillance processes, the *coercive* power of its prescriptions, and the effectiveness of countermovements to reforms backed by NEG prescriptions. As outlined in Table 1 above, the coercive power of a NEG prescription depends on its legal base and the location of a given country in the NEG enforcement regime at a particular time. We consider the coercive power of NEG prescriptions to be *very significant* for MoU conditions enunciated for countries under bailout programmes; *significant* for SGP- and MIP-related prescriptions for states within the EDP or with excessive macroeconomic imbalances; and *weak* for states without excessive deficits or excessive macroeconomic imbalances in a given year, and for prescriptions underpinned by the EU's non-binding 'Europe 2020' growth strategy (Baeten and Venhercke 2017; Jordan, Maccarrone, and Erne 2021).

Secondly, we consider that the spatial–temporal deployment of NEG prescriptions is in turn informed by policy contexts, whereby commodifying reforms have been unfolding unevenly from country to country and from year to year even before NEG. In our analysis, we thus situate NEG prescriptions in relation to reforms enacted both before and during NEG. Pre-NEG commodifying reforms help us understand why some countries have been shielded from NEG commodifying interventions. Those enacted during NEG help us understand NEG prescriptions as part of the Semester's coercive macro-economic surveillance process. As we have seen above, the latter involves the Commission's assessment of reform implementation as a trigger of both subsequent prescription iterations and the start, continuation, or ending of the sanctioning procedures that underpin the coercive power of prescriptions.

Thirdly, we consider that the meanings of policy terms are not independent of one another but are given by their semantic interrelations in wider taxonomies, which organize them hierarchically (VanPool and VanPool 2009). Because they are the result of symbolic struggles, policy terms and taxonomies reflect place- and time-specific understandings of social problems and the adequate solutions to them. Our analysis sought to deductively map NEG healthcare prescriptions against the various dimensions of commodification (Section 3) and then assess whether they were articulated in a larger policy taxonomy.

To understand the meaning of prescriptions in their semantic context, we also considered the Recitals in the Council Recommendations, as well as the Commission's Country Reports. We also used the latter to document the policy context of prescriptions during NEG and complemented them with an account of healthcare reforms in our four countries before and after NEG based on the corresponding national and international policy and scholarly literature.

Placing NEG prescriptions in their communicative, policy, and semantic contexts allows us to assess not only the numerical importance of commodifying prescriptions but also

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whether their deployment across countries and years follows a common commodifying *logic*. Otherwise said, we seek to determine whether NEG commodifying prescriptions sustain not only a semantically encompassing taxonomy but also a common *script* promoting commodification across countries and years.

For this purpose, we analyse the underlying semantic connections (Spradley 2016) between NEG prescriptions in healthcare issued for the selected countries between 2009 and 2019 and map their deployment across countries and years, also considering the national policy reforms undertaken before and during NEG. Our analysis traces the grouping of prescriptions around common themes and larger categories in three main areas: (1) resources for health services; (2) organization of health services; and (3) access to health services. The resulting account documents, under each category, the intertwined unfolding of NEG healthcare prescriptions, national reforms, and the Commission's feedback on the latter that informed the subsequent prescription cycles.

5. The EU's NEG regime in healthcare: a commodifying script

Our analysis shows that the most prevalent NEG prescription in our dataset is the request to increase cost-efficiency in healthcare. This vague, general prescription occurred 12 times and was issued for Germany, Ireland, and Romania. It seems to vindicate the socialization literature insofar as it is, at first glance, ambiguous (Crespy and Vanheuverzwijn 2019). It may mean doing more with the existing resources or doing the same with fewer resources. However, this prescription did not appear in isolation. It is semantically linked to other, more specific ones that serve to anchor its meaning in a commodifying policy direction (see Table 2, Supplementary Appendix Figures A1 and A2, and Supplementary Appendix Table B). These directions are: (1) curtailing public health expenditure and service levels; (2) reorganizing health services along managerial and market lines; and (3) privatizing access to healthcare. We analyse first the commodifying NEG healthcare prescriptions that come under these three rubrics (Supplementary Appendix Figure A1) and secondly those with a potential for decommodification. Finally, we evaluate whether NEG prescriptions followed an overarching commodification script in healthcare across the four countries and over time.

5.1 Curtailing public healthcare expenditure and service levels

A first semantic anchor of the prescription to increase cost-efficiency in healthcare concerns reducing public healthcare expenditure. Prescriptions adopting this policy direction include those aiming to achieve it either directly, through cuts in healthcare expenditure, or indirectly, through cuts in health service levels. All but one prescription in this category were issued for Romania and Ireland when both countries were under MoU conditionality.

At the onset of the financial crisis, Romania had a sizeable public hospital sector (in 2008, at 6.57 hospital beds per 1,000 inhabitants versus an EU average of 5.6) (Eurostat [TPS00046]), although its effective therapeutic capacity was curtailed by the country's underfunding of healthcare (in 2008 at 5% of GDP, one of the lowest in the EU) (Eurostat [hlth_sha11_hf and nama_10_gdp]). This was the context in which in 2010 the Romanian government was asked to 'streamline the number of … hospitals' (MoU 2009, 2nd update). The government's response was to close sixty-seven hospitals in 2011 (Vladescu *et al.* 2016). In turn, between 2008 and 2011, budgets dropped by 11 per cent for the Health Ministry and 2 per cent for the national health fund (Mladovsky *et al.* 2012). Regardless of these

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Table 2. NEG healthcare prescriptions: policy themes, categories, and directions.

		Commodification	Decommodification
Increase the cost–effectiveness of the healthcare system		Increase the cost–effectiveness of the healthcare system	
Resources for Health Services	Expenditure levels	Contain health expenditure	Remedy low funding in healthcare
		Reduce payment arrears in healthcare	Increase the budget for primary care
		Contain hospital expenditure	
	Service levels	Streamline hospital services	Improve provision of long-term care
		Reduce bed capacity	
		Shift to outpatient care	
		Focus on prevention, rehabilitation, and independent living	
Organization of Health Services	Management of health services	Streamline financial management in healthcare	
		Implement e-health systems	
		Increase government control over hospital budgets	
		Introduce case-based funding in public hospitals	
		Introduce performance-based payments in primary care	
	Competition among health service providers	Remove restrictions to competition in medical services	
		Increase competition in the health sector	
Access to Health Services	Cost coverage	Introduce co-payments for medical services	Curb informal payments in healthcare
		Establish private supplementary health insurance market	Adjust health insurance contributions
	Population and service coverage	Revise the basic benefits package	Increase access to healthcare
			Improve access to long-term care

Source: Supplementary Appendix Figures A1 and A2. Commodifying and de-commodifying NEG healthcare prescriptions for Germany, Ireland, Italy, and Romania, 2009–19.

cuts, the government was urged in 2011 to 'reduce payment arrears in healthcare' for private providers (MoU 2009, 3rd update), a prescription largely affecting the hospital sector. The government responded by transposing Directive 2011/7 on Combatting Late Payment in Commercial Transactions, which gives preference to reimbursing (private) creditors over financing public services (Vladescu *et al.* 2016). Rather than making healthcare more efficient, these cuts further weakened the capacity of an already poorly resourced hospital sector.

Despite reduced healthcare and hospital budgets, the 2011 provisional MoU (P-MoU) asked the government to further 'contain hospital expenditure'. Two years later, the government was urged to 'continue the reduction of bed capacity in inpatient acute care hospitals' (P-MoU 2013). Drawing on the 2011 National Strategy for Hospital Rationalization, the government responded by gradually reducing the public system's bed capacity (Vladescu *et al.* 2016). The 2013 P-MoU reframed calls to reduce hospital expenditure and service levels as calls to shift from hospital to outpatient care and to increase the budget for primary care. This shift could be realized, however, only at the expense of funds directed to the hospital sector. It also involved shifting resources to an outpatient sector where private providers were already dominant (Vladescu *et al.* 2016). In turn, state disinvestment in public hospitals fostered the rapid rise of private hospitals, the number of which increased almost 10-fold between 2008 and 2017 (see Supplementary Appendix Table A1).

Even before signing the MoU in 2010, Irish governments had curbed health spending. Nevertheless, by 2012, Ireland was requested to 'eliminate the spending overrun' in healthcare (MoU 2010, 6th update) and to 'contain healthcare expenditure within the €13.6 billion departmental ceiling for 2013' (MoU 2010, 7th update). As a result of the government's measures in this direction, per capita public spending on health in 2012 dropped 29 per cent by comparison to 2007 (Jowett, Thomson, and Evetovits 2015). The healthcare system had thus to do less with less rather than more with less (Burke *et al.* 2014). Between 2008 and 2017, Ireland's hospital bed capacity was cut by 10 per cent (Supplementary Appendix Table A2).

Italy did not receive explicit prescriptions on healthcare expenditure and service levels. In the early 1990s, the drive to abide by the EMU criteria had already led to reforms that reduced its healthcare expenditure (Ferre *et al.* 2014). This was followed in 1996 by a national bed-closure programme (France, Taroni, and Donatini 2005), which led by 2000 to a 28 per cent cut in the total number of hospital beds (OECD 2020, our calculations). As Italy was subject to the EDP from 2005 onwards, the government continued to contain real healthcare expenditure growth even before the crisis (Country Report SWD(2017)77). This led to a substantial reduction in the number of public hospital beds (de Belvis *et al.* 2012). After 2011, Italy received even harsher prescriptions to reduce its public debt-to-GDP ratio, given the enforceable ceilings on public expenditure introduced by the revised SGP. In response, between 2010 and 2019, the government subtracted €37bn from the health service (Servizio Sanitario Nazionale): €25bn between 2010 and 2015 through direct expenditure cuts, and €12.11bn between 2015 and 2019 through reduced service levels (Cartabellotta *et al.* 2019). These cuts led to a further reduction in Italy's hospital bed numbers to only 3.81 per 1,000 population by 2017 (Eurostat [TPS00046]). Although hospital beds were reduced also in private for-profit hospitals, the latter slightly increased their share (29% of the total by 2017) (Eurostat, [hlth_rs_bds2]). Even so, the Commission continued to slam the apparent bias 'towards hospital spending at the expense of primary care' (Country Report SWD(2019)1011: 44).

