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The New Economic Governance in Health Care: A Labour Perspective

Sabina Stan[1], Roland Erne

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[1] School of Nursing and Human Sciences, Dublin City University,
School of Business, University College Dublin
Email: sabina.stan@dcu.ie

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The New Economic Governance in Health Care: A Labour Perspective*

Sabina Stan (DCU, UCD) and Roland Erne (UCD)
sabina.stan@dcu.ie, roland.erne@ucd.ie

Abstract: Up to the 2008 financial crisis, the rise in the EU's role in healthcare policy-making was mostly the result of market integration, most notably in the area of cross-border care. This largely safe-guarded member states' competence in that field by eschewing the EU's direct intervention in national healthcare policies to the benefit of indirect, horizontal market constraints. Since the 2008 crisis, the development of the EU's New Economic Governance (NEG) has challenged this situation. Indeed, the NEG introduced direct intervention in social policy-making at large, including, more specifically, in healthcare. In this paper, we will look at the new economic governance in healthcare and its impact on labour politics in the sector. We will do so by mapping: 1) the nature and extent of NEG interventions in healthcare; by taking into account 2) the impact of these interventions on the space of action and power resources of trade unions and social movements active in the healthcare sector; and 3) the extent to which NEG interventions offer points of crystallisation for transnational collective action.

*This paper is work-in-progress.

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Despite the EU's limited competence in healthcare, in the last decades the pursuit of European market integration led to EU institutions having carved significant spaces of intervention in healthcare. While some of these interventions have contributed to foster labour and social rights in the sector[1], the dominant trend has been EU-driven commodification of health services, most notably in their cross-border component. Following the 2010 Euro crisis, the EU's 'new economic governance' (NEG) regime added to this horizonal market integration vertical policy interventions which put further pressure on labour and social rights (Erne 2015, 2018).

In this paper we argue that healthcare has been particularly affected by NEG prescriptions that put pressures on member states to contain health expenditure, and prescriptions that favour the commodification of healthcare. In as much as they do so, NEG interventions in healthcare offer contradictory possibilities for trade union and social movements as they both diminish the latter's power resources and space of action, and offer points of crystallisation for collective action. This paper looks at NEG prescriptions in healthcare elaborated in the context of the European Semester (ES) and the bailout programmes which preceded its set-up and then were integrated into it, by approaching them from the perspective of their potential to offer crystallisation points for labour and social movement contention.

Theoretical perspectives

Several analysts as well as the Commission have presented the European Semester as having undergone, in the last years, a gradual 'socialisation' of its policy prescriptions and overall character (Zeitlin and Vanhercke 2018). This encompasses the increasing participation of 'social actors' (such as the 'social' Directorates General of the Commission, e.g. DG Employment or DG Santé) in the drafting of prescriptions, but also the increasingly 'social' (as opposed to economic or fiscal) character of its these prescriptions. Other analysts (Erne 2015; Vanheuverzwijn and Crespy 2018; Copeland and Daly 2018) saw this 'socialisation' as being more problematic, given the pre-eminence of fiscal consolidation aims for prescriptions affecting social provision and services, and the ambiguous formulation of prescriptions that could be seen as oriented towards 'social investment' aims.

This paper addresses the question of the specific direction of the EU's new economic governance in healthcare. More specifically, it looks at NEG prescriptions in healthcare in terms of their advocating for the further commodification of health services, or, alternatively, for the preservation and/or enhancement of their public, solidaristic character traditionally upheld in EU member states' health systems. This distinction resonates with classifications used in the socialisation literature (e.g. between social retrenchment and social investment (Vanheuverzwijn and Crespy 2018), or between market-making and market-correcting interventions (Copeland and Daly 2018). Nonetheless, our starting point is different from theirs. In the socialisation literature, the criteria for deciding what counts as 'social' prescriptions echoe rather than challenge contemporary transformations of welfare provision along individualist arrangements and restricted solidarity (Lynch and Kalaitzake 2018). In this perspective, the focus on individual responsibility in labour activation or new public health policies may not obstruct the latter from being deemed to be 'social'. In contrast, the aim of our analysis is to inquire into the potential of NEG prescriptions to trigger collective action in reaction to the commodification of public health services and de-regulation of healthcare labour, and which may also have as a horizon fostering the collective, solidaristic character of these services.

