The crisis as catalyst for reframing health care policies in the European Union

Jan-Kees Helderman

Health Economics, Policy and Law / Volume 10 / Special Issue 01 / January 2015, pp 45 - 59
DOI: 10.1017/S1744133114000231, Published online: 21 July 2014

Health Economics, Policy and Law (2015), **10**, 45–59 © Cambridge University Press 2014
doi:10.1017/S1744133114000231

Overview

The crisis as catalyst for reframing health care policies in the European Union†

JAN-KEES HELDERMAN*

Associate Professor at the Institute for Management Research, Department of Public Administration and Political Science, Nijmegen School of Management, Radboud University, Nijmegen, The Netherlands

Abstract: Seen from the perspective of health, the global financial crisis (GFC) may be conceived of as an exogenous factor that has undermined the fiscal sustainability of European welfare states and consequently, their (expanding) health systems as well. Being one of the core programs of European welfare states, health care has always belonged to the sovereignty of European Member States. However, in past two decades, European welfare states have in fact become semi-sovereign states and the European Union (EU) no longer is an exogenous actor in European health policy making. Today, the EU not only puts limits to unsustainable growth levels in health care spending, it also acts as an health policy agenda setter. Since the outbreak of the GFC, it does so in an increasingly coercive and persuasive way, claiming authority over health system reforms alongside the responsibilities of its Member States.

Submitted 14 November 2013; revised 23 May 2014; accepted 11 June 2014; first published online 21 July 2014

1. Introduction

The global financial crisis (GFC) certainly is a critical case for understanding the impact of macroeconomic and related socio-political conditions on the sub-systems' health politics and policies of European welfare states. It is a 'critical juncture', challenging the socio-economic and political-economic foundations of post-industrial welfare states and within these welfare states, health care systems as well. One almost immediate effect of the macroeconomic crisis seems to be that European countries succeeded in slowing down (public) health expenditures for

*Correspondence to: Jan-Kees Helderman, Associate Professor, Department of Public Administration and Political Science, Institute for Management Research, Radboud University Nijmegen, PO Box 9108, 6500 HK Nijmegen, The Netherlands. Email: j.helderman@fm.ru.nl

† Paper prepared for the special issue of *Health Economics, Policy and Law* on the impact of the macroeconomic crisis on health care.

the first time since the 1960s (Morgan and Astolfi, this issue). Only time can tell us whether the recent slowdown of health care expenditures will be path breaking. Health systems, it should be admitted, do not have a particularly trustworthy reputation with respect to cost containment. Looking backward, Organization for Econonimc Co-Operation and Development (OECD) analysts could hardly find any positive correlation between past economic downturns (including economic recessions) and levels of total and public spending on health (OECD, 2009). Total and public expenditures on health have risen faster than both gross domestic product (GDP) and population growth since the 1960s.

However, this apparent immunity for past economic recessions does not tell us much about the current situation, nor does it imply that health care essentially is politics of the '*status quo*'. This paper aims to understand the relation between external shocks, the GFC and endogenous reformist change from a political science perspective. More specifically, the paper focuses on the growing importance of the European Union (EU) for the politics and policies of health care. From the perspective of health, the GFC may be perceived as an exogenous challenge, but the EU certainly no longer is an exogenous factor. Because of the European monetary and economic integration, European welfare states have become semi-sovereign states and the EU has taken its own stake in European health care systems. Moreover, the EU not only puts limits to unsustainable growth levels in health care spending, it is also involved in framing and reframing health policy. Since the outbreak of the GFC, it does so in an increasingly coercive and persuasive way, claiming authority over health system reforms alongside the responsibilities of its Member States.

In the next section, I explore the relation between crises and reformist change, arguing that from a political science perspective, a crisis can be understood as moments of decisive interventions, in which a perceived sense of urgency must be accompanied with a mandate to act. Policy framing is about the process of defining the image of a policy; how a particular situation and potential policy solutions should be understood. Policy venues are the institutional sites where the portrayal of problems and solutions take place (policy framing) and where authoritative decisions (decisive interventions) are made concerning a given issue. I will then examine how health policy has been framed as an issue of relevance in relation to the GFC and how the EU created new policy venues to deal with health care.