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Finally, in 2013, Germany received a prescription under the rubric of curtailing resources for health services. Justified on the grounds of needing to 'enhance the cost-effectiveness of public spending on healthcare and long-term care', it requested the government to 'focus on prevention and rehabilitation and independent living' (Council Recommendation 2013/C 217/09). Like elsewhere, the homecare services associated with these measures had been affected by the growth of private endeavours, either through informal employment arrangements or precarious contracts offered by placement agencies to domestic care workers, many of whom came from Eastern Europe (Lutz and Palenga-Mollenbeck 2010). The prescription was thus an invitation to shift away resources from institutional care but also to boost a sector dominated by private operators.

Moreover, the prescription to 'further enhance the efficiency of public spending on healthcare and long-term care' contained in the 2011 Council Recommendation for Germany (2011/C 212/03) was justified by the need to contain healthcare spending. Like in the Italian case, German governments had already reduced public hospital numbers and bed capacity and defined caps for hospital spending in two waves of healthcare reform in the 1990s and 2000s. As a result, the share of public hospitals in the total number of hospitals decreased, making space for a rising number of private for-profit hospitals (Schulten 2006). This trend continued during the 2010s, and by 2015, new legislation encouraged hospitals to further reduce beds and operational costs (Country Report SWD(2016)75). By the end of the 2010s, as Germany still had the EU's highest hospital bed capacity (above 8 per 1000 population) (Eurostat, [TPS00046]), the Commission continued to criticize Germany's hospital-centred system and advised further cuts in hospital beds (Country Report SWD(2018)204, SWD(2019)1004).

5.2 Marketizing health services

A second semantic anchor of the prescription to increase cost–effectiveness in healthcare concerns the prescriptions on health service organization. These focused primarily on (1) making the running of healthcare units, especially hospitals, more business-like (managerialization) and (2) opening the sector to private healthcare providers (liberalization).

5.2.1 *Managerializing health services*

Prescriptions under this heading aimed to transform the hospital sector by adopting business-like funding methods (namely, case-based DRG methods) and by tighter central control and monitoring over hospital finances.

The first prescription in this stream appeared in Romania's 2011 P-MoU. It requested central control over hospital spending by the Finance Ministry every month and was repeatedly restated between 2011 and 2014. In 2012, the government introduced monthly financial reporting by public hospitals and penalties if spending limits were exceeded (Vladescu *et al.* 2016). By 2013, the framework contract between the national health fund and the hospitals enabled the replacement of hospital managers if their hospitals ran arrears for three consecutive months (Country Report SWD(2013)373). The 2013 P-MoU urged Romania to 'continue implementing e-health solutions' to facilitate the financial management of hospitals, leading to the launch of the *e-card* (Country Report SWD(2015)42). Furthermore, the 2013 P-MoU demanded the introduction of performance-based payments in primary care, a measure seeking to put these providers in competition with one another.

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Hospital-sector managerialization was also a feature in NEG prescriptions for Ireland, namely, those to 'streamline financial management' in healthcare and 'introduce a case-based payment system for public hospitals' (MoU 2010, 9th update). To facilitate the financial management of hospitals through e-health systems, the government was urged in 2013 and 2014 to introduce individual health identifiers (MoU 2010, 8th update). The streamlining of financial management and the introduction of case-based payment methods and e-health systems aimed to increase government control over healthcare spending. Several steps were taken in this direction, culminating in the introduction of case-based funding in acute hospitals in 2016 and plans for the full implementation of an Integrated Finance Management System by 2020 (Country Report SWD(2016)77).

Italy received no NEG prescriptions on managerializing health services. Before the financial crisis, Italian governments had already implemented a series of reforms in this direction in response to pressures from the EMU convergence criteria. These included the transformation of healthcare providers into public enterprises, the opening of national health service contracts to private providers, and the introduction of the DRG method of hospital financing (France, Taroni, and Donatini 2005; Ferre *et al.* 2014). In 2006, the government's control over regional healthcare expenditure was reinforced by the introduction of deficit thresholds and compulsory financial recovery plans for regions exceeding them (Ferre *et al.* 2014). Furthermore, in 2016, the government responded to the prescription 'to implement the reform of the public administration' (Council Recommendation 2016/C 299/01) by regulating the management in the health sector, which also reinforced the application of the EU's fiscal and economic policy objectives (Country Report SWD(2017)77).

Neither did Germany receive prescriptions under the managerialization rubric, as the country had made good progress in this respect during the 2000s. Managerialization followed a similar scenario as in Italy, whereby pressures on public expenditure were passed on to local and regional authorities. These motivated municipalities and *Länder* governments to privatize their hospitals. Hospital privatization and the introduction in 2003 of DRG-based hospital financing by the Schröder government contributed to the emergence of publicly funded but privately owned healthcare multinationals. Although premature patient discharges and unnecessary procedures in for-profit hospitals contributed to raising costs (Wehkamp and Naegler 2017), the Commission continued to acclaim Germany's hospital financing reforms as costs reducing (Country Report SWD(2016)75).

5.2.2 *Liberalizing healthcare*

Commodifying prescriptions in the service organization rubric also include those seeking to liberalize healthcare services. No such prescriptions were issued for Romania, as at the start of the financial crisis private healthcare providers were already playing a major role, especially in ambulatory care (Stan and Toma 2019).

In contrast, Ireland's 2010 MoU urged the government to 'remove restrictions to competition in sheltered services, including … medical services'. The government was to do so more specifically by 'eliminating restrictions on the number of GPs [General Practitioners] qualifying and removing restrictions on GPs wishing to treat public patients.' Increasing the number of private GP practices entitled to treat public patients arguably improved the provision of primary care to patients with publicly funded Medical Cards. Tellingly, however, the MoU justified the prescription by its contribution to increased competition between privately operated GPs.

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Between 2011 and 2013 and in 2016, Italy received prescriptions to 'open up the services sector to further competition, including … professional services' (Council Recommendation 2011/C 215/02) and, between 2016 and 2019, to 'implement the annual competition law' (Council Recommendation 2016/C 299/01). As explained in the 2016 Council Recommendation for Italy (2016/C 299/01), these prescriptions also applied to healthcare. The government was thus explicitly urged to increase competition in the sector, which meant further opening it up to private providers. In response, the government revised its procurement and concessions laws in 2016. Even so, the Commission continued to criticize Italy's progress towards increased competition in healthcare as 'limited' (Country Report SWD(2017)77).

Germany received no prescription on the liberalization of health services. A law introduced competition between its statutory sickness funds in 1992, but the *Länder* resisted plans that would have transformed the sickness funds into enterprises and made them also responsible for the infrastructure costs of the hospitals that were still under *Länder* control (Dent 2005). Instead, the Schröder government advanced the liberalization agenda indirectly, by introducing the DRG system in 2003, as outlined above.

5.2.3 *Privatizing access to healthcare*

This rubric includes prescriptions that sought to offset cuts in public healthcare expenditure with an increase in private financing sources. This translated into a change from a more solidaristic to a more individualized model of access dependent on patients' private means. All prescriptions under this rubric were issued for Romania.

In 2010, the second update to the 2009 MoU requested the Romanian government to 'introduce co-payments for medical services', a prescription reiterated in 2011 and 2012. The government announced in 2011 the introduction of new user charges for GP visits and hospital stays. Given the social reactions that this announcement triggered, co-payments for inpatient care were not implemented until 2013 (Country Report SWD(2013)373).

In 2011, the government reduced cost-coverage for pensioners by obliging those with an income above 700 RON (only around €160 per month!) to contribute 5.5 per cent of their pension to the national health fund (Country Report SWD(2012) 325). In addition, it reduced public health service coverage by cutting the number of reimbursed GP and specialist visits (Mladovsky *et al.* 2012). Notwithstanding these cuts, in 2013, the government was told to revise the basic benefits package once more (P-MoU 2013), which meant a further reduction in services covered by the national health fund. In 2014, the government responded by reducing the basic benefits package. The government also defined a minimum package for the many uninsured people, typically those without formal wage or pension income, which only included care for emergency situations, infectious diseases, and pregnancy (Vladescu *et al.* 2016). To offset these cuts, the government was told to 'establish the framework for a supplementary private insurance market' (P-MoU 2013), a measure that would deepen patients' dependence on their private means in accessing healthcare.

Ireland received no prescription under this rubric, arguably because it already had a two-tier healthcare system where private means played an important part in access to healthcare. In 2008, only 30 per cent of the population had free access to public health services through the Medical Card (DHC 2010). Even so, the government increased hospital charges in 2008, and in 2009 replaced the automatic entitlement to Medical Cards for people over 70 with a

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means-tested one (Thomson, Jowett, and Mladovsky 2014). In 2013, it tightened the eligibility criteria for the Medical Card even further (Burke *et al.* 2014).

