An interview with Sabina Stan

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Can you explain what is the European Semester and what does it mean for healthcare?

The European Semester is an annual cycle of a multilateral surveillance and coordination of macroeconomic policies among EU member states. The Semester was set up in 2011 in reaction to the 2010 Eurozone crisis which itself followed the 2008 financial crisis. Multilateral surveillance was not entirely new but started already after 1992 with the Maastricht Treaty and its convergence criteria in view of achieving the European Monetary Union (EMU). Its second stepping-stone was at the end of the 1990s with the adoption of the Stability and Growth Pact (SGP) which defined specific thresholds for member states' public deficit and debt levels. While after the introduction of the euro at the turn of the 2000s the existing mechanisms of multilateral surveillance were less efficient in disciplining powerful EU member states like France and Germany, the EMU convergence criteria (for future euro member states) and the EU accession criteria (for Central and Eastern European countries) already exerted important fiscal pressures on healthcare expenditure, leading to various mixes of marketising and liberalising reforms across Europe. The 2008 crisis led to countries both in the Eurozone (such as Ireland) and out of it (such as Romania) displaying falling tax income and financial market rating levels in parallel to rising expenditure and interest rates on global private financial markets. This is when the European Commission together with the IMF and (for Eurozone countries) the European Central Bank moved in to offer financial support for the governments of these countries. This was the case, for example, for Romania (in 2009) and Ireland (in 2010). Support was nonetheless conditional on signing 'memoranda of understanding' (MoU) which detailed a series of policy prescriptions in fiscal as well as 'structural' adjustment areas. Given the fact that healthcare mobilises a significant part of government expenditure throughout the EU, healthcare prescriptions were included under both headings (i.e. fiscal and structural

adjustment). These memoranda were followed, starting from 2011, by yearly Country-Specific Recommendations (CSRs) issued under the European Semester. European Semester CSRs are proposed by the European Commission and adopted by the Council of the EU, and include, together with 'economic' and 'fiscal' recommendations, also recommendations in social policy areas, including healthcare. We thus see the EU henceforth directly intervening in social policy areas such as healthcare, and this despite the fact that the EU does not have the competence to do so according to the Treaties.

In the ERC project we analyse what we call 'NEG healthcare prescriptions', which include prescriptions found in MoU and CSRs and which explicitly contain 'healthcare' in their wording. We have selected for our study a combination of big and small countries, and centre and periphery ones (i.e. Germany, Italy, Ireland and Romania) and we analyse NEG healthcare prescriptions for these countries since 2009 and up to the present. We found that these prescriptions have a common commodifying agenda, meaning that most of them have the potential to transform healthcare into a commodity, a good to be bought and sold on the market, rather than into a common good distributed along solidaristic and universal criteria of access. Of course, healthcare is impacted also by other prescriptions (which we also include in pour analysis) most notably those dealing with public sector expenditure, employment levels, and wages. For example, both Ireland and Romania were asked in their MoU to reduce public sector employment levels and wages, with very painful consequences for employment and working conditions in healthcare, as well as for access to health services by patients.

Can you tell something more about this annual cycle?

Basically, the Semester cycle was designed with a view of controlling member states' budgets and macro-economic policies, on the assumption that this will prevent future crises in the EU. While this idea is of course debatable, it has become the dominant position advanced throughout the EU's multilateral surveillance. This whole mechanism involves thresholds for deficit and debt levels, already precisely defined since the SGP, and accompanied, since the turn of the 2010s' 'six-pack' and 'two-pack' of EU laws, by precise sanctions. The Stability and Growth Pact (SGP) was thus reinforced by penalties of up to 0.2% of a MS's GDP for repeatedly not addressing its 'excessive deficit' (EDP) and of 0.1% of GDP for doing the same in relation to 'excessive macro-economic imbalances' (MIP). The latter refer to a scoreboard of indicators in areas ranging from fiscal to employment, and include predefined value ranges for these indicators which are seen as 'normal'. While up to now a series of countries have been deemed by the Commission, in some years, to display excessive deficits and macroeconomic

imbalances, none has been sanctioned so far. Nonetheless, the threat of a sanction is there, making the European Semester a much more coercive and vertical process than pre-crisis cycles of multilateral surveillance. This is reinforced by the fact that sanctions can be reversed only if a qualified majority of EU member states decide to do so; this effectively places in the hands of the Commission the power to decide to sanction or not a member state, a possibility which, again, up to now remains hypothetical, but nonetheless acts as an informal threat for member states.