2. Crisis? What crisis?

How are crises and reforms related to each other in the political science literature? John Keeler defined a crisis as a situation of "large-scale public dissatisfaction or even fear stemming from wide-ranging economic problems and/or an unusual degree of social unrest and/or threats to national security" (Keeler, 1993: 440). Only when a (social) problem is severe enough to make the public audience receptive to its depiction as a crisis, we can expect it to have a significant impact on

the policy-making process. However, while economists claim to have clear measures for defining what economic downturns and recessions are, political scientists are less clear about what distinguishes a crisis from a normal situation. Following the work of Colin Hay, a crisis is not simply a condensation of contradictions that produces a condition of rupture and breakdown, but it must be understood as a moment in which a 'decisive intervention' can and should be made by an agent (Hay, 1996: 254). Furthermore, a crisis must be perceived as such by agents capable and willing of making a decisive intervention at the level at which the crisis is identified. In the real world outside there is often no commonly accepted threshold beyond which a problem should be defined as a crisis, nor is it always clear who is authorized to take any actions.

To understand how a crisis impacts upon politics and policies, we need to understand how crises and reformist action are related to each other and how institutional structures channel the conflicts that go along with these (Baumgartner and Jones, 1993: 12). The model of punctuated equilibriums, as it has been developed in the agenda-setting literature, provides us with some useful insights. The central claim of this model is that democratic policy-making is characterized by relatively long periods of stability, in which policy making evolves in an incremental way, but that these periods are linked to each other by disruptions and periods of rapid change during which established institutions and policy programs are seriously challenged and altered. It should be emphasized here that stability is not necessarily indicative of equilibrium. Even during periods of stability, institutions may be altered incrementally through processes of layering and conversion, bringing in new participants and reallocating power and authority (Helderman and Stiller, 2014). Stability in politics and policies is maintained by two major devices: the existing structure of political institutions, that allocate power and authority, and through the definition of issues that need to be resolved by public policies and that are processed by institutions (Baumgartner and Jones, 1993: 15). During periods of relative equilibrium, alterations in policies and institutions unfold in a gradual way, leaving the policy monopoly largely in the hands of those who have been assigned by the institutions with the mandate and authority to act.

Any issue that moves onto the formal government agenda has to pass a 'policy window' (Kingdon, 1984). Policy windows are agenda-setting opportunities that may be opened because of either an upheaval of the problem stream (problem-driven reforms) to which governments have to respond or because of shifts in the balance of power in the political stream (mandate-driven reforms). Most policy windows are relatively limited in scope in the sense that they open in a fairly predictable and routinized manner. Think of the annual budget cycle of the government. A crisis, however, has the potential to open policy windows in a less predictable way (Kingdon, 1984; Baumgartner and Jones, 1993; Keeler, 1993). Crises can open 'macro windows' basically in two different ways (Keeler, 1993). The first is the so-called *crisis-mandate mechanism* by which a crisis discredits the

ideas and policies of ruling governments and, through negative voting during elections, produces an unusually impressive mandate for the political parties in opposition to take over governmental authority. Alternatively, a crisis may create a socio-political context for ruling governments to gain extraordinary mandate to take immediate action: the *crisis-urgency mechanism*. The crisis then presents an opportunity for political actors and policy entrepreneurs to be exploited (never waste a good crisis) in which they may even draw related issues into the already opened window (the spill-lover effect). However, a crisis may also have a third and perhaps more indirect effect in the sense that it opens windows for new venues for interventions.

It is at this point that we need to bring in the concepts of 'policy framing' and 'policy venues'. Policy framing is about the process of defining the image of a policy; how a particular situation and potential policy solutions should be understood. Policy venues are the institutional sites where the portrayal of problems and solutions takes place (policy framing) and where authoritative decisions (decisive interventions) are made concerning a given issue (Baumgartner and Jones, 1993: 32). Policy venues are sites of strategic issue control, they are the locations where policies originate, obtain support and are adopted as binding decisions. There are many different types of policy venues, ranging from the formal political arenas such as the legislatures, the structure of executive governments and the judiciary, but also the more or less formalized arena's for interest group representation and interest-intermediation. Authority is not automatically assigned to particular venues. On the contrary, how an issue gets assigned to a particular arena of policy making is as much a puzzle as how the issue comes to be associated with one set of images rather than another. And just as policy images may change over time through processes of framing, so may venues change over time. Policy-makers thus attempt both to manipulate the dominant understanding of the issues at stake and to influence the venues that exert jurisdiction over them. Where images are in flux, one may expect changes in policy venues. Conversely, where the venues change, the terms of the debate may be altered. Venue assignments thus play a key role in both establishing the structures that create policy equilibriums for most issues most of the time, and in facilitating occasional dramatic changes when the structures fall apart or are replaced by others (Baumgartner and Jones, 1993).

