# Administrative Capacity Building in a Turbulent Environment

## *-The Implementation of a Health Strategy in Romania-*

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# Abstract

This paper examines the process of administrative capacity building (ACB) through the practical implementation of EU structural reforms in Romania in the post-accession context. It particularly focuses on capacity building within the health system by local administration forces at the local level in the city of Cluj-Napoca. This multi-level process is approached with an innovative theoretical design combining Europeanisation theory with the literature on the practical implementation of EU-driven reforms and administrative capacity building in developing countries. Theoretically, the lack of administrative capacity in the Romanian health system is expected to hamper practical implementation. Local political support and the application of tailor-made strategies by a professional administrative apparatus are expected to increase the likelihood of efficient practical implementation of ACB. This descriptively explorative research uses the country-specific recommendations of the European Semester, the national- and local health strategies, to examine the implementation process of the ACB. In addition, key experts were interviewed to study in detail the practical implementation in Cluj-Napoca. The analysis provides evidence that the centralised health system severely limits the capacity of local administrations to practically implement EU structural reforms. It also reveals that political will is a crucial factor in shaping the local reform's practical implementation.

# List of Abbreviations

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| **ACB** | Administrative Capacity Building |
| **CEE** | Central and Eastern Europe |
| **CEEC** | Central and Eastern European Countries |
| **CSR** | Country-Specific- Recommendations |
| **ECJ** | European Court of Justice |
| **ESI** | European Structural and Investment Funds |
| **ESF** | European Social Funds |
| **EU** | European Union |
| **NHS 2014-2020** | National Health Strategy 2014-2020 |
| **PD** | Process Determinants |
| **RC** | Reform Components |
| **RCD** | Reform Component Determinants |
| **WHO** | World Health Organization |

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# 1. Introduction

## 1.1 Issue and Literature Review

The Central and Eastern European Countries (CEEC) are rich in culture, history, and languages. If one looks at the European media today, different CEEC accordingly produce a wide variety of news. Estonia is commonly known as the European best practice for digitizing a country. In contrast, the Polish government violates European law by undermining the judicial system through political control (Commission, 2017). The Republic of Northern Macedonia has just agreed on the name of its state. The message is clear. Although the broad spectrum of these countries shares a communist heritage, their transition processes have been marked by difference since 1990. These differences come to the surface analysing the country's abilities to implement and properly execute reform endeavours. The European Union (EU) plays a key role in supporting and actively managing the transition processes under the operational leadership of the Copenhagen criteria of 1993. This transition dynamic culminated in the EU's Eastern enlargement in 2004 with the accession of eight former communist CEECs to the Union. The overall accession was preceded by a long-lasting adaption procedure of the countries aiming at the successful transposition of the acquis communautaire into national law (Schimmelfennig & Sedelmeier, 2005).

Three years later, 2007, Romania and Bulgaria joined the EU. These former communist countries had to go an even longer way until they could finally join the Union. The delayed point of entry was mainly due to the serious challenges of both countries to reform their judicial system and fight corruption. Twelve years later, both Member States still face severe problems in fulfilling EU requirements. Notwithstanding, the Romanian government has held the Council Presidency of the European Union for the first time in the first half-year of 2019. This event has thrown the spotlight of the European public on the state and on its government. The Romanian government is faced with demonstrations that loudly condemn the prevalent corruption of the public system as well as serious performance problems in the healthcare sector. In Romania, informal payments to doctors and nurses are still offered by patients out of fears to otherwise not receive the needed medical treatment (Moldovan & Van de Walle, 2013). Additionally, the life expectancy of the population and the number of healthy life years are both far below the EU average (Eurostat, 2019). In this vein, it is of importance to understand the dynamics of Europeanisation and European policy implementation driven by domestic

administrations to find solutions for pressing public problems. This thesis addresses the public problem of Romanian's dysfunctional healthcare systems.

The study of the implementation of public policy has attracted many researchers of public administration and political science, starting with the founding work of Pressman and Wildavsky (1974). In particular, the process of EU policy implementation offers the possibility to investigate the effects of the implementer's environment on the actual policy outcomes. The first attempts of scholars to study the effects of domestic systems on the implementation performance broadly used the goodness-of-fit theory which was however not able to sufficiently explain the implementation outcomes. Consequently, other scientists started to more narrowly analyse the implementer's preferences and implementation actions (Knill & Lenschow, 1998). Still, in the last years, scholars of Europeanisation mainly highlighted the role of legal compliance of national law with EU policies (Treib, 2014). This top-down approach of EU implementation considered the idea of discretion and implementation deviations at the national level as an obstacle to effective policy implementation (Thomann & Sager, 2017a). Nevertheless, the studies of a multi-level governance system's influence on the implementation of EU policies presented the finding that legal compliance tends to be decoupled from the actual practical application under specific circumstances (Zhelyazkova, Kaya, & Schrama, 2016). These highly distinctive patterns of Europeanisation were framed in the literature as Customisation. Thus, aiming to understand the phenomena of domestic factors and Europeanisation, scholars began to treat these phenomena as rather complementary and more often applied multi-sectoral as well as interdisciplinary-oriented approaches to tackle these analytical problems (Thomann & Sager, 2017a). Domestic factors of policy implementation necessarily include the study of administrative capacities. Administrative capacities according to El-Taliawi and Van Der Wal (2019: 2) matter because the "successful implementation of government initiatives requires capable organizations". These capacities, however, must be build first. Nonetheless, the analysis of these issues in CEECs is very limited (Falkner & Treib, 2008). The exploration of the process of administrative capacity building (ACB) in the local Romanian healthcare sector constitutes the main task of this thesis. pap

## 1.2 Scientific and Societal Relevance

The ongoing underperformance of the Romanian healthcare services raises serious questions about the sustainability and effectiveness of the healthcare system and the implementation of EU health policies. The Romanian government, strongly being forced to act, has put forward a National Health Strategy 2014-2020 reacting to the external pressure by the EU and the World

Bank (Popescu, 2015). "However, the lack of administrative capacity was delaying implementation of the 2014-2020 national health strategy"(Moarcas, 2018: 2). Thereof, the thesis intends to contribute to the understanding of ACB within the healthcare system and its shortcomings by analysing the actions of the local authorities of Cluj-Napoca in this sector. Ultimately, an in-depth understanding of the local dynamics and capacities helps to design policies and reforms properly for the challenges at the street-level. This thesis is therefore predominantly concerned with the practical consequences for local public management. Nonetheless, the insides gained are subsequently of a tremendous public relevance as ACB is the crucial prerequisite for successful implementation of system reforms. Only in this latter case, effective and impartial health services can be delivered to the people. Hereby, the thesis contributes to the third sustainable development goal of "ensur(ing) healthy lives and promote well-being for all at all ages" (United Nations, 2018). Thus, the societal relevance of the thesis arises.

This study aims to contribute to the state of art in a threefold way. First, it applies the analytical tools of the practical implementation literature in a CEE country, namely Romania. Although, scholars of Europeanisation have extensively studied the post-accession compliance and its explanatory factors in Romania, qualitative data-based research of practical implementation on the street-level remains understudied in the English and German academic literature. In this vein, this thesis lays the foundation to explore the actions of Romanian local administrative forces to solve public problems within a deficit health system. Administrative capacity is seldom used as the main concept in Europeanisation literature. It rather serves as an intervening or explanatory factor. Administrative capacity is particularly used to study implementation performance. Administrative capacity also must be constructed, which is one main aim of the healthcare system reforms and requires time and effort by its builders. Consequently, this study takes an innovative approach by exploring ACB through practical implementation of EU structural reforms rather than taking it exclusively as an explanatory or intervening factor for implementation performance. Thirdly, by conducting a deviant case study in the course of an exploratory research question, this thesis can provide the fundament for more extensive explanatory approaches in the field. Thus, the thesis has a strong scientific relevance.

## 1.3 Research Question

The thesis aims to answer this research question:

> *Which consequences does the practical implementation of EU health system reforms by local administrative forces have on the administrative capacity building in the health system of the city of Cluj-Napoca (Romania) under EU-post-accession monitoring from 2011 to 2018?*

This empirical, mainly descriptive exploratory research question constitutes the fundament for this thesis. As it lies in the explorative nature of the question, a specific theoretical grounding is not given. In this regard, the first sub-question (*SQ*) provides the opportunity to review literature of distinctive fields of research on this topic. This enables to retrieve first theoretical expectations. The timeframe was chosen based on two reasons. The financial crisis of 2008 has led to serious consequences for health policy making and marked a break within the development of the country (Duguleană, 2011). Therefore, it is important to examine the problem-solving capacity of local authorities in the critical post-crisis time for which Commission monitoring documents are available. Additionally, the European Semester documents as an EU post-accession monitoring tool were firstly introduced in 2011 as part of the Europe 2020 strategy. These documents provide in-depth information about the Romanian healthcare system. Besides that, the European Semester reports contain action recommendations for the necessary reforms to be made to improve the system aiming to meet the EU's standards. It is crucial to examine these reform components to get information about the reform content as no specific policy is at hand. This is aimed to be generated in answering the second sub-question. In the next step, the actions of the local administrative forces must be studied following the third and fourth sub-question. These latter questions are of a descriptive nature which in combination build the fundament for the exploration. The process of answering the question is executed under the awareness that further unexpected information can come up during the data collection which are not covered by the questions.

These sub-questions help to firstly structure the theory part of the bachelor thesis as well as the forthcoming empirical analysis.

