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The European health policy compound and the Greek bailout programme – A coherent endeavour?

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List of Abbreviations

AGS	Annual Growth Survey
AIDS	Acquired Immune Deficiency Syndrome
BSE	Bovine Spongiform Encephalopathy
CJD	Creutzfeld-Jacob Disease
CSR	Country-specific recommendation
DAE	Digital Agenda for Europe
DG	Directorate-General
DG SANCO	Directorate-General for Health and Consumers
DRG	Diagnosis-related groups
EC	European Commission
ECB	European Central Bank
ECJ	Court of Justice of the European Union
EMA	European Medicines Agency
ENVI Committee	Environment, Public Health and Food Safety Committee
EPC	Economic Policy Committee
EPSCO Council	Employment, Social Policy, Health and Consumer Affairs Council
ERDF	European Regional Development Fund
ESF	European Structural Fund
EU	European Union
EUCFR	Charter of Fundamental Rights of the European Union
IMF	International Monetary Fund
MoU	Memorandum of Understanding
MS	Member State
NRP	National Reform Programme
OMC	Open Method of Coordination
SARS	Severe Acute Respiratory Syndrome
SIP	Social Investment Package
SPC	Social Protection Committee
SWD	Staff Working Document
TFEU	Treaty on the Functioning of the European Union
TFGR	Taskforce for Greece

1. Introduction

1.1. Health policy in Europe in the light of the economic crisis

With the crisis still unfolding long-term effects on both EU and national level, there are only few cases where health care systems are exempted from drastic changes. Across Europe the health policy responses to the economic crisis were manifold, ranging from cash infusion and budget reallocation to strict austerity measures (Reeves, et al., 2014, p. 2). The latter is especially true for those countries supported by financial rescue packages conditional to economic adjustment programmes. This unprecedented bailout measure, monitored jointly by the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) – the so-called Troika –, imposed harsh austerity policies to counteract the sovereign debt crisis in Cyprus, Greece, Ireland and Portugal. The correspondent Memoranda of Understanding (MoUs) obligated the beneficiaries to execute concrete reforms, touching also upon health policy. In 2012 the British Medical Journal published a commentary article by Nick Fahy titled “Who is shaping the future of European health systems?”, a question that has found repercussion in the scientific discourse about health policy in Europe. Therein, Fahy expects a growth of direct EU interference, arguing that “as the EU moves towards much greater supervision of national budgets, the health systems in all countries may become subject to international requirements like those set out in the bailout agreements” (Fahy, 2012, p. 1). Following this train of thought, the EU would be implementing a ‘Europeanized’ health policy similar to the bailout imposed reforms. This thesis sets out to assess in how far that assumption is supported by empirical evidence.

In academic literature EU involvement in national health policy has been observed since the 1990s, with the bailout programmes being merely the currently visible tip of the iceberg. Despite it being a matter of national competence, several publications have presented evidence of the EU gradually widening its scope of activity on this field (See for example Lamping, 2005; Mossialos, et al., 2010; Brooks, 2012b). Altogether, the sphere of European health policy is delimited through a patchwork of soft-law mechanisms and hard-law rulings (Hervey & Vanhercke, 2010, p. 87). More recently – in response to the crisis – the scope has widened through the introduction of macroeconomic policies on EU level. With the European Semester, the Euro-Plus Pact, the Six Pack and Two Pack, the EU is moving towards stricter surveillance

of national budgets of which health expenditure has traditionally accounted for a large bulk¹. Due to the many stakeholders involved, Lamping and Steffen have used the term ‘chaordic’ – ‘chaotic’ mechanisms producing ‘orderly’ results – to describe the development of health policy at EU level. All in all they found “the [EU health policy] integration process as pragmatic, patchy, and sometimes accidental, yet essentially coherent” (Lamping & Steffen, 2009, p. 1363). With the political developments in the aftermath of the crisis it is up for debate whether health policy at EU level has taken a new turn towards planned and intentional policy interference on national politics.

1.2. The case of Greece

Relating to the Greek bailout programme, the EU interference with national health policy has been surprisingly explicit. The Greek government was forced to re-organize health care substantially to meet, among others, the requirement of cutting health-care expenditure down to 6% of the GDP. This legal obligation led to a social transformation. A number of scholars have examined the health effects of austerity in Greece, producing alarming results. Due to the shrinking budget for street-work programmes, the incidence of tuberculosis has doubled since 2012, the number of HIV infections rose from 15 in 2009 to 484 in 2012. Also municipal health programmes (e.g. mosquito-spraying) have been curtailed, with the result that locally transmitted Malaria has been observed for the first time in 40 years. Indirect effects of the austerity measures are also observed with mental health issues, suicide and child mortality rates being on the rise (Kentikelenis, et al., 2014, p. 748). Additionally, access to care has been affected negatively (Ibid.; Gaffney, 2013, p. 14). The underlying tenor seems to be, that the Troika-imposed health reforms have been the propelling force in causing Greece’s current health care crisis.

As austerity measures are criticised more and more among scholars², the question arises how the bailout programmes relate to the EU’s other health policy efforts. Slogans like ‘Promote health, prevent diseases and foster supportive environments for healthy lifestyles’³ seem to have little to do with the reality of Greece’s health care crisis. While Fahy (2012) and Karanikolos (2013) see the bailout programmes as an indication for more direct EU intervention

¹ According to a study executed by the European Observatory on Health Systems and Policies, public spending on health accounts for nearly 13% of the GDP on average in the European Region (Mladovsky, et al., 2012, p. 7).

² Among those voicing criticism are Niakas (2013): ‘Greek economic crisis and health care reforms: correcting the wrong prescription’, Gaffney (2013): ‘Austerity and the unraveling of European universal health care’, or Kentikelenis et al.(2014): ‘Greece’s health crisis: from austerity to denialism’.

³ This is the first of four overarching objectives of the third European Health Programme for the 2014 – 2020 cycle (Commission, 2014).

with national health policy, Gaffney (2013), Kodilis et al. (2013) and Kentikelenis et al. (2014) see the involvement of the IMF as the main root for the imposed health reforms. This brings up the question of how to interpret the bailout imposed reforms in the light of the whole European health policy compound⁴. Do the reforms promoted in the Greek bailout programme fall in line with the health policy efforts at EU level? If so, can it be assumed that the bail-out programmes are a new channel for EU stakeholders to push health interests on the national level? Or are these put in place as a mere economic rescue measure?

1.3. Aim of the thesis and research question

Scholars unanimously have found the EU's capacities and activities in health policy to be steadily increasing over the past two decades⁵. The reform of health systems via bailout programmes and thus direct interference of the EU in national health policy reinforces this understanding at first glance. Since the bailout procedure has been unprecedented in the history of Europe, academics have argued on what impact it has on future politics. The effect on economic governance structures is obvious, but clearly economic issues are closely linked to social issues, such as health system organization. By investigating the foreshadowing of Fahy (2012) and Karanikolos (2013) empirically, assumptions on the direction European health policy is taking can be made on an academic basis. However, most of the existing scientific literature is fairly descriptive, focusing on the modes of governance through which the EU is addressing health policy. A research gap exists in the respect that no study has tried to systematically assess whether this compound of activities is indeed taking a specific direction and working as a whole. In the view of Lamping and Steffen the European health policy is considered as 'essentially coherent' (2009, p. 1363). But Baeten and Thomson present some initial evidence for the Greek bailout programme to be in contradiction to otherwise stated policy objectives of the European Union (2012, p. 202). It therefore stands to reason whether the bailout agreement complements existing EU health policies, and thus marks the establishment of a new channel to push EU interests in health on to the MS level or not. To assess this problem, this thesis will analyze the coherence of health reforms contained in the

⁴ Lamping & Steffen (2009, p. 1375-1376) suggest the term 'compound' to describe the "dynamic distribution of authority between [...] several Community institutions, with shared competency and separate responsibilities, and an issue-specific division of labor" evident in European health policy.

⁵ Greer (2006, p. 134) described the "systematic encroachment on health policy by the EU". Lamping and Steffen (2009, p. 1364) describe the "expansion of powers", Hervey and Vanhercke (2010, p. 130) the "increasing interlinking" among classical EU law making and governance processes. An increasing importance of soft-governance tools is observed by Fierlbeck (2014, p. 23) and Brooks (2012b, p. 86). Baeten and Thomson (2012, p. 205) denote specifically that "the policy setting and content have developed rapidly in the last two years". Albeit the list is non-exhaustive, it is also worth noticing the contributions of Lamping (2005), Hervey (2008), Flear (2009), Greer, Hervey, Mackenback, & McKee (2013) to this subject.

bailout agreement with residual EU activities more closely. This thesis thus aims to answer the following research question:

In how far are the bailout imposed reforms of national health care in Greece coherent with the European health policy compound?

By addressing the coherence of the two sets of policies in the research question, the focus is shifted away from the typically problematic issue of cause-effect relationship in European integration. Baeten and Thomson – being the only ones to have empirically investigated this topic – have tentatively assessed the effect of the EU health discourse on domestic policies, but find it “difficult to establish the extent of the EU’s role in stimulating national reform” (2012, p. 203). In contrast, this thesis assumes that at the time being it is not of primary concern to attribute the origin of reforms to the EU. The current academic debate on the future of European health policy fails to consider whether the crisis has actually streamlined the EU’s health policy activities. Only by first determining whether bailout programmes and residual health policies are coherent in itself, a basis for interpreting the EU’s supposedly gained leverage on the domestic level is granted.

The starting point for the analysis are the health reforms stated in the Greek bailout programme. With regard to the carved out reforms the thesis will inductively examine (1) whether, in accordance to scholars previous argumentation, indeed a coherent approach among the stakeholders on EU level exists and (2) whether the bailout reforms for Greece are in line with this approach. Transferring the policy coherence analysis developed by Nilsson (2012), this thesis uses a systematic approach to understand and evaluate policy coherence in the field of European health policy. From a scientific perspective this thesis thus complements the existing body of knowledge on EU activities in health, but focusses specifically on the policy tools and goals of its health policy approach and their way of functioning as a whole. For future research this thesis can add a more thorough understanding of policy coherence in this field and determine in how far this premise is in fact accurate. Additionally, it will add to the scientific discourse as a basis on how to interpret the bailout mandated health reforms in the context of the entire EU health policy developments: separate or immanent.

1.4 Outline of the thesis

To approach the research question, firstly a more in-depth look into EU activities in health will be presented. Understanding the legal basis, the actors involved, as well as the requirement for coherence in health policy at the EU level shall facilitate following the argumentation of the analysis section. The third chapter will then deal with the methodological outline of the thesis,

arguing for the selection of the Greek case, as well as the choice for undertaking a policy coherence analysis. The analysis outlined in the previous chapter is executed in section four where coherence of the Greek bailout programme with residual EU health policy is tested. The last chapter will review and discuss the results of the analysis also laying up implications for future research.

2. The EU's health policy: Legal basis, current state and coherence

In order to assess the role of the bailout programme in relation to residual EU health policy activities a thorough understanding of existing health policies on EU level is required. This chapter seeks to point out the legal framework for EU health policy and present the current state of the policy compound to have a basis for acknowledging recent changes and developments in this field. The channels and actors forming this policy field will be outlined with the purpose of tracing the importance and influence of the individual stakeholders in the analysis section. Moreover, this chapter will discuss policy coherence as theoretical basis for the research question. The specific meaning of coherence in the light of EU policy will be addressed and existing evidence for a so far coherent 'European health policy' will be pointed out.