In the remainder of this paper, I explore how the GFC has influenced the process of health policy framing within the EU and how it created new venues, beyond the level of European Member States, to do so. The immediate effect of the GFC is that it created new venues for the EU to intervene more decisively in the health policies of its Member States.

3. Health entering the European agenda

From the Second World War onwards, governments have had to cope with three major challenges with respect to their maturating health care systems: first, how to

create and extend universal coverage; second, how to contain booming macro health care expenditures; and third, how to foster efficiency in health care services while guaranteeing the quality of these services (Bevan *et al.*, 2010). Although these were common challenges, each country was sovereign in its decisions concerning the scope and content of its health policy repertoire. The weak democratic structures of the EU did not even allow any interference in this (Majone, 1998; Scharpf, 1999). Nevertheless, despite the fact that Member States are still in the lead when it concerns their welfare state and health systems, as a consequence of further economic and monetary integration in the 1990s, they have in fact become semi-sovereign welfare states (Ferrera, 2005; Hemerijck, 2012).

It was at the Lisbon Summit of the European Council in March 2000, that the EU committed itself to become 'the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth and more and better jobs and greater social cohesion'. While the EU used to be primarily focused on economic integration and the creation of an internal market, and at a later stage at monetary integration, it now accepted responsibility and claimed at least some authority for social policy as well. Next to the goals of economic integration and the creation of the European Monetary Union (EMU), the EU began to develop its own social policy frame. The Lisbon Strategy was the first integrated agenda of the EU that gave equal weight to full employment and social cohesion, alongside economic growth and competiveness, on the acknowledgment that social policy essentially should be conceived of as a productive factor for economic growth.

In the years following the Lisbon Summit, this European frame on social policy has been further elaborated and diffused to the Member States. The key-word that since then has come to characterize this emerging European perspective on the welfare state and social protection and security is 'social investment'. Social investment is the denominator of a manifold of concepts and ideas (social development, the social developmental welfare state, the enabling state, inclusive liberalism) introduced in the 1990s and 2000s aimed at reconciling social policy goals with economic goals in the EU (Morel *et al.*, 2012). The central contention of the social investment perspective is that the sustainability of European welfare states, including their competiveness and inclusiveness, hinges on the number and productivity of future tax payers. At the core of the social investment perspective is the idea that social provisions and social security programs should be realigned along a 'life course perspective' (Esping-Andersen *et al.*, 2002; Hemerijck, 2012). It emphasizes the need to strengthening people's current and future capacities by helping them to prepare themselves with the various risks that they are confronted with at successive stages in their life course, rather than simply repairing the consequences of these risks with the ultimate goal to increase a healthy and good educated workforce. Social support should be better targeted to those in need at the times and at the stage in their life course when they need it. This calls for both individualized (tailor made) social services as well as for integrated services.

The primary focus is on active labor market policies and human capital improvement (including education, training, and better youth and child care services), which still is the central focus of the current Europe 2020 agenda and its strategy for smart, sustainable and inclusive growth [European Commission (EC), 2010b].

It goes beyond the scope of this paper to discuss the details of the social investment perspective (see Hemerijck, 2012; Morell *et al.*, 2012). It is certainly not a deeply rooted public and social philosophy that unites European citizens and EU leaders (Schmidt, 2013: 194), nor is it simply a portrayal of neo-liberal ideas, although it certainly contains some neo-liberal elements. It is neither a coherent policy paradigm or program (in terms of the diagnosis of the problems, the values and principles pursued, the norms for public action, policy prescriptions and the instruments to be used). It aims at best to combine two partially conflicting views on the welfare state; the Anglo-liberal 'Third Way' approach as advocated by Anthony Giddens with its emphasis on activating social policies with the 'social democratic' Nordic approach, which aims to combine both an investment strategy and a protection strategy (Esping-Andersen *et al.*, 2002; Morel *et al.*, 2012).