1) What is known from the literature about the impact of local administrative forces on the construction of administrative capacity through the practical implementation of EU reforms on the local level?

2) What are the main necessary reform components of the Romanian health system as addressed by the European Commission in order to build up administrative capacity in the local health system?
3) What administrative capacity building measures are integrated into the Cluj-Napoca Local Strategic Development Plan for Health?
4) How is the process of local administrative capacity building described and what are the main elements?

## 1.4 Structure of the Thesis

The first chapter introduces the reader to the issue of the thesis. It states the scientific and societal relevance as well as contains the research question and sub-questions. The second chapter provides the theoretical foundations combined with theoretical expectations and familiarises the reader with the concepts retrieved from the research question. Chapter 3 sets out the methodology applied. In Chapter 4, the analysis is presented. Chapter 5 then firstly discusses the exploratory findings by juxtaposing these and the theoretical expectations in opposition. Finally, chapter 6 concludes this thesis.

# 2. Theory

The following chapter explains the theoretical basis for the study. The phenomena of Europeanisation, practical implementation and administrative capacity building resulting from the research question are presented based on a literature review. This is done to provide an initial theoretical orientation in this understudied field and thus to formulate theoretical expectations as a starting point for the subsequent discussion of the topic. Sub-question 1 is answered at the end of this section.

## 2.1 Europeanisation

### 2.1.1 Development and Definition

In the course of the last 20 years, the influence of the European Integration on its Member States' administrative and political systems and vice versa has been subject to scholarly attention. At first, the study of Europeanisation mainly concentrated on the responses of the Member States on the strongly developing European polity and thus, followed an analytical bottom-up approach (Börzel & Risse, 2003). In the following years, a change of perspective subsequently led to a top-down approach as an examination of the domestic effects of Europeanisation on domestic policy, politics, and polity (Börzel & Risse, 2003). The term domestic includes both national as well as subnational layers of governance. Going beyond the analytical treatment of the strictly organised and formally interacting levels of government, the multi-level governance school approaches Europeanisation as the informal as well as formal interaction of different governmental levels (Dossi, 2017).

Importantly, the multi-level governance approach within the theory of Europeanisation includes all layers of governance and that does not exclude local and regional structures of power. Therefore, and by that providing first arguments for the use of the Europeanisation theory, this theory follows a multi-level governance approach. It provides a multifaceted framework for the analysis of the practical implementation of EU policies and reforms. It is contextually oriented and thus, pays attention to the historically grown characteristics of the different Member States. Furthermore, it is interdisciplinary ranging from EU studies to urban studies. The principal-agent theory as a competitive theory in the practical implementation literature can on the contrary only be applied in two-level settings. In the following, based on Dossi (2017: 21), Europeanisation is understood as

*"an interactive process wherein domestic systems of governance are in time changed by the diffusion of ideational construct, legal and social norms, regulations and instruments. These*

*are first identified, negotiated, contested and agreed upon within the EU-wide arenas, and eventually used by domestic actors to shape their institutional order."*

Institutional order here refers to the polity of the domestic system of which the administrative system is a crucial part of. Consequently, the multi-level governance approach incorporates the interplay and reciprocal influences of and on the distinctive layers of governance under the realm of the European Union.

### 2.1.2 Europeanisation in the Urban Context

The Europeanisation of cities and urban areas has been mostly studied within the context of the EU structural and cohesion policy and by that the allocation, use, and effectiveness of the affiliated funds. This constitutes a policy field and unit of analysis in which the hierarchy of governmental level is not an object of conflict within a Member State since regional developments are mostly in the shared interest of all levels involved. The EU instead has led to the disentanglement of the city out of the strong hierarchy of the national state by developing European policy networks and exchanges of urban best-practices (Kern & Bulkeley, 2009). This allows cities to partly act beyond the control of its central government in issues of urban governance reforms. Therefore, to explore the role of the city as a European "policy-maker", it is important to extend the analytical frame toward the city within the general public policy domain instead of analysing only policies with "urban" in their headlines (Dossi, 2017).

In the conclusion of his book, Samuelle Dossi (2017: 156) states that "European cities suffer from insufficient capacities to engage in, and achieve structural change". He concludes that it is necessary, in the absence of European legal basis for cities engagement and the highly different contexts, that cities guided by a "common logical framework" develop administrative capacities to strengthen communication, information gathering, strategic planning and effectiveness for long-term sustainable policy engagement This gives the first indication of an answer for sub-question 1. The knowledge within the Europeanisation literature of local administrations engagement in ACB through the implementation of EU reforms appears to be short reaching. However, following Dossi (2017) the process of ACB seems to be key for achieving structural change through reforms. This conclusion indicates the importance of ACB for urban structural change.

### 2.1.3 Post-Accession-Monitoring

The effects of pre-accession conditionality on the accession countries have been widely analysed (Schimmelfennig & Sedelmeier, 2004, 2005). The future promise of accession aligned with a positive incentive structure was effective in leading the transition process of the post-communist countries towards the EU (Sedelmeier, 2008). However, the process of the Eastern enlargement of the EU was steadily accompanied by expressions of concern whether the new Member States are capable to continue the transition and adaption process of the acquis communautaire after accession (Sedelmeier, 2008). Sedelmeier (2008) has analysed these post-accession dynamics within the new Member States and stresses that not only financial sanctions but also the constructed legislative capacities as well as the socialisation as EU members play a crucial role in complying to EU rules. Therefore, the national administrative characteristics are not only important for compliance with EU policies but also inter alia built up legislative structures and the citizen's as well as the administrator's EU perceptions. These contextual dynamics can influence the local administration forces' environment. Ganev (2013) points out by referring to the dismantling of the Anti-Corruption Directorate that the process of state-building in Romania after accession has been reversed. Since 2007 political elites seem reluctant to invest time and effort "in the creation of bureaucratic institutions endowed with bureaucratic capacity" (Ganev, 2013: 38). This process of dismantling pre-accession built administrative capacities induces high costs (Sedelmeier, 2012).

The European Commission has put mechanisms in place to track such issues in its Member States. One of these mechanisms is the 'European Semester' (hereafter only referred to as 'Semester') which includes detailed monitoring reports about the Member States' key challenges and reform progress. It is followed by Country-Specific-Recommendations (CSR). The monitoring tool was firstly invented in 2011. This post-crisis monitoring instrument covers a wide range of policy areas from fiscal policies to social policies including issues such as healthcare for which the main competences lays at the national level (Verdun & Zeitlin, 2018). The relatively new instrument of EU macro-economic governance, therefore, aims to increase the convergence of all Member States with binding standards. In recent years under Commission President Jean-Claude Juncker, the focus of the Semester has shifted more towards social policy and emphasised the need for the Member States to improve, for example, the effectiveness, accessibility, and adequacy of their health system (Zeitlin & Vanhercke, 2018). Additionally, the Commission consults Member States in drafting the documents to increase their commitment to the process since 2017 (Alcidi & Gros, 2017).

The Semester is an important instrument for the implementation of the Europe 2014-2020 framework. The European Social Fund (ESF) provides substantial funding for administrative reforms to strengthen the performance of the domestic administration for precisely this period (Heidbreder, 2014). In this vein, the Semester documents serve as monitoring instruments structurally presenting the situation of besides other administrative capacities in the domestic administrations. In the CSRs, tailor-made proposals for the process of administrative capacity building are successively provided. The Commission can relate the provision of European Structural and Investment Fund (ESI) to the fulfilment of the national conditions, for instance institutional capacities, for the effective and efficient use of these funds. This fulfilment is monitored for in the reports and called ”ex-ante conditionality” (Commission, 2019). Therefore, in the EU governance architecture special emphasis is laid on ACB to ultimately strengthen the convergence of Social Europe (Heidbreder, 2014; Zeitlin & Vanhercke, 2018). Empirically unclear, however, remains the “domestic implementation and the causal inference” of the EU monitoring tool and national reforms in for example the healthcare system (Zeitlin & Vanhercke, 2018: 169). Nevertheless, the "Semester" is a crucial instrument for the architecture and monitoring of EU governance and contributes to the further Europeanisation of the Member States after accession.

*Expectation 1a: The Semester increases the probability that national and local governments will participate in administrative capacity building as an essential EU requirement after EU accession.*

*Expectation 1b: The lack of administrative capacities of the local administrative forces hampers the ability to achieve local structural change in-line with EU-standards in Cluj-Napoca.*

## 2.2 Practical Implementation

The study of administrative capacity in the context of practical implementation can be regarded as a bottom-up perspective within the multi-level governance approach of Europeanisation. In contrast, the top-down implementation approaches address more macro-level factors such as adaptational pressure, aid conditionality or misfit (Börzel & Risse, 2003; Van Gerven, Vanhercke, & Gürocak, 2014). The subsequent section focuses predominantly on the meso-level, such as environmental and local administrative characteristics that can influence the practical implementation. In recent years, the attention has shifted beyond the issue of legal compliance toward the practical implementation of EU policies at the local level by domestic implementers (Thomann & Zhelyazkova, 2017).

Legal compliance can be regarded as the outcome of the technically correct legislative implementation of EU policies resulting in "legal conformity by legislative authorities" (Zhelyazkova et al., 2016: 828). In theory, formal implementation is followed by practical implementation. In this second step of the implementation procedure, the policy is put in practice by domestic administrative actors and unfolds its impact. However, the first step of formal compliance tends to decouple from practical implementation under specific circumstances in the Member States (Zhelyazkova et al., 2016). Therefore, legal compliance cannot be regarded as the end of the transposition process. The practical implementation of EU policies or reforms partly steps out of the realm of politics. It is executed by the Member-States' administration.