In order to do that, we situate contemporary (re)commodification of health services more squarely in the context of capitalist accumulation. Following Navarro (1976), we see

public, de-commodified health services as having historically played a fundamental role in the social reproduction of labour in capitalism. The development of these services through state intervention in their funding, management and delivery responded to the needs of capital for a labour force which renews itself over generations and is also physically and socially fit to work. The accompanying socialisation of health services (seen as the pulling together at collective level of both resources and health risks) affected both healthcare workers and service users. On the one hand, this socialisation introduced social citizenship rights (Marshall 1950) for citizens to access publicly covered services rather than unpaid domestic care or paid private services when in need for care. On the other hand, the socialisation of healthcare services also involved the enhancement of labour rights through protective regulation of work and employment conditions in healthcare. It thus led to the decommodification of both users' access to health services and of healthcare work.

Contemporary de-regulation and (re)commodification of public health services are likewise part of the larger process of capitalist expansion, most notably through the 'accumulation by dispossession' (Harvey 2004) of the commons of public services (Smith-Nonini 2006; Bieler and Jordan 2017). Accumulation by dispossession involves the twin process of vertical political interventions that lead to the privatisation, marketisation and liberalisation of public services (accumulation), on the one hand, and vertical political interventions that lead to state disinvestment from the funding, management and provision of services (dispossession), on the other (Stan and Toma 2019; see also Mercille and Murphy 2017). Like de-commodification, the re-commodification of public services affects both the users of services and the workers providing them. It leads to restrictions in the scope of labour and user rights (curtailment) and the redefinition of the modes of allocation of these rights along market lines (marketisation).

Moreover, in addition to these direct attacks on access and labour *rights*, public health services may be also affected by the commodification of *resources* necessary for their provision, most notably in the form of reduced public provision and increased marketized provision. This affects both labour engaged in public health services and users' rights of access to these services. Thus, rights of access to public health services are diminished both when access is directly restricted and marketized, and when there are less public health services available to access in the first place. Similarly, the labour rights of healthcare workers may come under attack if resources for the provision of public services are reduced or their mode of allocation is made increasingly more business-like. Given that an important part of these resources cover workers' wages or effectively provide for their working conditions (for example in the form of medical equipment) a reduction in healthcare resources leads to the segmentation of work and employment in the healthcare sector, and hence increased inequalities and a potential decrease in solidarity among various categories of workers. It is important to see that attacks on resources for public health services are intimately linked with attempts to de-regulate labour and increase its exploitation in the sector. An example are budget cuts in public hospitals leading to increased healthcare workers' workload.

After 2008, attempts to deregulate and (re)commodify European public health services have multiplied. This paper seeks to assess whether NEG interventions in healthcare have participated in this process by inquiring into their potential to offer new points of crystallisation for labour and social movement reactions to the commodification of healthcare.

Our analysis will look at NEG interventions from the point of view of an inclusive/solidaristic labour and user movement agenda. In this perspective, counting NEG recommendations may be of little help for determining their potential to trigger reactions (let alone inclusive/solidaristic ones) from workers and users. Indeed, a simple accumulation of

more 'social' measures does not necessarily translate in a reversal or even slowing down of commodification. In turn, reactions to commodification cannot be seen as part of an additive stimulus-reaction process, where the more commodifying measures users and workers get, the worse they feel and the greater their reaction. In fact, even measures leading to a partial commodification of access and labour rights may change the power resources and space for action available for future labour and user responses. In so doing, they may serve to inhibit counter-mobilisations and decrease transnational solidarity. Nonetheless, the vertical interventions of the EU's NEG may offer more visible targets for labour and user contention than those offered by the EU's horizontal market interventions outside the NEG (Erne 2018). In this case, it is not the number of prescriptions per se which triggers contention, as the combination between their commodifying potential and the fact that they are vertical - and thus constraining and elaborated by an identifiable agent (EU institutions). Transnational labour and user contention may occur if healthcare workers and users across EU MSs develop shared perceptions of a similarity of commodification processes affecting each of them and of a common EU-level target of their discontent.

The EU's new economic governance prescriptions

In order to assess the commodifying potential of NEG interventions in healthcare we first need to understand the legal basis and constraining power of NEG prescriptions.