Italy and Germany did not receive any prescription under this rubric either. In Italy, co-payments for outpatient consultations were introduced in 1982 (Ferre *et al.* 2014), and a basic benefit package was defined in 2001 (France, Taroni, and Donatini 2005). To compensate for decreased funding following budget cuts after 2012, the government increased co-payments for outpatient care and non-necessary emergency admissions (Mladovsky *et al.* 2012). In Germany, a federal law introduced co-payments in 2004 (Augurzky, Bauer, and Schaffner 2006). In 2014, another law increased employees' sickness fund contributions (Country Report SWD(2016)75).

Our analysis across the three rubrics shows that the prescription to 'increase cost-effectiveness in healthcare' is far from ambiguous. Rather, it is linked to a larger commodifying taxonomy that advocates the curtailment of resources for public health services, the managerialization and liberalization of their organization, and the privatization of access to healthcare. All prescriptions under these rubrics promote a diminishing scope for public services and an increase in business-type methods and private involvement in the funding, delivery, and management of health services. Moreover, and as outlined in Table 3, most commodifying prescriptions in our data set have very strong or strong coercive power, as they figure either in MoU conditions or in SGP/MIP-related CSRs for countries within the EDP or countries deemed to have excessive macroeconomic imbalances (see Table 1). But before discussing whether this taxonomy also amounts to a commodifying script, we also need to consider the rest of prescriptions in our data set, which we classified as decommodifying.

Table 3. NEG prescriptions on healthcare by policy orientation, countries, categories, and coercive power, 2009–2019

	POLICY ORIENTATION								
	DECOMMODIFYING				COMMODIFYING				
	Germany	Italy	Ireland	Romania	Germany	Italy	Ireland	Romania	
2009									2009
2010							▲	●■	2010
2011					☆		▲	●●▲■	2011
2012		●			☆		●	●●▲■	2012
2013		○		●■□	☆○		●▲▲▲	★●●●● ▲▲▲■■	2013
2014		●		□□	☆		★▲▲	☆△	2014
2015				○□			★▲		2015
2016				□		▲	☆	○	2016
2017				□				○	2017
2018				□			☆	○	2018
2019		■		□			☆	☆○	2019

Source: Supplementary Appendix Tables C1, C2, D1, D2, E1, E2, F1, and F2.
Categories of prescriptions: Increase Cost-Effectiveness of Public Spending on Healthcare [☆], Resources for Services [○], Organization of Services [Δ], and Access to Services [□].
Coercive power of prescriptions: Very significant [Black], Significant [Grey], and Weak [White symbols].

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5.3 Decommodifying NEG healthcare prescriptions

The prescription to increase cost-efficiency is linked in NEG documents to only one decommodifying prescription. In 2015, the Romanian government was urged to remedy 'low funding and insufficient resources' (Council Recommendation 2015/C 272/01). Although the Council acknowledged that these lacks are detrimental to 'reforms to improve the efficiency of the healthcare sector' (Council Recommendation 2014/C 247/21), it was silent on its support for NEG prescriptions requesting the curtailment of resources for public services, which underpinned these lacks. Besides this prescription, very few in our dataset could be considered as decommodifying (see Table 3; and Supplementary Appendix Figure A2). All of them concern Romania and Italy in two areas: resources for service provision and access to services. In all cases, however, the prescriptions' decommodification potential is far from clear.

In 2013, the Romanian government was urged to increase the primary care budget (P-MoU 2013). As noted, this was to be achieved by managerializing primary care and by cuts to the detriment of an already depleted hospital sector. That same year, the government was invited to increase access to healthcare, 'in particular for disadvantaged people and remote and isolated communities' (Council Recommendation 2013/C 217/17). This prescription was reissued between 2014 and 2019. Although the prescription is a sign of the inclusion of social concerns in NEG documents (Zeitlin and Vanhercke 2018), its weak enforcement power as a Europe 2020 recommendation undermined its efficacy by comparison to the binding NEG prescriptions on co-payments, private insurance, and basic service packages discussed above. In addition, in a bid to contain Romania's unit labour costs, in 2013 and 2014, the government was urged to 'adjust [i.e. lower] health insurance contributions' (P-MoU 2013). While beneficial to individual workers, this measure involved the further curtailment of collected healthcare funds. Finally, between 2014 and 2017, the Romanian government was repeatedly requested to 'curb informal payments' (Council Recommendation 2014/C 247/21). While this measure may lower access costs for patients, it may also be co-opted into a commodifying agenda seeking to convert informal payments into fees and co-payments—as it happened in 2011–2 during the government's attempt to further privatize Romania's healthcare system (Stan and Toma 2019).

Italy received similar prescriptions on the provision of, and access to, long-term elder care. Given women's too low 'participation in the labour market' (Council Recommendation 2011/C 215/02), Italy needed to activate them by facilitating their disengagement from unpaid care work. Several prescriptions thus requested improved long-term care provision (2012–4) and better access to it (2019). Importantly, however, both prescriptions were vague, as they left open the modalities of these improvements. Given that Italy's austerity cuts reduced the space for public provision, even these prescriptions *de facto* favoured private long-term care providers.

Overall, decommodifying NEG prescriptions are much more elliptic and sparser than commodifying ones. They are vague, imprecise, and difficult to implement in a context informed by EU executives' goals of fiscal restraint and marketization. Importantly, decommodifying prescriptions generally lack the more precise targets and the strong legal basis, and hence coercive power, of commodifying prescriptions (Table 3). Moreover, NEG documents semantically subordinate decommodifying prescriptions to the commodification taxonomy seen above. As noted, increasing the primary care budget is secondary to the managerialist transformation of primary care and the curtailment of public hospitals. Likewise, better access to care is secondary to the curtailment of public services and the fostering of private

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healthcare provision, management, and funding. Decommodifying prescriptions thus make their way into NEG documents as an addendum to the commodification taxonomy examined above rather than as an expression of a countervailing solidaristic agenda.

5.4 A commodifying script in healthcare

Already in 2010, the Commission's Joint Report on Health Systems used the cost-efficiency rationale to justify the inclusion of healthcare reforms in the NEG process (Stamati and Baeten 2015). Nonetheless, despite agreeing that NEG's healthcare prescriptions are framed by 'the discourse on sustainability of public finances rather than … of social inclusion' (Azzopardi *et al.* 2015), some analysts still considered the cost-efficiency agenda ambiguous (Vanheuverzwijn and Crespy 2018).

Our analysis shows instead that, far from being ambiguous, cost-efficiency prescriptions in NEG documents are semantically linked to an overarching healthcare commodification taxonomy. This taxonomy combines prescriptions favouring a reduced hospital sector restructured along managerial lines, managerialized primary care, the increased opening of the sector to private providers, reduced baskets of services, and increased private sources for funding and accessing healthcare. This commodifying taxonomy is coherent as resource curtailment and marketizing prescriptions mutually reinforce each other rather than being distinct. Like in multinational corporations (Erne 2015), control over expenditure is exercised through new management methods (DRG-based financing) and the fostering of competition among providers. The taxonomy is also consistently applied in NEG documents, as it manages to subsume decommodifying prescriptions to its commodification aims. Indeed, whereas MoU-, SGP-, and MIP-related prescriptions are squarely linked to resource curtailment and marketization goals, even EU 2020-related prescriptions link social aims to 'a strong emphasis on correcting financial and other imbalances' (Daly 2012: 277–278). Thus, even decommodifying prescriptions suffer from the framing of issues like access to services and health inequalities 'mainly in terms of the need for greater efficiency' (Daly 2012: 276–277).

NEG documents deployed the commodification taxonomy in country-specific ways. However, this deployment across countries and years points to a common commodification *logic*, and thus an overarching commodification *script*. Two countries were heavily targeted by commodifying prescriptions: Romania (13 in 30 overall occurrences) and Ireland (6 in 15). The two others were much less targeted: Italy (1 in 1) and Germany (2 in 7). What Romania and Ireland had in common in 2008 was that previous cuts in public healthcare were not yet matched by a thorough reorganization of their hospital sectors along market lines, as in Italy and Germany. By comparison to Italy and Germany, Romania and Ireland also had significantly lower shares of private hospitals and private hospital beds (Supplementary Appendix Tables A1 and A2). NEG prescriptions for Romania and Ireland therefore supported a true offensive against the public hospital sector, which implicitly involved giving more space to private, for-profit healthcare provision (Math 2017). In 2017, the shares of private hospitals and private hospital beds were higher than in 2008 in all four countries. In Romania, however, the figures increased even more significantly (Supplementary Appendix Tables A1 and A2).

Our analysis shows that past commodifying reforms have informed how NEG prescriptions targeted Member States: the countries that were heavily targeted by commodifying prescriptions (Ireland and Romania) were also those that lagged in terms of healthcare commodification. In contrast, different modes of healthcare financing across countries do

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not seem to matter, reflecting EU executives' dual aim to curtail public spending (in line with the EDP) *and* payroll-tax contributions to sickness funds to contain unit labour costs (in line with the MIP). Through NEG, they therefore introduced a radical change in how the EU intervenes in national healthcare policies. With healthcare reforms placed at the core of fiscal consolidation, the EU executives acquired unprecedented powers to intervene in national healthcare systems. These powers were most effective in countries under bailout financing, but our analysis shows that commodifying pressures continued beyond them until 2019.

6. Conclusions

This article shows that EU executives used NEG to deploy an overarching commodifying script seeking to exacerbate resource curtailment and health services marketization across all analysed countries, despite their different locations in the uneven EU political economy and regardless of the different modes of healthcare financing across countries. The deployment of this script across countries and years has been nonetheless *uneven*. NEG could then be described as a case of differentiated integration, but not in the usual pre-NEG sense of the optouts from EU laws that aim 'to accommodate economic, social and cultural heterogeneity' (Bellamy and Kröger 2017: 625). In contrast, EU executives' country-specific NEG prescriptions followed a *reversed* logic, as they targeted different countries differently to pursue a *common* commodifying agenda (Erne *et al.* 2024).