Following this argument, the theoretical elaboration of practical implementation is central to later describe and explore the ACB actions of the local administrative forces in Cluj-Napoca. It is nevertheless highly important to distinguish between practical implementation through administrative capacity and practical implementation of administrative capacity. This means, in the latter case, the process of ACB through the implementation of a reform encompassing these efforts. The literature on practical implementation, however, predominantly studies the practical implementation of EU policies such as regulations or directives (Dörrenbächer & Mastenbroek, 2017; Newig & Gollata, 2017; Zhelyazkova & Torenvlied, 2011). The next two subsections provide a literature overview of the practical implementation of EU policies and of the implementation of EU administrative reform.

### 2.2.1 Practical Implementation in a Turbulent Environment

The environments of public organisations are characterised by turbulence and interconnectedness (Rainey, 2014). Limited monitoring and enforcement capacity of the European Commission and the European Court of Justice (ECJ) reinforce the importance of local implementers in the multi-level governance context (Zhelyazkova et al., 2016). The Commission's capacity is limited in the sense that predominantly formal compliance with the EU rules can be monitored. The Member States are obliged to report any legislative action on a directive (Zhelyazkova et al., 2016). For practical compliance reports, the Commission relies heavily on national monitoring bodies such as civil society organisations and a functioning judiciary (Falkner & Treib, 2008). However, these organisations in CEE are still underdeveloped in comparison to Western European countries (Džatková, 2016). Their relation to the public authorities and politics is characterised by a lack of trust (Bădescu, Sum, & Uslaner, 2004).

Therefore, in theory, the national implementation process is expected to be strongly influenced by the policy preferences of the domestic policy actor (Falkner, Hartlapp, Leiber, & Treib, 2004; Zhelyazkova et al., 2016; Zhelyazkova & Torenvlied, 2011). If the political preference of the domestic policymaker deviates from the EU policy's objective, the policymaker may have an interest in formally obeying but not supporting the actual practical implementation by the administration. However, as analysed by Zhelyazkova et al. (2016) and Falkner et al. (2004), these policy preferences do not have as much influence on the appearance of decoupling of formal and practical compliance as a local lack of administrative capacity or the societal legitimacy of these rules.

The discretionary scope (Dörrenbächer & Mastenbroek, 2017) determines the legal frame in which the administrators can execute the implementation of the policy. This scope, however, is decided upon by the national legislative authorities and ministries, therefore by political actors. Rapid turnover of political actors as visible in unstable or corrupt government like in Romania constitutes a challenge for the administrators (Rainey, 2014; Vlădescu, Scîntee, Olsavszky, Hernández-Quevedo, & Sagan, 2016). Discretion, in fact, could be a tool for tailor-made solutions to domestic public problems. Dörrenbächer and Mastenbroek (2017) based on their analysis of transposition acts in three Western European countries, present the main finding that discretion is often not specifically tailored, in some cases even extended. Thus, practical implementers do have considerable space for action. The Europeanisation literature has mainly focused on the discretion provided either in the EU policy itself or in the national transposition act (Dörrenbächer & Mastenbroek, 2017; Zhelyazkova & Torenvlied, 2011). The practical implementation of administrative reforms, however, can differ which is to be explored.

Practical compliance requires more detailed situational knowledge. Domestic policy practices, administrative capacities and the local perception of the EU are consequently crucial for effective practical implementation. The perceived legitimacy of rules (Zhelyazkova et al., 2016) and the responsiveness to public demands (Rainey, 2014) are two exemplary factors. Lastly, the implementation of EU reforms could lead to questions of loyalty for local implementers in the case of contradictory policy objectives between EU policies and national law (Thomann & Sager, 2017b). The implementers on the frontline thus not only act as part of their environment, their octroyed political agenda or their organisational values but also decide as individuals with political preferences and values.

### 2.2.2 Practical Implementation of EU Administrative Reforms in CEE

The last section described the environmental impact on local administrations. This step was crucial as the environment remains the same for local administrative actors, despite differences in the content of policies and reforms. It is now necessary to provide theoretical insights into the practical implementation of ACB. More precisely, the process of ACB through the practical implementation of EU administrative reforms.

Public administrative reforms are defined in the literature "as any restructuring of the administrative part of the public sector to solve organisational and/or societal problems associated with this structure and intended to promote a professional, merit-based and neutral civil service" (Nemec & de Vries, 2012: 23). In the developing region of CEE, the national states as former-communist countries were forced to rapidly transform their administrative systems. In this vein, the administrative systems of these countries are often unitary defined based on their communist past. Nevertheless, they differ significantly (Pawel Swianiewicz, 2014). These differences are firstly based on their pre-communist administrative traditions as being part of the Prussian, Ottoman or Russian tsarist systems (Kuhlmann & Wollmann, 2014). The path dependencies of administrative reform endeavours must be theoretically served by paying attention to regional developments and local characteristics taking into account the historical incidents.

The administrative reforms were driven by the incentive to develop an administrative system that functions properly within the framework of the EU (Junjan, 2016). Problematically, the timing of the reforms in the "new" democracies in Eastern Europe went along with the Western European administrative reforms led by the paradigms of Public Management and New Public Management as supported by the EU and the World Bank (Pawel Swianiewicz, 2011). This means that

> *"CEE countries have had to introduce the Rule of Law (in the Weberian sense) and the New Public Management in parallel (…) so that in the East the tension between legalism and managerialism may threaten to fragment the local authority as an institution"* (Pawel Swianiewicz, 2011: 499).

Junjan, in Nemec and de Vries (2012) identifies three main patterns in the literature dealing with public administrative reforms in CEE. First, the definition of reform is highly multifaceted. Second, implementation problems are a crucial factor in studying the reform processes. These problems can stem from a lack of administrative and institutional capacities, political control

as well as motivational issues of designers and implementers which undermine long-term reform endeavours. The blind downloading of administrative reforms and the non-adaption to the specific local conditions constitutes the third main pattern. Interestingly, these factors seem to be similar to those identified by the practical implementation literature of EU policies.

Although the public sector is first and foremost regarded as a national competence, the impacts of EU driven public sector reforms are undeniable. Although this is academically broadly acknowledged, the study of broader impacts of EU driven reforms on ACB remains an unmeasured blind spot (Ongaro & Kickert, 2019). Heichlinger, Thijs, Hammerschmid, and Attström (2018) instead formulate four key areas as crucial for the successful practical implementation by the Member States of EU driven public administration reforms initiated on the EU-level. The authors firstly emphasise the need for political support and strong leadership while implementing the well-scoped reform alongside a strategic roadmap. Secondly, they propose a multi-level governance approach by including a strong external stakeholder network incorporating a wide variety of actors. Thirdly, the establishment of adequate resources and civil service system are necessary for effective implementation according to the literature. Finally, the authors propose that monitoring tools should be established to assess progress and results properly.

In conclusion of the section on the practical implementation of EU policies and EU administrative reforms, one main finding regarding sub-question 1 (*What is known from the literature about the impact of local administrative forces on the construction of administrative capacity through the practical implementation of EU reforms on the local level?)* appears. Although the literature on the practical implementation of EU policies and public administrative reforms entails a richness on analytical insights on environmental, and institutional factors influencing these processes, few theoretical insights can be found on the practical implementation of EU-driven reforms including measures for administrative capacity building on the local level. Nonetheless, based on the elaboration above, the second set of expectations can be derived:

*Expectation 2a: The likelihood of effective local practical implementation of EU administrative reforms increases if the domestic administrative forces of Cluj-Napoca perceive political and public support including the provision of policy space.*

*Expectation 2b: The likelihood of effective local practical implementation of EU administrative reforms increases if the domestic administrative forces of Cluj-Napoca follow a well-scoped reform plan including the allocation of resources and monitoring instruments.*

## 2.3 Administrative Capacity Building

As extensively outlined above, administrative capacities are key for the effective implementation of policies. These capacities incorporate the ability of the public administration to define problems, to make priorities, to allocate resources, and to possess the expertise to provide the public services properly (El-Taliawi & Van Der Wal, 2019). Of further importance are monitoring and evaluation capacities of the organisations (Milio, 2007). Milio (2007) concludes that the administrative capacity strongly accounts for regional performance. Poor performance outcomes often can be related to weak administrative capacities (El-Taliawi & Van Der Wal, 2019).

### 2.3.1 Administrative Capacities

Administrative capacity as a general concept is measured in three main dimensions concentrating on its organisational-operational dimension (Heichlinger, Thijs, & Bosse, 2014; Surubaru, 2017). The focus lays here on the ACB by the local administrative forces within a relatively well-functioning regional public sector in the Nord-Vest of Romania (Rothstein, Charron, & Lapuente, 2013). The first dimension relates to the institutional capacities or structures related to the institutional design and framework (Heichlinger, Thijs, & Bosse, 2014; Surubaru, 2017). These structures include mechanisms such as planning, monitoring, evaluation or structural measures to combat corruption. Together, these steps form a loop of administrative capacity that strengthens the capacity to implement upcoming policies or reforms (Heichlinger et al., 2014). During the programming process, the objectives and priorities of the organisation are defined and then provided with resources. The capacity of strategic planning is critical to avoid implementation errors due to wrong priorities or lacking resources. Monitoring these implementation processes thus ensures the proper use of resources, identifies problems and provides information for the management of institutions (Heichlinger et al., 2014). Finally, evaluation in multiple forms from different perspectives can indicate whether the process was carried out as originally intended (Milio, 2007). The second dimension is the bureaucratic capacity. The multi-faceted bureaucratic capacity refers to the stability and existence of internal rules and procedures to be applied and respected by practical implementers. It also includes the tools the bureaucrats can use such as e-government devices. The third dimension is human resources. It refers to the individual capacity of the administrative

forces such as personal expertise or professionalisation including incorruptibility. In the context of ACB, human resources are strengthened by means of training, personal policies such hiring as strategies and the implementation of incentive systems (Surubaru, 2017).