2.1. Legal framework

Health policy at EU level was first determined legally in 1993, where the Maastricht Treaty granted some limited resources to the Community. Via new treaties, provisions were added and competence expanded. Today the EU's competence is delimited mainly by Art. 168 TFEU, which implies a distinction between *health care and health services* and *public health* policy. The competence formally granted to the EU is in the latter which is concerned with complementing national activities on this field while always "[respecting] the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care" (Art. 168 VII TFEU). However, the EU interference is observable with both public health and health care dimensions (Brooks, 2012b, p. 87), as will be discussed in the next section. Art. 168 TFEU in conjunction with Art. 9 TFEU also states the 'Health in all policies' principle⁶, meaning that all levels of government are

⁶ This was introduced by the 2006 Finnish council presidency. It encompasses health impact assessment, intersectorial cooperative mechanisms, formal consultations, national policy reports and parliamentary scrutiny. It aims at "ensuring that health policies can be [...] implemented on the basis of health policy priorities" (Koivusalo, 2010, p. 502). However, efforts to implement this principle seem to have weakened over the last few years (Ibid., p. 501). Karanikolos et al. (2013, p. 7) also find that "despite its legal obligation to assess the health effects of EU policies, [DG SANCO] has not assessed the effects of the troika's drive for austerity".

“compelled [...] to accommodate health concerns into all policy areas” (Ibid., p. 95). Additionally Art. 4 and 6 TFEU grant the EU shared competence with the MSs to carry out supplementary activities when common safety is concerned, such as pandemics (EFA, 2014). The Charter of Fundamental Rights of the European Union furthermore states that “everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices” (Art. 35, EUCFR). This set of laws exempts the EU from implementing an autonomous health policy (Hervey & Vanhercke, 2010, p. 87; Schulte, 2013, p. 37). Clearly this policy field relies heavily on the subsidiarity principle. But scholars seem to disagree whether this regulation of authority attribution is functioning appropriately in health policy. Some find the EU’s capacities to influence MS’s health policies have developed “far beyond its rather modest formal competency” (Lamping & Steffen, 2009, p. 1374), clearly illustrating that subsidiarity is not the guarantee for non-involvement that many expect it to be (Mossialos, et al., 2010, p. 1). In contrast others find the EU’s activities legitimate (Schulte, 2013, p. 61), or the MSs to be still in the ‘driver’s seat’ when it comes to health policy formulation (Clemens, Michelsen & Brand, 2014, p. 62).

2.2. Framing the compound

Notwithstanding the legal basis, EU participation in health politics is executed in numerous ways not explicitly stipulated by the TFEU. As Lamping and Steffen put it, health is a “cross-cutting policy field, as many aspects of health policy are regulated in other policy sectors” (2009, p. 1362). This discloses an initial explanation for the expansion of EU influence in health. Indeed, since the establishment of the European Community MS’s health policy had to deal with unintended effects of EU law from other areas (Hervey & Vanhercke, 2010, p. 85). Over the past twenty years, though, a second path of policy intervention has firmly established itself in the area of health. Introducing soft governance tools, such as non-binding guidelines, peer-review or mutual learning, the EU was able to circumvent “almost all of the traditional, political impediments that hinder ‘harder’ progress in the health field and in integration more generally” (Brooks, 2012b, p. 87). Drawing from this observation, Brooks systematizes this ‘patchy’ and ‘chaotic’ set of activities along the two dimensions of direct, i.e. ‘hard law’ intervention and ‘soft governance’ tools of ‘diffusion’ (Ibid., see also Hervey & Vanhercke, 2010). A separate look will be taken at the new macroeconomic policy tools for budgetary supervision, which – due to their hybrid nature – do not integrate into any of the two categories (Bekker, 2013, p. 3).

2.2.1. The hard law dimension: Commission and Court of Justice, the ‘powerful duo’

This dimension constitutes traditional modes of intervention through formal law making processes with both direct and indirect effects on health policy, as well as binding policy tools such as rulings of the Court of Justice of the European Union (ECJ). Law on the field of health – as foreseen by the EU legal framework – evolves mainly around three issues, being the creation of agencies (e.g. for health programme initiatives), responses to public health threats and lastly direct regulation of health policies. The latter one – the smallest in number – is concerned with legislation about cross-border healthcare, regulation of blood, tissue and organ donation, and tobacco advertising and manufacture (Brooks, 2012b, p. 91). As the competence for this set of policy is drawn from the EU’s public health mandate, the emergence of health concerns, such as the Acquired Immune Deficiency Syndrome (AIDS), Creutzfeld-Jacob Disease (CJD), Severe Acute Respiratory Syndrome (SARS), and Bovine Spongiform Encephalopathy (BSE), has created windows of opportunity to “further centralize competencies and establish intervention capacities at EU level” (Lamping & Steffen, 2009, p. 1364). According to Greer and colleagues, though, the public health articles of the Treaty appear subordinate to the central issues of internal market and competition law (2013, p. 1136). Indeed, health policy has been affected extensively by legislation that drew its competence in other policy areas. Hervey and Vanhercke (2010, pp. 94-105) make out three policy fields that have substantially added to the body of existing health policy. The ‘Single Market’ principle in particular has granted the EU the possibility to establish community-wide regulatory frameworks, such as for marketing medical products, free movement of pharmaceuticals and mutual recognition of (medical) qualifications (Lamping, 2005, p. 23). Additionally, competition law applies to health care as well, with only few exceptions. One result was the 2004 introduced Public Procurement Directive⁷, which interfered with national systems of subsidies for public hospitals (Greer, 2009, p. 3). Unexpected effects also came from the implementation of EU social and employment law. The Working Time Directive of 2003⁸ was heavily criticized for overruling traditional practices of national health systems (Hervey &

⁷ The Public Procurement Directive (2014/18/EC) was adopted to align the single market principle also with regard to tender offers. This directive demanded that any significant contract let by the public sector be competitive, with public announcement and no preference for public actors. In health services this meant that in cases of public tenders for medical services, public hospitals could not be advantaged in comparison to private providers. Thus public hospitals relying on public funding were faced with substantial challenges with regard to their financing (Greer, 2009, p. 3).

⁸ The Working Time Directive (2003/88/EC) was introduced as a labour policy, but also affected working times of medical staff. It had essential repercussion in the organization of health care on the national level, as it set out requirements for the maximum hours of work per week, plus a minimum of resting and vacation time. It took effect above all in countries whose health system relied on long working shifts, predominantly of junior doctors. (Greer, 2009, p. 2).

Vanhercke, 2010, p. 104). As these laws draw from initiatives of the European Commission, the main actors involved are the correspondent Directorates General (DGs). Most active among these is the DG SANCO (Greer, et al., 2013, p. 1136; Lamping & Steffen, 2009, p. 1364), but also the DGs for Internal Market and Competition, as well as Employment and Social Affairs will be taken into account in the analysis section.

Not directly hard law but equally influential and binding, the rulings of the ECJ have had a role in changing the health policy landscape (Greer, et al., 2013, p. 1136; Brooks, 2012b, p. 87; Lamping & Steffen, 2009, p. 1372). As health policy at EU level is characterized by a ‘constitutional asymmetry’, with market efficiency policies regulated at the supranational level while social policies remain mostly in the hands of national decision-makers, implementing common legislation in health is almost impossible. The ECJ has filled this gap through a body of case law, now significantly shaping health policy (Brooks, 2012a, p. 34). In a number of cases⁹, the ECJ has reiterated that the principles of non-discrimination within the single market apply equally to health services whose deregulatory nature stands in contradiction to the highly regulated national health care systems (Greer, et al., 2013, p. 1136). The body of case law ultimately led to the adoption of the 2011 Patient Mobility Directive¹⁰, clearly illustrating the ECJ’s influential position in forming health related legislation (Brooks, 2012a, p. 35).

2.2.2. The soft law dimension: New modes of governance

Many of the more recent developments in health policy have come about through alternate mechanisms of intervention. These ‘new modes of governance’ are characterized by the lack of “obligation, uniformity, sanctions and/or an enforcement staff” (Scott & Trubek, 2002, as cited in Brooks, 2012a, p. 35). Although they apply mainly to areas from which EU competence is precluded, the involved EU institutions create normative elements, e.g. objectives, benchmarks or indicators (Hervey & Vanhercke, 2010, p. 87). Most of these mechanisms are bundled under the European Health Strategy¹¹, which constitutes an integrated framework of soft law

⁹ See for example landmark cases of Decker (C-120/95) and Kohll (C-158/96), that ruled hindrances to receiving dental care or spectacle prescription in a second country to be illegal. For a more complete overview, see Lamping (2005, p. 29) for the most important cases manifesting the contours of the SEM principle in health.

¹⁰ The officially titled ‘Directive on the Application of Patient’s Rights in Cross Border Healthcare’ (2011/24/EU) clarifies rights of patients and obligations of MS in the provision of cross-border health care (Brooks, 2012a, p. 35).

¹¹ The European Health Strategy was first introduced in 2003 and is now in its third programming period. The first cycle (2003-2007) focused on (1) sharing health information and knowledge, (2) tackling health threats, and (3) agree on health determinants. The second cycle (2008-2013) presented the objectives of (1) fostering good health in ageing Europe, (2) protecting citizens from health threats, and (3) support new technologies in health. The current cycle (2014-2020), in line with the Europe 2020 strategy, put forward to (1) promote healthy lifestyles, (2) tackling cross-border health threats, (3) contribute to innovative, efficient and sustainable health systems, and (4) facilitate access to better healthcare.

instruments to promote health. Strategy implementation consists of three elements: (1) legislation in accordance with Art. 168 TFEU, (2) financial instruments and (3) EU-wide cooperation. Financial instruments are used to foster cooperation through forums, conferences or platforms, but also to offer incentives for certain reforms or policy adaptations. In coordination with the EU's cohesion policy, the European Social Fund (ESF) and the European Regional Development Fund (ERDF) are applied to health care settings, e.g. in terms of "promoting efficient provision of services" (Hervey & Vanhercke, 2010, p. 91). Similarly, the European Health Strategy together with the DG Research and Innovation, funds international research cooperation for health care delivery optimization which could have implications for regulatory practices (Ibid., p. 90). A more bottom-up oriented process of soft governance has been established through the Open Method of Coordination (OMC). The Social OMC seeks to add issues of "quality and accessibility" to the EU's economic integration approach (Baeten & Thomson, 2012, p. 192) and was endorsed by the EC to be applied for health issues as well in 2006 (Puşcaş & Curta, 2010, p. 67). The impact on the domestic level, however, is less than evident, where the OMC Health remains a largely hidden process (Vanhercke & Wegener, 2012, p. 99). Altogether, two aspects are noteworthy with regard to the OMC Health: (1) the EC has been setting the tone of the OMC Health since the very beginning (Hervey & Vanhercke, 2010, p. 129) and (2) its importance seems to have been weakened substantially with the introduction of the Europe 2020 strategy (Baeten & Thomson, 2012, p. 193).

But broadly defined, the term 'soft law' incorporates all non-binding instruments exercised by EU institutions. In these terms Brooks lists also conclusions, council declarations, peer reviews, resolutions, frameworks, codes of conduct, commission guidelines and communications as part of soft law (2012b, p. 87). In 2010, the Economic and Financial Affairs Council adopted a conclusion which, among others, promoted the establishment of user-charges and enhancement of competition in the health sector (ECOFIN Council, 2010, p. 2). This document was noteworthy as it presented the "most detailed EU guidance on health system reform to date" (Baeten & Thomson, 2012, p. 196). Equally important, the EC adopted a communication which established the Social Investment Package (SIP) in 2013. This paper offers guidance on how to render social welfare and health systems more effective and efficient (EPHA, 2013, p. 3). All in all, the most relevant EU activities on the soft law dimension are the European Health Strategy and its correspondent stakeholders, but also specific statements and communications, e.g. of the respective DGs or committees in the EC, EP or Council need to be taken into account in the analysis.