Its ambiguous nature could be seen as its weakness, but also as its strength in the sense that it has probably contributed to its acceptance within the EU. However, in order to be able to engage in these complex and domestically sensitive social policy areas, where its authority is weak, the EU needed new policy venues and governance mechanisms that did justice to the highly delicate balance of authority and power in the EU, especially where it concerned social policies. To that end, the EU developed the Open Method of Coordination (OMC). The OMC has been gradually introduced in the 1990s, in order to develop a European employment strategy by coordinating Member States' economic and fiscal policies, but since the Lisbon treatment of 2000, it is also applied to areas of social protection and social inclusion (OMC-social). The OMC is based on iterative benchmarking of national progress toward Community objectives, while still allowing the Member States to chose their own preferred approach to achieve these commonly agreed objectives (Hemerijck, 2012). After consultation with stakeholders from the Member States, common EU policy objectives are defined. These objectives are then used to guide national policies by setting specific targets and guidelines within certain time frames for the Member States. Member States have to translate these guidelines into National Action Plans. The performance of each Member State is evaluated by the EC, against the agreed EU objectives, using quantitative or qualitative indicators. Finally, through benchmark exercises, the best practices are identified and diffused to the Member States (Hervey, 2008: 107).

Again, to discuss the OMC in detail goes beyond the scope of this paper. Critics argue that the OMC is a smokescreen behind which liberalization and privatization of social institutions is carried out (see Hervey, 2008: 107). Others see it as a promising new governance instrument that facilitates mutual learning and experimentation by exploiting the differences between European Member States (Sabel and Zeitlin, 2008). The European Council and the EC promote the OMC

explicitly as a collaborative mechanism that allows Member States to learn from another. However, the OMC certainly is a venue that results in policy priorities, objectives, guidelines and indicators that help to reframe existing policies.

As said, it was at the Lisbon Summit of the European Council in March 2000 that the EU began to develop its own social policy frame in which the emphasis on 'social investment' became the key-word. Although the social investment agenda centered primarily around active labor market policy and human capital development through better education and life-long learning programs, it soon started to spillover to other social policy areas, including health care and pensions. Health was not directly included in the social investment agenda, but it was soon recognized that the goal of making Europe 'the most competitive and dynamic knowledge-based economy in the world' would depend crucially on the fiscal sustainability of European welfare states and in particular of their health systems, if only because rising health care expenditures crowded out potential investments in other social policy domains (Pearson, 2012). Next to this emphasis on financial sustainability, was the challenge of demographic aging, which got a prominent place on the European agenda at the Stockholm Council meeting in 2001 (Lindh, 2012). Aging clearly has a more direct relationship to the life-course perspective that was adopted by the EU since the social risks related to aging are life-course risks by nature. Aging not only puts strains on pensions and social security systems, but it also calls for supporting the needs of an aging labor force (in order to enable them to participate longer in the labor process), the need to increase the number of trained health care professionals and to accommodate the higher demand for health care services and long-term (institutionalized) care (EC, 2009).

At the Lisbon Summit of 2000, it was reconfirmed that health care is the responsibility of the Member States (Paoli, 2012). However, it was also stated that the Commission, in close contact with the Member States, could take *any useful initiative* through the OMC to promote coordination on health-related policies and programs by means of establishing guidelines and indicators, exchanging best practices and periodic monitoring and evaluation (Paoli, 2012). The health policy image created by the EC, in close alliance with the WHO and the OECD, focused on two discrete but related dimensions of health care: the challenge of demographic aging and the subsequent need to develop long-term care programs, and second, the need to contain public health care expenditure levels in order to achieve fiscal sustainability in European welfare states. The emphasis on the fiscal sustainability of health care expenditures was legitimized by the widespread consensus among policy-experts that there are still many ways to enhance efficiency in health care systems, more than in any other social area. Second, health not only is the largest area of government expenditure after social protection, but it is also one of the main areas of public expenditure that is projected to come under additional pressure from demographic aging. It is estimated that on average 30% of the total age-related expenditures in the EU countries are public expenditures in health (EC, 2009; Lindh, 2012).

3.1. The OMC as 'soft' coordinating venue

The first health OMC was launched in October 2004 (Hervey, 2008). Part of the first health-OMC were: the 2005 National Preliminary Reports of the Member States; the 2006–2008 National Actions Plans; the 2005 Social Protection Committee (SPC) review (SPC, 2005); the 2006 indicators (EC, 2006). These reports resulted in the first European health strategy, published in the 2006 and 2007 Joint Reports of the Council and the Commission (Council of the European Union, 2006, 2007; EC, 2008). In 'Together for Health, 2008–2013', the EC emphasized the unique European challenge of demographic aging and the Commission formulated three strategic objectives: (1) fostering good health in an aging Europe; (2) protecting citizens from health threats; and (3) support dynamic health systems and new technologies by the development of a *Community framework* for safe, high quality and efficient health services. In order to develop this Framework, the Commission started to conduct its own health system analyses across European countries, in close collaboration with the OECD and the WHO (OECD, 2010). In collaboration with the Economic Policy Committee, the Commission published the *Joint Report on Health Systems*, which focused on the drivers of health expenditures beyond demographics through a series of detailed analyses of the organizational features of Member States' health systems (EC, 2010a).