Also, the World Health Organisation (WHO) increasingly acknowledges the role of effective governance through the administrative capacity for the functioning of health systems. For this purpose, the WHO has established a five-point list of crucial governance indicators for health systems on which further action plans are based (WHO, 2014). This set includes firstly, the formulation of policy and strategic plans for the development, implementation, and review of their systems. Secondly, the countries should develop general intelligence in terms of gathering core financial and policy data for decision-making. Thirdly, the countries should put instruments in place for implementing the strategies and policies. These can include an enforcement system, the system's organisation, and leadership's responsibilities. Fourthly, the WHO recommends the active construction and participation of external stakeholder networks. Lastly, the countries should develop strong systems of accountability to combat corruption by means of putting independent oversight in place. The combination of these similar set of measures provides a fruitful fundament for the forthcoming operationalisation of the "reform content".

### 2.3.2 Process of Administrative Capacity Building

These administrative capacities, however, need to be built up and must be steadily developed further to ensure effective work by the administrative forces. Therefore, ACB is a continuous, dynamic process and cannot be analytically treated as a static process reaching its goal at a certain point. This leads to the question of how to actually build these capacities and how to structure this process. The following argumentation of ACB is based upon El-Taliawi and Van Der Wal (2019). Although the authors neglect the Europeanisation literature, they provide a comprehensive list of ACB measurements retrieved from a wide variety of literature. As the public administrative system is a historical product of the national states trajectories, the ACB is equally an outcome of path-dependencies. Thus, ACB efforts and strategies should be executed in a tailor-made manner paying tribute to the specific circumstances and environment of the state, region or urban area. This argument subsequently includes that international best-practices or recommendations should not be downloaded nor implemented blindly. This could lead to a situation as experienced in CEEC after the fall of the communist regime as progressive public management approaches were implemented without having built up a stable administrative system's fundament based on the Rule of Law (Campbell & Coulson, 2006).

Administrative reform implementation and with that ACB is a long-term endeavour and requires time and patience by its designers and implementers (Nemec & de Vries, 2012).

Additionally, inter-governmental collaboration is necessary as well as the incorporation of external stakeholders (El-Taliawi & Van Der Wal, 2019). Public sector organisations function within a system that is under political steering. Political will and political actors that execute authority while keeping up impartiality are further main factors of effective ACB according to the authors. Lastly, governments and administration's leader should put mechanisms in place which steadily identify skill and capacity gaps. This ensures that the ACB is timely adequate and can react to new environmental developments or public demands (El-Taliawi & Van Der Wal, 2019). Further, it is necessary to develop and design support systems that accompany and lead the capacity building process. These support systems could be for example strategic planning or e-Government systems (El-Taliawi & Van Der Wal, 2019; Junjan, 2015).

*Expectation 3a: The likelihood of effective ACB on the local level increases if the reforms to be implemented are carefully applied to the specific socio-economic context of the city of Cluj-Napoca.*

*Expectation 3b: The likelihood of effective local ACB increases if the process is seen as a long-term endeavour, carefully monitored and evaluated by impartial bureaucrats equipped with the necessary resources.*

## 2.4 Theoretical Framework

Altogether, the expectations based on the literature review lead to the following mechanism of local ACB through the practical implementation of EU driven reforms in a European multi-level governance context:

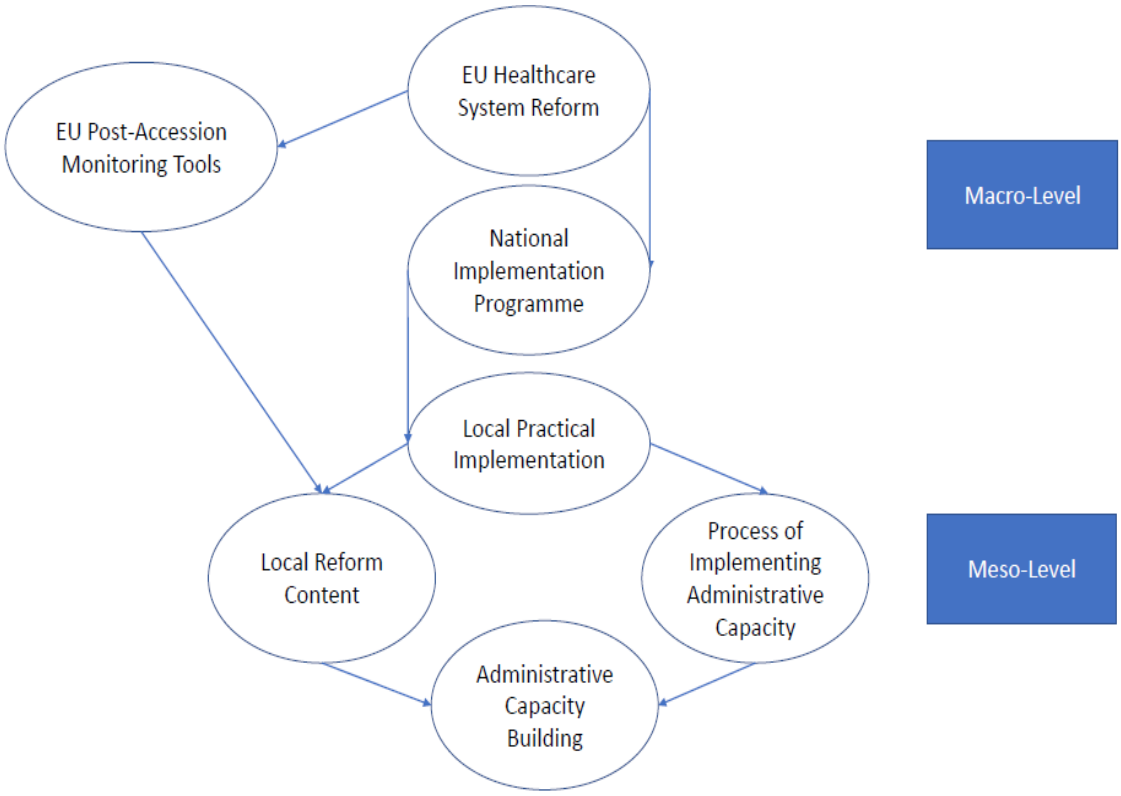


*Figure 1. Conceptual Framework (illustration by the author)*

In sum, sub-question 1 (*What is known from the literature about the impact of local administrative forces on the construction of administrative capacity through the practical implementation of EU reforms on the local level?*) can be answered as follows. The literature does not provide concrete or coherent evidence or theories on the local practical implementation of ACB through EU reforms. However, the overall literature review highlights the immense importance of administrative capacity in general. Interestingly, without referring to each other, the individual authors mention similar factors that are crucial for ACB. In this vein, the literature on the practical implementation of EU driven public sector reforms proposes strategies comparable to those mentioned in the ACB literature. One factor repeatedly mentioned is political and public support. Further, the literature suggests that blind downloading of reforms can lead to serious fragmentation and dysfunction of the local system. Therefore, tailor-made strategic planning based on the characteristics and resources of the city and the local administration is important. Finally, the literature attributes to local administration forces

the key role in ACB for urban structural change. Thus, these theoretical findings provide a crucial indication of which factors might affect the "process of local ACB" and its "reform content" for the local health system administration through the local administrators.

# 3. Methodology

The following chapter 3 explains the methodology of the thesis. The first section shows how the research is designed and provides arguments for the approach chosen. The second section explains the case selection procedure. The third section contains information on data collection. The fourth section presents the operationalizations of the "EU structural reforms", "process of local ACB" and "reform content" and coding. The thesis is regarded as a descriptive explorative case study. In general, it follows a qualitative design that is particularly suitable for small-*n* studies in which phenomena are analysed in their context (Flick, 2018). A case study is useful for the analysis of a contemporary phenomenon in a real context for which the relationship between the phenomenon and its context is not yet clear (Yin, 2003). Therefore, the chosen design provides a fertile basis to explore the process of local ACB through practical implementation in Cluj-Napoca. This chapter reinforces the reproducibility and comprehensibility of the present work.

## 3.1 Research Design

The following section presents the research design of this thesis including a discussion on the threats to validity based on Yin (2014). First, the research question in this article is of a descriptive exploratory nature. It asks for the "how" and wants to explore the "why". The research question that guides this work aims to examine the extent to which local forces can build administrative capacity through the practical implementation of EU structural reforms in a turbulent environment. Because of the explorative design of the study, there are no theory-based propositions. Nonetheless, six theoretical expectations are stated regarding contextual factors affecting the ACB. The implicit key presumption of the study is that the practical implementation of EU structural reforms leads to local "ACB" in the health sector.