By adopting an approach that is sensitive to healthcare commodification and labour politics, the article overcomes important limitations in current studies of NEG interventions in social policy. By asking whether NEG prescriptions in healthcare promoted a common commodifying script across countries and years, and thus whether it opened the possibility of *transnational* counter-movements, the study overcomes the methodological nationalism that is still dominating European social policy research (Erne 2018). The study also addresses the low predictive power of the existing literature in the field. By looking solely at national governments and EU institutions, we may indeed arrive at the conclusion that, in the EU, healthcare policy is overdetermined, as it results, most of the time, from interventions at both national and EU levels (Greer, Jarman, and Baeten 2016). A consideration of labour politics, and of the commodification of public health services as one of its key stakes, reopens the question of its determination and of changes in its policy orientation. A pressing area of future research concerns the role of business actors in European healthcare policy and commodification. In fact, financial market pressures importantly shaped the EU executives' fiscal and economic governance objectives during NEG (Greer, Jarman, and Baeten 2016), and for-profit hospital chains and other multinational corporations active in the sector may also have shaped its commodifying bent in healthcare.

Another pressing area for future research is the mapping of union and social movement reactions to NEG prescriptions in healthcare. By highlighting the existence of an overarching commodifying healthcare script informing these prescriptions, our study has identified the *potential* for transnational counter-movements. But what has been their actual realization? Elsewhere we show that after the financial crisis, unions and social movements have come together to defend public healthcare at a transnational European level (Erne *et al.* 2024). Nonetheless, most healthcare-related counter-movements have targeted mostly national governments rather than EU institutions (Stan and Erne 2016; Naughton 2022). Seemingly, the country-specific nature of NEG prescriptions and the embedding of their implementation in

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national politics have obscured the role of EU institutions in the further commodification of public healthcare after the 2008 crisis. Even so the *reversed* differentiated integration of healthcare services promoted through commodifying NEG prescriptions not only posed challenges for unions and social movements (Erne 2015), but it also provided opportunities for transnational counter-movements (Erne *et al.* 2024).

During the Covid-19 pandemic, the curtailment of public healthcare promoted by EU executives' NEG prescriptions suddenly disappeared from the Commission and Council's agenda when they activated on 20 March 2020 the general escape clause under the SGP, which de facto led to its suspension. Instead, EU executives' 2020 NEG recommendations tasked Member States to 'invest in access, effectiveness and resilience of the EU's health care systems' (Council of the EU, press release, 20 July 2020). EU leaders also agreed on a €672.5 billion Recovery and Resilience Facility (RRF) to support, *inter alia*, the resilience of healthcare systems through loans and grants. In turn, EU legislators' adopted Regulation 2021/241, which details the conditionalities of RRF disbursements.

In response to the pandemic, European policymakers adopted policies that only a few weeks earlier seemed unthinkable. Although some of these measures were afterwards reversed, such as the temporary subsumption of private hospitals under direct public authority in Ireland, there is now a stronger support for public healthcare across Europe. The dismantling of public healthcare systems is hardly palatable anymore; but this is no guarantee that the commodification of healthcare is about to stop, as private providers will certainly do their best to get as much as possible from the new EU funds for themselves. The ways in which RRF and corresponding national plans modified or not the commodification agenda documented in this article thus form another pressing research area.

Supplementary data

Supplementary data are available at *SOCECO Journal* online.

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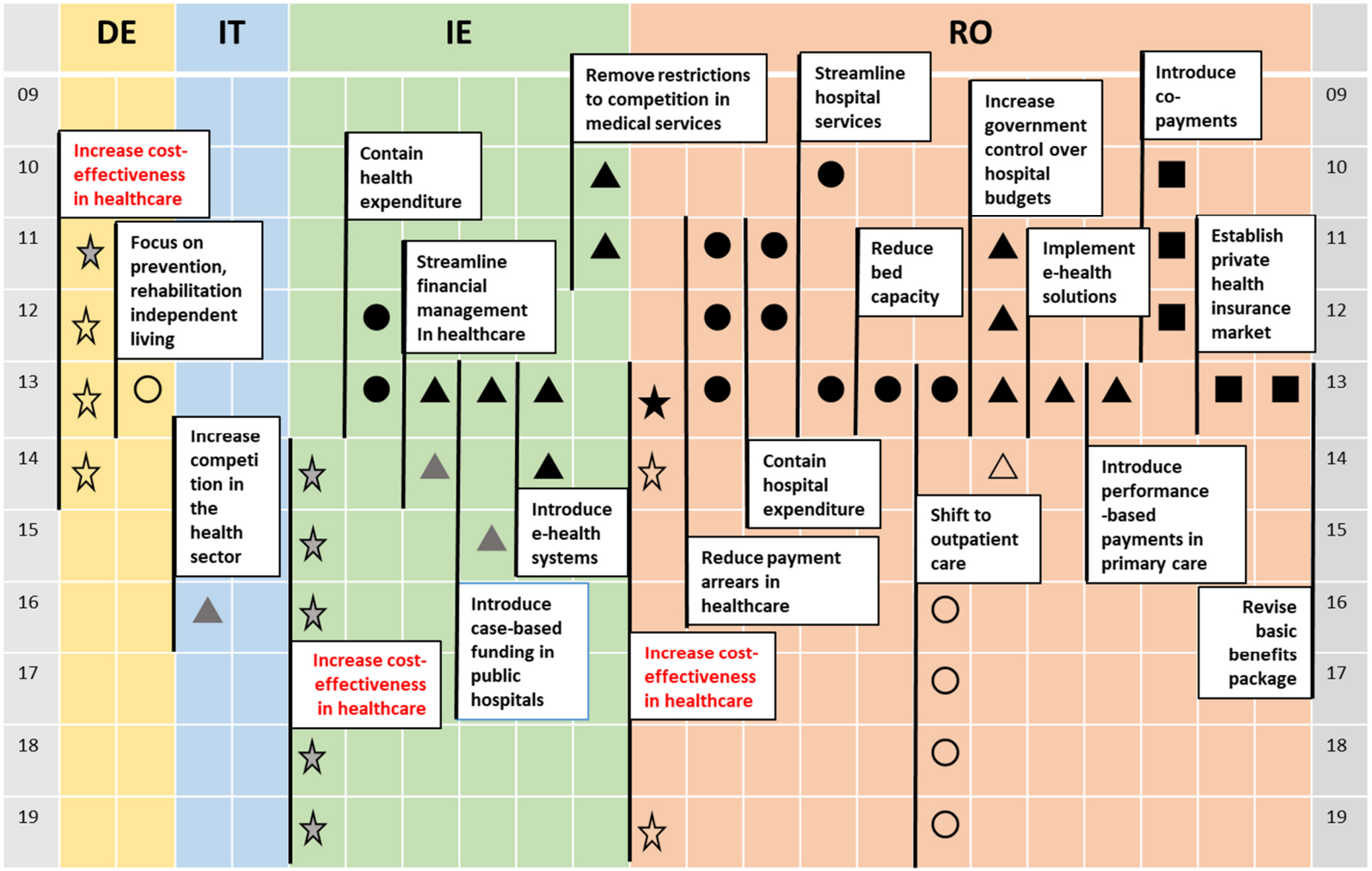
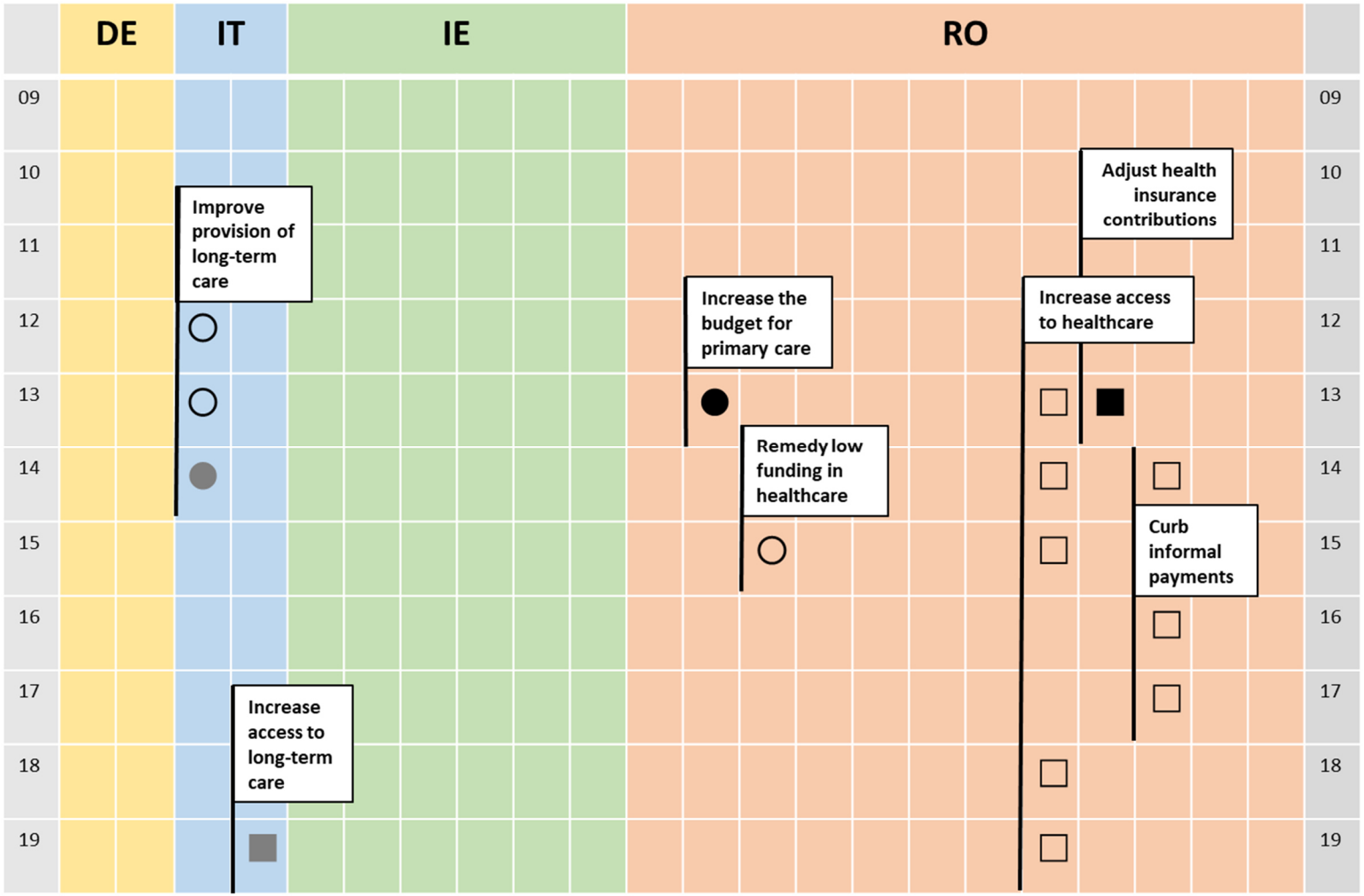
Online Appendix