In 2011, the Euro crisis led to the adoption of a "Six-Pack" of EU laws, which triggered the set-up of the European Semester as an enhanced mechanism of macroeconomic policy coordination among EU member states. The ES is allegedly aimed at preventing the occurrence of future crises in the EU by keeping their debt and deficit levels under certain thresholds through the tight monitoring and surveillance of MSs' fiscal policies and structural reforms. Compared to the pre-crisis period's weak macroeconomic surveillance mechanisms, and in addition to incorporating the 'soft' social policy coordination under Europe2020 strategy, the post-crisis ES relies on stronger, more vertical interventions. These include most notably an upgraded Excessive Deficit Procedure (EDP) and a novel Macroeconomic Imbalance Procedure (MIP). The two procedures benefit from harsher sanctions (up to 0.2% of a MS's GDP for the EDP and 0.1% for MIP) and a more difficult mechanism for the reversal by the Council of sanctions proposed by the Commission (i.e. reverse qualified majority) than pre-crisis multilateral surveillance (Erne 2012).

During the European Semester's annual cycle, each MS receives a number of Country Specific Recommendations (CSRs), which are adopted by the Council following proposals by the European Commission. CSRs basically offer a set of distinct policy prescriptions pertaining to fiscal policies and structural reforms, and are variously underpinned (in legal terms) by the EDP, the MIP or Europe2020 strategy. The constraining power of policy prescriptions is weak if underpinned by Europe2020 strategy (which involves no sanctioning mechanism) and strong if underpinned by the EDP and/or MIP. The strongest constraining power is when policy prescriptions underpinned by the EDP and MIP are made for MSs for which excessive deficits or excessive macroeconomic imbalances have been identified (as the non-compliance with the corresponding corrective procedures may led to sanctions)[2].

Public health services account for a significant part of government expenditure - rising in 2016 to an average of 15.3% across the EU (Eurostat 2019). It is no surprise that healthcare has been importantly impacted by European Semester's policy prescriptions and their drive to reduce public expenditure. First, public health services have come under the remit of the European Semester not only through explicit 'healthcare prescriptions' (i.e. those who explicitly mention 'healthcare' it their text) but also through prescriptions on public finances

and/or public sector resources (e.g. regarding employment and wage levels in the public sector) (Greer et al 2016). Being underpinned by the EDP and/or MIP, the latter have a potentially high constraining power. Second, even prescriptions specifically targeting healthcare have been mostly 'linked to public finances and not to labour market or social policy' (Degryse et al 2013:25). Many NEG healthcare prescriptions have thus been underpinned not so much by Europe2020, as by the EDP and MIP, with similar consequences for their constraining power.

In addition to looking at the constraining power of NEG prescriptions, we argue that as important is to see them as taking part in a historical process of changing governance modes at EU level. Thus, we argue that the EU's new economic governance policy orientations (including in the area of healthcare) have been built in time, starting most specifically during the troubled beginnings of the ES in the heat of the 2010 Euro crisis which followed the 2008 financial crisis. Indeed, it is during those first few years (2008-2011) that the EU legislation underpinning the post-2011 EDP and MIP (namely the Two- and Six-Packs of EU laws) has been developed. It is also in the same period that several countries both inside (e.g. Ireland) and outside (e.g. Romania) the Eurozone were submitted to the conditionality of EU/IMF bailout programmes. In being so, these countries were used as a testing ground for a series of interventions in areas (such as healthcare) which up to then have been seen as protected from direct intervention on the part of EU institutions. Policy prescriptions included in the conditions of bailout programmes (namely in the memoranda of understanding (MoU) between MSs and the European Commission) have an even stronger constraining power than that attached to the EDP and the MIP. They were also echoed and followed up in the CSRs for the countries under these programmes both during the duration of the bailout programmes as well as after they ended.

Methodology

In order to evaluate the orientations of NEG interventions in healthcare, we analysed the NEG 'healthcare prescriptions' for four countries, namely Germany, Italy, Ireland, and Romania, between 2009 and 2017. Hence, our set includes two larger countries and two smaller ones as well as countries that are located at different positions in the EU economy. We use these as proxies for the relative power of larger/smaller respectively richer/poorer states in the EU. We selected prescriptions which were included a) in Memoranda of Understanding (MoU) for Ireland and Romania, between 2009 and 2015; and b) in the post-2011 CSRs adopted by the Council for all four countries.

We argue that, in order to understand NEG interventions, we need to go beyond a 'classing and counting' approach of CSRs found in most socialisation literature. Instead, we acknowledge that most CSRs contain not one but several policy statements which may apply to quite distinct areas of intervention. We therefore divided the MoU conditions and CSRs in the shortest policy statements that make sense from a semantic point of view. These segments (which we call 'policy prescriptions') are our units of analysis.