In addition to the Excessive Deficit Procedure (EDP) of the Stability and Growth Pact (SGP) and the Macroeconomic Imbalance Procedure (MIP) introduced by the so-called 'Six-Pack' of new EU laws in 2011, the European Semester includes a third 'arm' which legally underpins its country-specific recommendations. This is Europe 2020, which is the EU's strategy in employment and social policies arena. But EU2020 has no powerful legal basis (in contrast to the SGP and the MIP), that is one which would make possible sanctions in case of non-respect of recommendations by MSs. Therefore, CSRs underpinned by EU2020, which are also dealing with social issues such as employment, housing or access to healthcare, are very weak.

So, to resume, the European Semester is an annual cycle whereby the European Commission evaluates each country's performance in terms of its deficit and debt levels, macroeconomic imbalances, and Europe 2020 goals. Based on this, the Commission proposes a number of recommendations which are country specific (hence the abbreviation CSR) which are then adopted (and sometimes amended) by the Council of the EU. Council recommendations are documents which are not very long, not very short, and which include a preliminary part (the recitals) followed by around three or four recommendations (these recommendations were more numerous at the beginning, but since 2015 and Junker's Commission have been streamlined). Each recommendation has a specific legal basis, either the 2 procedures (SGP or MIP, or occasionally both) or EU2020. If recommendations are underpinned by SGP or MIP for countries which display excessive deficits or macroeconomic imbalances, they may be considered 'hard' because they might lead to sanctions. Recommendations for countries outside SGP or MIP or underpinned by Europe 2020, are, in contrast, 'soft'. As there are no sanctions attached to them, they hence display weak enforcing power.

Healthcare has been included in the Memoranda of understanding (for Romania and Ireland) as well as in both types of Country Specific Recommendations (the 'hard' and the 'soft'). So not only in those that are underpinned by Europe 2020, which seemingly focus on social policy issues, but also, and importantly, in 'economic' or 'fiscal' recommendations underpinned by the SGP and the MIP (and which, at least theoretically, may involve, in certain cases, sanctions).

This is interesting and results from the importance of healthcare expenditure in state budgets and public expenditure.

Beyond the European Semester, the EU's hard and soft law may have also affected healthcare. Can you tell us a bit more of this?

The distinction between hard law and soft law covers EU policy making that have existed already before the European Semester. So when we look at hard law we have the Treaties and EU directives and regulations, as well as European Court of Justice (ECJ) case law which interprets the application of directives and Treaty articles. While the Maastricht Treaty included for the first time a Public Health title, it also explicated the principle of subsidiarity by excluding healthcare (as opposed to public health) from the competencies of the European Community. Nonetheless, after Maastricht Community competencies in public health were gradually extended, while also coming to include, in the Lisbon Treaty, health services in cross-border areas. In parallel, during the 1990s and 2000s, ECJ case law effectively brought Treaty internal market articles to bear on healthcare, most notably in their cross-border care component or when they involve outsourced good and services (i.e. procurement).

This led in 2011 to the adoption of the directive on patients' rights in cross-border care (11/24), which effectively extended individual rights to accessing public as well as private cross-border providers while also being covered by the public healthcare scheme in one's country of residence. The Directive sought to bring legal clarity by addressing the tension between the ECJ marketising case law in respect to cross-border care, and previous EU law in this area. The latter most notably included the regulations on the coordination of social security (the first of which was issued already at the end of the 1950s). The regulations sought to foster the free movement of workers in the EU by, one the one hand, establishing mobile workers' rights to access cross-border care which would be covered by the public healthcare scheme of their country of residence, and, on the other hand, also giving member states the means to control this access through prior authorisation.

