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EU Governance of Healthcare and Its Discontents

10.1 INTRODUCTION

After 1945, European welfare states developed national healthcare systems to ensure universal access to health services through either national healthcare systems or national sickness funds. Until recently, policymakers and analysts alike therefore regarded healthcare as a preserve of national welfare states. However, although health services were initially hardly subject to vertical EU interventions, the pursuit of European market integration has increasingly given EU institutions room to intervene in the sector (De Ruijter, 2019; Stan and Erne, 2021a). In this chapter, we examine the policy orientation of EU interventions in healthcare and their impact on healthcare workers and users. Were EU interventions seeking to commodify health services and what union and social-movement counterreactions did they trigger?

First, we assess the European Treaties and the European laws adopted through the EU's legislative procedures, the community method. Here, we focus on regulations, directives, and Court of Justice of the European Union (CJEU) rulings affecting healthcare both before and after the 2008 financial crisis. Subsequently, we assess the policy direction of the EU's new economic governance (NEG) regime in healthcare.

Since the 1990s, the policy direction of EU laws affecting healthcare has shifted towards commodification. This trend continued when the European Commission and Council of finance ministers (EU executives) pursued their policy agenda primarily through NEG, despite the European Parliament and Council having excluded healthcare from the remit of the EU Services Directive. Our assessment of NEG healthcare prescriptions issued for Germany, Italy, Ireland, and Romania from 2009 to 2019 shows that EU executives consistently requested member states to contain public health expenditure and to marketise healthcare services.

EU interventions also triggered countervailing movements, as we show in section 10.4. The more unions realised that healthcare systems in different countries were affected by similar commodification pressures, the more they joined forces. The European Parliament and Council would not have excluded health from the scope of the Services Directive in 2006 if hundreds of thousands of protesters across Europe had not criticised the Commission's proposal beforehand. By contrast, the technocratic and *country-specific* methodology of the NEG regime made it more difficult for unions and social movements to politicise it across borders (Erne, 2015). Nonetheless, the Commission and the Council suspended one of NEG's disciplinary arms, the Stability and Growth Pact, in March 2020, when the Covid-19 pandemic vindicated those who had warned that the commodification of healthcare would entail fatal consequences (Stan and Erne, 2023).

10.2 THE GOVERNANCE OF HEALTHCARE BY EUROPEAN LAWS AND COURT RULINGS

Since the creation of the European Economic Community (EEC) in 1957, European policymakers have gradually gained more room to intervene in the healthcare sector. This process is rooted in three legislative strands: the internal market, public health, and fiscal governance (Greer, 2014). Of these, the internal market strand was the first to materialise. Hence, EU law affected healthcare long before healthcare was mentioned in European treaties. This means that any study of European healthcare governance must adopt an analytical perspective that encompasses all historical phases and legislative strands mentioned above.

Phase One: Decommodifying Cross-border Care to Create a European Labour Market

In the 1950s, EEC policymakers agreed to create a common market, while also building national welfare states that gave people access to health services without having to rely on the market. Although European policymakers across countries built different types of decommodified health and welfare services (Esping-Andersen, 1990), they agreed to foster workers' mobility across borders (Haas, 1958 [2004]). Consequently, the EEC facilitated the free movement of workers across borders by adopting regulations that gave them access to health services in their host countries. Hence, European law effectively decommodified access to cross-border care, although that was done to create a common labour market.

Although the EEC Treaty did not include healthcare among the Community's competences, it stipulated that 'The Council, acting by means of a unanimous vote on a proposal of the Commission, shall, in the field of social security, adopt the measures necessary to establish the free movement of workers' (Art. 51 TEEC, now Art. 48 TFEU). This led to the adoption of the EEC's third regulation (Regulation 3/58), which sought to build a common labour market by ensuring that workers' social security rights were safeguarded if they moved to another member state. These rights included 'the acquisition, maintenance, and recovery of the right to [medical] benefits' (Regulation 3/58). Although stopping short of harmonising social security systems (Hatzopoulos, 2005), the regulation recognised the public, solidaristic character of health services in EEC member states and sought to reconcile this with the treaty's articles on the free movement of workers. As seen in Chapter 4, solidaristic welfare provisions (including in healthcare) aimed to support capitalist accumulation by partially shielding labour from market forces. Likewise, the regulation aimed to create a European labour market by seeking to increase migrant workers' protection in the event of sickness, thus partially decommodifying their social reproduction.

In the next decades, the regulation's remit was extended from mobile workers to 'all nationals of Member States insured under social security schemes for employed persons' (Regulation 1408/1971) and, further, to self-employed persons, civil servants, students, and third country nationals. These extensions resulted in a patchy, category-specific coverage (Fillon, 2009) but went hand in hand with the building, since the Maastricht Treaty, of European citizenship (Kostakopoulou, 2007). By the mid-2000s, these developments had culminated in the adoption of the Citizens' Rights Directive setting out the conditions for the exercise of the right of free movement (2004/38/EC), a new amendment to Social Security Regulation (631/2004), and a new Regulation (883/2004) 'on the coordination of social security systems'. The amendment aligned the rights of the different categories of people introduced by previous extensions, thus reshaping what we could call a social security route to cross-border care along non-discriminatory lines.

The contribution of social security regulations to the decommodification of access to cross-border care has nonetheless not been without contradictions. Under the regulations, reimbursement of cross-border care has been at the charge of the country of origin (rather than of the host country or a European health fund). Thus, although the regulation recognises the principle of solidarity, it limits it to the country of origin. Moreover, as shall be seen below, since the 1980s, the CJEU has progressively encroached on the regulations' (and thus member states') dominion over access to cross-border care and its

reimbursement (Fillon, 2009). In response, governments used the Amsterdam Treaty (1997) to state that European actions in public health should respect member states' 'responsibilities ... for the organisation and delivery of health services and medical care' (Art. 152 TEC, now 168 TFEU). This treaty change did not, however, prevent the EU from playing an ever-greater role in European healthcare governance, as outlined below.

In response to CJEU rulings, the Council and the European Parliament amended the social security regulations. The bone of contention was governments' use of pre-authorisation of cross-border care to keep healthcare expenditure under control. Pre-authorisation featured in the regulations as a condition for accessing care on changing residence to another member state as well as for accessing planned cross-border care, that is, care for which patients travel on purpose to another member state. Under pressure from CJEU case law, EU social security regulations had to stipulate the conditions under which member states may not refuse the authorisation (and thus the reimbursement) of cross-border care. Over time, these have moved from cases where competent (paying) countries cannot provide the treatment in question (Regulation 1408/1971), to those where they cannot provide it 'within a time limit which is medically justifiable' (Regulation 883/2004). In the process, member states' leeway in refusing the authorisation of cross-border care was reduced.

In addition, social security regulations allowed for coverage of unplanned cross-border care occurring during a temporary stay abroad. In this case, as no pre-authorisation was stipulated, the governance of access to cross-border care was left to medical professionals, who were to assess whether a migrant worker's 'condition ... necessitates immediate benefits' (Regulation 1408/1971) and, later on, whether insured persons needed 'medically necessary' care (Regulation 883/2004). The span of coverable care was consequently extended beyond strict emergencies.

The regulations further facilitated access to unplanned cross-border care by the introduction, in 2004, of the European Health Insurance Card (EHIC) (Regulation 631/2004). The card reflects the contradictory contribution of social security regulations to the decommodification of cross-border healthcare in Europe. Thus, on the one hand, the EHIC contributes to it inasmuch as it gives mobile Europeans who are insured in their home country access to health services in their host country under the same conditions as host country residents. The redistributive mechanisms on which decommodification is based remain, however, at national rather than EU level: it is the country of origin (rather than an EU healthcare fund) that bears the costs of cross-border care and of administering the card. As a result, care price differentials between

poorer and richer countries and large differences in healthcare expenditure between countries entails EHIC being a notable financial burden for poorer member states, whereas the richer states profit from it (Stan, Erne, and Gannon, 2021). Given the unequally distributed means to engage in international travel across the EU (Hugree, Penissat, and Spire, 2020), the card's use has been uneven between different social classes and regions in the EU. EHIC use thus sustains rather than reduces healthcare inequalities across the EU; this goes against the EU's stated ambition to foster territorial and social cohesion (Stan and Erne, 2021b).

Through the social security regulations, EU law thus generated a limited, but definite, decommodifying potential for cross-border healthcare. From the 1990s onwards however, the single market, economic and monetary union (EMU), and EU accession processes put new pressures on healthcare spending, thereby triggering commodifying policy changes in the sector.

Phase Two: Single Market, EMU, and Healthcare Commodification

In a second phase, which shaped the 1990s, national health services began to be exposed to European market integration pressures – despite the introduction of a decommodifying public health title into the Maastricht Treaty in 1993. The treaty's EMU convergence criteria, however, were more consequential, as they led governments to restrain healthcare expenditure and to introduce reforms marketising their health services. In countries with healthcare services directly financed by state budgets, as in Italy and Ireland, these reforms were meant to help those countries meet the public debt and deficit criteria to join the eurozone. In countries where healthcare is financed through payroll taxes for sickness funds or health insurances, as in Germany, healthcare reforms were meant to contain unit labour costs to boost the country's competitiveness. In Central and Eastern Europe (CEE), the Copenhagen EU accession criteria exerted similar economic and fiscal adjustment pressures. As a result, the more policy reforms commodified healthcare services, the more they became subject to EU competition law, and corresponding Commission and CJEU actions.