The key message of the 2010-Joint Report was that the usual macro-type controls on health care expenditures that Member States tended to rely on needed to be complemented with efficiency and effectiveness enhancing health system reforms. To that end, 10 measures are identified that can positively enhance efficiency and cost-effectiveness without eroding equity. Among these measures are: adjusting existing cost-sharing systems; increasing hospital efficiency; improving and better distribute primary health care services; improving the management of health systems; a more cost-effective use of medicines; increasing the use of health technology assessment; and improving data collection and information channels and using available information to support performance improvement. Since the recommended measures are derived from the analyses of national health reforms, illustrated with good practices from the various Member States, it comes with no surprise that they can generally rely on broad agreement from the Member States. The measures will also sound familiar to health policy experts, since they are merely a collection of measures from reforms that were already underway in the European countries (Mladovsky *et al.*, 2012).

Hence, in terms of concrete influence on national health systems and the objectives and priorities of Member States, the influence of the EU has only been marginal. Based on her discursive analysis of the OMC-health, Tamara Hervey concluded in 2008 that the EU institutions did not aim at using the OMC to alter existing health care policy paradigms fundamentally (Hervey, 2008: 113). Since the EU cannot enter into national trade-offs between equity, quality and costs, the health-OMC concentrated mainly on efficiency-enhancing measures. Yet, this emphasis on efficiency-enhancing policy reforms has also been the central focus of

national health policy reforms in the last two decades. The only difference is that the EU cannot enter into health system retrenchment policies and that national governments do not want to enter into these policies.

But framing takes time and although the influence of the EU has been modest, there are signs of a discursive transformation since the EU became interested in health policy. The European health policy frame that has been developed in the last decade aims to reconcile the WHO view on 'health for all' with the OECD perspective on the contribution of 'good' health to economic prosperity and the negative effect of too expensive health systems on economic growth. Public health expenditures are carefully labeled as *growth-friendly* expenditures, as long as these are cost-effective and efficient. This discursive transformation can be illustrated with the change of titles of successive European health action programs. In 'The Public Health Program' (2002–2008), which was based on a Memorandum of Agreement with the WHO, the primary objective was still to 'enable good health for all', in line with the WHO 'Health for All' program. For the EU, however, 'health for all' was not an exclusive end in itself, but it should also contribute to the goal of making Europe the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth and more and better jobs and greater social cohesion. To that end, the WHO definition of active aging (the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age) has been reframed by the European Council into 'being able to participate longer in the labor force and to retire at an older age'.

In the new 'Health for Growth' program (2014–2020), which also sets the contours for the European research agenda (Horizon2020), health is more explicitly seen as a productive factor (and/or precondition) for economic prosperity and growth (EC, 2010b). In the Social Investment Package, launched in February 2013 by the Commission in reaction to the GFC, health system reforms and long-term care reforms policies are explicitly interpreted within the discursive frame of the social investment perspective. Health care is now being recognized as an important internal European market for services (and industries) with the highest employment potential, but also as a social policy area with the highest potential to undermine the long-term fiscal sustainability of European welfare states.

With respect to the challenge of demographic aging and the need to develop long-term care programs, the Commission still puts all its hopes on 'social innovations'. One of the coordinating tools for implementing the Europe2020 Agenda – the successor of the Lisbon Agenda – is the *European Innovation Partnership on Active and Healthy Ageing* whose final goal is to add two healthy life years to the average healthy life span of European citizens by 2020. To that end, the Innovation Partnership aims to bring all actors in the innovation cycle together, with an explicit role for the industry, along with those engaged in standardization and regulation in order to identify and overcome potential barriers for reforms and to mobilize new instruments. The development of integrated care

programs for chronic and elderly people, has become one of the founding pillars of the Partnership in Active and Healthy Ageing. Another pillar of the Innovation Partnership is to support the long-term sustainability and efficiency of health and social care systems.