These expectations and the sub-questions provide direction to structure the study. It might be the case that the expectations will be proved wrong (Yin, 2014). The unit of analysis in this single-case study is the process of practical implementation within the health sector of Cluj-Napoca. The subject of the study, the phenomenon to be explored must be distinguished from its context (Yin, 2014). The study analyses the implementation process as a part of its context. The study's intent is to extract the mechanism and underlying logic of ACB in the EU's multi-level governance system. This step requires the collection of in-depth qualitative data. Two types of data are collected and analysed: interview and document data. The analysis of "EU structural reforms" to extract the main reform components for ACB in the health system (*SQ2*) is based on the CSRs and the National Health Strategy 2014-2020. This study uses a

longitudinal approaching the CSRs from 2011-2018. The "reform content" is analysed by using the local health strategy for Cluj-Napoca to extract the respective ACB measures on the Meso-level (*SQ3*). Information regarding the "process of local ACB" is gathered through three key-expert interviews to explore the mechanisms of practical implementation on the local level *(SQ4*).

In case study research, various threats to validity may occur. The developed research design must, therefore, include measures to combat these threats. First, it must take into account construct validity (Yin, 2014). This explorative study faces the challenge that the analysis of implementing ACB is ambiguous as a continuous and highly context-dependent phenomenon. To address this threat, this study actively uses several sources of evidence from different literature streams to extract measures that take account of ACB through practical implementation. In addition, the exploratory design jeopardises the data validity of the study because the information provided by respondents can hardly be verified and respondents may be biased (Van Thiel, 2014). Triangulation supports data validity. It is used to ensure the convergence of the data by controlling for the information of "reform content" in the interviews and for the "process of local ACB" particularly in EU monitoring documents (Maxwell, 2009). A second way is to consult the respondents for validation. This was done by asking respondents for results that had previously been obtained in document analysis and analysis of previous interviews. In this way, several perspectives on the result could be obtained. This encounters the personal bias of the researcher and wrong understandings in the interpretation of the data (Maxwell, 2009). The issue of generalisability (Yin, 2014) is elaborated in the following section.

## 3.2 Case Selection

This section explains the methodological reasons for the case selection based on Seawright and Gerring (2008). Studying a multi-level implementation procedure focusing on practical implementation requires the selection of an analytical level. The practical implementation of reforms is mainly carried out at the ground-level of the system. Moreover, the macro-level does not provide for the examination of specific local determinants affecting the implementation performance. Therefore, the key analytical level to focus on is the meso-level (local-level). In order to select the case at meso-level, this study made a two-step approach. Firstly, the selection of the Member State must satisfy two conditions. First, due to the geographical focus of the project group on CEECs, the Member State must be chosen accordingly. Second, it must provide a deficit sector embedded in a turbulent environment to indicate lacking AC and the

need for reform implementation. Romania as a CEEC spent the lowest amount of money in healthcare, faces an increasing problem with the migration of health professionals and remains highly centralised (Paina, Ungureanu, & Olsavszky, 2016). This national setting provides the possibility to explore the local practical implementation under pressure to find solutions to public problems (Dossi, 2017). Additionally, it is of importance to choose a sector that is not typically urban. In this vein, the Romanian healthcare system was chosen.

The second step was the selection of the case itself located at the meso-level. The deviant case type which Seawright and Gerring (2008) elaborate seems best suited for this thesis. The deviant case shows a surprising value in relation to other cases on several dimensions. This case type makes the investigation of theoretical irregularities possible that are visible in real cases but are still poorly explained (Seawright & Gerring, 2008). The city of Cluj-Napoca represents such a deviant case. In Romanian healthcare, Cluj-Napoca surprisingly stands out positively. It is a university city with a medical faculty and school for public health which leads to the local availability of scientific expertise. The regional development centre of Cluj-Napoca attracts investment, leads to the settlement of enterprises and is interesting for health professionals to remain. The Nord-Vest region, including Cluj, was in the European top-eight regions of female and youth employment (Rothstein et al., 2013). In 2010, only Bucharest as the capital had better health infrastructure than the Nord-Vest region. Additionally, Rothstein et al. (2013: 216) explicitly state that "if there are steps that must be taken towards modernizing public services and saving public money responsibly, Cluj-Napoca is always the first city to make them." Consequently, this case selection is appropriate for the exploratory purpose of this thesis. Representativeness of the case cannot be achieved, which by its nature, lies outside the aim of this deviant case design. If the deviant case becomes representative it does no longer deviate. Therefore, non-representativeness is not a limitation to the study. The deviant case rather provides a fruitful fundament for exploring determinants of ACB (Seawright & Gerring, 2008).

## 3.3 Data Collection

The following section introduces the reader to the data collection. The study uses two types of data sources: document data and interview data. Three different types of documents are used. First, the Semester's CSRs were used as one component of the Semester's cycle providing the necessary reform components for the Romanian health system as requested by sub-question 2. These eight CSRs were retrieved in English from the Commission's official website in May 2019. Second, the "National Health Strategy 2014-2020- Health for Prosperity" (NHS 2014-2020) is used to coherently link the European- and local level. It is the official national

document by the Romanian government in this regard. It was accessed in Romanian on the website of the National Ministry of Health. The relevant parts of the NHS 2014-2020 were manually translated into English with Google Translate and were subsequently cross-checked by a native speaker. Third, Cluj-Napoca's strategic development plan for the health system constitutes the data fundament for the analysis of "reform content". This document is publicly available only in Romanian and was accessed in June 2019. It was similarly translated via Google Translate and cross-checked by a native speaker. The table of documents including the specific names and sources of each document used is attached to the appendix (A)(A.3).

The collection method might facilitate selection bias (Yin, 2014). Especially, the language barrier constitutes a threat because the Romanian documents could not be fully translated professionally due to the limited scope of the thesis. The tables of content were translated and then the for the thesis relevant parts were subsequently translated. The selection bias could, therefore, occur in the prioritisation of parts for translation. This threat was encountered by cross-checking the selection and translation by a native speaker which is familiar to the field to constrain the bias. Additionally, only documents were chosen which were referred to in official reports and academic literature indicating their importance. In terms of the internal reliability of the translation, the documents are attached to a separate appendix available upon request. In general, all documents are analysed with content and document analysis. The analytical steps covered by this data analysis method are further explained in section 3.4

Secondly, three key-expert interviews were conducted to gather more detailed information about the "local ACB process" in Cluj-Napoca. The interviews were created in a semi-structured way that consists of open-end questions covering specific topics (Van Thiel, 2014). Hereby, it is ensured that the interviewee has the chance to explain things in detail (Flick, 2018). The interviews were conducted in English. The interviews were transcribed, and the transcripts were subsequently analysed. The transcripts are attached to a separate appendix which is available upon request on special conditions. The interview partners were selected both for their expertise in the Romanian health care system and their involvement in drafting the Health chapter of the local development strategy in the years 2013/2014.

This selection procedure goes along with a threat to data validity since the retrieved data displays the subjective respondent's positions on the issue under investigation. Additionally, recollection issues must be considered since the drafting process took place in 2013/2014. Nonetheless, the involvement and experiences of the interviewees provide a strong added value of in-depth expertise that allows to disentangle the components of the mechanisms at local level.

Explanations and more detailed information are lacking regarding the process of local political decisions-making. The collected interview data does only allow for assumptions in this regard. An interview with a representative of the local government would have strongly added value. As Van Thiel (2014) mentions the use of semi-structured interviews in an exploratory research setting might threaten the reliability of the collected data since the theoretical framework does not provide a clear indication for the interview structure. This threat to reliability can be countered by the detailed transcription that provides the possibility for analytical reproducibility. Further problems can be a response bias or reflexivity if the interviewee states what the interviewer wants to hear (Yin, 2014). Addressing these threats, the interview guide entails questions that are formulated neutrally. The interview guide is attached to the appendix (A.4). Within the expert interviews, additional information was gathered for ACB measures to cross-check the findings of the document analysis.

## 3.4 Operationalisation

The following section describes the operationalisations of the theoretical concepts developed and described in theory. Subsection 3.4.1 presents the operationalisation of "EU structural reforms". Subsequently, subsection 3.4.2 further operationalises "reform content". Subsection 3.4.3 provides the operationalisation of the "process of local ACB". The operationalisations serve as the basic fundament for the data analysis and data collection. Nonetheless, unexpected findings beyond the scope of the theoretical concepts, following the exploratory approach, were not excluded but further investigated. In this sense, the reader should approach the following subsections as a flexible framework rather than a rigid structure that is strictly maintained under all circumstances.

### 3.4.1 Operationalising EU Structural Reforms

As outlined in section 2.1.3 post-accession monitoring the Semester is an annual monitoring tool of the Commission and the Council of the European Union. This includes the monitoring of national healthcare systems. Based on the monitoring of the system's performance the Commission formulates the CSRs. Their implementation is subsequently monitored in the successive year. Especially, the CSRs are of major interest for the thesis at hand being the starting point for the implementation process of the EU driven reforms. In terms of the research question, it consequently provides the content of the EU health system reforms on an operational level. It additionally serves the analysis of the empirical context "EU-post accession monitoring". The inclusion of the EU monitoring documents into the analysis underlies the theoretical assumption of "what gets measured gets done" (De Bruijn, 2003: 10). Structural

systematic change and ACB are long-term endeavours. Therefore, the CSRs are analysed from 2011-2018. The inclusion of the national implementation programme (macro-level) is also necessary following the theory providing the link between the macro- and meso-level. For the case at hand, this programme is the document NHS 2014-2020. Therefore, it is necessary to analyse the NHS 2014-2020 concentrating on the ACB measures mentioned for the local level.