Fiscal governance and healthcare commodification: In 1993, the Maastricht Treaty introduced 'ensuring a high level of health protection' among the objectives of the Community (Art. 3(o) TFEU) and the competences it shared with member states (Art. 4(k) TFEU). Although 'health protection' seems broad enough to include healthcare, the treaty's new health title referred only to public health (Art. 168 TFEU), implying that the EU may adopt legislation to prevent diseases rather than to treat them. Crucially

however, the treaty not only mentioned public health but also urged a tighter coordination and convergence of member states' fiscal and macroeconomic economic policies. This treaty introduced debt and deficit convergence criteria and placed the Commission at the steering wheel of the multilateral surveillance process underpinning convergence (Arts. 121 and 126 TFEU). In a parallel process, the Copenhagen EU accession process created similar multilateral surveillance procedures. The resulting fiscal governance strand in EU healthcare law was thus born.

The fiscal convergence criteria placed increasing pressure on healthcare expenditure in EU member and accession states. In countries with taxation-financed health systems (like Italy and Ireland), convergence criteria put pressure on public budgets, which then trickled down to their healthcare component. This was the case for Italy, where public health expenditure fell from 6.6 per cent of GDP in 1991 to 5.3 per cent in 1995. Although it recovered thereafter, it was still below 6 per cent by 2000 (France, Taroni, and Donatini, 2005: 191–192). In response to increased international competition prompted by the European single market and EMU, many governments sponsored social pacts and other corporatist arrangements with social partners to moderate unit labour costs (Erne, 2008). In countries with payroll tax-financed health systems, governments also acted unilaterally to contain them. In Germany for example, the Schröder government not only curtailed wage growth with its Hartz labour market reforms (Chapter 6) but also cut payroll taxes for sickness funds by 0.9 per cent to boost Germany's competitiveness (Schulten, 2006). Thereafter, German sickness funds faced increased constraints, even though their budgets were not directly affected by national or EU debt-brake rules.

In response to pressures on healthcare expenditure, governments across Europe adopted healthcare reforms that sought to reduce their responsibility for funding and providing health services. These reforms took similar pathways, irrespective of whether healthcare was financed through national health systems or sickness funds. This was done either directly by curtailing resources for public healthcare or indirectly by making provider-level governance more market-like, by opening the sector to competition from private providers, and by privatising access to health services. In 2003 and 2004 for example, the Schröder government introduced the case-based (diagnostic-related groups: DRG) payment method for financing hospitals, reduced sickness funds' basic benefits package, and introduced co-payments for medical services (Busse and Blümel, 2014; Kunkel, 2021). Furthermore, many regional *Länder* and local governments privatised and corporatised their public hospitals in response to the fiscal constraints that they were facing, despite trade union and

social-movement protests (Schulten, 2006; Erne and Blaser, 2018). Major publicly funded but privately owned for-profit healthcare operators emerged in turn. In Italy, healthcare reforms during the 1990s and 2000s transformed local healthcare providers into enterprises, opened the national health service to contracting with private providers, introduced from 1995 onwards the DRG method for hospital financing, and limited the basket of services in 2001 (Ferre et al., 2014; France, Taroni, and Donatini, 2005). During the 1990s and the 2000s, Ireland's healthcare system continued to be strongly reliant on private provision, with around half of the population having recourse to private insurance to access quicker treatment and doctors being allowed to treat private patients in private beds situated in public hospitals (McDaid et al., 2009). At the turn of the millennium, the Romanian government transformed its healthcare system from a state-funded national health system into an insurance-funded one and introduced the DRG method for financing hospitals. In 2006, a new law allowed the externalisation of services to private contractors and the opening of the national health fund to contracts with private providers (Stan, 2018; Stan and Toma, 2019).

The increased horizontal market integration pressures triggered by the European single market, EMU, and EU eastward enlargement led governments to commodify healthcare, albeit along varying dimensions and to different degrees. By doing that, governments sought not only to cut costs but also to use a governance-by-numbers approach (e.g., DRG financing methods) to insulate healthcare from democratic policymaking (Lascoumes and Le Galès, 2004; Kunkel, 2021). As shall be seen in section 10.3, this became relevant for the ways in which NEG was deployed across member states from 2008 on.

Healthcare and EU competition policy: As outlined in Chapter 7, since the launch of the single market programme by the Single European Act of 1986, the Commission has pushed for the commodification of public services, notably in network industries. Initially however, it excluded health services from this process. Nonetheless, the more healthcare reforms led to the commodification of health services, the more the CJEU could bring in EU competition law and treat health providers and insurers as undertakings engaged in commercial activities (Arts. 101–106 TFEU) (Hatzopoulos, 2005; Hervey and McHale, 2015). At the same time, the CJEU had to consider the notion of 'services of general economic interest' (SGEI) (Art. 106(2) TFEU), which provides a basis for exempting healthcare providers from competition rules (Hatzopoulos, 2005). In so doing however, the CJEU used 'purely economic' criteria in its assessment (2005: 159) and granted SGEI exceptions only on a case-by-case basis. As a result, it became 'almost impossible to know in advance with any degree of certainty whether EU competition rules will apply at all, and, if so, between which entities and to what

degree' (2005: 160). These legal ambiguities allowed private healthcare operators and governments to instrumentalise EU competition law to promote the further commodification of healthcare systems (Kunkel, 2021).

In the 2005 legislative package adopted in response to the Altmark court case (Chapter 8), the Commission clarified the exemptions to EU restrictions on 'state aid' (Art. 107 TFEU) if an undertaking is paid for fulfilling a 'public service obligation' (Directive 2005/81/EC). The package specifically exempted compensations for hospitals providing SGEI from the notification procedure. Seven years later, the 2012 Almunia package extended this exemption from hospitals to 'health and long-term care more generally' (Decision 2012/21/EU), but only if SGEIs are provided at a cost that reflects 'the needs of an efficient undertaking' (Hervey and McHale, 2015: 250). Thus, while largely exempting healthcare providers from state-aid rules, these packages opened arrangements for the compensation of public health services to the Commission's and the CJEU's scrutiny.

Member states' capacity to use overriding reasons of general interest as grounds for shielding healthcare entities and activities from EU state-aid law depends on the degree of commodification of their health systems (Hatzopoulos, 2005). The opening up of 'previously publicly owned and managed hospitals to the private sector' and the more general experimenting 'with changes to ... health systems that involve the state acting as an economic operator' (seen in the previous subsection) led to the increasing 'likelihood that EU competition and free movement law will apply to hospitals within the health system' (Hervey and McHale, 2015: 247–248, 235).

Since the late 1990s, the scope for plaintiffs who aim to further liberalise health services through litigation has increased. However, as the application of EU competition law to healthcare entities on a case-by-case basis remained very laborious, the Commission began to seek a more straightforward avenue for commodifying healthcare, namely, by proposing new EU legislation on public procurement and the freedom of movement of services.

Phase Three: Failed Frontal Commodification Assault and Return to Incrementalism

In a third phase, in the 2000s, the Commission added to its laborious, case-by-case approach to health services a legislative programme with an explicit commodification objective. This happened despite the Amsterdam Treaty explicitly shielding the organisation of national healthcare services from EU intervention. In 2006 however, Commissioner Bolkestein's draft Services Directive (COM(2004) 2 final/3), which included health services, failed, given the unprecedented countermovements that it triggered. Subsequently, the Commission pursued an incremental healthcare commodification

approach, for example with its 2008 draft directive on patients' rights to cross-border care (COM (2008) 414 final) (see below). This mirrored its earlier approach to liberalising public network industries (see Chapters 8 and 9).

Creating a European market for health service providers: In a first step, Commission and CJEU activism brought procurement to bear more forcefully on health entities (Hatzopoulos, 2005). Until the 1990s, procurement directives did not explicitly mention health and only rarely included health bodies among contracting bodies. In 1998 however, a European court ruling[1] confirmed that 'healthcare entities are subject to the rules of public procurement' (Hatzopoulos, 2005: 165). Subsequently, the Commission used the revision of public procurement directives as a more straightforward attempt to open public services, and thus healthcare, to market forces. This met with resistance from the European Federation of Public Service Unions (EPSU) and a social movements' coalition (Fischbach-Pyttel, 2017). As a result, the 2004 Procurement Directive (18/2004/EU) did cover 'health and social services' but only as non-priority services to which more flexible rules applied. The directive even so confirmed that public hospitals and healthcare authorities (Hatzopoulos, 2005) and 'the purchase of devices and equipment within health systems' may be subject to EU procurement rules (Hervey and McHale, 2015: 272).

Cross-border care offered another avenue for Commission and CJEU activism for a further commodification of health services. During the 1990s, the healthcare reforms triggered by the financial constraints discussed above increasingly framed patients as consumers in search of the best deal. Some patients thus came to seek reimbursement for cross-border care outside the scope of the social security regulations, through several CJEU rulings.[2] In its rulings, the CJEU 'established that there is no *general* exclusion for healthcare (or other welfare) services' from provisions on the free movement of services (Hervey and McHale, 2015: 77, their emphasis). The rulings thus reframed access to cross-border care from an issue of collective solidarity (as in social security regulations) to one of individual patients' rights. During the 2000s, the CJEU applied this view[3] to various member states, 'irrespective of the

[1] Case C-76/97 *Walter Tögel* v. *Niederösterreichische Gebietskrankenkasse* [1998] ECR I-05357.