3.2. Creating new venues: bailouts and the European semester

What is then the influence of the GFC on this process of 'soft' and 'slow' health policy framing in the EU? The effects are twofold, one being exceptional (the bailout programs) but the other (the Economic Semester) has the potential to create a more enduring venue for the EU to intervene in Member States' health policies.

For a few countries in Europe, the immediate effect of the GFC and the Euro crisis was dramatic and European interventions went far beyond the soft coordination style that was common in the EU before the outbreak of the crisis. Detailed prescriptions for health system reforms were part of the national bailouts for Ireland and Greece in 2010 and for Portugal in 2011. The reforms were forced by the EC, the International Monetary Fund and the European Central Bank as conditionally for the bailout packages that these countries needed in the aftermath of the crisis (Fahy, 2012). The bailout program for Portugal included no less than 33 commitments affecting the health system, including increases in co-payments, reductions of overtime and limits on total expenditures on pharmaceutics, in addition, there were a number of detailed measures on hospital services and primary care services. Greece had to accept an overall cap of public expenditure on health at 6% of GDP in its bailout program, while it already had one of the lowest levels of health expenditures. Most health-related commitments were directed at the management and administration of the Greece health system, including the consolidation of health insurance funds. The economic adjustment program for Ireland had lesser to say about health care, but it included actions to remove restrictions to trade and competition in sheltered sectors including medical services.

To be sure, the bailout programs were born out of exceptional circumstances, but the GFC has also resulted in a more enduring venue for the Commission to intervene in Member States' health systems' reforms through the annual budget cycle. The influence of the EU on Member States' fiscal policies has its origins in the Treaty of Maastricht of 1992 and the creation of the EMU. In the years preceding the introduction of the Euro, the EU Member States developed and complied to the so-called Stability and Growth Pact (SGP). The main goal of the SGP is to facilitate and maintain the stability of the EMU, based on Articles 121 and 126 of the Treaty on the Functioning of the EU. It was initially proposed by Germany in the mid-1990s as a way to guarantee and maintain low-inflation and fiscal responsibility of the Member States in the Euro and to limit the ability of governments to exert inflationary pressures on the European economy. The SGP facilitates fiscal monitoring of the Member States by the EC and the European

Council and mandates the Commission and the Council to recommend policy actions to Member States when their Government budgets exceed European EMU standards. All EU members (including the non-Eurozone countries) are members of both the EMU and SGP, which means that their national budgets have to stay within the limits on government deficit (3% of GDP) and debt (60% of GDP). All EU Member States are obliged to submit an annual SGP compliance report to the EC and the European Council, that will present the country's expected fiscal development for the current and subsequent three years. If Member States fail to comply to the EMU standards economic sanctions can follow. Since 2005, the stability and convergence programs that are issued by the EC also include medium-term budgetary objectives for each Member State. Although in theory, the SGP could function as a 'Sword of Damocles', in the years before the outbreak of the GFC, the EC was reluctant in using its coercive mandate to sanction countries that did not comply.

Since the outbreak of the GFC in 2008, the rules concerning the SGP have seriously been reinforced and complemented with a new venue for the European Council and the Commission to interfere with Member States' fiscal policies. The EU has strengthened its monitoring capacity and its economic policy cycle by means of the introduction of the so-called European Semester (Fahy, 2012; Paoli, 2012). Each year, the Commission publishes an Annual Growth Survey in which the targets of Europe2020 are translated into operational priorities, which are then to be translated in the National Reform Programs of the Member States. On the basis of these national reports, the Commission adopts a set of Country-Specific Recommendations. The manner in which these recommendations are implemented by the Member States is closely monitored and the results of this monitor feed on their turn the next Annual Growth Survey (Fahy, 2012). The first semester of 2011 did not mention any health-specific recommendations, but in their response to the Commission, several countries mentioned health system reforms spontaneously as proof of their efforts to improve efficiency in health care and the long-term fiscal sustainability of their health programs (Paoli, 2012). This led on its turn to four specific country recommendations (Austria, Cyprus, Germany and the Netherlands). The number of recommendations increased to eight health-related country recommendations in the second semester and 17 recommendations in the third semester. Most of these recommendations were about increasing the cost-effectiveness and efficiency of their health care systems and to make progress with the development of efficient long-term care programs. In its recommendations to all the Eurozone countries in the Annual Growth Survey of the second semester in 2012, the Council also made a general statement about the need to reform long-term health entitlements.