NEG policy prescriptions range from very general and vague (e.g. 'increase the cost-effectiveness of public spending in healthcare') to very detailed and specific (e.g. 'keep the public wage bill under 3.9 bn euro'). But the meaning of prescriptions is not immediately accessible to readers solely based on their content and their more precise or vague character. What some analysists have seen as 'ambiguous' prescriptions (Vanheuverzwijn and Crespy 2018), upon further consideration may prove to be much more semantically precise. Following several perspectives from linguistics (de Saussure, Bakhtin), we consider that the meaning of prescriptions is not immediately or unproblematically accessible to the reader, but is rather given by their wider semantic contexts.

There are two main types of wider semantic contexts that are relevant for a prescription. First, the synchronic context points to a prescription's relation to other prescriptions co-present a) in the same NEG source document for a particular country in a particular year and b) in the set of NEG documents for all EU MSs produced in the same year as the prescription under consideration. The semantic relation between different prescriptions under consideration in this case may be direct or indirect, in as much as an explicit or implicit link it is made on a semantic level between them. Second, the diachronic context points to a prescription's relation to prescriptions present in other NEG documents produced in time (i.e. since the set-up of the NEG up to present) for the same country and for the other EU MSs. For the purpose of this study, we selected the set of NEG healthcare prescriptions for the four countries of the study (DE, IT, IE, RO) between 2009 and 2017, and considered it offers a sufficiently wide and varied semantic context for the analysis of the orientation of these prescriptions in time.

The synchronic and diachronic contexts of NEG prescriptions are important because they give us access to the historical construction of meaning in a transnational space of policy-making. The meaning of NEG prescriptions has been constructed in time through a generative process that has its strong roots in the aftermath of the 2008 crisis – the 'MoU years' between 2009 and 2013. We consider NEG prescriptions as being not so much like distinct (country-specific) statements produced independently from one another in separate (country-specific) policy-making traditions, but more like policy statements the cannons and meanings of which develop in time through transnational conversations among those involved in their production.

NEG prescriptions occur in the context not so much of a sum of distinct dialogues between the European Commission and each Member State, as of many times simultaneous and overlapping transnational conversations in which politicians, public servants and experts from the Commission and MSs participate. This means that EU-MS conversations around a specific policy prescription for a specific country in a specific year are informed by the awareness of participants in these conversations of the range of possible meanings that specific NEG prescription may take in NEG documents for other MSs and for other years. It is by looking at these transnational conversations and the historical construction of their semantic roots that we can more fully grasp the meaning of a particular policy prescription. The challenge is therefore to also decode the second-level meaning of NEG healthcare prescriptions by also acknowledging the links made between different prescriptions both inside a particular document and across all documents produced in the history of the NEG. Finally, we also need to take into account that these overlapping transnational conversations take place in an uneven field of power, where power differences between different MSs, and between them and EU institutions (most notably the Commission and the Council), are complemented by those involved in the multilateral surveillance of the ES and the inclusion or exclusion of particular MSs in disciplinary procedures (EDP and MIP).

In addition to looking at the historical and transnational construction of the meaning of NEG prescriptions, we thus also need to take into consideration their varying constraining power. It is in this constraining power that the vertical character of the NEG is revealed. As we have seen above, this constraining power goes from very strong for conditions under bailout programmes (MoU); strong for policy prescriptions underpinned by the EDP and MIP and which are elaborated for MSs for which the EDP or MIP have been started; and weak for prescriptions underpinned by Europe2020 or by EDP/MIP but for countries which are not under these procedures.

DEGREES OF CONSTRAINT OF NEG PRESCRIPTIONS

Legal status of NEG prescription/ MS status in NEG constraining procedures	Degree of external constraint	Symbol
Very binding (Condition for MSs under MoU)	*Very strong*	
Binding (SGP/MIP CSR for MS under EDP/SDP/ExIMB)	*Strong*	
Non-binding (EU2020 CSR or SGP/MIP CSR for MS outside EDP/ SDP/ExIMB)	*Weak*	

The new economic governance in healthcare: a commodification agenda

Our analysis shows that, far from being ambiguous, NEG healthcare prescriptions follow a specific direction. The most prevalent prescription for the four countries has been the somehow vague invitation to 'increase cost-effectiveness in healthcare' (see Figure 1). This prescription occurred 12 times in our corpus of data, most specifically in prescriptions for Germany (2011-2014), Ireland (2014- 2017) and Romania (2013- 2016). The prescription seems to vindicate the socialisation literature in as much as, besides being the most frequent theme, it is also, at first glance, ambiguous. It may mean to do more with existing resources, or as well to do the same with less resources. It also apparently makes sense –aren't we living in aging societies with soaring healthcare needs and limited resources? – which just adds to its ambiguity and common-sensical nature.