[2] Including Case C-158/96 *Raymond Kohll* v. *Union des caisses de maladie* [1998] ECR I-01931; Case C-368/98 *Abdon Vanbraekel and Others* v. *Alliance nationale des mutualités chrétiennes (ANMC)* [2001] ECR I-05363; Case C-157/99 *B.S.M. Geraets-Smits* v. *Stichting Ziekenfonds VGZ and H.T.M. Peerbooms* v. *Stichting CZ Groep Zorgverzekeringen* [2001] ECR I-05473.

[3] Case C-385/99 *V.G. Müller-Fauré* v. *Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and E.E.M. van Riet* v. *Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* [2003] ECR I-04509; Case C-372/04 *Yvonne Watts* v. *Bedford Primary Care Trust and Secretary of State for Health* ECR I-04325; Case C-444/05 *Aikaterini Stamatelaki* v. *NPDD Organismos Asfaliseos Eleftheron Epangelmation (OAEE)* [2007] ECR I-03185; Case C-173/09 *Georgi Ivanov Elchinov* v. *Natsionalna zdravnoosiguritelna kasa rulings* [2010] ECR I-08889.

organisation of their health system' (2015: 195). This is how a commercial route to cross-border care based on CJEU case law came to complement the social security route (Fillon, 2009). Patients were now encouraged to adopt a consumerist approach and choose between having cross-border care reimbursed at rates in the country of destination using the social security route or at those in their home country, through the commercial route (Hatzopoulos, 2005).

To further liberalise healthcare, the Commission envisaged proposing new legislation (Hervey and McHale, 2015). In its Internal Market Strategy for 2003–2006, the Commission included 'a well-managed application of Internal Market rules to the health care sector' among its legislative priorities (COM (2003) 238 final). The strategy praised the benefits to patients and providers of cross-border care CJEU case law, as it would make 'the most efficient possible use of resources across the EU'. In 2004, David Byrne, the then Health Commissioner, committed the Commission to 'integrating health into the Lisbon agenda as a driver of competitiveness' (*Euractiv.com*, 16 July 2004) and then stated, like his successor Markos Kyprianou one year later, that improving health should be regarded as an '*economic* priority' (emphasis added) (*Euractiv.com*, 28 July 2005). Accordingly, the Commission included healthcare in its draft Services Directive. As outlined in Chapter 6, the directive reinterpreted the EC Treaty's free movement of services provisions by the application of the country-of-origin principle. It also included provisions on the 'assumption of costs of cross-border-care' (Art. 23), which aimed to enshrine CJEU case law on cross-border care in EU law. The proposal also deemed the public financing of hospitals 'irrelevant for the purposes of classifying such care as hospital care' (Art. 4(10)). The intention was to give mobile patients the right to be reimbursed for care obtained abroad from both private and public providers by their home country's public healthcare funds. As, however, shown in Chapter 7, an unprecedented transnational countermovement of a trade union–social movement coalition motivated the European Parliament and Council to remove health services from the remit of the 2006 Services Directive (della Porta and Caiani, 2009; Crespy, 2016).

Creating cross-border patient markets: In response to the Commission's activism to create a European market for health services, several states sought to oblige all EU institutions to mainstream health concerns across all EU policy areas and activities (Bartlett and Naumann, 2021) and to make the national competence for the organisation of health services more explicit. In response, the drafters of the Lisbon Treaty of 2007 added to the treaty's public health title provisions that 'a high level of human health protection

shall be ensured in the definition and implementation of all Union policies and activities' (Art. 168 (1) TFEU) and the recognition of 'the responsibilities of the Member States' not only 'for the organisation and delivery of health services and medical care' (as stated in the Amsterdam Treaty) but also 'for the definition of their health policy' (Art. 168(7) TFEU).

Undeterred by these provisions and by the Services Directive setback, the Commission continued in its attempts to build a European healthcare market, albeit by pursuing a more incremental, sectoral approach, as previously applied to the transport industry (Chapter 8), and proposed a directive 'on the application of patients' rights in cross-border healthcare' (Cross-Border Care Directive). The proposal (COM (2008) 414 final) reinstated many of the provisions on the assumption of costs in cross-border care that were part of the draft Services Directive. In 2011, the European Parliament and Council adopted a slightly amended directive (2011/24/EU), responding to the extensive 'rivalry' between economic and health policymakers involved in EU healthcare policy (Vanhercke, 2016: 296), the tensions between solidarity-based and marketising approaches to cross-border care (Crespy, 2016), and the criticism of European trade unions via EPSU (Fischbach-Pyttel, 2017). Tellingly, the treaty's new health mainstreaming and national responsibility clauses, mentioned above, did not prevent EU policymakers from basing the Cross-Border Care Directive not only on public health (Art. 168 TFEU) but also on Article 114 TFEU, which sponsors EU legislation with the objective of the 'establishment and functioning of the internal market' as a legal basis for the new directive.

The directive has been described as 'the first explicit measure to address the market's role in health services' (Brooks, 2016: 97) and a 'prime example of liberalisation in healthcare' (Crespy, 2016: 42). By allowing, in line with the draft Services Directive, public coverage of private cross-border care, it further develops the commercial route to cross-border care, notably in areas not shielded by pre-authorisation (i.e., non-hospital, low and mid-priced care, and day hospital care). This introduces competition between (domestic) public healthcare providers and (foreign) private ones, thus allowing horizontal market integration to exert pressure on public health services (Martinsen and Vrangbaek, 2008; Greer and Rauscher, 2011). On its web site, the Commission's Directorate General in charge of the internal market tellingly called the Cross-Border Care Directive a 'Medical Tourism Directive' (European Commission, 2011), thus framing it as a tool for developing profit-oriented patient mobility. The directive, in fact, further commodifies access to health services, as it treats patients not only as citizens with access to (social) benefits but also as consumers in pursuit of the best deals (Baeten, 2012; Mainil, 2012; Crespy, 2016; Stan, Erne, and Gannon,

2021). Given patients' need to pay upfront for travel *and* health services, the Cross-Border Care Directive furthermore favours better-off patients and those from richer states even more than the EHIC route to cross-border care discussed above.

In parallel with their work on the Cross-Border Care Directive, EU legislators adopted a new Insurance Directive (2009/138/EC). Although the directive 'explicitly exempted social health insurance schemes from its scope', it subjected supplementary health insurance 'to the rules of the market' (Hervey and McHale, 2015: 241); and, in 2011, the Commission renewed its attempt to bring healthcare more straightforwardly under EU procurement law. The ensuing 2014 Procurement (2014/24/EU) and Concessions (2014/23/EU) Directives for the first time explicitly mentioned health services in their body rather than just in their annexes. Following objections from EPSU (Fischbach-Pyttel, 2017), healthcare was still framed as 'services to the person' to which a 'light regime' continued to apply (OECD, 2016: 4). This means that 'Member States and public authorities remain free to provide those services themselves or to organise social services in a way that does not entail the conclusion of public contracts' (Directive 2014/24/EU) or concessions (Directive 2014/23/EU) and that there is a higher threshold above which the notification procedure should kick in. Although, in this case, 'liberalisation was accompanied by a fair level of re-regulation' (Crespy, 2016: 105), like previously with the 2004 Procurement Directive, the new directives reconfirmed that public hospitals and national healthcare authorities may be subject to their rules (Hervey and McHale, 2015). Thus, these directives entail not so much decommodification as what we may call contained commodification.

In the 2000s, the Commission's drive to promote the commodification of healthcare services became clearly visible. However, its bold attempt to create an EU healthcare market through its draft Services Directive failed dramatically. In response, EU executives used the EU's ordinary legislative procedures more carefully to pursue incremental changes, for example through the Cross-Border Care Directive. The shift to the NEG regime after 2008, however, gave EU executives also new tools to pursue their commodifying policy objectives.

10.3 PROMOTING COMMODIFICATION BY NEW MEANS: NEG PRESCRIPTIONS ON HEALTHCARE

In 2010, EU leaders described 'the health sector as a lever for controlling government debt, public expenditure and the sustainability of national finances' in their Europe 2020 economic growth strategy (Brooks, 2016: 11). In the same year, a joint report on health systems by the Commission and the Council's Economic Policy Committee articulated this view even more clearly.

The EU's 'first dedicated health report to be prepared' by the Commission's Directorate General for Economics and Finance (2016b: 111) framed healthcare as a 'productive sector' with an 'impact on economic growth' and 'a potential for high-skilled and flexible employment' that should be driven by goals of cost-containment and efficiency (European Commission, 2010c: 7–8). According to a national Deputy Permanent Representative who was in charge of European healthcare policy in the Council at the time, this shift amounted to a 'silent revolution' (De Ruijter, 2019: 1). Written during the crucial, founding moments of the EU's NEG regime, the report justified the inclusion of health policy in the ensuing NEG prescriptions (Stamati and Baeten, 2015). Given the importance of health services as a share of public spending (EU average of 14.6 per cent in 2011), they thus became one of NEG's key targets.