### 3.4.2 Operationalising Reform Content

"Reform content" refers to the ACB measures for healthcare contained in the local reform plans. To operationalise the "reform content" for the local level, this study pursues a dual strategy. The first step is theory-based. The theoretical subsection 2.3.1 "Administrative capacities" defines two different approaches for the conception of administrative capacities. The first perspective, based on Surubaru (2017), approaches administrative capacity from an analytical, more general perspective of public administration. It provides a comprehensive set of necessary components for AC that allow structuring "reform content" into three theoretical dimensions (Reform Content Dimensions (*RCD*)): Institutional capacity (*RCD1*), bureaucratic capacity (*RCD2*) and human resources (*RCD3*). WHO's second perspective offers a stronger sectoral focus on ACs in the health sector. The consideration of those components which apply to the case and their combination with the operationalisation of ACs by Heichlinger et al. (2014) enables the operationalisation of "reform contents". Both an example of developing the operationalisation and the operationalisation table itself are attached to the appendix (A.1) in detail for the sake of readability. The second step was to actively use this operationalisation to compare it with the RCs retrieved from the CSRs and the NHS 2014-2020. This step was used to explore if measures for ACB were mentioned on the macro-level which were not mentioned in the selected theories.

### 3.4.3 Operationalising Process of Local ACB

The analytical decision was made to focus on the process of ACB at the meso-level. Thus, the practical implementation literature which focuses on the street-level (sections 2.2.1- 2.2.2), as well as the literature on local ACB (section 2.3.2), provides the fundament for this methodological step. Both sets of literature present similar factors that determine the effectiveness of both practical implementations of administrative reforms and local ACB. These environmental factors constitute accordingly the dimensions of the dynamic "process of local ACB" (Process Dimensions (*PD*)): Political support (*PD1*); Incorporation of external stakeholder networks (*PD2*); Usage of monitoring- and evaluation-tools (*PD3*); Time structure (*PD4*); Adaption to local context (*PD5*). To create an analytical basis that examines the

appearance and extent to which these dimensions apply to the present case, respondents are asked to describe the process and its elements (*SQ4*). On this basis, the various measurements of the dimensions are queried and then examined for their degree of process determination. The detailed operationalisation with the attached measurements plus example can also be found in the appendix (A.1).

### 3.4.4 Coding

This subsection presents the coding strategies for data analysis. Coding procedures function by means of a set of words indicating essential information about, in this case, ACB measures for the local health system (Maxwell, 2009). The coding for the three types of documents is executed differently. The coding procedure was carried out by means of the *Atlas.ti* software.

First, the eight CSRs were exploratively coded, which means the codes were not pre-set theoretically, but retrieved directly from the documents. This was done to avoid the exclusion of unexpected topics within the documents. The CSRs were analysed regarding healthcare and public administration from 2011 onwards. Each issue raised in the context of CSRs was coded separately, if, for instance, the sentence is "Low funding and the inefficient use of resources limit the effectiveness of the healthcare system, against the background of a sizeable shortage of doctors and nurses" (CSR, 2018: 5), the codes retrieved are "low funding", "use of resources" and "shortages of professionals". This process was reproduced in the document of the successive year. New problems led to new codes to take account of new developments, and the issues already coded were marked. The procedure was performed in reversed chronological order to search for duplicate or missed issues enabling to determine the number of problem occurrences for each year. If an issue was present, it was marked with an ***X*** and if it was not present, with marked with a -. An argumentation to leave the coding at this binary level is attached to the appendix (A.2.5).

The translated parts of the NHS 2014-2020 were subsequently coded. If the analysis of the document is carried out in Romanian, the findings might differ due to the different wordings. The coding of the document was carried out to first examine whether and to what extent the reform components (*RC*) derived from the CSRs can be found in the NHS. Three code descriptions are used in this context. If the *RC* was found at a detailed level (analysis of the status quo, planned measures to address the problem, objectives), it was marked +. If the *RC* is only mentioned (formulation that the problem exists and explanation that it needs to be addressed, but no concrete steps), it was marked with a **0**. If the *RC* was not mentioned at all, with a -. In cases of the extensive elaboration of the strategic steps for a measure but no

mentioned resources or accountabilities, it was coded as **0/+**. With only one superficial mention of the problem, it was coded as **0/-**. Secondly, the NHS 2014-2020 combined with the CSRs were used to check the operationalisation of "reform content" by checking for unmentioned ACB measures. Based on the operationalisation of "reform content" (A.1), the coding was conducted for the translated parts of the local health strategy. The coding of the documents was conducted alongside the coding applied for the NHS 2014-2020 **(+; 0/+; 0; =/-; -)**. Each measurement refers to its specific *RCD*. As the operationalisation is reviewed by the CSRs and NHS' *RCs*, the internal coherence of the coding with the implementation process is ensured.

The second type is data retrieved from the key expert interviews. The information provided by the interviews is firstly analysed based the operationalisation of "process of local ACB" to explore the extent to which theoretical dimension appears. It was explored during the data collection that the process of local ACB must be separated into the planning phase and implementation phase. The coding was conducted alongside this separation. Instead of being based on mentioning in the documents, the coding was conducted on the level of appearance in the process (**-** = no appearance; **0** = appearance; **+** = strong appearance). The interview parts regarding the local practical implementation performance and the related explanations were subsequently used to answer sub-question 4. The entire coding procedure was conducted by the author and is, therefore, subjective. Also, a second coding round to ensure full intra-code reliability was not conducted due to the scope and timeline of this thesis. This is to be kept in mind for subsequent research.

### 3.4.5 Reporting the findings

After having established the process of collecting, operationalising and coding the data, the reporting of the data must be shortly explained. The different types of documents require distinct kinds of reporting. The CSRs issue's analysis is presented by a table showing the appearance of the issues over the years. The specific recommendations are also presented in a table. These tables are attached to the appendix (A.2.1-4). The NHS analysis's results are shown in a table displaying the addressed level of detail for each *RCs* in the document. The analysis of "reform content" is similarly presented in a table presenting the results of the coding. Lastly, the information on the "local process of ACB" is also presented a table following the detailed description of the current environment of the Romanian health system serving the goal of exploring the data in its context.

# 4. Analysis

This chapter presents the analysis and aims to answer the three remaining sub-questions mentioned in the introduction. The structure of the analysis follows the theoretical framework presented in section 2.4. First, the context of the case is outlined to introduce to local specificities. Secondly, the results of the EU's CSRs document analysis are presented to give an answer to sub-question 2. In this subsection, the Romanian NHS 2014-2020 is analysed to examine the extent of the legal implementation of the EU structural reform components. Thirdly, the concept of "reform content" is used to analyse the local health strategy and to provide a response to sub-question 3. Fourthly, the concept of the "local ACB process" is employed to analyse the information given in the interviews to answer sub-question 4.

## 4.1 Context of the Case

This subsection provides the context of the case. This is necessary to present the basic characteristics of the environment in which the case is embedded and thus serve the theoretical condition of being aware of historical path dependencies.

Before the nineteenth century, the territory of present-day Romania was dominated by the regions of Moldova, Transylvania, and Valachia. The state of Romania has a long tradition of centralism. At first, this began with the first Romanian constitution of 1866, which laid the foundations for a constitutional monarchy with a centralised administration and a strong executive. After independence from the Ottoman Empire in 1887, Romania was recognised as a unitary state for the first time in the treaties after the First World War. Men's suffrage was introduced in the 1920s and the first steps towards democratisation were taken until Carol II took the throne in 1930 and established a dictatorship from 1938 until the end of World War II. The successive forty years of communist rule destroyed the efforts to decentralise administration undertaken between 1862-1938. The communist legacy today also includes the lack of efficient institutions at the regional and local levels, since these institutions were subordinated to the will of the communist party for 40 years. After 1991, this strong tradition of centralism became visible in the construction of the new Romanian state, which was built to a certain extent on this very centralism (Dobre, 2010).

Nevertheless, as Dobre (2010: 689) notes, the tradition of the historical regionalism of the state and the pre-communist decentralisation steps in conjunction with the external influences of the EU, led to two major developments: “The introduction of political, administrative and fiscal decentralisation combined with trends of local deconcentration and the emergence of

administrative-statistical regionalization." In the current political-administrative system, the local government consists of two levels: the local- and the county level. The political authorities are democratically elected. In 2003, the principles of local government were laid down in the constitution for the first time in the context of EU accession: deconcentration, local autonomy, and deconcentration of public services. In this sense, the local level has exclusive and shared competences. Exclusive competences include the management of public health facilities of local interest, sanitation and the management of public and private domain belonging to local government (Dobre, 2010). A shared competence in social health with the central level is, for example, socio-medical support for people with social problems. The municipality is financed for fifty percent from its own tax revenues. The rest of the local public funding is paid by the national level. Overall, this means relatively little financial responsibility for the local administration (Dobre, 2010).