Nonetheless, the prescription to increase cost-effectiveness in healthcare did not appear in NEG documents as an isolated prescription. Many times, it has been both explicitly and implicitly linked on a semantic level with a series of other prescriptions. The latter are not in the least ambiguous but point to specific directions. One is to reduce public spending for healthcare. Prescriptions under this theme include those for Germany - to place stronger focus on prevention (2013) and to discontinue free access to health insurance for second earners (2016-17); and those for Ireland, to contain cost increases (2012-13 and 2015). They also include a series of prescriptions for Romania, namely to reduce hospital expenditure (2011-2017), and to adopt a series of cost reduction measures, such as to introduce co-payments for accessing services (2010-1, 2013), to define a cost-effective basic services package and to make allowances for supplementary private insurance (both of the latter in 2010-2012). So a first anchor of the meaning of the prescription to increase cost-effectiveness is to reduce public spending in healthcare.

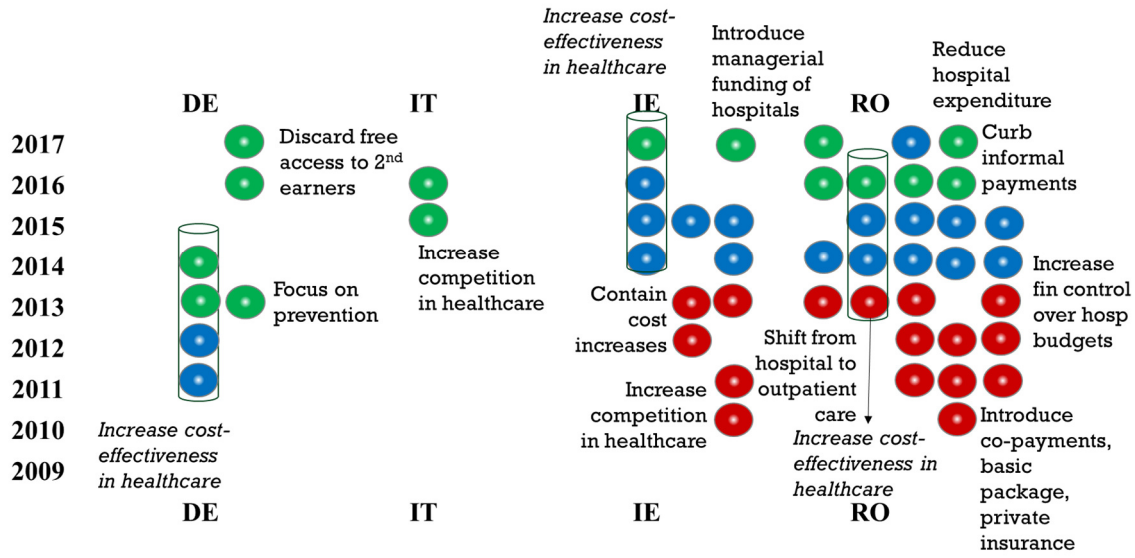
A second anchor of the meaning of the prescription to increase cost-effectiveness is provided by a series of other prescriptions to which it has been linked and which advocate the marketisation of the allocation of healthcare resources. These include prescriptions for Italy (2015-2016) and Ireland (2010-11) to increase competition in healthcare, and those for Ireland to introduce managerialist modes of hospital funding (2013-15, 2017). They also include a number of prescriptions for Romania, namely to increase central governments' financial control over hospital budgets through monitoring and targets (2011-14); to shift from hospital to outpatient care (2013-14 and 2016-17); and to curb informal payments in healthcare (2014-17). The two latter prescriptions seem at a first glance to make sense: care should mostly be provided outside the heavily medicalised hospital environment and access to care should not be impeded by informal payments. Nonetheless, the shift from inpatient to outpatient care may sometimes lead in practice to 'indirect privatisation' (ref), as in many countries, including in

Romania, such a shift involves one from *public* hospital services to *private* outpatient care. Similarly, while the fight against informal payments in healthcare is commendable, in post-2010 Romania, the measure has been explicitly used by Romanian governments as one of the main justifications for the further privatisation of health services (Stan 2016).