In 2000, the EU shifted employment and social policy-making from hard law to softer versions, most notably the Open Method of Coordination (OMC). The first OMC started by dealing with employment issues, but later on healthcare was incorporated in the 'social' OMC. The OMC's idea, as far as I understood, was to bring the convergence of member states' social policies (including healthcare) through peer learning and peer pressures, best practises and bench marking. But it is very interesting that, in addition to the healthcare OMC, after Maastricht we also see the formulation of so-called 'broad economic policy guidelines' (BEPGs). The

guidelines substantiated Maastricht' multilateral surveillance through a series of 'country specific recommendations', which covered not only fiscal but also social policies (including occasionally healthcare). It is these BEPGs which will be built upon and extended after 2011 in the European Semester's 'fiscal' and economic CSRs. In parallel, the social OMC was incorporated in Europe 2020, which, as we have seen, is one of the three legal bases of European Semester CSRs.

What is the role of hard and soft law in transferring new economic governance policies and do the latter have an impact on health policy?

We see that the European Semester has roots in soft law and multilateral surveillance mechanisms which have been 'hardened' after 2011. The resulting 'new economic governance' of which the Semester is part has been constructed in the troubled years of the 2008 financial crisis and the 2010 euro crisis and can be seen as having its beginning in the 'hard' financial assistance (MoU) conditionality offered to countries such as Ireland or Romania. As such, the Semester constitutes a hardening of multilateral surveillance, while also living the soft' character' of the social OMC (now EU2020) intact.

The relationship between the European Semester and hard law is more indirect, as they are two separate processes which only occasionally intermingle. For example, some CSRs, or their explaining recitals, request member states to implement certain EU directives. Beyond this, nonetheless, both MoU and Semester CSRs dealing with healthcare issues participate to the same dominant drive in EU law (and especially the ECJ's interpretation of internal market Treaty articles as being applicable to healthcare) to further liberalise and marketise healthcare services in the EU.

This was also visible in our analysis of MoU and Semester healthcare prescriptions, which predominantly asked countries to further reduce funding, expenditure and services in public healthcare. For example, Romania was asked to reduce the number of hospitals and the number of hospital beds, while Ireland was asked to reduce expenditure on public health services; moreover, both countries were asked in their respective MoUs to reduce employment levels and wages in the public sector, including, that is, healthcare workers. Countries were also asked to decrease coverage of services (e.g. Romania was asked to introduce a basic package of services which effectively reduced the number of services covered by the national health insurance) and to increase private sources of funding health services (for example, Romania was asked to introduce co-payments for medical services as well as to establish supplementary private insurance). All these measures, of course, help make place for the further involvement of private

interests in the funding, management and delivery of health services. NEG prescriptions also asked MSs to further marketise public services (by introducing managerialist methods of funding public hospitals such as the one based on 'Diagnostic Related Groups'; or of funding primary care by drawing on 'performance-based payments') and liberalise health services (a prescription which was issued for both Ireland and Italy, which were encouraged to increase competition in healthcare or again lower barriers to it).

Many of these prescriptions (especially if they were included in MoU or if they were addressing countries that were under the SGP's Excessive Deficit Procedure) were implemented, with dire consequences for the countries' public healthcare services. For example, Romania importantly slashed employment levels in healthcare and already low healthcare wages; and Ireland did so as well. Some measures took more time to be implemented (such as the DRG method of financing public hospitals in Ireland), but we have to remember that they also have more lasting consequences. In the end, reductions in expenditure, employment or wage levels may be reversed, as happened in Romania and Ireland after economic growth resumed towards mid-2010s. However, towards the end of the decade, Ireland finally started to implement the DRG in its healthcare system, introducing thus managerial, market-like financing for its public hospitals, the consequences of which are still to be seen. Overall, Eurostat data show that in all countries in our study, the share of private hospitals and private hospital beds in the total increased. For Ireland and Romania, which received most commodifying as well as hard healthcare prescriptions, this increase is even starker.