Figure A1. Commodifying NEG Healthcare Prescriptions for Germany, Italy, Ireland, and Romania, 2009–2019



Subject field: Increase Cost-Effectiveness of Public Spending on Healthcare [☆], Resources for Services [○], Organisation of Services [△], Access to Services [□].
Coercive strength of prescriptions: Very significant [Black symbols], Significant [Grey symbols], Weak [White symbols].
Source: Own compilation based on NEG healthcare prescriptions documented in Tables C1, C2, D1, D2, E1, E2, F1, F2 below.

Figure A2. Decommodifying NEG Healthcare Prescriptions for Germany, Italy, Ireland, and Romania, 2009–2019



Subject field: Increase Cost-Effectiveness of Public Spending on Healthcare [☆], Resources for Services [○], Organisation of Services [△], Access to Services [□].
Coercive strength of prescriptions: Very significant [Black symbols], Significant [Grey symbols], Weak [White symbols].
Source: Own compilation based on NEG healthcare prescriptions documented in Tables C1, C2, D1, D2, E1, E2, F1, F2 below.

Table A1. Hospitals by Form of Ownership, Germany, Italy, Ireland, and Romania, 2008 and 2017

Ownership	2008			2017		
	Public & Private Not-for-Profit	Private for-Profit	Private for-Profit (% of total)	Public & Private Not-for-Profit	Private for-Profit	Private for-Profit (% of total)
DE	1988	1334	40	1755	1329	43
IT	590	669	54	463	600	56
RO	425	22	5	367	209	36
IE	58	13	18	55 [a]	13 [a]	19 [a]

Sources: Romania, 2008: (Romair Consulting, 2009: 8); RO, 2017: (INS, 2018). Germany and Italy: (OECD 2020). Ireland: (Mercille, 2018)
[a] 2015 data.

Table A2. Hospital Beds by Hospital Ownership, Germany, Italy, Ireland, and Romania, 2008 and 2017

Ownership	2008			2017		
	Public & Private Not-for-Profit	Private for-Profit	Private for-Profit (% of total)	Public & Private Not-for-Profit	Private for-Profit	Private for-Profit (% of total)
DE	480,153	194,267	28.8	460,559	200,889	30
IT	160,097	62,918	28.2	136,123	56,425	29
RO	140,204	1,123	0.8	127,843	7,155	5.3
IE	12,602	1,015	7	11,308 [a]	1,075 [a]	9 [a]

Sources: Germany, Italy, and Romania: (Eurostat, [hlth_rs_bds2]). Ireland: (Mercille, 2018).
[a] 2015 data.

Table B. Map of Explicit Semantic Links Between the Prescription 'Increase Cost-Effectiveness in Healthcare' and Other Healthcare Prescriptions for Germany, Italy, Ireland, and Romania, 2011–2019

	Increase cost-effectiveness in healthcare								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
Contain health expenditure	DE	DE	DE	DE				IE	
Reduce payment arrears in healthcare			RO			RO			
Streamline hospital services			RO	RO		RO			
Shift to outpatient care			RO	RO	RO	RO	IE	IE	IE & RO
Focus on prevention & rehabilitation & independent living			DE	DE					
Curb informal payments in healthcare				RO	RO				
Remedy low funding in healthcare				RO					
Streamline financial management				IE		IE	IE	IE	
Introduce case-based funding for hospitals					IE		IE	IE	
Increase government control over hospital budgets				RO					
Implement e-health systems					IE	RO	IE		
Introduce performance-based payments in primary care			RO						

Sources: Council Recommendations on National Reform Programmes (2011–2019). Fields market in yellow denote an explicit semantic link between the Country Specific Recommendation (CSR) 'Increase Cost-Effectiveness in Healthcare' and other CSRs for Germany (DE), Ireland (IE), and Romania (RO).

Table C1: Short Quotes of NEG Healthcare Prescriptions for Germany, 2009–2013

Themes	2009	2010	2011	2012	2013
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care					
Increase cost-effectiveness in healthcare Link to curb spending increases			Council Recommendation, Recital (R) 9: Since the recent reform of the health-care system introduced measures to curb spending increases mainly in 2011 and 2012, further steps to enhance the efficiency of public spending on health-care and long-term care would support the envisaged consolidation path. Council Recommendation, Country-Specific Recommendation (CSR1), SGP: **further enhance efficiency of public spending on health-care and long-term care**.	R 12: The Federal Government has taken measures to improve the efficiency of public spending on healthcare and has proposed a reform of long-term care. Additional efforts to improve efficiency in health care are necessary to *contain expected further expenditure increases.* CSR1, SGP: **[Make] additional efforts to enhance efficiency of public spending on health-care and long-term care**.	R 10: Germany has made only limited efforts to improve the efficiency of public spending on healthcare and long-term care. Past reform efforts in the health sector as well as this year's reform of long-term care appear *insufficient to contain expected future cost increase.* CSR1, SGP: **[Make] additional efforts to enhance efficiency of public spending on health-care and long-term care**.
Resources for Health Services					
Expenditure Levels					
Service Levels					
Focus on prevention and rehabilitation and independent living Link to cost-effectiveness					R 10: Germany has made only limited efforts to improve the efficiency of public spending on healthcare and long-term care. Past reform efforts … appear insufficient to contain expected future cost increases. CSR1, SGP: *Enhance the cost-effectiveness of public spending on healthcare and long-term care through …* a **stronger focus on prevention and rehabilitation and independent living**.
Organisation of Health Services					
Access to Health Services					

Table C2: Short Quotes of NEG Healthcare Prescriptions for Germany, 2014–2019

Themes	2014	2015	2016	2017	2018	2019
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care						
Increase cost-effectiveness in healthcare Link to curb spending increases	R 10: Only limited progress has been made by Germany in enhancing the cost-effectiveness of public spending on healthcare and long-term care, although new initiatives have been announced. While their aim is to improve the cost-effectiveness of healthcare, *these plans might not be sufficient to contain expected future cost increases.* CSR1, SGP: **Increase cost-effectiveness of public spending on healthcare & long-term care**.					
Resources for Health Services						
Organisation of Health Services						
Managerialisation						
(Remedy) low performance in e-health services					R 9: Performance in digital public services and in e-health is also far below the Union average.	R 10: Performance in digital public services and in e-health is far below the EU average. (…)
Access to Health Services						
Cost Coverage						
Abolish free access to health insurance for second earners			R 11: Specific characteristics of the tax system and health insurance discourage second earners from taking up a job or increasing the number of hours worked.	R 12: Free healthcare insurance coverage for non-working spouses discourages second earners, in many cases women, from taking up a job or increasing the number of hours worked.		

Table D1: Short Quotes of NEG Healthcare Prescriptions for Italy, 2009–2014

Themes	2009	2010	2011	2012	2013	2014
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care						
Resources for Health Services						
Expenditure Levels						
Service Levels						
Improve provision of long-term care Link to participation of women in the labour market			R 2: Take steps to promote greater participation of women in the labour market, by increasing the availability of care facilities throughout the country and providing financial incentives to second earners to take up work in a budgetary neutral way.	R 4: Despite efforts made to improve the employability of women, mainly through targeted fiscal incentives, the employment rate of Italian women is significantly lower … Further action on childcare and elderly care facilities is needed. CSR 4, MIP: Incentivise labour market participation of women, in particular through the **provision** of childcare and **elderly care**.	R 16: The participation of women in the labour market remains weak and the employment gender gap is one of the highest in the Union. CSR 4, MIP: Reduce financial disincentives for second earners to work and **improve the provision of care, especially** child- and **long-term care**.	R 13: Labour market continues to be marked by segmentation and low participation, which affects women … in particular. CSR 5, MIP: Adopt effective action to promote female employment, by … providing **adequate care services**.
Organisation of Health Services						
Liberalisation						
Increase competition in the service sector Link to public services and procurement			R 13: There is still ample scope for removing regulatory and administrative barriers in (…) services markets, particularly in professional services. CSR 6, MIP: Open up the services sector to further competition, including in the field of professional services [CSR not included in Table 3, as healthcare is not yet explicitly mentioned, by contrast to 2016].	R 17: Italy has adopted important measures to liberalise services, in particular professional services. CSR 6, MIP: Implement the adopted liberalisation and simplification measures in the services sector [CSR not included in Table 3, as healthcare is not yet explicitly mentioned, by contrast to 2016].	R 18: The reform of regulated professions should be taken further to address remaining restrictions. CSR 6, MIP: Remove remaining restrictions in professional services and foster market access; for instance, in the provision of local public services where the use of public procurement should be advanced, instead of direct concessions [CSR not included in Table 3, as healthcare is not yet mentioned, by contrast to 2016].	
Access to Health Services						