2.2.3. The hybrid channel: Macro-economic governance encroaching on health

Bekker (2013) closely examined the adaptation of the EU's economic governance in response to the financial crisis, finding that it introduced more binding elements to its soft governance approach in social policies. As one prominent example, the annually prepared National Reform Programmes (NRPs) demanded for by the Stability and Growth Pact are now combined with the stricter European Semester¹². Thereby health is affected notably, being a major item of public expenditure across Europe with great potential for improving efficiency (Fahy, 2012, p. 1-2). In the frame of the 2011 introduced European Semester, the Annual Growth Survey (AGS) has commenced to include health care in 2012, assessing cost-effectiveness, performance and quality of care (EPHA, 2013, p. 3). In the resulting country specific recommendations (CSRs) the EC has incorporated recommendations on health reform for six MSs in 2012 (Ahtonen, 2013) and for thirteen MSs in 2013, not taking into account Cyprus, Greece, Ireland and Portugal (EPHA, 2013). These recommendations, albeit leaving the MSs with the choice on how to realize the policy adaptations, can ultimately be enforced through incentives and sanctions, if not complied with (Baeten & Thomson, 2012, p. 189). The Euro Plus Pact though, strengthens the role of the EC further with regard to enforcing the commitments made in the NRPs or CSRs (Ibid.). The Six Pack works parallel to this, with MSs receiving separate recommendations from the council of finance ministers and 'automatic sanctioning', when facing an excessive deficit. The Two Pack agreement functions as an early warning system, testing whether a MS's budgetary plans are in line with the recommendations issued in the previous cycle (Ibid., p. 191). Clearly, economic governance is emerging as a "powerful tool" shaping national health policy, and should thus be closely examined within the wider frame of European health policy efforts (Ahtonen, 2013, p. 3).

2.3. Policy coherence

After having thoroughly retraced the developments in EU health activities over the last two decades it may have become clear why policy coherence is of particular interest in this policy field. The number of channels used to shape policies and numerous stakeholders participating in this process illustrate how Hervey and Vanhercke's image of a 'policy patchwork' is adequate. To no surprise the importance of policy coherence has been acknowledged by the EU

¹² The European Semester reviews Member States' budgetary and structural policies during a six-month annual cycle to detect inconsistencies and emerging imbalances. The cycle starts in January with publication of the European Commission's Annual Growth Survey (AGS), which sets out EU priorities for boosting growth and job creation in the coming year. Following discussion of the AGS by the Council and the European Parliament, the spring meeting of the European Council identifies the main economic challenges facing the EU and gives strategic advice on policies via country specific recommendations. (cf. Baeten & Thomson, 2012, p. 189).

in various documents, but also scholars and international organizations have taken up on the issue (Nilsson, et al., 2012, p. 369). Still, the term is little theorized. Den Hertog and Stroß define policy coherence as the “synergic and systematic support towards the achievement of common objectives within and across individual policies” (2011, p. 4). In distinction to policy effectiveness, which assesses the impact of a singly policy, coherence refers to relationships between policies (Nilsson, et al., 2012, p. 397). Nilsson and colleagues have developed a systematic analysis to assess policy coherence on various levels. They differentiate between vertical and horizontal coherence, i.e. between MS and EU level or on a single EU level between different involved actors; and internal versus external coherence, referring to coherence within a single or between different policy fields. On whatever level coherence analysis is focused on, the aim is to lay up possible contradictions between specific policy objectives and the de facto impact of implemented policies. These conflicts between objectives and implementation practices have been observed over decades where “administrators [...] filter, interpret and distort formal policy in [...] ways that may result in outcomes that differ significantly from the legislator’s intention” (Pressman and Wildavsky, 1973, as cited in Nilsson, et al., 2012, p. 399). Yet, policy coherence analysis has been applied mainly in development policy¹³ contexts, to assess the interplay between policies of various fields in reaching the Millennium Development Goals. In health policy, coherence is similarly required for by the ‘Health in all policies’ principle. It dictates that all Commission initiatives in health or policy fields relevant for health must be reviewed in terms of impact assessment. However, this assessment focusses on health effects on the individual citizen level and does not take into account whether a whole set of policies is functioning synergistically. Despite this appearing as an obvious research gap, academia has not yet seen to testing coherence of health policies. In the light of the research question, reviewing the coherence of the Greek bailout programme with residual health EU policies is expected to grant insights to the role bailout agreement are playing in shaping health policies now and possibly in the future. To summarize the considerations laid out above, coherence is, for the purpose of this thesis, defined as ensuring that within this multi-actor frame, individual activities of stakeholders do not conflict or constrain the achievement of promoted policy goals. Consistent policy goals are therefore the minimum requirement of an assumed policy coherence in this field.

But if the EU is precluded from implementing an autonomous health policy and many of the developments derive from ‘unintended’ effects or are promoted by a multitude of actors

¹³ See for example: Carbone, M. (2009): Policy Coherence and EU development policy. London: Routledge; Thierry, M. (2006): Policy Coherence for Development. Paris: OECD Publishing.

involved – how can coherent policy objectives be presumed? The premise of the thesis builds upon earlier scientific publications that despite not having applied a standardized policy coherence analysis have laid up evidence for a consistency among the health policies at EU level. Greer anticipated that the Lisbon Treaty would be the starting point of a coherent public health policy at EU level (2006, p. 139), a finding reiterated in an article by Puşcaş and Curta (2010, p. 68). The “success story” of EU health policy derives according to Lamping and Steffen from turning competing components into a “coherent EU health policy approach” (2009, p. 1373). Coherence on the soft law dimension is observed by Fierlbeck, finding that the discourse resolved mainly around ‘investment in better health services’ (2014, p. 21). Clemens, Michelsen & Brand observe an indication that the patchwork character of health policy is dissolving, due to the emergence of a prevailing health discourse at EU level (2014, p. 64-65). However, none of these articles examine this ‘coherent health policy approach’ more into detail, leaving out from which indicators they draw their conclusions. Applying a more systematic approach, Baeten & Thomson (2012) reviewed objectives laid out in the Social OMC as of 2006, ECOFIN Council conclusions from 2010, the NRPs of 2011 and the MoUs of Greece, Ireland and Portugal. While the documents examined present a development from uncontroversial and loose policy objectives to more debatable and specific policy tools, the more detailed documents do not fall out of line with the initially formulated objectives. Recurrently stressed objectives are ‘ensuring financial sustainability through raising efficiency’ and ‘safeguarding equity in access to high-quality care’ (Ibid. p. 202). But in this article also the disconnectedness between reforms required for in the Greek bailout programme and its overarching policy goals are expressed. This observation stresses the importance of understanding the relation of the MoUs with residual EU health policy.

The results of this brief review bring forth the following considerations: (1) the term ‘policy coherence’ does not have a defined meaning and scholars may have a different understanding of it, than assumed in this thesis. (2) The findings are only loosely connected to empirical evidence and therefore the assumption of an existing coherence in health policies needs to be closely reviewed. All the more, this stresses the existing research gap, which this thesis aims to address.

2.4. Insights

This chapter has shed light on the legal context and the complex set of actors involved and policies existent in health policy in the EU. Of Particular interest for the following analysis are the actors formulating EU health policy. For the EC the DGs SANCO, Internal Market and Competition, as well as Employment and Social Affairs will be taken into account. From the

EP the Committees for Employment and Social Affairs, and Environment, Public Health and Food Safety are of interest. Additionally the ECOFIN and EPSCO Council will be considered. However, most activities – being on all of the three observed dimensions – stem from initiatives taken by the EC. Nevertheless, the different entities should be considered separately, as even within the EC (i.e. between the respective DGs) approaches to deal with certain issues differ (Vanhercke & Wegener, 2012, p. 71). With the numerous stakeholders involved in this policy field, there is an apparent research gap in terms of reviewing the coherence of policies produced so far. In the light of the research question the coherence analysis can assess the overall leverage of the EU in formulating health policies, also taking into account the bailout programmes as possible new channel.

3. Methodology: Inductive policy coherence analysis

This section seeks to introduce the methodological approach taken in the thesis. To recapitulate, the central research question of the thesis is: In how far are the bailout imposed reforms of national health care in Greece coherent with the European health policy compound? This brings forth the following hypothesis: The bailout imposed reforms of health care in Greece are synergetic towards the EU's health policy goals and in line with implementation methods envisaged in the residual EU health policy compound. In order to approach the research problem, the choice of Greece as unit of observation will be discussed firstly. Following this, the dataset serving as the pool of evidence for the analysis shall be presented. Then, the analysis method on the basis of Nilsson's approach will be explained step by step to render the process as transparent as possible.

3.1. Case selection: Greece

The choice of Greece as the unit of investigation has been made for the purpose of generating maximum insights from the research problem. Within the frame of countries that have received bailout packages, the number of cases up for discussion is rather limited, being Greece, Portugal, Ireland and Cyprus¹⁴. The reason why Greece is chosen, is because initial research has shown that this country has been affected most in terms of changes to health and health care systems. The Greek bailout programme is the most extensive concerning policy adaptations in health and developments have been monitored over a longer period than in e.g. in Portugal. In Ireland and Cyprus, the bailout programmes have had little to say about health policy reforms. Additionally, a large bulk of literature exists for Greece, though mainly on the health effects of

¹⁴ Spain is not taken into account here, as the bailout package received was granted by the EU only and only addressed reforms in the finances sector.

austerity (See e.g. Stuckler et al. (2009), Kentikelenis et al. (2011), Zavras et al. (2012) and Kodilis et al. (2013)). These can be consulted where applicable in order to assess the impact of certain reforms.

3.2. Data collection method

The mode of analysis applied in this thesis is document analysis. In order to assess policy objectives, implementation practices and patterns of argumentation, documents of the following stakeholders will be reviewed: European Commission (DG SANCO, DG Economic and Financial Affairs, DG Employment, Social Affairs and Inclusion), European Parliament (Employment and Social Affairs Committee and Environment, Public Health and Food Safety Committee), Council of the European Union (EPSCO Council and ECOFIN Council) and, if applicable, the ECJ. For the bailout programme documents from the IMF and the Taskforce for Greece (TFGR) are also of interest. It is important to take into account soft-law, hard-law and hybrid channels, i.e. documents to be analyzed are: Directives, Conclusions, Statements, Communiqués, Health Strategy Documents (e.g. Staff Working Documents (SWD)), CSRs, Reports, MoUs and other relevant publications.

All necessary data will be attained by using database research. Official EU documents will be retrieved from www.europa.eu. The documents are retrieved by keyword search using the following terms: health, healthcare, Greece, Troika, bailout, DRG, diagnosis-related group, co-payment, cost-sharing, e-health, ehealth, generic, pharmaceuticals. The resulting documents are scanned briefly for context and content and chosen according to the following criteria: reliability, precision, and added value. The first criterion refers to the source of information, with reliability granted when it is an official (EU/governmental/administrative) document or reliable source (e.g. established newspaper or institution, peer reviewed article). The criterion of precision refers to the context of the contained information; i.e. the document should be no older than of 2000 and clearly refer to the issue (i.e. policy objective/interaction) of interest. Lastly, a source of content is only valuable to the analysis if it adds value to the research issue. A complete list of the retrieved and analyzed documents is attached under appendix A. Where appropriate, secondary literature will be consulted by using the scientific database 'disco' of the University of Münster, as well as online search tools.