Following our methodology outlined in Chapters 4 and 5, we analysed the EU's NEG prescriptions in healthcare issued to Germany, Italy, Ireland, and Romania from 2009 to 2019 to assess their policy orientation. Accordingly, we classified all prescriptions in terms of their (commodifying or decommodifying) policy orientation in five thematic categories. As outlined in Table 10.1, three categories concern the provision of healthcare services (resource levels, sector-level governance, and provider-level governance) and two pertain to people's access to them (coverage levels and cost-coverage mechanisms).

Tables 10.1 and 10.2 reveal that most prescriptions in healthcare pointed in a commodification direction, and few of them may be seen as favouring decommodification.

Table 10.2 also shows that the coercive power of most commodifying prescriptions was very significant or significant, whereas most decommodifying prescriptions were weak in this respect. Among the commodifying prescriptions, most aimed to curtail resource levels and marketise sector- and provider-level governance. Only a few sought to curtail coverage levels and marketise cost-coverage mechanisms. Romania and Ireland were most affected by commodifying prescriptions, although Germany and Italy also received some. Italy and Romania also received a few decommodifying prescriptions. We now analyse the NEG healthcare prescriptions by considering them in more detail category by category.

Provision of Healthcare Services

Resource levels: Most prescriptions under this category were issued for Romania and targeted both healthcare expenditure and the material infrastructure of hospitals. In 2010, the second update of the 2009 Memorandum of Understanding (MoU) tasked the government to 'streamline' the number of hospitals (MoU, Romania, 2nd addendum, 20 July 2010). Then, the

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TABLE 10.1 *Themes of NEG prescriptions on healthcare services (2009–2019)*

	Categories	Policy orientation	
		Decommodification	*Commodification*
Provision of services	**Resource levels**	Increase the budget for primary care (RO) Remedy low funding in healthcare (RO) Improve provision of long-term care (IT)	Contain health expenditure (IE) Contain hospital expenditure (RO) Streamline the number of hospitals (RO) Reduce bed capacity in hospitals (RO) Focus on prevention, rehabilitation, and independent living (DE) Shift to outpatient care (RO)
	Sector-level governance mechanisms		Streamline financial management in healthcare (IE) Increase government control over hospital budgets (RO) Increase competition in the health sector (IT) Remove restrictions to competition in medical services (IE) Enhance efficiency of public spending on healthcare and long-term care (DE) Increase cost-effectiveness of healthcare (IE) Improve cost-efficiency of healthcare (RO)

	Provider-level governance mechanisms		Introduce case-based funding in public hospitals (IE) Reduce payment arrears in healthcare (RO) Introduce performance-based payments in primary care (RO) Implement e-health systems (IE) Implement e-health solutions (RO)
Access to services	**Coverage levels**	Improve access to long-term care (IT) Increase access to healthcare (RO)	Revise the basic benefits package (RO)
	Cost-coverage mechanisms	Adjust health insurance contributions (RO) Curb informal payments in healthcare (RO)	Introduce co-payments for medical services (RO) Establish private supplementary health insurance market (RO)

Source: Council Recommendations on National Reform Programmes; Memoranda of Understanding. See Online Appendix, Tables A10.1–A10.6.
Country code: DE = Germany; IE = Ireland; IT = Italy; RO = Romania.

TABLE 10.2 *Categories of NEG prescriptions on healthcare services by coercive power*

	Decommodification				Commodification				
	DE	IT	IE	RO	DE	IT	IE	RO	
2009									2009
2010							●	▲ ♦	2010
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2013		△		▲ ☆ ♦	△○		▲● ■²	▲³●² ■³ ★ ♦	2013
2014		▲		☆ ◊²	○		●² ■	○²	2014
2015				△ ☆			● ■		2015
2016				◊		●	○	△	2016
2017				◊				△	2017
2018				☆			○	△	2018
2019		★		☆			○	△ ○	2019

Source: Council Recommendations on National Reform Programmes; Memoranda of Understanding. See Online Appendix, Tables A10.1–A10.6.
Categories: △ = resource levels; ○ = sector-level governance; □ = provider-level governance; ☆ = coverage levels; ◊ = cost-coverage mechanisms.
Coercive power: ▲●■★♦ = very significant; ▲●■★♦ = significant; △○□☆◊ = weak.
Superscript number equals number of relevant prescriptions.
Country code: DE = Germany; IE = Ireland; IT = Italy; RO = Romania.

Provisional MoU (P-MoU) of 2011 committed the Romanian government to 'check that the aggregate figures for hospital budgets are consistent with the expenditure programmed' (P-MoU, Romania, 29 June 2011: 9), a request reiterated one year later (P-MoU, Romania, 2nd supplemental, 22 June 2012). In 2013, the second P-MoU reiterated the request not only to rationalise 'the hospital network' and to streamline 'hospital services' but also to continue 'the reduction of bed capacity in in-patient acute care hospitals' and to shift 'resources from hospital-based care towards primary care and ambulatory care' (P-MoU, Romania, 6 November 2013).

Thereafter, NEG prescriptions for Romania repeatedly reiterated the request to 'shift to outpatient care' (Council Recommendations Romania 2016–2019).[4] Although this shift was to be accompanied by an increase in the primary care budget (P-MoU, Romania, 6 November 2013), it involved, in the context of a contraction in overall healthcare spending, a curtailment of hospital expenditure, favouring commodification. Moreover, these measures redirected resources to an already strongly privatised outpatient sector (Chivu, 2011), favouring commodification. Hence, Romania's hospital sector and overall healthcare were heavily targeted by NEG's prescriptions. Most of them occurred between 2010 and 2013 and had a very significant coercive power as they were included in the MoUs and their updates. The invitation in 2015 to remedy 'low funding and insufficient resources' in healthcare (Council Recommendation Romania 2015/C 272/01), although potentially decommodifying, not only obscured NEG's previous resource-curtailing prescriptions for Romania but also had weak constraining power.

Ireland, Germany, and Italy also received one prescription each under the resource levels category. Thus, in 2012, the sixth update of the 2010 MoU tasked the Irish government to 'eliminate the spending overrun' in the health sector by the end of the year (MoU, Ireland, 6th update, 13 September 2012). The 2013 reiteration of this prescription was accompanied by the precise request to 'contain health expenditure next year to within the €13.6 billion departmental ceiling for 2013' (MoU, Ireland, 7th update, 25 January 2013). In turn, Council Recommendation (2013/C 217/09) asked the German government in 2013 to place a 'stronger focus on prevention and rehabilitation and independent living'. This measure echoed the shift to outpatient care requested from Romania and was intended to shift resources towards an already heavily privatised homecare sector (Lutz and Palenga-Mollenbeck, 2010). Both Ireland's and Germany's prescriptions point in a

[4] Council Recommendations Romania 2016/C 299/18, 2017/C 261/22, 2018/C 320/22, and 2019/C 301/23.

commodification direction. In turn, in order to 'incentivise labour market participation of women' (Council Recommendation Italy 2012/C 219/14), between 2012 and 2014 the Council Recommendations[5] tasked the Italian government to increase the provision of long-term elder care. Although these prescriptions thus pointed in a decommodification direction, their coercive power was significant in 2012 and 2014 but weak in 2013. More importantly, as Italy's system of elder care relies not so much on public as on private residential care (Basilicata, 2021), measures seeking to increase long-term care provision usually favour private provision and, hence, commodification.

To these prescriptions directly targeting healthcare resource levels, we must add those targeting the public sector in general, most notably in terms of the curtailment of public spending, public sector wages, and employment levels (Chapter 7). Between 2010 and 2019 for example, the Italian government subtracted €37bn from the national health service (Servizio Sanitario Nazionale): €25bn between 2010 and 2015 through direct expenditure cuts and €12.11bn between 2015 and 2019 through reduced service levels (Cartabellotta et al., 2019). Given the importance of healthcare in public spending and employment, the impact of these prescriptions on the sector has been considerable.

Sector-level governance mechanisms: The countries that received sector-level governance prescriptions are Romania, Ireland, and Italy. All these prescriptions affected the internal operation of the sector rather than the legal status of sector regulators and service purchasers.

EU executives tasked both Romania and Ireland to adopt measures seeking to tighten the government's financial control in healthcare. As seen above, their 2011 P-MoU requested Romania to contain hospital expenditure by strengthening central control over hospitals budgets. In so doing, the P-MoU also shifted the location and rationale behind government control from the objective of improved health outcomes enforced by the Ministry of Health to the objective of financial discipline and cost-containment enforced by the Ministry of Finance. Thus, the Ministry of Finance was tasked to 'take action' so that 'the aggregate figures for hospital budgets are consistent with the expenditure programmed' (P-MoU, Romania, 29 June 2011; P-MoU, Romania, 1st supplemental, 14 December 2011). In 2012 and 2013, EU executives reiterated this request (P-MoU, Romania, 2nd supplemental, 22 June 2012; P-MoU, Romania, 6 November 2013). The second P-MoU spelled out more clearly the resulting 'budget control mechanisms', which were to include 'improved reporting and monitoring frameworks, in particular with regard to hospitals' and 'monthly hospital budget reporting' (P-MoU,

[5] 2012/C 219/14, 2013/C 217/11, and 2014/C 247/11.

Romania, 6 November 2013). In 2014, EU executives reiterated the need for tighter managerial controls in healthcare, highlighting the need for 'proper management and control systems' (Council Recommendation Romania 2017/C 261/22).