The Economic Semester can be interpreted as a new venue for the EU to intervene in a more persuasive and coercive manner in Member States' policies, including their health policies. To be sure, sanctions have not yet been used by the Commission and, as with the OMC, countries are more or less free to decide

which reforms they wish to bring to the attention of the Commission through their National Reform Programs. However, the main difference with the OMC is that the Semester provides the Commission with a much larger mandate to intervene. In other words, the GFC made it possible for the Commission to intervene in a more decisive manner in the health policy responses of the Member States. Given the widespread consensus, supported by European benchmarks, that there is still large potential scope for efficiency gains in health care (much more than in other segments of welfare state), it can be expected that the number of health-related recommendations following up the next semesters of the EU will increase and that health care reforms increasingly will become part of the annual negotiations between Member States and the EC.

4. Conclusions

It is far too early to be conclusive about the precise impact of the GFC on European health systems. Seen from the perspective of health, the GFC may still be conceived of as an exogenous factor that undermines the fiscal sustainability of European welfare states and consequently, their (expanding) health systems as well. Together with the challenge of demographic aging, the problem of unsustainable health care expenditures, urges the governments of European Member States to develop and innovate cost-friendly long-term care programs and to make faster progress with efficiency-enhancing reforms in their health care systems. Both challenges were already on the agenda in European countries long before the outbreak of the crisis and the policy measures that are currently advocated at the level of the EU coincide in many ways with reforms, already set in motion in many countries. This is not surprising, given the fact that these policy measures were on their turn collected from the 'good practices' of national health care reforms, but the OMC certainly has accommodated the further diffusion of the European health policy frame in progress.

Nevertheless, given the far more severe constraints that the GFC puts on public expenditures and the EU SGP to which European countries have committed themselves, the crisis clearly acts as a 'spillover' window, accelerating reforms that were set in motion before the outbreak of the crisis in many European countries, but that now no longer can be neglected. One immediate consequence of the GFC is that it has created two new policy venues at the European level: the European Semester and the bailout programs. Since the outbreak of the GFC, the EC has become increasingly more persuasive in its recommendations toward Member States, claiming authority alongside national governments over domestic health care reforms (decisive interventions). This has created new multi-level games in which national governments not only obtain their mandate to act from their national electorates, but also from the EC. On the one hand, this may make it easier for national governments to force through reforms that were already on their agenda, while avoiding the political blame that comes along with these

reforms, on the other hand, this may strengthen the negativity bias toward further European integration. To give up national sovereignty over one of its most valued social policy programs would probably undermine political and societal support for the EU too much.

The growing influence of the EU on Member States' health policies has also consequences for comparative health policy studies. Health policy analysts need to go beyond methodological nationalism, especially in the European context, without losing sight of the institutional and cultural diversities among European health systems. The precise influence of supranational organizations such as the WHO and the OECD or the EC on national health policy reforms, the causalities and transfer of policy experiences across countries in the range from diffusion to coercion, remains difficult to assess and deserves more careful analysis. Within the EU, the variety of health systems is large, not only in terms of their institutional composition, their scope, content and health policy repertoire, but also in terms of their political–cultural understandings, political and democratic institutions, and national policy styles. An interesting research question would be how different Member States react on similar pressures and benchmarks from the EU, not only in terms of content but also in terms of policy style. For political scientists, the GFC opens up a wide variety of natural multi-level experiments of most similar and most different cases.

Acknowledgements

The author would like to express their thanks to Gwyn Bevan, Rudolf Klein, John Appleby, Sarah Gregory and the editor of this journal for their comments and suggestions that helped them to improve this article.

References

Baumgartner, F. R. and B. D. Jones (1993), *Agendas and Instability in American Politics*, Chicago: Chicago University Press.

Bevan, G., J. K. Helderman and D. Wilsford (2010), 'Changing choices in health care: implications for equity, efficiency and cost', *Health Economics, Policy and Law*, **5**(3): 252–267.

Council of the European Union (CEU) (2006), *Joint Report on Social Protection and Social Inclusion*, Doc. No. 7294/06, Brussels: Council of the European Union.

CEU (2007), *Joint Report on Social Protection and Social Inclusion*, Doc. No. 6694/07, Brussels: Council of the European Union.