3.3. Data analysis

In order to test the hypothesis, a policy coherence analysis will be applied. Nilsson et al. (2012) have introduced a systematic approach for analyzing whether a set of policies creates synergies towards reaching promoted policy goals. They apply their approach to test coherence between

environmental policies and specific sectors, which can be understood as a horizontal and external coherence analysis. By contrast the coherence analysis approach taken here is at the intersection of activities between EU actors (horizontal) and their take on specific health policies (internal). The method developed by Nilsson et al. follows three steps: first undertaking an inventory of policy objectives, second a review of interaction by way of a screening exercise – to see whether policies create synergies towards reaching the stated objectives – and third an in-depth mapping of key interactions. A similar approach will be taken here, although due to the constraints of the thesis, the scope will be limited to issues addressed in the Greek bailout programme. Adjusting the methodological approach to the specific requirements of this thesis, the following steps will be undertaken in the analysis: (1) the Greek MoUs of 2010 and 2012 will be examined to carve out the reforms that will be taken into consideration in the coherence analysis. (2) Regarding the thus chosen reforms, an inventory of policy objectives at EU level will be prepared. (3) Finally, the interaction between bailout imposed reforms and policy goals will be investigated producing a screening matrix as proposed by Nilsson and colleagues. Each of the steps is executed in form of a document analysis. The corresponding documents are scanned for passages containing statements on the policies in question. These statements are interpreted in the context. The analysis will use primarily direct quotes to avoid misinterpretation of statements. The individual steps will be conducted as follows:

Step 1: Defining the scope of analysis: Greek bailout reforms

Before testing the coherence of certain reforms, it needs to be clear which will be the ones of interest. In the case of health this is particularly difficult, as this field can be characterized to consist of 56 policy topics (May, Sapotichne, & Workman, 2006). For reasons of restraint, this thesis will inductively pick up the topics that are addressed in the Greek bailout programme only. The aim is to choose five distinct reforms of health policy or health care organization demanded for in the bailout agreements. Here, precise reforms will be taken into consideration, whereas inexplicit demands or commonplace expressions will be neglected, since they require highly debatable interpretation.

Step 2: Inventory of policy objectives

The second step will consist of laying up the policy objectives expressed by EU stakeholders for the chosen topics of the bailout agreement. This step serves a double purpose. On the one side an inventory of policy objectives will be undertaken. On the other hand, this review of policy objectives among various stakeholders, grants an insight to the degree of coherence

among existing activities at EU level. Here, it is of particular interest to incorporate statements of all involved EU actors, i.e. the EC, EP and Council.

Step 3: Interaction analysis

This third step consists of undertaking an in-depth analysis of the interactions between policies and policy objectives. In the case of Nilsson et al. this has been done by a panel of experts, however, their approach incorporated thirty-two policy objectives. Due to the inductive approach taken here, the number of policy objectives will be much less. In contrast to Nilsson's approach, the policy objectives will be screened against the policies laid out in the bailout programme via a document analysis, taking a more in depth-approach right away, making the in-depth mapping envisioned in Nilsson's method superfluous. In this main analysis, overall coherence is operationalized along the two dimensions 'strength of interaction' and 'coherence with policy objectives'. Strength of interaction deals with the cause-effect relationship between two institutions, in this case EU stakeholders and the bailout imposed reforms in Greece. The individual interactions will be scored as 'non-existent' or 'non-measurable' (0), weak (1), or strong (2), also adding +/- to classify the direction (synergetic/contradictory). The scores will be chosen according to the content of statements found in the document analysis. Equally with regard to the coherence score, it will range from -2 to +2, measuring in how far the bailout reforms are synergetic or discordant towards the individual policy objectives.

3.4. Conclusion: Methodological approach and scientific value

The three-step approach suggested by Nilsson (2012) creates a transparent process to evaluate the relation between the bailout programme of Greece and the EU's health policy. Reviewing first the Greek bailout agreement documents sets the boundaries for the analysis, extracting the reforms of interest for the analysis. In the second step the policy objectives at EU level corresponding to the chosen reforms are reassessed systematically in order to test whether the assumption of a coherent EU health policy discourse is accurate – at least on the conceptual level. The main analysis is undertaken in step three, where overall coherence is tested along the two dimensions of strength of interaction and policy coherence.

The thus produced results are expected to give an overview on how to understand the Greek bailout programme, both regarding the interaction of the EU with it, as well as the coherence with the EU's policy objectives in this field. The results can be interpreted as to whether the bailout program is to be considered as a policy set independent from other EU activities (weak interaction, weak coherence); as part of the 'chaordic' health compound (weak interaction, strong coherence) or even an indication for decisive EU involvement in national healthcare

organization (strong interaction, strong coherence). However, the selection of sources is to be considered as deliberate and non-exhaustive. As the results obtained in the analysis only reflect developments in Greece they do not allow for inferences across Europe. However in the context of other scientific findings, the results presented in this thesis can serve as a basis for interpretation on how health policy in the EU is developing.

4. Analysis

Having thoroughly reviewed the state of European health policy, identified the most important scientific findings relating to the research question and laid out the methodological approach, the following section protocols the execution of the analysis. First, the Greek bailout agreements will be screened for specific policy reforms, of which five will be chosen. Then, corresponding policy objectives at EU level will be extracted. The main analysis is executed in section 4.3., where overall coherence is tested. Lastly, the main results will be summarized.

4.1. The Greek bailout programme

The Greek bailout programme was concluded in May 2010 through ratification in the Greek parliament. Linked to the programme were the ‘Memorandum of Understanding on Specific Economic Policy Conditionality’ and the ‘Memorandum of Economic and Financial Policies’. This was complemented by a second bailout package in March 2012, whose conditions were laid out in the ‘Second Economic Adjustment Programme’. All three of these documents contained targets touching upon health policy. Reviewing first the Memorandum of Economic and Financial Policies, the document calls for Greece to (1) reform hospital accounting system to a double-entry accrual system with regular publication of the accounts, (2) to improve ‘pricing and costing mechanisms’, (3) to merge existing health funds to simplify the fragmented system and (4) to unify all health activities under one ministry. The MoU on Specific Economic Policy Conditionality is somewhat more extensive and demands for (5) the promotion of usage of generic medicines, (6) the introduction of an electronic prescription and procurement system and general computerization of hospitals, (7) a co-payment system with user charges for outpatient services in public hospitals. Furthermore, it reiterates the targets (1) and (2). The second economic adjustment programme initiated in February 2012 specified some of the demands that “seemed self-explanatory in the beginning of the economic meltdown” (Kremalis, 2013, p. 106). It is thus much more extensive and explicit with its requirements. Not all will be taken into account here, but the most important conditions were the following: The Greek government was obliged to (8) bring health expenditure below 6% of the GDP, (9) reduce pharmaceutical expenditure by roughly one billion, (10) cut the headcount of doctors by 10%,

and (11) introduce diagnosis-related groups (DRGs) for hospital reimbursement. Furthermore, this reviewed programme restates all targets set out in the first bailout package, albeit increases the scope of co-payment schemes (for both pharmaceuticals and services), makes e-procurement compulsory for 90% of all medical acts, requires the share of generic medicine sold in pharmacies to reach 35% and in hospitals to reach 50% and calls for intensifying monitoring and assessment.

For the analysis the following five reforms will be examined more closely regarding overall EU activity on this field: (i) cutting health expenditure, (ii) the introduction of co-payment schemes regarding health care services as well as pharmaceuticals, (iii) the introduction of e-procurement systems, (iv) increasing the application of generic medicine, and (v) establishing DRGs as reimbursement system. These five targets are pronounced repeatedly in the different documents, while also being well applicable in the analysis for being relatively specific.

4.2. Inventory of EU objectives in health policy

One of the earliest set of commonly agreed objectives in health policy were laid down in the 2006 Social OMC. Within this frame, the MSs agreed on universal access to health care, increasing quality of care through standard setting and sustainable financing¹⁵. Reviewing EU documents in the light of the chosen issues, a recurrent pattern seems to legitimize the promotion of reforms by referring to these common objectives. For example, the SWD ‘Investing in Health’ for the current social investment package states that “Fiscal consolidation and structural reform of health systems must go hand in hand to continue delivering on public policy goals and ensure that efficiency gains will guarantee universal access and increase the quality of healthcare” (DG SANCO, 2013, p. 20). The similarity in content is particularly striking, taking into account that several scholars have found these objectives to be open to interpretation, ambiguous or contradictory (Public Policy and Management Institute, 2011, p.

¹⁵ The original wording of the three objectives is: (a) access for all to adequate health and long-term care; that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed; (b) quality in health and long-term care, and the adaptation of care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients; and (c) that adequate and high-quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.

23). The influence and interplay of these targets will be reviewed more closely in the light of the chosen bailout targets.

4.2.1. Health budget cuts

With regard to straight budget cuts, the documents reviewed are much less explicit than in the Greek bailout agreement. Mostly in line with OMC common objectives, comments evolve around ‘sustainable finances’. Also in this respect most statements that touch upon health expenditure are linked to the EC, which makes sense in so far as this institution is responsible for budgetary supervision. In the 2011 Commission proposal on establishing a ‘Health for Growth’ programme it is stated that “challenges have increased with curbs on public spending in the wake of the financial crisis. Evidence suggests, however, that effective health system reforms have the potential to contain ‘excess cost growth’”. Nevertheless, it is acknowledged that “health system reform must clearly consist of [...] immediate efficiency gains” (European Commission, 2011, p. 4). Also the 2012 CSR for the Euro Area expresses that “reforms [...] in health and pensions are urgently needed to underpin the long-term sustainability of public finances” (European Commission, 2012a, p. 3). These two statements clearly put emphasis on the urgency of reforms, but do not suggest straight budget cuts as such ‘reform’. The Joint Report on Social Protection and Social Inclusion by the EC and the Social Protection Committee (SPC) in turn argues that differences in health system performance have been aggravated by policy responses to the economic crisis, especially in countries opting for health budget cuts. “Budget pressure apart, [...] in these countries, higher and more effective health care spending will be needed” (Social Protection Committee, 2010, p. 10). This openly presents a view in opposition to budget cuts. The EPSCO council somewhat reinforced this view, albeit less explicit by inviting “MS to reposition the perception of health policy making it more visible when macroeconomic issues are at stake and shifting it from being regarded as just an expenditure post to being an acknowledged contributor of economic growth” (EPSCO Council, 2011, p. 3). The Commission Communication regarding the 2012 AGS advises “to ensure cost-effectiveness and sustainability, assessing the performance of [...] systems against the twin aim of a more efficient use of public resources and access to high quality healthcare” (European Commission, 2012b, p. 5). Overall, the last three statements thus shift the focus from quick health policy responses to the crisis, to more carefully reviewing possible effects of reforms. In any case, the single mentioned policy objective corresponding to this reform is achieving financial sustainability in the health care sector.

4.2.2. Introduction of co-payment schemes

Just like statements regarding health budget cuts were limited, debate on co-payment systems is also rather inexplicit. Pérez notes, that apparently “European institutions try to stay out of the controversy” (Pérez, 2013). This was also true for the negotiation process of the cross-border healthcare directive, where the original proposal entitled MSs to freely decide on the level of co-payment to be installed. But despite granting MSs full freedom in choice, this paragraph was criticised and the EPSCO council demanded it to be left out altogether (Council of the European Union, 2009, p. 18). However, a few documents pinpoint toward a certain take on the introduction of co-payment schemes in Europe. Here it needs to be taken into account that co-payment can refer to both cost-sharing for medical services as well as payments for prescribed pharmaceuticals. Statements in this regard are almost always linked to underpinning the importance of universal coverage. For example the Joint Healthcare Report affirms that although “the current economic situation [...makes] it necessary to [...] improve/adjust cost-sharing schemes” it is universal access that remains as the common principle and value of health systems (European Commission & Economic Policy Committee, 2010, p. 87). This is also the point of critique in the 2013 CSR for Hungary, where it was found that “out of pocket payments are high and constitute an additional barrier as there are no exemptions for low income or high risk groups” (EPHA, 2013, p. 9). Also the ECOFIN Council adopted an opinion, in which MSs are asked to encourage “a cost-effective use of care, through adequate incentives including cost-sharing [...] while ensuring the protection of those more vulnerable” (ECOFIN Council, 2010, p. 2). Respecting each MS’s choice for co-payment schemes is also reflected in the case law concerning patient mobility (Greer, 2014, p. 73). All in all, these findings depict rather clearly, which two policy objectives are taken into account for co-payment reforms: financial sustainability, as well as universal access to care.