The Irish government also received prescriptions that called, like those for Romania, for tighter central managerial control over hospital and healthcare expenditure. In 2013, EU executives urged the Irish government to 'streamline and consolidate multiple and fragmented financial management and accounting systems and processes' (MoU, Ireland, 9th update, 3 June 2013; MoU, Ireland, 10th update, 11 September 2013), a request that was reiterated the following year (Council Recommendation Ireland 2014/C 247/07). The coercive power of the NEG prescriptions for the ministries of finance and public expenditure to tighten central financial control in the healthcare sector was very significant for both Romania and Ireland up to 2013 and significant for Ireland and weak for Romania thereafter.

In addition, EU executives tasked both the Irish and the Italian government to increase economic competition in the healthcare sector. The 2010 MoU committed the Irish government to 'remove restrictions to trade and competition in sheltered sectors including ... medical services'. This included primary care, as the government was tasked to eliminate 'restrictions on the number of GPs qualifying' and to remove 'restrictions on GPs wishing to treat public patients' (MoU, Ireland, 16 December 2010; 1st update, 28 April 2011; 2nd update, 3 September 2011). The prescription points to a move from one form of commodified provision of healthcare to another, namely, from a limited to a greater number of private GPs with national health service contracts. In turn, in 2016, Council Recommendation (2016/C 299/01) tasked the Italian government to 'increase competition in regulated professions [and the] ... health sector'. This prescription occurred in the context of repeated and more general requests for increased competition in 'professional services' (Council Recommendations Italy 2011/C 215/02, 2013/C 217/11), 'services' (Council Recommendations Italy 2012/C 219/14, 2018/C 320/11), and 'all the sectors covered by the competition law' (Council Recommendation Italy 2015/C 272/16). Prescriptions for both Ireland and Italy under this rubric fostered further commodification in healthcare. As shown in Table 10.2, their coercive power was either significant or very significant.

In addition to these more targeted prescriptions, the governments of Ireland, Germany, and Romania received more encompassing prescriptions with the common theme of increasing the cost-efficiency of their healthcare systems. They affected healthcare governance at both sector- and provider-level, but, for convenience, we classed them under the first, more

encompassing category. These prescriptions occurred four times in the German (2011–2014), five times in the Irish (2014–2016, 2018–2019), and three times in the Romanian (2013, 2014, 2019) case, thus contributing to making this theme the most frequent one in our dataset of NEG healthcare prescriptions. Although their exact formulation varies across countries – 'further enhance efficiency of public spending on healthcare and long-term care' (Germany), 'increase the cost-effectiveness of the healthcare system' (Ireland), 'improve cost-efficiency of healthcare' (Romania) – these formulations are all linked to a common quest for cost-efficiency in the sector. As mentioned in Chapter 5, these prescriptions could be understood in two different ways: (1) as requesting an increase in the level of health services provided while keeping the level of expenditures constant or (2) as requesting the level of health services to be kept constant while reducing the level of expenditures. As prescriptions to increase the cost-efficiency of healthcare were semantically linked to the more concrete prescriptions discussed above and below that sought a curtailment of resource levels and structural reforms along marketisation lines (see also the discussion in Chapter 5), the commodifying direction of these apparently ambiguous prescriptions is very evident (see also Stan and Erne, 2023).

Provider-level governance mechanisms: The two countries that received prescriptions under this category are Ireland and Romania. All these prescriptions concern the internal operation of providers rather than their legal status.

The first MoU for Romania already saw payment arrears of public healthcare providers to private suppliers as a key factor hindering financial discipline in public hospitals (MoU, Romania, 23 June 2009). In 2011, the third update of the 2009 MoU obliged the Romanian government to engage in 'major action' to prevent the re-emergence of arrears in the healthcare sector, a request reiterated in 2011, 2012, and 2013 (MoU, Romania, 3rd addendum, 19 January 2011; 4th addendum, 8 April 2011; P-MoU, Romania, 29 June 2011; 1st supplemental, 14 December 2011; 2nd supplemental, 22 June 2012; P-MoU, Romania, 6 November 2013). The payment of arrears meant redirecting the already scarce resources of public healthcare providers towards private creditors and away from supporting current services. It also consolidated the involvement of private healthcare operators and the increased marketisation of hospitals. The request to implement 'e-health solutions' (P-MoU, Romania, 6 November 2013) was also meant to facilitate this transformation, as it enhanced managerial control over expenditure at both provider and sector level. Moreover, as seen above, the 2013 P-MoU urged the government to increase the primary care budget, while simultaneously inviting it to make savings in the sector through the 'use of

performance-based payments'. This questions the decommodifying potential of the prescription to increase resource levels in primary care, as performance-based payments foster the commodification of health services by increasing competition among service providers (Friedberg et al., 2010).

In its turn, the Irish government had to commit to introduce a 'case-based payment system for public hospitals' (MoU, Ireland, 9th update, 3 June 2013; MoU, Ireland, 10th update, 11 September 2013). The 2014 Council Recommendation (2014/C 247/07) reiterated the need to 'roll out activity-based funding throughout the public hospital system'. This meant aligning Irish hospital financing with the DRG method, which introduces competition both inside and between public healthcare providers and thus marketises their governance at both provider and sector level. Moreover, in 2013 and 2014, NEG prescriptions committed the government to implement 'e-health systems' (MoU, Ireland, 8th update, 12 April 2013; MoU, Ireland, 9th update, 3 June 2013; MoU, Ireland, 10th update, 11 September 2013) and to 'roll out individual health identifiers' (Council Recommendation 2014/C 247/07) needed to implement an e-health system. This is important, as effective e-health systems are needed for the operation of a case-based hospital financing system and for enhancing, more generally, central managerial control over both provider-level and sector-level expenditure, as we saw in section 10.2.

By contrast, there was no need to issue any commodifying prescriptions on healthcare services to the Italian and German governments. After all, they had already implemented crucial healthcare reforms before, including the introduction of the DRG method of hospital financing (see section 10.2).

Users' Access to Healthcare Services

Coverage levels: Romania and Italy are the countries that received prescriptions under the coverage levels category. In 2013, Romania received a prescription affecting the scope of services covered by the National Health Fund, namely, to 'define, by end-September 2013, the publicly reimbursable basic benefits package based on objective, verifiable criteria, to be financed within the limitations of available funding' and to subsequently revise it 'based on a cost-effectiveness analysis' (P-MoU, Romania, 6 November 2013). This prescription basically tasked the government to reduce the scope of services covered by national health insurance. It resulted in some health services no longer being covered by the National Health Fund. Patients thus henceforth had to fund them by private means, thereby increasing the commodification of healthcare.

Romania received one prescription under the coverage levels category that points in a decommodification direction. In 2013, the Romanian government

was asked to increase the 'accessibility, in particular for disadvantaged people and remote and isolated communities', to health services (Council Recommendation Romania 2013/C 217/17), a request reiterated in 2014, 2015, 2018, and 2019. This prescription had decommodifying potential, as it aimed to increase the range of population covered by the National Health Fund. However, it failed not only to define what 'accessibility' was supposed to mean but also to acknowledge NEG's role in curtailing the level of Romania's healthcare resources and patients' service coverage levels. The prescriptions moreover failed to outline how to increase people's access to healthcare in a context of diminished resources and service levels.

Italy received one prescription under the coverage levels category. Thus, after previously deploring the 'limited availability of affordable care services' (Council Recommendation Italy 2016/C 299/01: Recital 16), EU executives in the 2019 Council Recommendation (2019/C 301/12) urged the Italian government to improve not only, as between 2012 and 2014, the provision of long-term care, seen above under the resource levels category, but also access to it, as a way to support women's participation in the labour market. Notwithstanding its decommodifying potential, its vague formulation eschews the question of the resources needed to improve access. This compromises its potentially decommodifying impact, just as in the case of the similar prescription for Romania. Moreover, neither the prescription for Italy nor that for Romania effectively mentions whether improved access involves the increased availability of public as opposed to private healthcare. This is significant, as, as we have already seen, both Italian long-term care and Romanian outpatient care had been significantly privatised already prior to the introduction of NEG. As shown in Table 10.2, the constraining power of the prescriptions with a decommodifying potential in this category was again weaker compared with the constraining power of commodifying prescriptions in this category.

Cost-coverage mechanisms: Romania is the only country that received prescriptions under the cost-coverage mechanisms category. Thus, Romania received two prescriptions that sought to balance cuts in public healthcare expenditure with increasing reliance on private means to cover the cost of public health services. In 2010, the second update of the 2009 MoU tasked the Romanian government to introduce 'a co-payment system on medical service' (MoU, Romania, 2nd addendum, 20 July 2010). This request was reiterated in 2011 (MoU, Romania, 3rd addendum, 19 January 2011; 4th addendum, 8 April 2011; P-MoU, Romania, 29 June 2011; 1st supplemental, 14 December 2011) and 2012 (P-MoU, Romania, 2nd supplemental, 22 June 2012). In 2013, the second P-MoU committed the government to 'establish the framework for a private supplementary insurance

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market' (P-MoU, Romania, 6 November 2013). The introduction of both co-payments and private insurance as cost-coverage mechanisms amounts to the marketisation of healthcare access, most notably by making the coverage of costs dependent on patients' private means, hence favouring commodification.