European Commission (EC) (2006), *Portfolio of overarching indicators and streamlined social inclusion, pensions, and health portfolios*, http://ec.europe.eu/employment_social/social_inclusion/docs/2006/indicators_en.pdf [14 March 2014].

EC (2008), 'Together for Health: A Strategic Approach for the EU 2008–2013'. White Paper, COM (2007) 630, EC, Brussels.

EC (2009), *The 2009 Ageing Report: economic and budgetary projections for the EU-27 Member States (2008–2060)* Joint Report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG).

EC (2010a), Joint Report on Health Systems. Prepared by the European Commission and the Economic Policy Committee. Occasional Papers 74, December 2010. Brussels.
EC (2010b), *Europe 2020: A Strategy for Smart, Sustainable and Inclusive Growth*, Brussels: EC.
Esping-Andersen, G. (ed.) (2002), *Why we need a new welfare state?* Oxford: Oxford University Press.
Fahy, N. (2012), 'Briefing on current and future developments in European Union policy and practice in healthcare' *Health Services Management Research* (25): 152–153.
Ferrera, M. (2005), *Boundaries of Welfare. European Integration and the New Spatial Politics of Social Protection*, Oxford: Oxford University Press.
Hay, C. (1996), 'Narrating crisis: the discursive construction of the 'Winter of Discontent', *Sociology*, **30**(2): 253–277.
Helderman, J. K. and S. Stiller (2014), 'The importance of order and complements. A new way to understand Dutch and German Health Insurance Reforms', *Journal of Health Politics, Policy and Law*, **39**(4): 811–840.
Hemerijck, A. C. (2012), *Changing Welfare States*, Oxford: Oxford University Press.
Hervey, T. K. (2008), 'The European Union's governance of healthcare and the welfare modernization agenda', *Regulation & Governance*, **2**: 103–120.
Keeler, J. T. S. (1993), 'Opening the Window for Reform: Mandates, Crises, and Extraordinary Policy-Making', *Comparative Political Studies*, **25**(4): 433–486.
Kingdon, J. W. (1984), *Agendas, Alternatives and Public Policies*, Boston: Little, Brown and Company.
Lindh, T. (2012), 'Social investments in the ageing populations of Europe', in N. Morel, B. Palier and J. Palme (eds), *Toward a Social Investment Welfare State? Ideas, Policies and Challenges*, Bristol: The Policy Press.
Majone, G. (1998), 'Europe's 'Democratic Deficit': the question of standards', *European Law Journal*, **4**(1): 5–28.
Mladovsky, P., D. Srivastava, J. Cyclus, M. Karanikolos, T. Evetovits, S. Tomson and M. McKee (2012), *Health Policy Responses to the Financial Crisis in Europe*, Policy Summary 5 Copenhagen: World Health Organization/European Observatory on Health Systems and Policies.
Morel, N., B. Palier and J. Palme (2012), *Towards a Social Investment Welfare State? Ideas, Policies and Challenges*, Bristol: The Policy Press.
Morgan, D., R. Astolfi (In press), 'The financial impact of the GFC: health care spending across the OECD', *Health Economics, Policy and Law*.
Organization for Econonimc Co-Operation and Development (OECD) (2009), Health and the Economic Crisis, Note to Health Committee, Directorate for Employment, Labour and Social Affairs. DELSA/HEA (2009) 1, OECD, 2009.
Organization for Econonimc Co-Operation and Development (OECD) (2010), *Health at a Glance: Europe 2010*, Paris: OECD.
Paoli, F. (2012), 'Health systems efficiency and sustainability: a European perspective', *Eurohealth*, **18**(3): 14–17.
Pearson, M. (2012), Financial sustainability and affordability of health care systems. Lessons from OECD countries. OECD.
Sabel, C. F. and J. Zeitlin (2008), 'Learning from eperience: the new architecture of experimentalist governance in the EU', *European Law Journal*, **14**: 271–327.
Scharpf, F. W. (1999), *Governing in Europe. Effective and Democratic?* Oxford: Oxford University Press.

Schmidt, V. (2013), 'Speaking to the markets or to the people? A discursive institutionalist analysis of the EU's sovereign debt crisis', *The British Journal of Politics and International Relations*, **16**: 188–209.

Social Protection Committee (SPC) (2005), *Review of preliminary national policy statements on health care and long-term care*, http://ec.europe.eu/employment_social/social_protection/dpc/spc_ltc_2005_en.pdf [14 March 2014].