4.2.3. Establishing e-health systems

In contrast to the first two issues discussed, debate on e-health is far more extensive. But as can be directly observed, most EU documents explicitly refer to e-health, while the Greek bailout agreement specifies e-procurement, prescription and computerization of hospitals. In how far these issues overlap will be discussed in the policy interaction analysis of section 4.3.1. First the general consistency of statements of involved stakeholders will be examined here. Promotion of e-health has been addressed extensively in two action plan cycles (2004-2011, 2012-2020). Also a SWD concerning telemedicine was published in 2012 and a voluntary e-health network of representatives of national authorities has been set up in 2011. This network seeks to foster cooperation of MSs in the frame of the cross-border health care directive and

provides guidelines for better use of electronic health systems and interoperability. In an EC citizen's summary on EU activity in public health it is stated that e-health "will become an increasingly essential element of EU health policy in the future" (European Commission, 2013a, p. 15). In 2011 the EPSCO council stated that MSs should "foster health technology assessment and ensure smarter use of e-health solutions to ensure value for money and benefits for health and health systems" (EPSCO Council, 2011, p. 4). Apparently, the implementation of e-health is sought to achieve efficiency gains. This is also reflected in the 2013 SWD on the SIP, wherein e-health "is often perceived as substantially increasing productivity, and therefore as an instrument to support the reform of health systems" (DG SANCO, 2013, p. 8). The citizen's summary on public health also describes e-health as "using digital technology to improve access to care [...] and make the healthcare sector more efficient" (European Commission, 2013a, p. 15). Similarly the SWD on the 2012-2020 eHealth Action Plan formulates the objective to "increase sustainability and efficiency of health systems by [...encouraging] organizational changes" (European Commission, 2012c, p. 24). Even the more critical Committee for environment, Public Health and Food Safety conceded that "for all its shortcomings, eHealth has great potential and could benefit to the professionals involved in healthcare, to patients and informal carers" (ENVI Committee, 2013, p. 6). Altogether, the multitude of documents broaching the issue of e-health are fairly consistent in voicing that the introduction of e-health solutions can foster efficiency gains and enhance access to care, especially in a cross-border context.

4.2.4 Increasing the use of generic pharmaceuticals

According to the Directive on the community code relating to medicinal products for human use (2001/83/EC) a generic medicinal product "shall mean a medicinal product which has the same qualitative and quantitative composition in active substances and the same pharmaceutical form as the reference medicinal product". Generic products are usually only appearing on the market after the reference product's patent expires. In contrast to the aforementioned issues, pharmaceuticals are highly regulated on the European level. Marketing authorization of drugs is handled by the European Medicines Agency (EMA) and additionally intellectual-property law applies. Accordingly, EU stakeholders are more outspoken about this issue. In the 2010 Joint Report on health systems it is stated that "one policy field which is gaining interest is that regarding generic medicines as a means to ensure cost-containment in relation to pharmaceuticals while increasing patients' access to care" (European Commission & Economic Policy Committee, 2010, p. 129). And this view seems to be a tenor along all reviewed documents. The European Economic and Social Committee adopted an opinion in 2009 which

asserted that “generic medicines are an opportunity for savings in health care” (European Economic and Social Committee, 2009, p. 1). DG SANCO also reiterates the objective of the SIP to achieve smarter spending for efficient healthcare, e.g. through “increasing the use of less expensive equivalent (generic) drugs, for example through pricing measures” (DG SANCO, 2013, p. 6). And also in the frame of the European Semester the EU is promoting the use of generics directly to MSs. While France is asked to increase “the cost-effectiveness of healthcare expenditure, including the areas of pharmaceutical spending” (EPHA, 2013, p. 8), Slovakia is praised for its newly introduced policies that encourage the prescription of generic medicines (Ibid., p. 14). Also Ireland and Portugal were called upon to “improve the cost-effective use of medicines”, including “more extensive use of generics” (Ibid., p. 10-12). All in all, the documents voice similar statements. The policy objectives to be taken into account for this issue are both financial sustainability and equity in access.

4.2.5 Introduction of DRG-based reimbursement for hospitals

The last reform promoted in the bailout agreement that will be further investigated is the introduction of a DRG-based reimbursement system for hospital care. Diagnosis-related groups are a systematization of medical treatment cases that allows for transparent payments. Reimbursement of costs is allocated according to expected treatment costs of a disease pattern, rather than to the actual individual treatment applied. These classifications of cases seek to “reimburse providers fairly for the work they undertake, but intend to encourage efficient delivery and to discourage the provision of unnecessary services” (Busse, 2009, p. 1). As this issues interferes with the organizational aspect of national health care, it can be expected that EU actors may refrain from taking a clear position, such as in the case of co-payment or health budget cuts. However, it seems that the issue is actively debated, especially in the light of increasing cross-border health services. Busse and colleagues. noted in 2011 that “in a context of growing patient mobility facilitated by the [...cross border health care directive], an increasingly important issue relates to whether there is scope for harmonization of DRG systems within Europe” (Busse, et al., 2011, p. 23). In this sense, DRG-reimbursement is advocated in a number of documents. Already in 2002 a Commission decision expressed that in the case of hospital services DRGs are considered as a ‘most appropriate method’ for measuring prices in national accounts (European Commission, 2002, p. 11). In the Joint Report on health systems, Germany’s DRG-based hospital reimbursement system is pointed out as a best practice (European Commission & Economic Policy Committee, 2010, p. 154). Furthermore, the report states that “if cost-containment is the issue [...] line item budgets and per diem systems have been discouraged” (Ibid., p. 126). In 2009, the EU has also funded a

three-year research project assessing the effects and elaborating ‘optimal design features’ of DRG systems across Europe. The SWD for the 2013 SIP mentions DRGs as an adequate incentive to encourage more cost-effective provision of health services (DG SANCO, 2013, p. 5). DRG-resembling systems are even promoted in the frame of the European Semester. In the case of Slovakia’s CSR, DRGs are welcomed, as this “would lead to substantial efficiency gains” (EPHA, 2013, p. 14). The Czech Republic, one of the few countries not applying DRGs is called upon to “significantly improve cost-effectiveness of healthcare expenditure, in particular for hospital care”. Similarly Bulgaria’s financing system “provides no incentives for efficiency in service provision”, it therefore should ensure “effective access to healthcare and improvement of the pricing of healthcare services” (Ibid., p. 5). Taking these findings into account, the different stakeholders involved are relatively unanimous in considering DRG-based reimbursement as appropriate for achieving efficiency gains in hospital treatment and thus sound financing of the health care sector.

4.2.6. Summary of the findings

This step was aimed to produce an overview of how the different stakeholders perceive the issues at hand, and whether within the specific cases common objectives exist. Regarding health budget cuts, the found statements were rather implicit and not necessarily without ambiguity. Apparently different stakeholders have diverging views on the usefulness of this reform. However, agreement existed in so far that health budget cuts are *intended* to achieve sustainable financing. In the same way, statements regarding co-payments were few. But those found reflected a very consistent pattern of argumentation. This consistency in argumentation also proved true in the remaining three topics of e-health, generic pharmaceuticals and DRG-reimbursement. There is an obvious overlap regarding the policy objectives the EU is striving for with its health policy activities. (1) Achieving financial sustainability in health care is aimed for in all policy approaches; (2) accomplishing universal access is explicitly called for in the context of co-payment schemes, e-health solutions and generic pharmaceuticals. These two overarching goals fall in line with two of the three common objectives for health set out in the Social OMC of 2006. Overall, these findings suggest that Lamping’s assumption of an ‘essentially coherent’ European health policy is accurate outside of the Greek bailout programme. How these two policy objectives relate to the reforms set out in the Greek bailout programme will be subject of the following section.

4.3. Coherence analysis

In line with the conceptualization of Nilsson et al. (2012), the coherence will be tested more in depth by closely reviewing ‘strength of interaction’ (cause-effect-relationship) and ‘coherence

among objectives' (synergy towards achieving determined objectives) for the reforms selected from the bailout agreement with Greece. Strength of interaction will tentatively assess the role of the involved EU stakeholders in formulating the individual reforms of the bailout agreements.

4.3.1. Strength of Interaction

Regarding the process of the bailout induced reforms in Greece, it seems noteworthy that a Task Force (TFGR) has been supporting reforms since 2011 in the frame of technical assistance called for by Greece (Taskforce for Greece, 2012b, p. 38). The TFGR is led by the Head of the TFGR, Horst Reichenbach¹⁶, and under the political guidance of Olli Rehn, Vice-President of the EC. Further members are of the DG Regional Policy and DG Employment, Social Affairs and Inclusion, the German Ministry of Health (as 'Domain Leader'), and representatives of a number of MSs (cf. EUbusiness, 2012). Additionally with regard to reforms in the health sector a Health Reform Steering Committee has been set up in 2012. This Committee consists of representatives of the Greek Ministry of Health, members of the 'Domain Leader' Germany and the TFGR¹⁷ (Taskforce for Greece, 2012b, p. 28). This set-up shows a strong involvement of EU stakeholders in the reform process in Greece, in particular in the health sector. However the work of the TFGR and Steering Committee is difficult to outline, as documents are not publicly available. So far the TFGR published six quarterly reports, which provide quite imprecise and redundant information, though. Thus it is difficult to interpret the relationship between reforms undertaken in Greece and the role of the EC.

With regard to health budget cuts, the EU institutions – as outlined in section 4.2.1 – have been cautious with general statements. But concerning the case of Greece, the Council has picked up the objectives laid out in the MoU regarding budget cuts. In 2011 it calls for the “implementation of the comprehensive reform of the health care system started in 2010 with the objective to keep public health expenditure at or below 6 % of GDP” (Council of the European Union, 2011, p. 23). Furthermore, in a communication from the Commission to the Council with regard to reforms to be implemented by Greece to address the excessive deficit, it is stated that “the fiscal surveillance of the social security and health sectors has to be improved” (European Commission, 2012d, p. 12). But apart from this, there is no explicit

¹⁶ Reichenbach has followed a career in the European Commission, in particular the DG Economic and Financial Affairs (European Commission, 2014a).

¹⁷ The Steering Committee has set up seven sub-committees, namely 1) EOPYY (The National Organization for Health Care Provision), 2) Hospital Management, 3) Diagnosis-Related Groups, 4) ePrescription, 5) Pricing and Reimbursement of Pharmaceuticals, 6) Primary Health Care, 7) Health tourism. These sub-committees are responsible for the development, coordination, and implementation of the individual pillars of Greece's health reform road map.

evidence for an interaction of the EU to impose the budget cuts. In this context, academic publications have a clearer interpretation. The articles of Gaffney (2013, p. 13), Kentikelenis et al. (2014, p. 751) and Reeves et al. (2014, p. 4) see the IMF as primarily responsible for capping health expenditure at 6% of the GDP. Interaction in this field can therefore be considered as weak to non-existent.

Similarly with regard to the introduction of co-payment schemes, the strength of interaction is difficult to interpret. As laid up above, EU stakeholders have not necessarily objected the introduction of co-payment schemes, as long as universal access to health care was maintained. This conditionality is not evident in documents referring to Greece, though. In a decision of 2011 the Council calls on Greece to complete the “enforcement of co-payments for regular outpatient services” (Council of the European Union, 2011, p. 18). The EC reiterated the necessity of this reform, mentioning to expand co-payment by “increasing cost-sharing for healthcare delivered by private providers” (European Commission, 2012e, p. 8). Albeit the indications are few, a weak interaction between EU stakeholders and the introduction of co-payment in Greece can be assumed.