Romania received two prescriptions on cost-coverage mechanisms that pointed in a decommodification direction. Thus, in 2013, the Romanian government was tasked to 'adjust health insurance contributions' (P-MoU, Romania, 6 November 2013) in a bid to reduce labour costs. The prescription was reiterated in the 2014 Council Recommendations for Romania. Although this reduction implied lower costs for patients, favouring decommodification, it curtailed the funds available to the National Health Fund, favouring commodification. In 2014, the government was asked to 'curb informal payments' in the healthcare system, a prescription that was reiterated in 2016 and 2017 (Council Recommendations Romania 2014, 2016, 2017).[6] Curbing informal co-payments in the public healthcare system reduces patients' costs to access it; this points in a decommodifying policy direction. Successive Romanian governments, however, have used this prescription to justify a further privatisation of the healthcare system, which, instead of eliminating informal co-payments by patients, would have just formalised them (Stan, 2018). As shown in Table 10.2, the coercive power of the commodifying prescriptions in this category was again more significant than in the case of the decommodifying ones.

Pursuing a Healthcare Commodification Scrip through NEG Prescriptions

Our analysis shows that, overall, NEG prescriptions on healthcare favoured more often and more strongly commodification than decommodification. Not only were commodifying prescriptions more numerous, they were also more precise and had a stronger coercive power. In contrast, decommodifying prescriptions were fewer, vaguer, and weaker. At times, they accommodated commodification through the back door. Although the coercive power of NEG healthcare prescriptions decreased with the end of bailout programmes and countries coming out of executive deficit procedures, in 2015 the Annual Growth Survey still included health under 'structural reforms', signalling the 'acceptance of the treatment of health as an *economic* sector' (emphasis added) in the European Semester process (Brooks, 2016: 138).

The predominance of commodifying NEG healthcare prescriptions is noteworthy given the notable differences between the four countries under

[6] 2014/C 247/21, 2016/C 299/18, 2017/C 261/22.

study. Our sample includes larger/smaller and richer/poorer states and states with different modes of healthcare financing. The four national healthcare systems had also been affected to differing degrees by prior commodifying reforms. Accordingly, NEG prescriptions targeted our four countries differently. We can thus describe NEG as a case of differentiated integration, but not in the usual sense of the opt-outs from EU legislation that aim 'to accommodate economic, social and cultural heterogeneity' (Bellamy and Kröger, 2017: 625). On the contrary, NEG seems to be a case of reversed differentiated integration (Chapter 3), which uses country-specific prescriptions to pressure reluctant states to accept policies seeking to boost the convergence of health policies along the lines of an overarching commodification policy script.

The nature of this script becomes apparent when one tries to understand why NEG targeted different countries differently in terms of the number and coercive power of commodifying healthcare prescriptions. To account for this, different modes of healthcare financing across countries do not seem to matter, as the two states most targeted by NEG (Ireland and Romania) finance their public healthcare systems differently. Whereas Ireland finances its healthcare system (like Italy) directly out of the state budget, Romania's health system is funded (like in Germany) through pay-roll tax contributions. Given NEG's dual aim to curtail both public spending and unit labour costs, it is hardly surprising to see that those different modes of healthcare financing did not matter in NEG's approach to healthcare.

Our analysis shows instead that the different ways in which NEG prescriptions targeted member states depended on their progress on the path towards healthcare commodification before 2008. In all four countries, governments had already adopted commodifying healthcare reforms before the EU's shift to NEG, albeit to different degrees. The countries most heavily targeted by NEG (Ireland and Romania) were also those where healthcare commodification, most notably in the hospital sector, lagged behind compared with those less targeted by it (Germany and Italy).

Pre-NEG private for-profit hospitals came to play an important role in Germany and Italy: by 2008, they accounted for 40 per cent of the total number of hospitals in Germany and 54 per cent in Italy (OECD, 2020). In contrast, in the same year, 18 per cent of hospitals were private for-profit in Ireland (Mercille, 2018) and only 5 per cent in Romania (Romair Consulting, 2009: 8). Ireland was also the only country in our dataset that by 2008 had not yet adopted the DRG method of financing hospitals. NEG prescriptions for Ireland and Romania sought to accelerate the commodification of health services in these two countries not only by targeting healthcare expenditure

(in common with pre-2008 fiscal governance) but also by directly prescribing the marketisation of health service governance. The result was, amongst others, a rise in the importance of private for-profit hospitals. By 2017, 19 per cent of Ireland's hospitals were private for-profit (Mercille, 2018), whereas a staggering 36 per cent (representing a 9.5-fold increase from 2008) were so in Romania (INS, 2018). These findings are not of academic interest only, as the curtailment of public hospital beds and the rise in private for-profit hospitals negatively affected member states' capacity to respond to the Covid-19 pandemic.

The way in which NEG healthcare prescriptions targeted each of the four countries under study therefore responds to NEG's agenda to advance healthcare commodification across member states by accelerating it in countries where it lagged prior to NEG's advent. Because it is doing this, we may say that NEG uses country-specific rules to promote convergence towards an overarching transnational script of healthcare commodification. Thus, because they display a common *logic* in their deployment across countries and time, commodifying NEG healthcare prescriptions participate in an overarching policy *script*.

However, although most NEG prescriptions in healthcare follow a commodification script, some of them point towards decommodification. To assess whether decommodifying prescriptions manage to challenge the commodification script, we need to map the larger *policy rationales* that inform their formulation. In healthcare, decommodifying prescriptions are semantically linked to four policy rationales: enhance social inclusion, reduce payroll taxes, expand labour market participation, and improve efficiency.

The two latter rationales point to larger commodification agendas deployed, respectively, in the cross-sectoral areas of employment and public services. In turn, the rationale of reducing payroll taxes points in a decommodifying direction, but only partially. Indeed, as we have seen above, it is linked to a prescription to adjust healthcare contributions, which also involves an overall reduction in collected healthcare funds, and hence commodification.

The only rationale that more clearly points in a decommodifying redistributive direction, and can be understood as reflecting social policy actors' attempts to alter the dominant commodifying orientation of NEG documents, is that of enhancing social inclusion. This rationale was invoked in relation to the inclusion of disadvantaged groups and low-income earners in several prescriptions issued for Romania, namely, to increase access, adjust healthcare contributions, remedy low funding, and curb informal payments in healthcare. However, even this conjunction between decommodifying prescriptions and a more clearly decommodifying policy rationale does not manage to make

decommodification an alternative script informing NEG prescriptions in healthcare. Indeed, two of the four prescriptions in this set are also informed by commodifying rationales (increase efficiency); and the only prescription that seems to hold on to a purely decommodifying agenda (increase access) has consistently had poor constraining power (Online Appendix, Figure A10.4). Thus, decommodifying prescriptions were backed by policy rationales that either served commodifying agendas or, if not, did not have significant coercive power. We thus conclude that decommodifying prescriptions, although present in NEG documents, were subordinated to, rather than challenged, the dominant commodification script.

Overall, EU executives' NEG prescriptions and legislative agendas in healthcare reveal a striking continuity of policy preferences. Since the 1990s, EU legislation on cross-border care has shifted from a decommodifying to a commodifying approach, whereby patients have been increasingly conceived of as consumers and EU executives have increasingly understood healthcare providers as commercial undertakings. Furthermore, the multilateral surveillance regime set up in view of the single market, EMU, and accession processes led governments to adopt a series of commodifying healthcare reforms. When the Commission wanted to commodify health services in a more straightforward way however, it failed, as the European Parliament used its role in the EU's ordinary legislative procedure to exclude health services from the scope of the Services Directive. By contrast, the country-specific methodology of NEG and the Parliament's self-inflicted exclusion from the formulation of NEG prescriptions allowed EU executives to issue NEG prescriptions in healthcare that went 'far beyond the mandate intended in the founding treaties' (Brooks, 2016: 110).

Horizontal market and vertical political integration pressures have played an intertwined role since the outset of EU health policymaking. European executives' creation of the European internal market and EMU amplified horizontal market integration pressures, leading national executives to adopt commodifying healthcare reforms in turn. This not only increased the exposure of health services to EU competition and free movement law but also amplified private cross-border patient mobility (medical tourism) and the rise in healthcare corporations (Lethbridge, 2013). Transnational healthcare corporations grew most in states where healthcare commodification was already proceeding apace before the EU's shift to NEG, for example in Germany and Italy. The more they grew in size, the more political clout they gained, which they and their organisations (e.g., European Union of Private Hospitals) used in strategic legal battles and the lobbying of national and EU institutions (Kohler-Koch and Quittkat, 2013) – incidentally, not with the aim of fully

privatising health services but rather for private for-profit providers to gain access to public healthcare funds (Stan, 2018). The predominantly commodifying policy orientation of EU executives' healthcare governance interventions by law (see section 10.2) or NEG prescriptions (see above) attests a convergence between them and the interests of transnational healthcare corporations. But how have trade unions and social movements reacted to them in turn? We turn to this issue in section 10.4.

10.4 EU HEALTHCARE GOVERNANCE AND TRANSNATIONAL COLLECTIVE ACTION

The extraordinary countermovements triggered by Commissioner Bolkestein's draft Services Directive motivated the European Parliament to exclude healthcare and other public services, such as water (Chapter 9), from it. The very encompassing threat that the draft directive posed to workers' rights and people's access to public services united a wide range of social movements and unions across different regional and political backgrounds in transnational collective action (Chapter 7). Once the Commission scaled its encompassing commodification strategy back to a more incremental, sectoral approach (Fischbach-Pyttel, 2017), European unions and social movements found it difficult to sustain the momentum created by their struggles against the Services Directive – despite the Commission henceforth applying its sectoral commodification approach not only to transport (see Chapter 8) but also to water (see Chapter 9) and health services (see section 10.2).