Table D2: Short Quotes of NEG Healthcare Prescriptions for Italy, 2015–2019

Themes	2015	2016	2017	2018	2019
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care					
Resources for Health Services					
Organisation of Health Services					
Liberalisation					
Increase competition in the health sector Link to health services and public procurement	R 20: Restrictions on competition still hamper the proper functioning of … services markets. Significant barriers remain in ... healthcare.	R 17: A number of areas are still over-protected or regulated, in particular regulated professions, the health sector, … CSR5, MIP: Swiftly adopt and implement the pending law on competition. Take further action to increase competition in regulated professions, the transport, **health** and retail sectors and the system of concessions.	R 18: Significant barriers to competition persist in certain sectors, such as regulated professions, concessions, public procurement and (…) local public services.	R 17: Significant barriers to competition persist in certain sectors, such as professional services.	R 26: Increasing competitive processes to award public service contracts and concessions for access to public goods would positively affect the quality of services.
Access to Health Services					
Service Coverage					
Increase access to long-term care Link to participation of women in the labour market		R 16: The limited availability of affordable care services also hampers [women's labour market] participation.	R 21: Access to affordable care services (for children and the elderly) remains limited, with wide regional disparities.	R 24: Low employment rate of Italian women (…) insufficient supply of adequate, affordable and quality childcare and care services.	R 14: More home and community-based care and long-term care is key to provide support to people with disabilities and other disadvantaged groups. R 17: Investment in care services and women's participation in the job market remains insufficient. CSR2, MIP: Support women's participation in the labour market through a comprehensive strategy, including through **access to quality childcare and long-term care**.
(Tackle) unequal access to / availability of care				R 26: Self- reported unmet needs for medical care are high, and differences between regions in the organisation and quality of care delivery persist.	R 14: The provision of healthcare largely varies across regions, affecting access, equity and efficiency, and could be improved through *better administration and by monitoring the delivery of standard levels of services*.

Table E1: Short Quotes of NEG Healthcare Prescriptions for Ireland, 2009–2013

Themes	2009	2010	2011	2012	2013
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care					
Resources for Health Services					
Expenditure Levels					
Contain health expenditure				MoU_2010 6th update: Specify the measures to eliminate the **spending** overrun by year end.	MoU_2010 7th update: Take the measures necessary to **unwind the overrun in health spending** and … **contain health expenditure** next year to **within the €13.6 billion departmental ceiling** for 2013.
Service Levels					
Organisation of Health Services					
Managerialisation					
Streamline financial management					MoU_2010 9th & 10th update: Adopt a framework by end-October to **streamline and consolidate multiple and fragmented financial management and accounting systems and processes**.
Introduce case-based funding for hospitals				-	MoU_2010 9th & 10th update: Introduce… **a prospective case-based payment system for public hospitals,** in line with a principle of case-based cost recovery for use of public hospitals by public and private patients.
Implement e-health systems					MoU_2010 8th, 9th, 10th update, 11th review: Develop an **eHealth Strategy** in conjunction with the HSE by end Q2 2013. This will serve as a time-bound action plan for the **implementation of eHealth systems**, including a **comprehensive system of ePrescription which uses a unique patient identifier**… to support and enable the **delivery of integrated patient care** under the reform agenda.
Liberalisation					
Remove restrictions to competition in medical services		MoU_2010: Introduce legislative changes to remove restrictions to trade & competition in sheltered sectors including **…medical service**, eliminat[e] **restrictions on the number of GPs qualifying** and remov[e] restrictions **on GPs wishing to treat public** patients as well as restrictions **on advertising**.	MoU_2010 1st & 2nd update: Introduce legislative changes to remove restrictions to trade & competition in **…medical service** … eliminat(e) restrictions on the number of **GPs qualifying** and remov(e) restrictions on GPs wishing to treat public patients as well as restrictions **on advertising**.		
Access to Services					

Table E2: Short Quotes of NEG Healthcare Prescriptions for Ireland, 2014–2019 (page 1 of 3)

Themes	2014	2015	2016	2017	2018	2019
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care						
Increase cost-effectiveness in healthcare	R 11: Current service levels can be maintained only if value-for-money gains are achieved over the medium to long term… Financial management and accounting systems and processes are fragmented across healthcare providers. This … also hinders the monitoring of healthcare expenditure and efforts to achieve value-for-money CSR2, SGP: Advance the reform of the healthcare sector to … **increase cost-effectiveness**.	R 10: Intermediate steps are being pursued in the introduction of universal health insurance to address some of the pressing challenges and improve cost-effectiveness. Effectively rolling out e-health tools, activity-based funding and improved prescription practices have significant potential to increase cost-effectiveness. CSR2, SGP: **Increase the cost-effectiveness of the healthcare system**.	R 7: Cost-effectiveness, equal access and sustainability remain critical challenges to the healthcare system. CSR1, SGP: Enhance the quality of expenditure, particularly by **increasing cost- effectiveness of healthcare**.	R 11: The spending review should in particular address the cost-effectiveness of the health sector …Ireland has introduced some important efficiency measures, such as ..., a financial management system, eHealth and activity-based funding. However, more could be done, … by strengthening the role of primary care as a gatekeeper for Ireland's overburdened hospitals.	R 11: The Irish healthcare system is costly… Moreover, *primary and community care services* are not yet capable of alleviating the mounting pressure on capacity and costs within hospital care. CSR1, SGP: Address the expected increase in age-related expenditure by **increasing the cost-effectiveness of the healthcare system**.	R 11. Short-term costs will also need to be contained to fulfil the Sláintecare vision in the long run. CSR1, SGP: Address the expected increase in age-related expenditure by **making the healthcare system more cost-effective**.
Resources for Health Services						
Expenditure Levels						
Contain health expenditure		R 10: The health system needs deeper structural reforms to contain expected cost increases.			R 11: The planned move towards universal healthcare needs to be supported by multi-year budgeting and better expenditure control. In addition, it has to be informed by the findings from a comprehensive spending review of the effectiveness and efficiency of the health sector.	R 11: Spending on healthcare is projected to rise from 4.1% of GDP in 2016 to 5.1% in 2070, with a peak of 5.2% in 2013.
Service Levels						
Shift to outpatient care Link to cost containment						R 11: Planned reform represents a credible vision for making the health system universally accessible and sustainable …. This is likely to have a positive impact in reducing the reliance on acute care, thereby making healthcare more cost-effective.

Table E2: Short Quotes of NEG Healthcare Prescriptions for Ireland, 2014–2019 (page 2 of 3)

Themes	2014	2015	2016	2017	2018	2019
Organisation of Health Services						
Managerialisation						
Streamline financial management in healthcare Link to monitoring expenditure in healthcare	R 11: Financial management and accounting systems and processes are fragmented across healthcare providers. This … hinders the monitoring of healthcare expenditure and efforts to *achieve value-for-money and an appropriate allocation of resources*. CSR2, SGP: **Reform the financial management systems of the national health authority** to **streamline systems across all providers** and to support better claims management. Roll out *individual health identifiers* starting by the end of the first quarter of 2015 at the latest.		R 7: [In healthcare] financial management and information systems remain weak. R 11: *Ireland has introduced some important efficiency measures, such as* … a financial management system.	R 11: Ireland has introduced some important efficiency measures, such as … a financial management system.	R 11: Ireland has *introduced some significant efficiency measures such as* … a financial management system.	
Introduce case-based funding for hospitals Link to cost containment		R 10: Effectively rolling out e-health tools… have *significant potential to increase cost-effectiveness*. CSR2, SGP: Roll out **activity-based funding throughout the public hospital system**.	R 11: Ireland has introduced some important efficiency measures, such as … activity-based funding.	R 11: Ireland has introduced some important efficiency measures, such as … activity-based funding.	R 11: Ireland has introduced some significant efficiency measures such as … activity-based funding.	
Implement e-health systems Link to cost-effectiveness	R 11: Financial management and accounting systems and processes are fragmented across healthcare providers. This causes delays and hurdles in collecting and processing information. It also hinders the monitoring of healthcare expenditure and efforts to achieve value-for-money and an appropriate allocation of resources. CSR2, SGP: Roll out individual **health identifiers** starting by the end of the first quarter of 2015 at the latest.	R 10: Effectively rolling out e-health tools, activity-based funding and improved prescription practices have significant *potential to increase cost-effectiveness.*	R 11: Ireland has introduced some important efficiency measures, such as … a financial management system, eHealth and activity-based funding.			