In turn, a clearer link between EU targets and development of reforms in Greece can be laid up examining the goal of establishing e-health. The Council in particular calls on Greece to “implement a comprehensive and uniform health care information system (e-health system)” which should be in “in compliance with EU procurement rules” (Council of the European Union, 2011, p. 30). The TFGR also comments that “Over-consumption of health-care products and services is widespread in Greece [...] (almost twice as high as elsewhere in the EU). [...] The introduction of e-Prescription should assist with this” (Taskforce for Greece, 2012a, p. 24). A third link should be taken into account. Albeit it is not noted down in any of the reviewed documents, the parallel development between the first and second economic adjustment programme for Greece and the 2010 launched Digital Agenda for Europe (DAE) is striking. The first economic adjustment programme only refers to e-procurement and e-prescription in health reform, while the second takes into account overall computerization and health-technology assessment. This development is reflected in the EU’s activity in promoting digital development. For 2004-2011 there was an ‘Action Plan on eHealth’ operational, stimulating MSs to set up electronic prescription and procurement systems (European Commission, 2014b). Within the frame of the Europe 2020 strategy, one of the seven flagship initiatives is the DAE. Among others, it aims at creating “sustainable healthcare and ICT-based support for dignified and independent living” (European Commission, 2010). It comprises projects such as electronic health records, telemedicine, portable monitoring, online access to medical health data and

interoperable digital patient records. At the same time the second economic adjustment programme calls for compulsory e-prescription, hospital computerization and electronic medical records to achieve health-technology assessment. With these developments undeniably similar, a strong interaction of EU stakeholders with the reform is concluded.

With the issue of generic pharmaceuticals, EU actors have been quite outspoken and unanimous. Among the reviewed documents of stakeholders, increasing the use of generic medicines seems to be a generally applicable method of cost-containment. Likewise, the documents concerning the Greek bailout programme have strongly promoted the use of generics, up to defining a share of prescriptions to be reached. But apart from the apparent overlap of it being a tool for curbing expenditure, the interaction is again difficult to determine. The Council, in the frame of the excessive deficit procedure, advises Greece to “ensure that at least 50 % of the volume of medicines used by public hospitals by the end of 2011 is composed of generics and off-patent medicines” and furthermore to designate prices “on the basis of the experience of other EU Member States” (Council of the European Union, 2011, pp. 11, 13). The TFGR has been called upon also to grant Greece technical assistance in the reform toward transparent and sustainable pricing of pharmaceuticals (Bahr, 2013, p. 93). Through this channel, interaction between EU actors and the reforms can also be assumed as relatively strong.

With regard to the introduction of a DRG-based reimbursement system, the TFGR was entrusted as well. As noted before in section 4.2.5., EU actors have openly discouraged the use of per diem payment schemes for hospital services. But this system is what Greece had in place pre-crisis. In fact, apart from Greece only seven¹⁸ other MSs of the EU-27 have not yet switched to a DRG-based reimbursement in hospitals (European Commission & Economic Policy Committee, 2010, p. 123). Of these, two countries – Czech Republic and Bulgaria – were advised to revise hospital reimbursement (EPHA, 2013, pp. 5-6). However, the EU is not straightforward promoting the switch to DRGs, but neither is it discouraging. The SWD of the Commission on the SIP ‘Investment in Health’, states that the “Commission and the Economic Policy Committee identified a number of areas where structural reforms and efficiency gains could improve the sustainability of health systems”, for example “introducing activity- and/or quality-based payment for diagnosis-related groups of cases or for hospital financing” (DG

¹⁸ Belgium (payment per case), Bulgaria (payment per case), Czech Republic (global budget), Luxembourg (global budget), Malta (global budget), Poland (payment per procedure) and Spain (line-item budget).

SANCO, 2013, pp. 4-5). But no further indication was found for a strong involvement of the EU in pushing Greece to adopt DRG reimbursement.

Altogether, involvement of the EU is – at least partly – assumed with regard to all the examined reforms. This makes sense in so far, that both EC and ECB are fully involved in the bailout process in Greece and additionally in the case of e-health, pharmaceutical pricing and DRG reimbursement through the TFGR. But as documents concerning the negotiation process for the MoUs or working paper of the TFGR are not accessible, indications for relatively strong involvement were scarce and could only be laid up in the case of e-health, generic pharmaceuticals and DRGs.

4.3.2. Coherence between Greek reforms and EU objectives

In their work on policy coherence analysis, Nilsson et al. emphasize that “it is well known in policy making that conflicts are often hidden at the higher levels of abstraction such as overarching goal formulations and strategies [...] these conflicts may come to the fore in the selection of instruments and how these instruments are applied” (Nilsson, et al., 2012, p. 399). To assess in how far this observation applies also for the Greek bailout programme, this section will examine whether the individual reforms can be considered as ‘synergetic’ or ‘contradictory’ towards the overarching EU goals of ‘sustainability of financing’ and ‘universal access to care’. The analysis will try to primarily review opinions or objections voiced in documents of concerned EU stakeholders. Where appropriate, academic literature will be consulted to assess the effects of reforms.

4.3.2.1. Financial sustainability

The importance of sustainability in health financing is voiced in many EU documents¹⁹, especially in the light of the crisis, but also with regard to the development in demographics and rise of costs in health services through new technological developments. As central as this objective may seem, the restricted competence apparently inhibits the EU from adopting a clear stand through which specific policy tools this can be achieved. This is particularly true for the health budget cuts imposed on Greece. Apart from the Greek case, there is no indication whatsoever that EU institutions see budget cuts as a tool to achieve sustainability in financing the health sector. Rather, some actors have even voiced criticism as was shown in section 4.2.1. The long-term effectiveness of this reform is also doubted in the fourth review of the second economic adjustment programme, where it is noted that although cuts in expenditure were able

¹⁹ See for example the 2007 Commission White Paper ‘Together for Health’, the 2013 SWD ‘Investing in Health’, the ‘Regulation 282/2014 on the establishment of a third programme for the Union’s action in the field of health’, the 2014 Commission communication ‘On effective, accessible and resilient health systems’.

to compensate shortfalls in social security contribution collection, “savings from the expenditure side [...] are largely of a temporary nature” (DG Economic and Financial Affairs, 2014, p. 21). Additionally the IMF itself conceded that the drastic austerity measures aggravated the recession overall (IMF, 2013, p. 1). Drawing from these insights, the reform of health budget cuts seems rather contradictory to the objective of achieving financial sustainability.

With regard to the introduction of co-payment in Greece, section 4.2.2 elaborated that EU stakeholders did not object the application of co-payment schemes. In fact the Joint Report on health systems presents it as a best practice to channel patients to make use of less cost-intensive primary care (European Commission & Economic Policy Committee, 2010, p. 152) Also it is generally wide-spread among MSs, with 23 of the EU-27 having installed some form of cost-sharing. But 18 of these are found to apply this system ineffectively (Ibid., p. 86). Still the Commission Communication ‘On effective, accessible and resilient health systems’ voices that “co-payment [...] can help ensure that health services are used responsibly” (European Commission, 2014c, p. 9). The second MoU of 2012 comments that “the increase in co-payments [in Greece] aims at reducing unnecessary demand for healthcare services”, but concedes that “increase in costs borne by patients has amounted to a small fraction of the overall reduction in costs” only. (DG Economic and Financial Affairs, 2012, p. 9). In conclusion, even though the effectiveness of the reform may have to be investigated further, it can be considered as somewhat synergetic towards reaching financial sustainability.

E-health is apparently the reform that the EU is promoting most ambitiously, also outside of the bailout context. Referring back to section 4.2.3 this policy tool is praised in terms of efficiency gains that could be achieved. From the side of EU actors, e-health thus seems to be considered as a legitimate tool to achieve long-term fiscal sustainability. Scholars seem to have a different view on this, finding that because of the high instalment costs it is “questionable whether investment in large-scale e-health projects should be a priority for health systems facing serious financial problems” (Baeten & Thomson, 2012, p. 201). And also the EU health policy forum finds that e-health solutions should be closely reviewed in terms of cost-efficiency, as technological process is one of the main cost-drivers in the health sector (EU Health Policy Forum, 2013, p. 16). These objections only apply to short-term costs, though. Also, it may be misleading to evaluate e-health as a package, as for example the introduction of e-prescriptions “has streamlined a previously inefficient system” (McKee, et al., 2012, p. 349). Thus a weak synergy is concluded.

Examining the coherence in enforcing a greater share of generic pharmaceuticals with sustainability of finances, a clear synergy can be outlined. As concluded in section 4.2.4. the use and increase of generic pharmaceuticals is widely promoted among EU stakeholders, in particular with regard to enhancing cost-effectiveness and creation of savings. Additionally, the EU Health Policy Forum – a pan-European organization of health sector stakeholders – rather criticizes the Commission for not being explicit enough in asserting the benefits of generics in its SWD ‘Investing in Health’ (EU Health Policy Forum, 2013, p. 6). Baeten and Thomson even call increasing the use of pharmaceuticals the ‘low-hanging fruit’ of efficiency gains, as they are considered “relatively easy targets”, while sustainable efficiency on the whole “rarely comes at a low cost” (2012, p. 202, 205). A study from 2012 furthermore presents evidence that public drug expenditure decreased from € 5.09 billion in 2009 to € 4.10 billion in 2011 (Ifanti, et al., 2013, p. 10). Overall evidence depicts a strong synergetic relation of this reform towards the EU goal of financial sustainability in health care.

Section 4.2.5. addressed the question how EU stakeholders supported the use of DRG-based reimbursement systems in hospitals. Apparently, while not necessarily pushing the original DRG-system, it showed a clear trend toward case based reimbursement procedures which are usually closely linked to DRGs. In particular in comparison with per diem payment schemes, the benefit of cost-effectiveness is emphasized here. This assumption is only partially backed by scientific findings. In an EU funded study from 2009 to 2011 it was found, that efficiency gains were observed in some countries, but not in all. The authors sum up the results saying that “DRG-based hospital payment systems have had a somewhat positive effect on efficiency” (Busse, et al., 2011, p. 153). With regard to Greece, a study overlooking the 2012 testing phase of the newly introduced DRGs found that the system was working as expected with the exception of a few regulatory deficits. These have already been met with corrective action, though (Polyzos, et al., 2013, p. 17). In contrast Niakas found that the system “is resulting in a 30 percent increase in reimbursement prices of public and private hospitals and is expected to create more debt for the new Fund, above the current 2.8 billion euros” (2013, p. 598). But overall, long-term developments will only be reviewable in a few years, as the system will become fully operational in 2015 only. Summing up the findings, DRG systems seem, with some exceptions, to be recognized as fairly useful with regard to achieving efficiency gains and thus work towards financial sustainability.

4.3.2.2. Universal access to health

Every individual in the EU is entitled to access of health care, as laid down in Art. 35 of the EUCFR. This is what the EU’s overarching goal of universal access to health refers to, but also

equity in access is part of this right. However, access to health care is difficult to measure, and so far no standardized approach exists on EU level. Most data derives from self-rated criteria of residents, wherein for 2012 Greek citizens reported above-average²⁰ unmet needs of medical examinations mostly due to high costs (European Commission, 2014c, p. 8). The EC defines universal access to health care as an interaction between factors such as health insurance coverage, depth of coverage, affordability of care and availability of care (Ibid.).

The economic adjustment programme for Greece stated that the “objective is to [...] keep public health expenditure at or below 6 percent of the GDP, while maintaining universal access” (DG Economic and Financial Affairs, 2011, p. 28). Baeten and Thomson express their doubt on “how large cuts in public spending on health can be reconciled with the objective of ‘maintaining universal access [...]’” (2012, p. 202). Regarding the maintenance of universal access to care, some studies have presented evidence that the share of citizens falling out of social benefit schemes has become larger. Gaffney observed that “Reliance on ‘street clinics’ and charitable care, which previously had been used primarily by illegal immigrants without access to the public system, became more common” (2013, p. 14). And Kentikelenis et al. comment that “officials have denied that vulnerable groups (e.g. homeless or uninsured people) have been denied access to health care, and claim that those who are unable to afford public insurance contributions still receive free care” (Kentikelenis, et al., 2014, p. 751). But it is very difficult to establish a direct link on how health budget cuts may be beneficial to achieving greater equity in access in Greece; or the other way around, how the health budget cuts themselves may be the immediate cause of worsening access to health. After all, it is the Greek administration that ultimately decides on where and how these cuts are to be allocated. Therefore the coherence is rated as non-measurable.