EPSU framed the draft Cross-Border Care Directive as a 'Bolkestein Directive' for health that would open up healthcare provision to private actors (EPSU, 2008) and increase 'competition in the health sector' (Fischbach-Pyttel, 2017: 88). The reframing of the reimbursement of cross-border care as an issue of 'patients' rights' (Baeten, 2012), however, made alliances between unions and other social actors more difficult. Not only patient organisations, but also 'some representatives within the European trade union movement' and 'the Socialists and Democrats Group of the European Parliament' (Fischbach-Pyttel, 2017: 115) welcomed the Commission's new focus on patient rights. Nevertheless, the objections from EPSU and several member states led to legislative amendments to the initial Commission proposal, changing it 'from a fairly crude market approach to an overall much more balanced text' (2017: 120). However, whereas the struggles around the Cross-Border Care Directive ensured that healthcare continued to figure prominently on EPSU's agenda during the 2000s, EPSU focused its attention in the following decade on another public service area – public water services (see Chapter 9).

In 2013, EPSU feared that the Commission's draft Concessions Directive would open the gate for the externalisation (and thus commodification) of public services and demanded the 'broad exclusion of public services' from it (EPSU Circular, 27 February 2013). The Commission's draft, however, challenged primarily public water services, and health services were listed solely in a longer list of services, mirroring its designation as a 'non-priority' service in the Procurement Directive (2004/18/EC). EPSU's reactions to the provisions on healthcare in the new draft Procurement and Concessions Directives therefore aimed primarily to preserve the status quo. EPSU achieved that objective in 2014, when the final Procurement and Concessions Directives listed health services among 'services to the person' to which a lighter regime applies (see section 10.2).

This suggests that, after the 2008 financial crisis, EPSU's activities in the area of healthcare continued to be shaped by Commission proposals for ordinary EU laws rather than the EU's country-specific NEG prescriptions, despite, as we have seen in section 10.3, the latter putting public health services under direct vertical commodification pressures. In the 2010s, union protests about health services therefore occurred primarily at local or national, rather than transnational level. Across Europe, local and national unions responded to wage cuts, employment ceilings, increased workload, and service closure (see Chapter 6) but also to more outright attempts to privatise health services, for example in Romania (Kahancová and Szabó, 2015; Stan and Erne, 2016; Adascalitei and Muntean, 2019; Szabó, 2020). In Germany, healthcare unionists were absorbed in intricate company-level battles for union recognition and better wages and working conditions, after the widespread privatisation of healthcare services meant that most healthcare workers were no longer covered by sectoral collective bargaining agreements for public sector workers (Artus et al., 2017; Krachler, Auffenberg, and Wolf, 2021). By contrast, most Irish and Italian healthcare workers continued to be covered by national collective agreements for the public sector. However, whereas the Irish Nurses and Midwives Organisation (INMO) gathered widespread popular support for its 2017 national nurses' strike after a decade of austerity cuts (Naughton, 2021), its sister unions in the largely privatised Irish long-term care sector were absorbed in endless company-level battles for union recognition and better wages and working conditions (Murphy and O'Sullivan, 2021). Nonetheless, even in Ireland, which historically has not been a central location for transnational EU-level trade union activism (Golden, 2015), calls for a coordinated European trade union response against the commodification of the healthcare emerged after the Covid-19 pandemic (Murphy and O'Sullivan, 2021).

In the early 2010s, unions from Germany, France, Great Britain, Ireland, Poland, and Sweden gathered in a series of conferences (Amsterdam and Katowice in 2011, Nanterre and Warsaw in 2012) to establish the basis for a common fight against the privatisation and commercialisation of healthcare and for the defence of public healthcare systems everywhere in Europe. After laying out a charter and plan of action at the 2012 Warsaw conference, these unions two years later created the European Network Against Privatisation and Commercialisation of Health and Social Protection (the Network) (ENPCHSP, 2014a). The Polish August 80 and the French SUD-Health Social unions were the drivers behind the first two meetings, and the Belgian Platform for Action on Health and Solidarity and the Belgian EPSU-affiliate CNE, which is the most left-wing union in the Christian union confederation ACV-CSC (Faniel, 2012: 26), played a central role in the next two meetings and the constitution of the Network and its subsequent actions, including the organisation of several European days of action against the commercialisation of healthcare (see Table 10.3).

The core membership of the Network was formed by Belgian, French, Italian, Spanish, and Dutch unions and social movements. The Network also established close relations with People's Health Movement-Europe. This mirrors CNE's social-movement unionism approach and its capacity to build bridges across political divisions, for example by allying itself in the Belgian Platform for Action on Health and Solidarity with the socialist ABVV/FGTB union confederation. CNE's militantism resonates with that of other unions and social movements that are part of the Network, such as the Spanish Marea Blanca or the SUD-Health Social: the first is a post-2010 social movement coalition fighting against healthcare austerity in Spain; the second is a rank-and-file union affiliated to the radical French trade union confederation SUD, which, unlike the other unions in the Network, is not part of EPSU.

The Network's main objective is the convergence of 'social movements and struggles' (ENPCHSP, 2014b). Since its creation in 2014, these efforts have coalesced around yearly European days of action under the banner 'our health is not for sale'. Organised around the World Health Day on 7 April, these actions sought to create a European Day 'against the commercialisation of health and social protection'. The most important action day took place in 2019. It started with a demonstration in Brussels, where more than a thousand people walked between the Belgian Ministry of Health and the European Parliament. The Belgian CSC and FGTB, which supplied the largest contingent of demonstrators, were joined by the Belgian Platform for Action on Health and Solidarity, Belgian networks

TABLE 10.3 *Transnational protests politicising the EU governance of healthcare (1993–2019)*

Date	Location	Action Type	Topic	Coordinators
5 June 2004	Brussels	Demonstration	Bolkestein Directive: 'Non à la directive Bolkestein – Oui à l'Europe sociale'	ETUC, other unions, social movements
24 November 2004	Brussels	Demonstration	Bolkestein Directive, 'Bolkestein Directive = Frankenstein Directive'	ETUC, other unions, social movements
19 March 2005	Brussels	Demonstration	Bolkestein Directive: 'More and better jobs - Defending social Europe - Stop Bolkestein'	ETUC, other unions, social movements
21 March 2005	Brussels	Demonstration	Bolkestein Directive	European antipoverty network
15 October 2005	Multi-sited	Demonstrations	Bolkestein Directive, European Day of Action	ETUC, other unions, social movements
25 October 2005	Strasbourg	Demonstration	Bolkestein Directive	ETUC, other unions, social movements
11 February 2006	Strasbourg, Berlin	Demonstrations	Bolkestein Directive	DGB, ETUC, Attac
14 February 2006	Strasbourg	Demonstration	Bolkestein Directive: 'Services for the people'	ETUC
28 May 2013	Brussels	Demonstration	EU rules on public procurement to fully respect workers' rights	FGTB, UNI Europa, ETUI, CSC, EFFAT, EFBWW
7 February 2014	Brussels	Demonstration	European Day of Action against privatisation and commercialisation of health	ENPCHSP
15 May 2014	Multi-sited	Demonstrations, strikes	European Doctors' Action Day: 'Let's stop them! We want to defend the right to health'	FEMS, AEMH, EPSU

7 April 2016	Brussels, multi-sited	Demonstration	European Day of Action against the Commercialisation of Health and Social Protection: 'Our health is not for sale'	ENPCHSP, EPSU, PHM, Alter Summit
24 October 2016	Multi-sited	Demonstrations, strikes	European Doctors' Action Day: 'Let's defend our health!'	FEMS
7 April 2017	Multi-sited including Brussels	Demonstrations	European Day of Action against the Commercialisation of Health and Social Protection: 'Our health is not for sale'	ENPCHSP, EPSU
20 October 2017	Multi-sited including Brussels	Demonstrations, strikes	European Doctors' Action Day: 'Let's defend everybody's health'	FEMS
7 April 2018	Multi-sited including Brussels	Demonstrations	European Day of Action against the Commercialisation of Health and Social Protection: 'All for health'	ENPCHSP, PHM Europe
2 April 2019	Multi-sited including Brussels	Demonstrations	European Day of Action against the Commercialisation of Health and Social Protection: 'Our health is not for sale'	ENPCHSP, EPSU, PHM

Source: Transnational Socioeconomic Protest Database (Erne and Nowak, 2023).
Table 10.3 includes protest events targeting political authorities in relation to the European governance of healthcare services, using the database's political level category, excluding socioeconomic protests at company, sectoral, and systemic level.

of health centres, unions and patient collectives from Belgium, Netherlands (FNV), France (SUD Health Social, CGT), and Poland (August 80), and activists from People's Health Movement's chapters in Belgium, Italy, Croatia, and France. In view of upcoming European Parliament elections in 2019, the demonstration was followed by several European Parliament members and candidates signing a pledge for the defence of public health systems and then a conference supported by the Greens/European Free Alliance in the European Parliament. The European Network's action days were, however, relatively small scale and had a weak media echo and a weak political impact. It remained a very small organisation that relied on voluntary action. An official on a half-time contract coordinated the initiatives of Network members across the EU, and a board of union and social movement activists from four countries (Belgium, France, Italy, and Spain) led it (interview, Network activist, December 2018).