The Romanian health system in this manner remains centrally organized (Vlădescu et al., 2016). The health system's governance is based on the law 95/2006 on Health Care Reform which combined the existing national legislation with the acquis communautaire (Vlădescu et al., 2016). The National Ministry of Health is the central administrative actor in the system which sets the general system's objectives, the regulatory framework and is responsible for the implementation health policies. This includes the monitoring and evaluation of the population's health status and human resources policies. In Since 2009 some tasks have been delegated to the local level (county level). The county public health authorities execute tasks that mainly cover the tasks of the Ministry of Health at the local level. These, in particular, are "monitoring the health status of the population; developing, implementing and evaluating public health programmes; organizing health promotion and health prevention activities; as well as controlling and evaluating health care provision and the functioning and organisation of health care providers" (Vlădescu et al., 2016: 21). Nonetheless, the local level's competences in the field of health remain constrained.

This case description serves as the basis for the following analysis. The literature on Europeanisation as well as the writings on the history of Romania recognise the influence of the EU on the post-communist development of the country as essential (Dobre, 2010; Spendzharova & Vachudova, 2012). The following first section of the analysis, therefore, presents the analysis of "EU structural reforms" as the beginning of the official implementation process.

## 4.2 EU Structural Reforms

This subsection aims to satisfy a twofold endeavour. Firstly, the data retrieved from the CSRs are analysed, and the findings are presented. An answer to sub-question 2 is provided by analysing the CSRs for Romania's health system from 2011-2018. Secondly, the NHS 2014-2020 will be analysed to check the extent to which the *RCs* derived from CSRs have been adopted at the national level as the link between the European and local level. It is also used to explore unexpected ACBs measures not covered in the operationalisation of "reform content".

### 4.2.1 Analysing the CSRs

***Analysing the CSRs' issue section.*** The CSRs of the Semester are divided into two main parts. First, the documents briefly summarise and explain the predominant issues and development steps of the country on the basis of the country reports of the Semester. The sector-specific recommendations are then formulated on this basis. Both the formulation of the issues and the recommendation vary in size and level of detail over the years. In this regard the Coding Table 1 and Coding Table 2 show the issues of the Romanian public administration and health system which were mentioned at least twice in between 2011-2018. The coding tables are attached to the appendix for the sake of readability (Table 1: A.2.1; Table 2: A.2.2). Interestingly, most problems appear in the documents unchanged or only slightly modified in wording several times over the years. The most pressing problem arising from the sheer frequency of occurrence in the segments on the health system is the dependence on inpatient care, which in turn points to a weak outpatient care infrastructure that impairs accessibility and places a financial burden on the system. The problems of inadequate funding or inefficient use of resources have occurred each year since 2013 with two exceptions (funding not in 2013; resources not in 2017). This strong presence in the specific sequences signals a recurrent phenomenon considered problematic at report level. In particular, the inefficient use of resources points to malfunctions of the administrative system due to a lack of strategic planning capacity or a weak public procurement system.

These issues constitute two major problems of the system. First, the strategic planning capacity is decisive for the needs-based design and implementation of policies and strategies as the fundament for efficient local public investment planning and execution (Heichlinger et al., 2014) of for example the building of the local hospital infrastructure. Second, the public procurement system is then crucial supporting the execution of these planned actions in an efficient and effective manner. This latter challenge was especially highlighted by the Commission: "Efficiency and transparency challenges associated with public procurement

apply in particular to the large healthcare infrastructure investments in the regional hospitals for Iaşi, Cluj and Craiova" (CSR, 2018: 6). In this manner, including the public procurement system, structural weakness is mentioned as an issue three times since 2015.

Since 2014, informal payments and corruption/ independence were elaborated as major problems in Romania seven times. The lack of accountability and the unclear delegation of responsibilities combined with fragmented management and control systems are framed as a key threat to the functioning of the system contributing to the still-prevailing appearance of corruption in the health system. Moreover, shortages of professionals of doctors and nurses as well as problems with human resource management are indicated in the CSRs several times. Interestingly, the latter is mentioned only in the years 2013-2015 and the former only in the years 2017/2018. This may be due to different priorities of the Commission in the elaboration of CSRs, as the literature provides the knowledge that both issues have arisen before and after the presentation in the CSRs.

Since 2015, the issue of weak implementation of reform strategies was critiqued each year by the Commission. These implementation problems were related to several strategies and reform endeavours. In the context of the health system, the CSR of 2016 provides the key sentence that the efforts to implement the NHS 2014-2020 are hampered by a lack of administrative capacity: "However, the lack of administrative capacity is delaying implementation of the 2014-2020 national health strategy" (CSR, 2016: 5). This general lack of administrative capacity is also addressed four times within the eight years. It is however not to be seen as a single and isolated issue. Administrative capacity, as indicated by Surubaru (2017) is the umbrella concept including three dimensions of administrative capacities, which are also included as issues found in the CSRs. Furthermore, the theory mentions the possibility for the Commission to link the accession to the ESI funds to distinctive conditionalities regarding national capacities for the efficient and effective use of the funds. This process is called ex-ante conditionality and is interestingly mentioned for the Romanian case: : "(…) addressing a country-specific recommendation and in the context of ex-ante conditionality for the 2014-2020 EU funding period, Romania took some policy action (…)" (CSR, 2017: 7). This shows the use of post-accession-monitoring tools for the case at hand.

***Analysing the official CSRs.*** In order to filter out the most important necessary reform components, the health sector-related recommendations are used. Table 3 (A.2.3) shows the development of the CSRs over the years. No health-specific recommendations were issued for 2011 and 2012. The CSRs of the years 2013 and 2014 formulated the need for a comprehensive

reform of the health sector. In 2014, the CSR also issued a recommendation to curb informal payments as the biggest threat to equality of access and quality in the Romanian healthcare system. The 2015 CSR sets out the goal of implementing the NHS 2014-2020, which was introduced by the Romanian government in the previous year. Nevertheless, the main recommendations for 2016-2018 remain the issues of informal payments, which promote inequality in access to healthcare and excessive dependence on inpatient care. In total, the three main reform components addressed in the CSRs for the Romanian health system are 1) *combating informal payments* (14,16,17), 2) *reducing inpatient care* (13,16,17,18), and 3) *implementing a healthcare sector reform which strengthens the efficiency, quality, and accessibility of the healthcare system* (13,14,15).

Interestingly, especially the first and third components seem to relate to a lack of capacities in the health system's administration. The still prevailing issue of informal payments is recommended to be addressed by raising salaries and strengthening human resources management in the 2017 CSR. Also, the lacking efficiency and quality of healthcare indicate structural problems in the system's organisation. The years 2013 and 2014 already comprehensively put forward the issues which were included in the NHS 2014-2020. As to be seen in the year 2015, the Commission prioritised the implementation of this strategy and mentioned no other recommendations which indicate the importance of this endeavour. However, the strategy was not implemented in the successive years as stated in the issue section. The problems of informal payments, accessibility, and outpatient care remain, pointing at the weak administrative capacities of the system hampering the reform's implementation. This issue of the interrelatedness of poor quality of the health system and weak administrative capacities will be more theoretically addressed in chapter 5.

In this vein, sub-question 2 asks for measures to build administrative capacity in the local health sector. This cannot be fully answered by solely focusing on the health system recommendations. To convey the administrative perspective on this topic, it is also necessary to consider the recommendations of the CSRs in this respect. As shown in the analysis of the issue section, the CSRs of 2016 and 2018 also relate administrative capacity to the implementation performance of the NHS 2014-2020. Thus, it is necessary to cover the public administration reform recommendations to extract the main reform components and to understand this mutual reinforcing process ACB and implementation performance.

Table 4 (A.2.4) more clearly puts forward measures for building administrative capacity. It was decided to focus on measures which include local government activities such as strategic

planning or human resource management. Goals covering only national competences were excluded for example conducting nation-wide impact assessments. Consequently, the necessary main reform components from the public administration's CSRs for local ACB are: 1) *increasing the strategic planning capacity* (13,14,17), 2) *professionalise public services including through better human resource managements* (13,14,16,17), 3) *improve public procurement* (13,14,17), 4) *strengthen the coordination between the different government levels* (13, 14), 5) *simplifying administrative procedures* (16).

Importantly, the main recommendations for the public administration system particularly highlight the measures to build up administrative capacities that enable the implementation of the reforms mentioned. Strategic planning capacity is crucial for the realistic design of the implementation process in terms of the attached resources, expertise, evaluation, and monitoring systems. The professionalisation of the public service in that manner supports the availability of expertise and of accountable, responsible public administrators who enforce this implementation on the ground level as strongly emphasised in the different theoretical sections on effective practical implementation by Zhelyazkova et al. (2016) and on ACB by Heichlinger et al. (2014). The public procurement system is decisive to prevent the effective use of funds allocated to the process. The intergovernmental coordination, in this manner, helps to prevent miscommunication, diverging interests and supports the effective delegation of tasks in implementing the reform (El-Taliawi & Van Der Wal, 2019). This must be finally executed in transparent and clear administrative structure improving the implementation's effectiveness.

***Answering SQ2***. In total, and by that answering sub-question 2 (*What are the main necessary reform components of the Romanian health system as addressed by the European Commission in order to build up administrative capacity in the local health system?),* the CSRs on Romania contain eight main necessary reform components *(RC)* for ACB in the health sector:

- *RC1*: Combating informal payments
- *RC2*: Reducing inpatient care
- *RC3*: Implementing a healthcare sector reform which strengthens the efficiency, quality, and accessibility of the healthcare system
- *RC4*: Increasing the strategic planning capacity
- *RC5*: Professionalise public services including through better human resource management
- *RC6:* Improve public procurement
- *RC7:* Strengthen the coordination between the different government levels

- *RC8:* Simplifying administrative procedures

The first three *RCs* are based on the health system CSRs. They rather constitute the performance goals and indicate the area in which ACB is necessary than include ACB measures themselves. It is crucial to remember the difference between practical implementation through administrative capacity and the practical implementation of ACB measures to achieve better performance. Consequently, the analysis of the NHS 2014-2020 focuses on the five latter *RCs* as these aim at ACB in the local health sector to combat informal payments, strengthen outpatient care and implement the reform endeavours as performance goals.