Table E2: Short Quotes of NEG Healthcare Prescriptions for Ireland, 2014–2019 (page 3 of 3)

Themes	2014	2015	2016	2017	2018	2019
Access to Health Services						
Service Coverage						
Equal access to health services Link to cost-effectiveness			R 7: Cost-effectiveness, equal access and sustainability remain critical challenges to the healthcare system… unequal access to primary care is still an issue. Approximately 40% of the population has free access to general practitioners, while the rest bear the full cost.	R 11: Steps towards a universal single-tier health service are fragmented and lack an overarching vision.	R 11: Some measures have also been taken to improve the availability of primary healthcare.	R 11: The planned reform represents a credible vision for making the health system universally accessible and sustainable, meeting the demands of an ageing population and shifting care into the community, with a stronger focus on prevention. This is likely to have a positive impact in reducing the reliance on acute care, *thereby making healthcare more cost-effective.*

Table F1: Short Quotes of NEG Healthcare Prescriptions for Romania, 2009–2013 (page 1 of 5)

Themes	2009	2010	2011	2012	2013
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care					
Increase cost-effectiveness in healthcare Link to shift to outpatient care					PMoU_2013: [Propose & implement] legislative amendments that may have material impact on the **fiscal sustainability or efficiency of the healthcare sector** … Improve efficiency and effectiveness **in the healthcare system**. PMoU_2013: The authorities will **prepare a comprehensive health strategy** covering also **the revenue side together with the MoPF** [Ministry of Public Finance] by end-2013.… Implement according to the deadlines the binding action plan for healthcare reform as committed to by the authorities, specifying the plan with measurable indicators, objectives and publishing supporting evidence and impact assessments of the reform proposals. R 12: Reforms to improve the efficiency of the healthcare sector have begun but continuous efforts are needed. The cost-effectiveness of the system could be increased by reducing the excessive use of hospital in-patient care and by strengthening primary care and referral systems. CSR3: **Pursue health sector reform to increase its efficiency**.
Resources for Health Services					
Expenditure Levels					
Reduce payment arrears in healthcare			MoU_2009 3rd update: The **health sector** would accumulate substantial arrears by the end of 2010. MoU_2009 3rd & 4th updates [5th inst]: Prevent re-emergence of arrears in the healthcare **sector** based on effective measures being in place. PMoU_2011: Avoid a re-accumulation of **payment arrears**. PMoU_RO_2011 & PMoU_RO_2011 1st update: Avoid a re-accumulation of **payment arrears**.	PMoU_2011 2nd update: Take the necessary action …to **avoid a re-accumulation of payment arrears** … gradually reduce the payment delays in the health sector from 210 days to 60 days as required by Article 4 (4) of the EU late payments directive (2011/7/EU). R 12: The main risks to the budgetary targets are … **potential re-accumulation of arrears** … in the health sector, even if some measures have been taken.	PMoU_2013: Continue implementing outstanding measures [on] …**clearing arrears in the health sector**… In the health sector, budget control mechanisms will be strengthened … to **avoid a re-accumulation of payment arrears**. Preserve the achievements of the previous two programmes, implement the further measures agreed under those programmes, and fulfil any remaining parts of yet unfulfilled conditionality. This applies in particular to: iv) **the reduction of payment delays in the health sector**.

Table F1: Short Quotes of NEG Healthcare Prescriptions for Romania, 2009–2013 (page 2 of 5)

Themes	2009	2010	2011	2012	2013
Contain hospital expenditure Link to containment of arrears in healthcare	-	-	PMoU_2011 & PMoU_2011 1st update: The Ministry of Finance should **check that the aggregate figures for hospital budgets are consistent with the expenditure programmed** in the general government budget… & *take the necessary action … to avoid a re-accumulation of payment arrears*.	PMoU_2011 2nd update: The Ministry of Finance should **check that the aggregate figures for hospital budgets** are consistent with the expenditure programmed in the general government budget… & *take the necessary action …to avoid a re-accumulation of payment arrears*.	
Streamline hospital services Link to cost-effectiveness		MoU_2009 2nd update [4th instl]: Streamlining the number of schools and **hospitals**.			PMoU_2013: *Improve efficiency and effectiveness in the healthcare system….* Continue the preparation of the **reorganisation and rationalisation of the hospital network** based on the government' s project financed by the World Bank for health sector reform, slated for Board Approval by end-2013. This includes **streamlining hospital services**, shifting the delivery of health services to outpatient services, building physical and functional integrated referral networks, **including regional hospitals**, and the referral system that surrounds them from primary health to post-hospital care as well as patient pathways in the health system. R 13: *The cost-effectiveness of the system could be increased by* **reducing the excessive use of hospital in-patient care**. CSR3: **Reduce the excessive use of hospital care**, including by strengthening outpatient care.
Reduce bed capacity in hospitals Link to cost-effectiveness					PMoU_2013: *Improve efficiency and effectiveness in the healthcare system. This will be done by* **… continuing the reduction of bed capacity in in-patient acute care hospitals** in accordance with the national health strategy…. Continue the preparation of the **reorganisation and rationalisation of the hospital network** based on the government' s project financed by the World Bank for health sector reform, slated for Board Approval by end-2013.

Table F1: Short Quotes of NEG Healthcare Prescriptions for Romania, 2009–2013 (page 3 of 5)

Themes	2009	2010	2011	2012	2013
Shift to outpatient care Link to cost-effectiveness					PMoU_2013: Improve efficiency and effectiveness in the healthcare system. This will be done by **shifting resources from hospital-based care towards primary care and ambulatory care**. **Shifting the delivery of health services to outpatient services**, building physical and functional integrated referral networks, including regional hospitals, and the referral system that surrounds them from primary health to post-hospital care as well as patient pathways in the health system. R 12: The cost-effectiveness of the system could be increased by **reducing the excessive use of hospital in-patient care and by strengthening primary care** and referral systems. CSR3: **Reduce the excessive use of hospital care, including by strengthening outpatient care.**
Increase the budget for primary care Link to performance-based payments and cost-effectiveness					PMoU_2013: Improve efficiency and effectiveness in the healthcare system. … **The budget for primary care will be increased** via use of **performance-based payments** to at least 10% of public health expenditure managed by the health house [national health insurance fund, CNSA] within the next 2 years….
Organisation of Health Services					
Managerialisation					
Increase government control over hospital budgets Link to contain arrears in healthcare			PMoU_2011 & PMoU_2011 1st update: Check that the aggregate figures for **hospital budgets are consistent with the expenditure programmed** in the general government budget… & **take the necessary action …** to avoid a re-accumulation of payment arrears.	PMoU_2011 2nd update: Check that the aggregate figures for hospital budgets are consistent with the expenditure programmed in the general government budget … & take the necessary action *… to avoid a re-accumulation of payment arrears*.	PMoU_2013: In the health sector, **budget control mechanisms will be strengthened through improved reporting and monitoring frameworks,** in particular with regard **to hospitals** … continue implementing outstanding measures [on] **preserving budget control mechanisms** (such as … **monthly hospital** budget reporting).
Introduce performance-based payments in primary care Link to cost-effectiveness					PMoU_2013: The budget for primary care will be increased via **use of performance-based payments to at least 10% of public health expenditure managed by the health house within the next 2 years**….
Implement e-health solutions					PMoU_2013: Continue implementing outstanding measures [on]… **implementing e-health solutions**.

Table F1: Short Quotes of NEG Healthcare Prescriptions for Romania, 2009–2013 (page 4 of 5)

Themes	2009	2010	2011	2012	2013
Access to Health Services					
Cost Coverage					
Introduce co-payments for medical services Link to containment of healthcare expenditure		MoU_2009 2nd update, [5th instl]: **Introduction of a co-payment system on medical services**. The share of exemptions to the obligation to make such payments should not exceed 40%.	MoU_2009 3rd update: **Structural reforms in the health sector (including the introduction of co-payments) became essential**. [5th instl]: Approval of **legislation to introduce a means-tested co-payment system for medical services** developed in cooperation with the World Bank. 4th update: There are also a number of conditions whose fulfilment cannot be verified at a significantly earlier stage and will therefore be carried over to the expected follow up precautionary assistance programme. These concern: i) **the approval of the means-tested co-payments system in the healthcare sector**. PMoU_RO_2011 & 1st update: Approval of **legislation to introduce a means-tested co-payment system for medical services** developed in cooperation with the World Bank.	PMoU_2011 2nd update: Approval of **legislation by mid-June 2012 to modify the co-payment system for medical services** in cooperation with the World Bank.	

Table F1: Short Quotes of NEG Healthcare Prescriptions for Romania, 2009–2013 (page 5 of 5)

Themes	2009	2010	2011	2012	2013
Establish private health insurance market Link to increased share of private in total health expenditure					PMoU_2013: **Establish the framework for a private supplementary insurance market** aiming at increasing the share of private in total expenditure on health.
Adjust [public] health insurance contributions Link to labour taxation					PMoU_2013: Considering the funding needs of the healthcare system and the possible need to **adjust health insurance contributions**, conduct a comprehensive review of labour taxation with a view to reducing, in a budget-neutral manner, the effective tax burden on labour for low- and middle-income earners.
Population and service coverage					
Revise basic services package Link to containment of public health expenditure					PMoU_2013: **Define, by end-September 2013, the** publicly reimbursable **basic benefits package** based on objective, verifiable criteria, to be financed within the limitations of available funding…As of 2015, the revision of the **basic benefits package will be based on a cost-effectiveness analysis**.
Increase access to healthcare Link to efficiency and healthcare reform					R 12: The health sector in Romania features major inequities in terms of access to services provided and their quality. CSR3: Pursue health sector reform to **increase its** efficiency, **quality and accessibility**, in particular for **disadvantaged people and remote and isolated communities**.