As we have seen above, prescriptions to reduce and marketise the allocation of resources for public healthcare may also lead to the curtailment and marketisation of labour and user rights. For example, the introduction of co-payments, the definition of a 'cost-effective' basic package of services and the introduction of private insurance in the same time curtail the social right of access to public health services (e.g. as the definition of the basic package limits the number of services to be covered by the public healthcare scheme) and marketise the mode of allocation of this right (e.g. as the introduction of co-payments leads to making access dependent on the income which patients feel they need in order afford these co-payments).

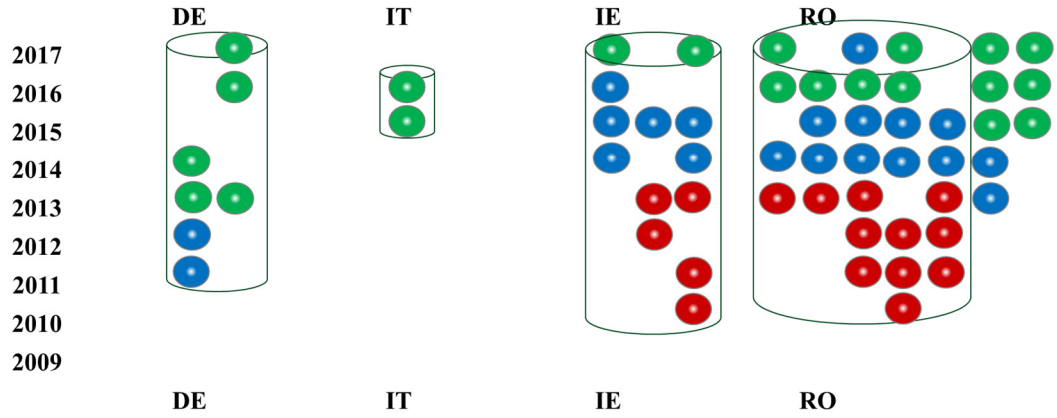
Therefore, far from being 'ambiguous', the prescription to increase cost-effectiveness in healthcare is linked in NEG documents to a larger semantic field of meaning which specifically targets the reduction of public spending in healthcare and the marketisation of the allocation of healthcare resources and access to health services. Both types of prescriptions promote a diminished scope for public health services and an increase in business-like methods and private involvement in the funding, delivery and management of health services. As we have seen above, these are but the two sides of a same coin of the further commodification and 'accumulation by dispossession' of the commons of public health services.

Figure 1. NEG prescriptions 2009-2017 advocating the commodification of health services



In contrast, in the corpus of prescriptions analysed in the study, only a few could be considered as being more explicitly 'social' (see in Figure 2 the discs outside those included in cylinders). These concern prescriptions for Romania deploring or inviting to remedy low funding in healthcare (2015-17), and those to increase accessibility of health services for disadvantaged people and remote rural areas (2014-17). But these prescriptions are not only numerically marginal to the other, commodifying ones, they are also vague and imprecise. Importantly, they lack the precise targets of commodifying prescriptions and have been issued after Romania left the bailout programmes – having thus little or no constraining power.

Figure 2. NEG prescriptions 2009-2017 advocating the de-commodification of health services vs. those advocating commodification



This comes down to NEG documents indeed also advocating 'social' policies, but in an utterly unassuming manner. As we have seen above, most 'commodifying' prescriptions have very strong or strong constraining power, Indeed, they either figure among MoU conditions (for RO, 2009-2015, and IE, 2010-2013), or in CSRs, which are underpinned by EDP/MIP for countries under the EDP (RO, 2009-2013; IT 2009-2012; IE, 2009-2015; DE, 2009-2011: Jordan, Maccarrone, and Erne 2019). Thus, the semantic field of NEG healthcare prescriptions has taken a particular orientation, that of a reduction of resources and access to healthcare and of a marketisation of resource and access rights' allocation. Granted, to what we may see as a NEG agenda of commodification of public health services, more recent NEG documents added de-commodifying prescriptions. Nonetheless, as these prescriptions are sparse, vague and contradictory, they may add to the dark clouds of commodification the silver lining needed to 'socially' legitimise EU institutions and mechanisms behind the NEG - but not necessarily change its course.