Turning once more to the introduction of co-payment schemes, there is a closer connection with impacts on accessibility of care. As stated in section 4.2.2. it was clear that from the perspective of EU actors, the introduction of co-payment schemes was deemed appropriate under the condition of maintaining the principle of universal access to health. The mere conditionality of saying that co-payments should only be introduced ‘as long as’ they don’t inhibit universal access, lays up how prone this policy is to do exactly that. Moreover, this policy is clearly put in place with the primary objective to achieve cost-savings, not to enhance accessibility. In the SWD ‘Investing in Health’ the DG SANCO calls for thoroughly reviewing the possible

²⁰ Greece ranks in sixth place, after Latvia, Romania, Poland, Estonia and Bulgaria (European Commission, Communication from the Commission - On effective, accessible and resilient health systems COM(2014)215 final, 2014, p. 8).

consequences, saying that “Measures such as those that increase co-payments risk aggravating the economic hardship borne by vulnerable populations by reducing access to healthcare.” (DG SANCO, 2013, p. 18). Equally, scholars voice concerns on the effects of this reform. Clemens, Michelsen and Brand see contradiction in the Structural Funds investments in health infrastructure, when imposed austerity measures – such as the introduction of co-payments – “are limiting access to health care overall and increasing health inequities further” (2014, p.58). McKee and colleagues state that the benefits of introducing user charges are “not supported by evidence” (McKee, et al., 2012, p. 349). Kentikelenis lists the numerous fees introduced²¹ over the course of reforming the health care sector, concluding that these have “created barriers to access” (2014, p. 749). Additionally, Milionis states that the “transfer of a portion of public health expenses to private individuals [...] acts in an inhibitory manner on the right for equal access to healthcare services and products” (2013, p. 23). Summarizing this information, the introduction of user charges is considered as counterproductive for reaching universal access to care.

Among the reforms reviewed in this thesis, e-health has clearly been the one promoted the strongest by the EU. But in the context of achieving universal access to health, this does not follow quite as obviously. The argumentation for establishing e-health as retraced in section 4.2.3. is focused mainly around achieving efficiency gains and less about improving access to care. And this is reflected perfectly when trying to find arguments on how e-health can indeed ameliorate access to the health system. The only indication of it being beneficial towards equity in access was found in the context of cross-border health care, where however “inter-operability has remained a major obstacle as, for instance, the case of the European Health Insurance Card shows” (Vollard, Bovenkamp, & Vrangbaek, 2013, p. 228). Apart from this, none of the reviewed EU or academic documents list benefits or drawbacks of this reform for access to care. Accordingly, the coherence score will be marked as ‘non-measurable’ with a slight positive tendency.

The Joint health care report of the EC and the EPC states that generics are an increasingly important topic, as an increased use of these can achieve both significant expenditure savings,

²¹ Kentikelenis et al. summarize them as follows: “In 2011, user fees were increased from €3 to €5 for outpatient visits (with some exemptions for vulnerable groups), and co-payments for certain medicines have increased by 10% or more dependent on the disease. New fees for prescriptions (€1 per prescription) came into effect in 2014. An additional fee of €25 for inpatient admission was introduced in January 2014, but was rolled back within a week after mounting public and parliamentary pressure. Additional hidden costs—eg, increases in the price of telephone calls to schedule appointments with doctors” need to be taken into account (Kentikelenis, Karanikolos, Reeves, McKee, & Stuckler, 2014, p. 749).

as well as grant better access to health (European Commission & Economic Policy Committee, 2010, p. 129). In accordance with this, EU stakeholders have widely promoted the use of generic pharmaceuticals and provided a number of policy tools (e.g. positive lists for reimbursement or greater user charges for original medicine) on how to implement this best. Nevertheless, the link between pushing a greater share of pharmaceuticals and improved access to care remains blurry after reviewing the chosen documents. Falling back onto the Commission communication ‘On effective, accessible and resilient health systems’, the following criteria for accessibility are laid out: insurance coverage (share of population), depth of coverage, affordability, and availability of care (European Commission, 2014c, p. 8). Taking these into account, possible benefits become apparent. If the use of generics is promoted through e.g. positive reimbursement lists, this limits down the out-of-pocket payments that patients might have to carry out, reducing financial barriers. On the other hand the availability of pharmaceuticals has been problematic in Greece, in particular throughout the course of the crisis. Parallel export driven by the lowered prices for pharmaceuticals has led to severe shortages of medicinal products in Greece (Ifanti, et al., 2013, p. 10). The coherence of this reform with achieving universal access is apparently difficult to assess, as both positive and negative developments are brought forth. For this reason, coherence is scored as ‘non-measurable’.

Lastly, the coherence between the introduction of the DRG-based reimbursement system and the objective of achieving universal access to care is reviewed. As apparent in section 4.2.5. the primary goal of this reform is to achieve more efficient treatment in hospitals, discouraging unnecessary procedures. This reform therefore affects primarily hospital personnel in charge of ordering the specific treatments. To no surprise, the document analysis did not produce any indications on what effects a DRG-based reimbursement may have on the accessibility of health care systems. According to Cots and colleagues DRG systems encompass three incentives, namely reducing cost per patient, increase revenue per patient and increase number of patients (2011, p. 82). The effects can go both ways though – while personnel may be discouraged to undertake unnecessary treatment that will not be reimbursed, they may also refrain from necessary treatment that has already been paid for or discharge patients early to create savings. Also hospitals may select ‘low-cost patients’ while avoiding or transferring unprofitable cases (Ibid., p. 83). Taking this into account, while also no specific information on the effectiveness of the DRG system of Greece is yet available, the link will be scored as ‘non-measurable’.

4.4. Results

Summarizing the findings from the analysis, the screening matrix shows the following results:

	Policy Coherence		
	Interaction	Coherence with Objectives	
Policy Tools		Financial Sustainability	Universal Access
Budget Cuts	0/+1	-1	0
Co-Payment	+1	+1	-1/-2
E-health	+2	+1	0/+1
Generics	+1/+2	+2	0
DRGs	+1/+2	+1	0

Interaction of EU stakeholders with the reforms stipulated in the bailout programme is rated as evident in the most cases, in particular concerning the last three reforms. This stronger interaction is mainly attributed to the work of the TFGR on these issues. Overall, this dimension was difficult to be assessed as corresponding documents regarding the working process of the Troika or the TFGR are not available. The coherence dimension was easier to be assessed, at least with regard to financial sustainability. This makes sense in so far as the bailout agreement is put in place to achieve financial sustainability. Apparently, the other objective of achieving or maintaining universal access is not of primary concern in the bailout programme, as in most cases there was no indication on how the specific reform could help or hinder access to health care.

5. Conclusion

How are these findings to be interpreted in the light of the research question? The method of Nilsson et al. (2012) aims at laying up conflict and synergy at the level of policy objectives and policy instruments. For the level of policy objectives, it can be concluded, that these have been quite static over the past years. Laid down in 2006, the common objectives for health policy are still referred to in many documents. Of the original three objectives, two were explicitly and repeatedly referred to in the reforms reviewed in this thesis: sustainable financing of health care and universal access to care. The objective of quality in care was not prioritized. As Nilsson and colleagues have stated, the conflict between objectives and implementation practices usually becomes evident “in the selection of instruments and how these instruments are applied” (Nilsson, et al., 2012, p. 399). This is not so much the case for the various EU stakeholders. The analysis section dealing with the inventory of policy objectives found the different actors involved to be rather unanimous on how they appraised e-health, generic pharmaceuticals and

DRGs in the light of the stated policy objectives. With co-payments, opinions differed on the ‘universal access’-dimension. Only with regard to budget cuts differing opinions occurred on both examined dimensions. This falls very much in line with the considerations of Greer (2006), Lamping and Steffen (2009), Baeten and Thomson (2012) and Clemens, Michelsen and Brand (2014) implying the emergence of a consistent European health discourse. Summarizing this information a first conclusion can be drawn:

1. The assumption of a coherent health policy approach at the EU level is fairly accurate.

This may very well be for the increasingly strong role that the EC is playing in spelling out the course of action. In particular the rather recently established macroeconomic surveillance mechanisms have granted the Commission further channels to dictate reforms in the health sector. But while coherent policy objectives seem to exist at EU level, these have undergone a shift in focus. Looking at the policy coherence scores, a very clear focus of the reforms in achieving financial sustainability was laid up. This is not necessarily surprising for a policy package that has been established for fiscal consolidation in the first place. Much more interesting is the interplay of the different dimensions. In tendency, where a cause-effect relationship between the EU and the bailout reform was established, coherence was generally greater. The exception from this finding is the health budget cut at 6% of the GDP. Indeed, cuts in social policies have been conditional to IMF bailout programmes in many developing countries. And also an inquiry of the EP on the working process of the Troika has noted that the IMF’s stated objective was ‘internal devaluation’ which was never endorsed by the EC or the ECB, who rather aimed for fiscal consolidation (Committee on Economic and Monetary Affairs, 2013, p. 8). This may be an explanation why this reform falls out of line in both dimensions of coherence with EU objectives. The results concerning the dimension of ‘universal access’ seems to give little away, as the coherence is mostly marked with ‘0’. It was therefore clearly not a priority, and additionally most reforms increasing accessibility may be linked to additional costs. On the other hand, the reforms chosen – apart from the introduction of co-payment – have not been found as detrimental to achieving or maintaining access to health care. In summary the findings support the view, that the bailout programme is first and foremost an economic rescue measure. However, the review of EU documents in the light of policy interaction has shown, that the EU has become more precise in its published policy documents and the reforms stimulated in the frame of the European Semester are closely linked to the reforms of the bailout agreement. Apparently – just as Fierlbeck (2014) and Clemens and colleagues (2014) observed – the focus of EU activity in health has overall shifted its focus on financially sustainable health systems, neglecting quality of care and equity in access

somewhat. The Second Programme of Community Action in the Field of Health of 2008-2013 is the most obvious exemplification, as it concentrates explicitly on MS's health care systems in terms of financial sustainability (Lamping & Steffen, 2009, p. 1354). This could explain the promotion of co-payment despite its acknowledged detrimental effects on access to care. Overall this clearly affirms the hypothesis built in the beginning of this thesis. The second conclusion therefore is:

2. The bailout agreement is coherent with the EU's residual health policy efforts.

5.1. Excursus: State of EU involvement in health policy

As this thesis focused around a case study of Greece it is not possible to draw inferences across Europe. Nevertheless, there are some indications on the role the EU is nowadays playing in health policy. In his 2012 published commentary article Fahy anticipated, that the EU might take the economic crisis as an opportunity to stricter influence on national health systems (2012, p. 2). He expected the requirements laid out in bailout programmes to become the yardstick on how the EU would shape national health systems from now on. And indeed, this thesis has presented evidence, that the EU is on the one hand highly involved in the reforms implemented in Greece and that on the other hand, numerous documents (reports, conclusions, SWD's (soft-law), as well as AGS and CSRs (hybrid)) are postulating similar policy tools. And while in 2009 Lamping and Steffen, described the integration process in health as 'patchy' and 'accidental', this is not evident in the reforms reviewed. Rather EU stakeholders in some cases seem to refrain from taking a clear stand (e.g. in health budget cuts or co-payment) to avoid conflict with national competencies, but tacit consent exists. As Lamping observed "governments have been willing [...] to transfer competencies to a higher level when facing critical junctures" (Lamping & Steffen, 2009, pp. 1363-1364). In this spirit the analysis has shown, how in the course of the crisis, the EU – in particular the EC – has established itself as a strong actor in health policy that interferes with national health policies way over merely addressing public health. With the crisis as a window of opportunity, the EU has successfully created a precedent for legitimizing stronger involvement in health policies. And in addition to that, it has gained momentum in being more precise and explicit in the policy tools it promotes.