Table F2: Short Quotes of NEG Healthcare Prescriptions for Romania, 2014–2019 (page 1 of 4)

Themes	2014	2015	2016	2017	2018	2019
Increase Cost-Effectiveness of Public Spending on Healthcare and Long-Term Care						
Increase cost-effectiveness in healthcare	R 11: Reforms to improve the efficiency of the healthcare sector and its financial sustainability have begun but continuous efforts are needed. Some of the measures are incurring delays and *suffer from insufficient funding and the services' low capacity… Reducing the excessive use of hospital inpatient care and strengthening primary care and referral systems will* **increase cost-effectiveness**. CSR3: *Step up reforms in the health sector* to **increase its efficiency**.	R 15: The Romanian healthcare system is characterised by … **inefficient use of resources**… the system … suffers from the **extensive** inefficient **hospital network** … and **reduced efficiency of the system**…Various measures and healthcare reforms that have been introduced have narrowed the funding gap and **improved the standard and efficiency of services**. … The Ministry of Health and the National Health Insurance House are considering various **measures to improve the system for financing healthcare**.	R 16: Romania has taken action to **address … its inefficient use of public resources… the efficiency of the health system is** constrained by **delays in streamlining the hospital sector**.		R 17: *Low funding and* ***the inefficient use of resources limit the effectiveness of the healthcare system***.	R 18. *Low funding*, **inefficient use of public resources** and the lack of reform **limit the effectiveness of the health system**. CSR2, MIP: **Improve** access to and **cost-efficiency of healthcare,** including through the shift to outpatient care.
Resources for Health Services						
Expenditure Levels						
Reduce payment arrears in healthcare			R 16: Romania has taken action to address … its inefficient use of public resources. … including clearing arrears in the health sector.			
Remedy low funding in healthcare Link to efficiency Link to low funding of health services	R 11: Reforms to *improve the efficiency* of the healthcare sector and its financial sustainability have begun but continuous efforts are needed. Some of the measures are incurring delays and suffer from insufficient funding and the services' low capacity.	R 15: The Romanian healthcare system is characterised by … **low funding** … The system suffers from the … weak and fragmented referral networks, and the low proportion of spending directed to primary healthcare….Various measures and healthcare reforms that have been introduced have **narrowed the funding gap.** The Ministry of Health and the National Health Insurance House are considering various **measures to improve the system for financing healthcare**. CSR3, MIP: Pursue the national health strategy 2014-2020 to **remedy issues of … low funding and insufficient resources**.	R 16: Romania has taken action to address the low funding of the healthcare system.	R 19: Accessible quality healthcare is impaired by … shortages of health professionals, under-funding…	R 17: **Low funding** and the inefficient use of resources limit the effectiveness of the healthcare system against the background of a **sizeable shortage of doctors and nurses**.	R 18: **Low funding,** inefficient use of public resources and the lack of reform limit the effectiveness of the health system. **Continued emigration** has resulted in **a sizeable shortage of doctors and nurses**. **Health infrastructure** and the prevalence of informal payments remain **sources of concern… Coverage and public spending on long-term care are among the lowest in EU**.

Table F2: Short Quotes of NEG Healthcare Prescriptions for Romania, 2014–2019 (page 2 of 4)

Themes	2014	2015	2016	2017	2018	2019
Service Levels						
Shift to outpatient care Link to cost-effectiveness and access	R 11: Reducing the excessive use of hospital inpatient care and strengthening primary care and referral systems *will increase cost-effectiveness*.	R 15: There is high reliance on in-patient services and the system suffers from the extensive inefficient hospital network, the weak and fragmented referral networks, and the low proportion of spending directed to primary healthcare.	R 15: … over-reliance on hospital care remain major concerns. R 16 ... the efficiency of the health system is constrained by delays in streamlining the hospital sector and switching from inpatient to more cost-effective outpatient healthcare CSR3: **Increase the availability of outpatient care**.	R 19: Romania took some policy action to shift from inpatient to outpatient care… Nonetheless, the reinforcement of community care, ambulatory care and referral systems is still at an initial stage. CSR2: **In healthcare, shift to outpatient care**.	R 17: Addressing the country-specific **recommendation to shift to outpatient care has seen limited progress** so far. CSR2: Improve access to healthcare**, including through the shift to outpatient care**.	R 18: Improvements in community care are much needed but are delayed. The pilot project for setting up community care centres has started with a delay, impacting the roll-out of integrated care services. CSR2, MIP: Improve access to and cost-efficiency of healthcare, including through the **shift to outpatient care**.
Reduce extensive use of hospital services Link to cost-effectiveness, efficiency, and accessibility	R 11: **Reducing the excessive use of hospital inpatient care** (…) *will increase cost-effectiveness.*	R 15: The Romanian healthcare system … suffers from the **extensive *inefficient* hospital network**.	R 15: …**over-reliance on hospital care remain major concerns**. R 16: Romania has taken action to address … the **healthcare system** …. These reforms included… devising a strategy to shift resources from hospital-based care towards preventive and primary care…. the efficiency of the health system is constrained by delays in streamlining the hospital sector and switching from inpatient to more cost-effective outpatient healthcare.	R 19: Accessible quality healthcare is impaired by … **over-reliance on hospitals**.		
(Tackle) low capacity of long-term care, rehabilitation & palliative care						R 18: The long-term care sector is not ready to deal with a rapidly ageing population. There are very few at-home and day-care services, mainly concentrated in areas with higher income. … access to long-term care, rehabilitation and palliative care is poor.

Table F2: Short Quotes of NEG Healthcare Prescriptions for Romania, 2014–2019 (page 3 of 4)

Themes	2014	2015	2016	2017	2018	2019
Organisation of Health Services						
Managerialisation						
Increase government control over hospital budgets Link to informal payments	R 11: Inefficient use of resources and poor management increase the fiscal sustainability risk in the health sector. CSR3: Increase efforts to curb informal payments, including through **proper management and control systems**.					
Implement e-health solutions			R 16: Romania has taken *action to address the low funding of the healthcare system and its inefficient use of public resources*. These reforms included… **implementing e-health solutions**.			
Liberalisation						
Improve public procurement in hospitals and for healthcare infrastructure Link to efficiency			R 16: Romania has taken action to address the low funding of the healthcare system and its inefficient use of public resources. These reforms included … centralised procurement procedures.	R 19: Beside informal payments to medical professionals, corruption concerns public procurement in hospitals.	R 20: Efficiency and transparency challenges associated with public procurement apply in particular to the large healthcare infrastructure investments in the regional hospitals for Iași, Cluj and Craiova.	

Table F2: Short Quotes of NEG Healthcare Prescriptions for Romania, 2014–2019 (page 4 of 4)

Themes	2014	2015	2016	2017	2018	2019
Access to Health Services						
Cost coverage						
Curb informal payments in the healthcare system Link to efficiency and accessibility	R 11: Widespread informal payments in the public healthcare further hinder the accessibility, efficiency and quality of the system. CSR3: Increase efforts to curb **informal payments**.	R 15: The widespread use of informal payments in the public healthcare system *further reduces the accessibility, efficiency and quality of the system.*	R 15. Widespread informal payments *reduce access to healthcare for people with low incomes*. CSR3: Curb **informal payments in the healthcare system**…	R 19: Beside informal payments to medical professionals, corruption concerns public procurement in hospitals … Legislation was adopted to revamp the feedback system on informal payments …. Nonetheless… informal payments remain prevalent, transparency in hospital management is yet to be ensured. CSR2: **In healthcare, … curb informal payments**.	R 17: Access to healthcare is limited by the prevalence of informal payments… Romania made some progress addressing the country-specific recommendation to curb informal payments, and a monitoring mechanism is being implemented, though its actual impact is still to be assessed.	R 18: Health infrastructure and the prevalence of informal payments remain sources of concern.
Adjust [public] health insurance contributions	R 10: The tax wedge on low and middle-income wage earners remains high. CSR2, SGP: Reduce tax burden for low- and middle-income earners in a budget-neutral way.	R 12: The recent cut in employers' social security contributions has reduced the labour tax wedge, but in an untargeted way. The tax wedge for lower income earners remains high (40%) relative to other European countries.				
Population and service coverage						
Increase access to healthcare Link to cost-efficiency and the shift to outpatient care	R 11: Further reforms of the healthcare system aimed at improving the health of the population by promoting, among other things, equitable access to quality health services has been launched. CSR3: Step up reforms in the health sector to increase its efficiency, **quality and accessibility**, including for disadvantaged people and remote and isolated communities.	R 15: The Romanian healthcare system is characterised by poor results of treatment, poor financial and geographical accessibility. CSR3, MIP: Pursue the national health strategy 2014-2020 to **remedy issues of poor accessibility**, low funding and insufficient resources.	R 15: Health outcomes in Romania are poor. …Access to healthcare … remain major concerns. Romania has adopted measures to improve access to healthcare for low-income pensioners and people in remote and isolated communities. A network of social and health mediators is being developed and a draft law on community services has been proposed. The deinstitutionalisation of people with disabilities remains a challenge.	R 12: Inequalities [in the distribution of disposable household income] are driven to a large extent by unequal access to healthcare, education, services and the labour market. R 19: Accessible quality healthcare *is impaired by shortages of health professionals, under-funding and over-reliance on hospitals, and corruption*, affecting people with low income and rural areas in particular… Regional healthcare plans were developed to identify needs for infrastructure and services.	R 17: Access **to healthcare remains a challenge**, with negative impacts on child development, workforce employability and healthy ageing. CSR2: **Improve access to healthcare,** including through the *shift to outpatient care*.	R 15: The limited integration of employment, education, **health** and social services does not allow for the sustainable inclusion of various disadvantaged groups. R 18: Access to healthcare services for those living in rural areas and vulnerable groups is limited. …. The long-term care sector is not ready to deal with a rapidly ageing population. There are very few at-home and day-care services, mainly concentrated in areas with higher income. … access to long-term care, rehabilitation and palliative care is poor. CSR3: **Improve access to and cost-efficiency of healthcare,** including through the shift to outpatient care.

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