Mirroring the Network's action days were those of the European Federation of Salaried Doctors (Fédération Européenne des Médecins Salariés: FEMS), a European organisation comprising doctors' trade unions and professional organisations from fourteen EU member states. In 2014, FEMS organised its first European action day under the banner 'Let's stop them! We want to defend the right to health' and coordinated country-level actions responding to austerity-driven policies with requests for quality health for all European citizens and for decent salaries and working conditions for all European doctors. The action was replicated in 2016 and 2017, but its scale diminished in time and was not continued thereafter.

EPSU supported both FEMS' and the Network's action days but placed the onus on its members to mobilise for their actions. The EPSU official for health and social protection usually also participated in the Network's action day events. In 2016 for example, EPSU supported the Network's action day and organised a joint press conference, seminar, and demonstration in Brussels. EPSU and the Network also organised a joint roundtable against austerity for the 2017 action day. In 2019, EPSU's health sector official took part in the demonstration and spoke at the subsequent conference in the European Parliament organised by the Network. Finally, at its 2019 Congress in Dublin, EPSU echoed the Network's objectives by including the fight against healthcare privatisation among its principal objectives.

EPSU participated in the Network's action days in a spirit of partnership, as requested by its Belgian affiliates. Even so, EPSU did not become a major driver of transnational counter-mobilisations against healthcare

commodification. There are several explanations for this situation. After its fight to amend the Cross-Border Care Directive, EPSU directed most of its energies to other areas, most notably to its campaign against water privatisation (see Chapter 9). Furthermore, it was engaged in sectoral European social dialogue procedures with HOSPEEM, the European Hospital and Healthcare Employers' Association. This led in 2009 to a European Framework Agreement on 'prevention from sharp injuries in the hospital and healthcare sector', which became one of the last agreements that the Commission implemented through a binding EU directive (Directive 2010/32/EU) before it stopped doing that in the mid-2010s (Golden, 2019; Tricart, 2019; Syrovatka, 2022b). Moreover, EPSU's limited resources and differences in its affiliates' militancy levels may explain its sympathetic but cautious stance vis-à-vis the Network and the latter's anti-privatisation agenda. Finally, it is important to note that, before NEG, countermovements against the commodification of healthcare were possible because the adoption of laws by the EU's ordinary legislative procedures (i.e., the community method) requires the consent of both the European Parliament and Council. This provided union–social movement coalitions with an opportunity to influence the policymaking process, namely, when they were able to politicise draft Commission proposals in the public sphere, as happened most notably in the case of the draft Services Directive. By contrast, under NEG, unions and social movements have lost this opportunity, as the European Parliament can neither veto nor amend the NEG recommendations, which are proposed by the European Commission and approved by the Council.

Most importantly however, the commodifying effects of the EU's country-specific NEG prescriptions affected workers and patients across Europe in a disjointed way, depriving EPSU of an urgent, tangible target that could unite unions and social movements across Europe in collective action, as previously happened in the case of the draft Services Directive. Importantly, so far, no German trade union has become a leading member of the Network or otherwise embraced the cause of transnational responses to healthcare commodification, despite the growing awareness among German healthcare trade unionists and activists of the European drivers of healthcare commodification (Bündnis Krankenhaus statt Fabrik, 2020). This mirrors the fact that healthcare reforms had already significantly commodified German health services during the 2000s, leading both to a fragmentation – local-hospital-by-local-hospital (Böhlke, Greer, and Schulten, 2011) – of industrial mobilisations by healthcare workers and to a political focus of their mobilisations on the German government. If one compares EPSU's difficulties in politicising the EU's NEG interventions in healthcare with its successful mobilisations against

the draft Services Directive or its successful Right2Water European Citizens' Initiative (see Chapter 9), however, one can hardly explain them by its leadership's lack of interest in transnational collective action. Thus, European unions' difficulties in politicising NEG can be better explained by the structure of the supranational NEG regime that facilitates a nationalisation of social conflicts (Erne, 2015). However, the constitution of the Network in 2014, their yearly European days of action, and EPSU's sustained support for these actions over time reveals an increasing awareness among trade unions and social movements of the significance of EU NEG interventions in the healthcare sector.

10.5 CONCLUSION

The first EU laws on healthcare focused on cross-border care and respected the solidarity principle of national welfare states as the central criterion for accessing it. Since the 1990s, commodifying approaches to healthcare have increasingly shaped the EU's legislative agenda, culminating in Commissioner Bolkestein's draft Services Directive. Transnational countermovements by European unions and social movements largely succeeded in resisting its thorough liberalisation agenda. EPSU later managed to contain the commodification of healthcare by the Procurement and Concessions Directives and, albeit only partially, to limit healthcare commodification by the Cross-Border Care Directive. Compared with the encompassing liberalisation agenda of the Bolkestein Directive however, the impact of the Cross-Border Care Directive on both workers and patients has to date been relatively small, given patients' still limited use of cross-border care.

Despite this, since the late 1990s, healthcare commodification has gathered pace across the EU. In countries with a state-financed public health system, the fiscal convergence criteria for the EMU and accession processes constrained health expenditure, motivating governments to implement commodifying healthcare reforms. Countries with health systems financed by wage-based sickness fund contributions were also put under pressure, as the increased horizontal integration pressures on wages and payroll taxes in the enlarged single European market (Erne, 2008) also indirectly constrained health budgets.

After the 2008 crisis, the EU's NEG regime furthermore enabled the European Commission and Council to issue binding country-specific policy prescriptions, thereby enabling the promotion of healthcare commodification without having to fear any countervailing amendments by the European Parliament. Whereas the Commission's draft Services, Cross-Border Care,

Procurement, and Concessions Directives provided European trade unions and social movements with a clear target, EU executives' NEG prescriptions in healthcare were neither very visible nor did they affect all countries at the same time. This made any coordinated transnational action against them very difficult. Although trade unions and social movements fought against the fallout of commodifying healthcare reforms in all our four countries, EPSU concentrated its efforts at EU level on the public water sector, which was threatened by the EU's draft Concessions Directive. This left the reactions to NEG to the intersectoral European Trade Union Confederation, which began lobbying the Commission to render its NEG prescriptions more social after the Commission incorporated the European social partners in its European Semester process in 2014 (Erne, 2015).

As shown by our detailed analysis of NEG healthcare prescriptions issued for Germany, Ireland, Italy, and Romania from 2009 to 2019, these prescriptions were informed by a common commodification script. So far however, unions and social movements have failed to trigger a transnational countermovement against them at the scale of their preceding, and successful, counter-mobilisations against the draft Services Directive. Despite their vertical orientation, the country-specific methodology of commodifying NEG prescriptions and their invisibility to the greater public effectively hampered a transnational countermovement against them. In addition, the (self-inflicted) exclusion of the European Parliament as a co-decision maker in NEG dramatically reduced the opportunities for collective movements to make themselves heard inside the EU's governance system. Instead, unions and social movements in all four countries under analysis recurrently contested commodifying healthcare measures at national and/or local hospital level, as mentioned in section 10.4. For sure, unionists and social movement activists from several countries realised at the beginning of the 2010s that they were facing a common healthcare commodification agenda and therefore created the European Network to coordinate their struggles. The Network saw the links between healthcare privatisation and commercialisation and the EU's NEG interventions in the field. So far however, the Network, EPSU, and the involved unions and social movement organisations have not succeeded in building an encompassing countermovement able to effectively confront NEG and its healthcare commodification agenda.

Early in 2020, a leading scholar in the field concluded that 'we cannot expect EU institutional actors to reverse stability rules and numerical targets that have become embedded in their practices as well as touted in their discourses – even in the unlikely event that there were to be a shift in the political orientation of the EP and the Council' (Schmidt, 2020: 303). And

yet, only a few weeks later, the Commission and Council suspended the Stability and Growth Pact when they realised the huge human costs that a continuation of NEG's austerity regime would entail for public health services faced with the Covid-19 pandemic. Instead, EU leaders agreed to create a €672.5bn Recovery and Resilience Facility (RRF) to support, inter alia, the resilience of European healthcare systems through loans and grants. In response to the Covid-19 emergency, European leaders have thus adopted policies that only a few weeks earlier seemed unthinkable (see Chapters 12 and 13). Although some of these measures were afterwards reversed, such as the subsumption of private hospitals under public authority in Ireland (Mercille, Turner, and Lucey, 2022), there is now strong support for public healthcare throughout Europe. When the pandemic highlighted the importance of public health services, the immediate pressure to commodify healthcare declined. Even so, there is no guarantee that the commodification of healthcare is about to stop. First, private providers will certainly do their best to get as much Recovery and Resilience Facility funding as possible for themselves (Chapters 12 and 13). Second, the EU's commodifying NEG interventions were hardly a result of a conspiracy of detached EU elites, as one might have thought listening to Brexit campaigners, but rather a reflection of a general propensity within capitalist systems to open up new areas for capitalist accumulation (see Chapters 2, 3, and 14). The transnational struggles over healthcare commodification are therefore set to continue.