5.2. Strengths and weaknesses of the method

The aim of the thesis was to understand more clearly the role of the bailout programme within the compound of the EU's whole health policy activities. Most of the academic articles in this field have used a purely explorative approach in understanding European health policy. Falling back onto a methodological approach for analyzing policy coherence granted a strong frame of

reference, both for the steps to undertake, as well as on how to summarize the findings (i.e. by translating them into numbers). However, this mechanism has also created some pitfalls. First of all, this relatively new approach has not been applied very broadly, yet. Thus for some passages where the approach was not explained as precisely – e.g. how to interpret policy-interaction – there was no point of reference. Also, albeit the final coherence score table is very useful as an overview, it should not be the single basis for drawing conclusions. Both the step of translating the evidence into numerical scores, as well as translating the scores back to results is very likely to create distortion of the evidence. Therefore, the focus needs to remain clearly on the quantitative document analysis. As always with content analysis, the choice of documents is the decisive factor for the outcome. The restraints of this thesis vis-à-vis the vast field of health policy do imply that the selection of documents was by chance and not representative. Especially in the case of bailout programmes, documents are for the most part inaccessible for the public. Despite efforts of the European Parliament to investigate the legitimacy of the work of the Troika since end-2013, the roles of the different stakeholders are not outlined clearly. Moreover, content analysis deals with linguistic representation of ideas and opinions. One of the major difficulties to be dealt with is the high degree of “linguistic ambiguity” evident in EU documents (Lamping, 2012, p. 74). However, within the existing body of knowledge available on EU health policy, the results of this thesis connect fairly well. This can be seen as an indication for reliability of the results.

5.3. Implications for further research

Firstly, this thesis has reviewed only five of the reforms of health care called for in the bailout agreement. To complete and fully test the findings, a coherence analysis for the remaining reforms would be appropriate. In addition to that, a comparison of developments in the other bailout countries (Portugal, Ireland and Cyprus) should be considered. Moreover, this thesis has featured merely a case study of Greece and thus it is difficult, if not impossible to draw inferences on the future of European health policy. But indications are strong for the EU pushing interoperability among health systems, not only in the frame of cross-border health care. Having that in mind, a pan-European longitudinal study of convergence in health systems could produce a more in-depth understanding of the impact of EU health policies at the national level. Furthermore, this thesis has presented strong evidence for the EU exceeding more and more the competences in health policy formally granted by the treaty provisions. From a legal perspective, the question of legitimacy of current EU action in health should therefore be closely reviewed.

Lastly and most strikingly the analysis section of this thesis did not produce any indication of which policy adaptations are causing the severe health crisis Greece has been left with since the reform of the health sector has been initiated. That the Troikas involvement is somehow linked to it seems evident, but could not be supported in the review of reforms undertaken in this thesis. Greece has been merely left with the requirement to stabilize health expenditure at below 6% of the GDP, without guidance on how to reach this. And as Kentikelenis et al. (2014, p. 748) cite the former Minister of Health, Andreas Loverdos, “the Greek public administration...uses butcher’s knives [to achieve the cuts]”. It seems the Troika does not want to be held responsible for these outcomes. It is clearly necessary to investigate further the mandate of EU and IMF actors and to create transparency in this process. The efforts of the European Parliament to lay up the working procedures of the Troika are welcomed, but apart from that the rights and obligations of the stakeholders involved in the bailout process need to be clearly outlined. Academic research may help to expose shortcomings and failures of the current mechanisms, forcing decision-makers to reorganize crisis responses for the future.

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7. Appendix A: Dataset

Stakeholder	Document	Type of Source	Date of Publication	Official Document Number	Keywords	URL
EC	Directive on the community code relating to medicinal products for human use	Directive	2001	2001/83/EC	generic pharmaceuticals	http://ec.europa.eu/health/files/eudralex/vol-1/dir_2001_83_consol_2012/dir_2001_83_cons_2012_en.pdf
EC	Commission Decision of 17 December 2002 further clarifying annex A to Council Regulation (EC) No 2223/96 as concerns the principles for measuring prices and volumes in national accounts.	Decision	2002	C(2002) 5054	DRGs	http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32002D0990
EC	Communication from the European Commission to the Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: A Digital Agenda for Europe	Communication	2010	COM(2010) 245 final	e-health	http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0245:FIN:EN:PDF
EC	Proposal for a regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period of 2014-2020	Proposal	2011	COM(2011) 709 final	health budget cuts	http://ec.europa.eu/health/programme/docs/prop_prog2014_en.pdf
EC	Recommendation for a Council Decision amending Decision 2011/734/EU addressed to Greece with a view to reinforcing and deepening fiscal surveillance and giving notice to Greece to take	Recommendation	2012	COM(2012) 116 final	Co-payment	http://ec.europa.eu/economy_finance/economic_governance/sgp/pdf/30_edps/104-09_commission/2012-03-09_el_126-9_commission_en.pdf

	measures for the deficit reduction judged necessary to remedy the situation of excessive deficit					
EC	Recommendation for a Council Recommendation on the implementation of the broad guidelines for the economic policies of the Member States whose currency is the Euro	Recommendation	2012	COM(2012) 301 final	health budget cuts	http://ec.europa.eu/europe2020/pdf/nd/csr2012_euroarea_en.pdf
EC	Communication from the Commission to the Council. Follow up to the Council Decision 2011/734/EU of July 12 2011 addressed to Greece, with a view to reinforcing and deepening fiscal surveillance and giving notice to Greece to take measures for the deficit reduction judged necessary to remedy the situation of excessive deficit	Communication	2012	COM(2012) 739 final	health budget cuts	http://ec.europa.eu/economy_finance/economic_governance/sgp/pdf/30_edps/communication_to_the_council/2012-11-30_el_communication_en.pdf
EC	Communication from the Commission: Annual Growth Survey 2013	Communication	2012	COM(2012) 750 final	health budget cuts	http://ec.europa.eu/europe2020/pdf/ags2013_en.pdf
EC	Commission Staff Working Document: eHealth Action Plan 2012-2020 – innovative healthcare for the 21 st century	SWD	2012	-	e-health	http://ec.europa.eu/digital-agenda/en/news/commission-staff-working-document-ehealth-action-plan-2012-2020-%E2%80%93-innovative-healthcare-21st
EC	EU policy for eHealth	Online Source	2014	-		http://ec.europa.eu/digital-agenda/en/eu-policy-ehealth
EC	Communication from the Commission – On effective, accessible and resilient health systems	Communication	2014	COM(2014) 215 final	co-payment, universal access to health, generics	http://ec.europa.eu/health/healthcare/docs/com2014_215_final_en.pdf

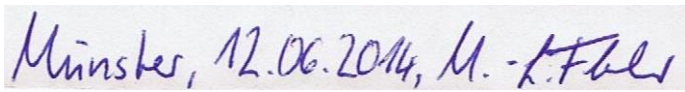
EC (DG Communication)	The EU explained: Public Health	Publication	2013	-	e-health	http://ec.europa.eu/health/health_policies/docs/improving_health_for_all_eu_citizens_en.pdf
EC (DG Economic and Financial Affairs)	The economic adjustment programme for Greece. Third review – winter 2011	Report	2011	Occasional Papers 77	health budget cuts, co-payment, e-health, generic pharmaceuticals, DRGs	http://ec.europa.eu/economy_finance/publications/occasional_paper/2011/pdf/ocp77_en.pdf
EC (DG Economic and Financial Affairs)	The second economic adjustment programme for Greece March 2012	Report	2012	Occasional Papers 94	health budget cuts, co-payment, e-health, generic pharmaceuticals, DRGs	http://ec.europa.eu/economy_finance/publications/occasional_paper/2012/pdf/ocp94_en.pdf
EC (DG Economic and Financial Affairs)	The second economic adjustment programme for Greece. Fourth review – April 2014	Report	2014	Occasional Papers 192	health budget cuts, co-payment, e-health, generic pharmaceuticals, DRGs	http://ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp192_en.pdf
EC (DG SANCO)	Commission Staff Working Document: Social Investment Package - Investing in Health	SWD	2013	-	co-payment, e-health, generic pharmaceuticals, DRGs	http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf
EC (TFGR)	Quarterly Report December 2012	Report	2012	-	e-health	http://ec.europa.eu/commission_2010-2014/president/pdf/qr3_en.pdf
EC (TFGR)	Second Quarterly Report March 2012	Report	2012	-	role of the TFGR	http://ec.europa.eu/commission_2010-2014/president/news/speeches-statements/pdf/qr_march2012_en.pdf
EC, ECB and IMF	Memorandum of Understanding on Specific Economic Policy Conditionality	MoU	May 2010	-	bailout arrangements	https://www.imf.org/external/np/loi/2010/grc/080610.pdf
EC, ECB and IMF	Memorandum of Economic and Financial Policies	MoU	May 2010	-	bailout arrangements	https://www.imf.org/external/np/loi/2010/grc/080610.pdf
EC, ECB and IMF	Second Economic Adjustment Programme	MoU	March 2012	-	bailout arrangements	http://ec.europa.eu/economy_finance/publications/occasional_paper/2012/pdf/ocp94_en.pdf

EC and EPC	Joint Report on health systems	Report	2010	Occasional Papers 74	co-payment, generic pharmaceuticals, DRGs	http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf
EC and SPC	Joint Report on Social Protection and Social Inclusion	Report	2010	-	health budget cuts	http://ec.europa.eu/social/BlobServlet?docId=4665&langId=en
Council	Council Decision addressed to Greece with a view to reinforcing and deepening fiscal surveillance and giving notice to Greece to take measures for the deficit reduction judged necessary to remedy the situation of excessive deficit	Decision	2011	(12352/11)	Health budget cuts, co-payments, e-health, generic pharmaceuticals	http://www.eurozone.europa.eu/media/migrated/596078/council_decision_greece_12_july_11.pdf
Council (EPSCO)	Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border health care	Proposal	2009	2008/0142 (COD) Version 7379/09	co-payment	http://www.dkgev.de/media/file/5682.rs082-09_anlage3.pdf
Council (EPSCO)	Council conclusions: Towards modern, responsive and sustainable health systems	Conclusion	2011	-	Co-payment, generic pharmaceuticals, universal access to health	http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/122395.pdf
Council (ECOFIN)	Council conclusions on the EPC- Commission report on health systems in the EU	Conclusion	2010	-	Co-payment	http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/ecofin/118273.pdf
EP (ENVI)	Report on the eHealth Action Plan 2012-202 – Innovative healthcare for the 21 st century	Report	2014	A7-0443/2013	e-health	http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A7-2013-0443+0+DOC+PDF+V0//EN
EP (Committee on Economic and	Enquiry report on the role and operation of the Troika (ECB, Commission and IMF) with regard to the euro area programme countries	Draft Report	2013	2013/2277(INI)	role of the Troika	http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML%2BCOMPARL%2BPE-526.111%2B01%2BDOC%2BPDF%2BV0//EN

Monetary Affairs)						
European Economic and Social Committee	Opinion on the ‘Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: Safe, innovative & accessible medicines: a renewed vision for the pharmaceutical sector’	Opinion	2009	-	generic pharmaceuticals	http://eescopinions.eesc.europa.eu/viewdoc.aspx?doc=ces/int/int478/en/ces1456-2009_ac_en.doc
IMF	IMF Country Report 13/156 – Greece: Ex-post evaluation of exceptional access under the 2010 stand-by arrangement	Report	2013	-	health budget cuts	http://www.imf.org/external/pubs/ft/scr/2013/cr13156.pdf

Declaration of Academic Honesty

I hereby declare that the present bachelor thesis is solely my own work, and that if any text passages or diagrams from books, papers, the Web or other sources have been copied or in any other way used, all references – including those found in electronic media – have been acknowledged and fully cited.



Münster, 12.06.2014, M.-L. Fabel

(Place, Date, Signature)