Thus, we may conclude that, for the four countries analysed in the study, the NEG has been a mechanism which generated prescriptions pressing for the commodification of health services rather than for the reinforcement of their public, solidaristic character. This process may be even stronger, as this study has looked solely at NEG prescriptions explicitly focused on healthcare. The NEG's commodifying potential may be much bigger as to the latter we also need to add (and analyse in a future study) NEG prescriptions on public sector wages, employment and expenditure levels, which have certainly and heavily impacted on resources for public health services and labour and user rights in healthcare.

Some analysts sympathetic to the socialisation thesis have pointed to the allegedly 'soft nature' of CSRs (Pochet 2019), given the gradual fall in the implementation rate of CSRs (Efstathiou and Wolff 2018; Al-Kadi and Clauwaert 2019; Darvas and Leandro 2015)". The studies on CSR implementation, however, rely on the Commission's own evaluation of implementation - itself a process caught in the naming and shaming game by which the Commission seeks to enforce compliance pace of applying real sanctions (see also Al-Kadi and Clauwaert 2019, p. 13). For one, declining implementation rates only confirm the latter's dependence on the declining constraining power of NEG prescriptions as a result of MSs exiting bailout programmes, or the ES's constraining procedures (EDP and MIP). Second, these studies also analysed the implementation rates of the whole set of CSRs (Efstathiou and Wolff 2018) or again of 'social' CSRs (Al-Kadi and Clauwaert 2019) – and did not distinguish among the latter those prescriptions specifically affecting public health services. Analyses of healthcare reforms during the crisis (Clemens et al 2014; Greer et al 2016; Baeten and

Vanhercke 2016) have pointed nonetheless that they included, especially in MSs under bailout programmes, EDP and MIP, reduced hospitals budgets and a series of attacks on users and workers' rights - including the introduction of user charges, the limitation of services, and cuts in workforce and pay and benefits in the healthcare sector.

Labour and social movements responded to this surge in the commodification of public health services with numerous protests, strikes and other forms of collective action (Kahancova and Szabó 2015; Stan and Erne 2016; Adascalitei and Muntean 2019). These actions do not seem to have ended with the return of economic growth after 2015 (Romanian Insider 2018; Italian Insider 2018; Szabo 2019; Local 2019). They seem nonetheless to have remained mainly at a local or at most national level. While some trade unions and social movements started to develop transnational connections and actions (see the European Network against Privatisation and Commercialisation of Health and Social Protection or Public Health – Europe), the depth, breath and power of these transnational endeavours needs still to be assessed.

Conclusions

The EU's new economic governance regime has led to increased pressure on public finances and public health expenditure. In the last decade, the EU has thus moved on towards more direct and commodifying interventions in healthcare in the name of fiscal sustainability. The last few years' return to economic growth has led to most countries leaving the EDP and MIP, and the ES healthcare prescriptions therefore becoming 'lighter' and even more 'social'. While this 'socialisation' is marginal and unassuming, the core commodification agenda and mechanisms are however in place for when the next crisis hits to re-tighten pressures towards fiscal discipline. Given the history of the NEG, it is most likely that these pressures will translate into new rounds of commodification of healthcare, among other measures. Or not. But for the latter to occur, labour and social movements' struggle against the further commodification of healthcare and the corresponding retrenchment of its solidaristic character needs to continue and become transnational.

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[1] For example, the Working Time Directive (Directive No. 104/93) or the Regulation on the Coordination of Social Security (Regulation No. 883/2004).

[2] EU Financial Assistance to a member state is conditional on the implementation of the corresponding MoU. Since 2011, a member state of the euro area that has not 'taken effective action to correct its excessive [budget] deficit', also risks 'a fine, amounting to 0,2 % of the Member State's GDP in the preceding year.' (Art. 6, Regulation No 1173/2011 of the European Parliament and of the Council). Furthermore, a member state of the euro area that 'has not taken the corrective action [against excessive macroeconomic imbalances] recommended by the Council' risks an 'annual fine of 0,1 % of the GDP in the preceding year of the Member State concerned' (Art. 2, Regulation No 1174/2011 of the European Parliament and of the Council). Since 2014, European Structural and Investment funding to all EU member states is also conditional on 'sound economic governance', i.e. the implementation of corrective MoU, EDP, and MIP prescriptions (Article 23, Regulation No 1303/2013 of the European Parliament and of the Council).