### 4.2.2 Analysing the NHS 2014-2020

This subsection presents the analysis of the NHS 2014-2020 that is twofold. First, the document's analysis investigates the degree to which the RCs are mentioned in the NHS. Second, the operationalisation of "reform content" is used to explore unexpected findings regarding ACB measures in the NHS 2014-2020 and the CSRs. The NHS 2014-2020 was published in November 2014. It is separated into three strategic intervention areas: "*1. Public Health"; "2. Health Services"; "3. Cross-cutting measures for a sustainable and predictive health system".* These descriptions are followed by the elaboration of the implementation plan. In particular, the third area of intervention covers planning and measures for ACB in healthcare and was translated manually as the most important part for this analysis. The implementation mechanism was also translated due to its relevance. The third area is structured into the objectives which are accompanied by specific strategic goals such as developing an "inclusive, sustainable and predictable health system through the implementation of priority cross-cutting programs and policies" (NHS 2014-2020, 2014: 57). With regard to the national implementation of the *RC* identified in the CSR, the NHS is analysed below:

Table 5. National Implementation Programme of EU Structural Reforms

| **RC retrieved from CSR** | **Level RC issued in NHS 2014-2020** |
|---|---|
| Increasing the strategic planning capacity | + |
| Professionalise public services | + |
| Improve public procurement | - |
| Strengthen inter-governmental cooperation | 0 |
| Simplifying administrative procedures | 0/+ |

*Source: Coding Translation National Health Strategy 2014-2020*

These results apply only to the third intervention field and to the elaboration of the implementation. Table 3 shows that not all *RCs* are treated equally in the NHS 2014-2020. First of all, measures to improve public procurement do not appear in the sections examined. Public procurement, which is a serious weakness of the public administration problem, is treated separately by the Romanian government (see e.g. "Public Procurement Strategy 2016-2020"). Health infrastructure projects such as the construction of a regional hospital infrastructure are mentioned in the strategy, but not in the context of public procurement as a public instrument to be improved. Intergovernmental cooperation can be found in the NHS rather implicitly. Measures are planned which aim to strengthen regionalisation and decentralisation of the health system. The future monitoring of the health system performance is planned to be executed collaboratively as an example. Nonetheless, a clear organisational framework in this regard is not present in the text. Simplifying administrative procedures is mainly planned by means of the evaluation of existing distributions of competencies as well as by reorganising the responsibilities between the different levels of governments: "Analyse and review the competences and responsibilities of the institutions public health system at all levels of the health system" (NHS 2014-2020, 2014: 74).

The NHS treats the professionalisation of its public services in the area of healthcare as well as the strategic planning capacity as most important for the development of the system. Both areas are strongly elaborated under the strategic goal 5.1: " Improving the capacities of the national administration, the regional and local authorities and communicating change". Capacities for strategic planning will be improved by strengthening capacities for information retrieval in public services through ICT tools, external stakeholder involvement, and increased support for the local level for quality control management of health facilities on the basis of common guidelines. The results of these monitoring actions within the public administration and the health system will then be included in annual action and evaluation plans as a basis for further strategic action. The professionalisation of public services follows a threefold approach in the NHS. Firstly, based on the restructuring of the competencies, fitting staff shall be recruited with the necessary expertise. This shall help to reinforce the knowledge capacity on all levels of the health system. Secondly, the public services and shall be supported by ICT tools for which they are specifically educated to improve the efficiency, and the quality of the healthcare provision such as telemedicine services. Thirdly, the NHS 2014-2020 acknowledges the threats of informal payments for the functioning of the system. Measures to strengthen public integrity, as for example, "rigorous public spending controls" are proposed (NHS 2014-2020, 2014: 60).

Regarding the improvement of human resources, financial incentives and career prospects are planned to combat the migration of doctors and nurses.

The first and third *RCs* are, therefore, continuously addressed within the NHS as the performance goals for the health sector achieved through ACB. Especially, the inefficient use of resources and the public investment in the health system are strongly issued in the NHS, which is a crucial part of *RC3*. Inpatient care as *RC2* is predominantly addressed in the strategic intervention areas 1 and 2. These include also further measures for the other *RCs*. In general, the strategy is very ambitious and addresses crucial issues of the health system which were identified on the EU level (Popescu, 2015). However, as also identified in the CSRs, the practical implementation of this determined strategy is hampered by lacking administrative capacities. In terms of the operationalisation of "reform content", the analysis of the CSRs and NHS reveals two issues relating to ACB. The issues of accessibility through deficient health infrastructure and public procurement were not mentioned before. The former is subsequently added and included under *RCD*1 at the measurement level as "measures to improve local health infrastructure" to explore this measure also in the local health strategy. The latter, however, will not be added to the operationalisation because it does not constitute a major reform component which can be tackled on the local level health sector.

## 4.3 Local Reform Content

This subsection presents the analysis of the local health strategy for Cluj-Napoca "Strategia Municipiului Cluj-Napoca în domeniul sănătăți". In this sense, this subsection shows the results of the local document analysis. These results are then examined to give an answer to sub-question 3. Interestingly, the local health strategy was firstly published in March 2014 and was shortly after included in the overall Cluj-Napoca local development plan 2014-2020. This was nine months before the publication of the NHS 2014-2020 and nine months after the health system reform was firstly mentioned in the CSR of 2013. This indicates on the one hand awareness of the local administration of the issue and its capacity for strategic responsiveness supporting the arguments for Cluj-Napoca as a deviant case outlined in section 3.2. On the other hand, this raises the question of whether the linear practical implementation process (see theoretical framework 2.4) derived from the literature takes place in this way. This is more strongly discussed in the conclusion taking account of all the evidence gathered.

To begin with, the existence, structure, and content of the document show a high degree of tailor-made adoption of the strategy to the characteristics of Cluj-Napoca. The strategy is built upon an extensive analysis of the local health system including a wide-ranging field of issues

based on the WHO's healthy cities model (WHO, 2019). Predominantly, it includes the issues for which the local level possesses the competencies as described in section 4.1. This is, exempli gratia, the competence of public health prevention. Additionally, the document includes a section on the main competitive advantages in the health sector of the city, the strong and weak points of the local health system and the opportunities and threats for the system. Based on this, the strategy provides a strategic enumeration including objectives, target levels and indicators for the issues identified in the previous analysis. This three-step is then combined with specific strategic actions varying in length. The extent to which ACB for the health system are addressed is presented in Table 6.

Table 6. Reform Content of ACB at Local Level in Local Health Strategy

| **Reform Component Dimension** | **Measures for ACB in Local Health Sector** | **Level of Elaboration in Local Health Strategy** |
|---|---|---|
| RCD1 | RCD1.1 Combat Corruption | - |
| | RCD1.2 Monitoring of Capacities Gaps in the Health Sector | 0 |
| | RCD1.3 Simplifying Administrative Procedures | - |
| | RCD1.4 Improve Public Health Infrastructure | 0/+ |
| RCD2 | RCD2.1 Development of e-Governance Tools | 0/+ |
| | RCD2.2 Optimisation of Internal Procedures | 0 |
| | RCD2.3 Improving the Management of Resources | 0 |
| RCD3 | RCD3.1 Preventing Migration of Health Professionals | 0/- |
| | RCD3.2 Training for Healthcare Professionals | 0/+ |

*Source: Coding Translation of Local Health Strategy (2014)*

Regarding institutional capacities (*RCD1*), it becomes clear that while the objective is to reduce delays in official administrative procedures and thus make administration more effective (O18.1), no measures to fight corruption and simplify administrative procedures are included in the strategy. In practice, according to the CSRs, both challenges are crucial for the professional functioning of the system. Only access to public and legal information shall be simplified. Focusing on the monitoring of capacity gaps, the strategy includes two actions: gathering public intelligence on the public health situation which is in line with the local competence (section 4.1) and gathering intelligence on the processes in the medical units in Cluj. However, the monitoring of public health administration procedures is not mentioned in the documents, nor are responsibilities or resources. As regards the construction of public health infrastructure, the document sets clear targets for health facilities to be built by 2020. However, there are no plans mentioned to align it with existing funds, but the focus seems to be rather to improve the internal capacity to access European and national funds through cooperation with external stakeholders and to train administrative staff in this respect. This lack of own resources could be due to the limits in the financial autonomy of the municipality or of the Cluj county.

The bureaucratic capacities (*RCD2*) also relate to the development of e-Governance tools to be developed for improved networking between medical units and with the administration of Cluj-Napoca. These units shall initially be connected to the integrated computer system. In addition, e-Health tools are planned to better monitor patient satisfaction. Although these seem to be the first steps of digitisation, no resources or responsibilities are foreseen for implementation. Optimising the internal procedures is addressed in several areas: the increased use of external stakeholder networks to better deliver services, receive financial support and support the implementation of the strategy. This includes improving the working environment of the local government and strengthening the communication capacity of the administration to influence decision-makers to achieve specific objectives. Finally, resource management is included in *RCD2*. The strategy, as outlined above, essentially does not provide for adjustment of resources and human resources to the planned measures. Where the need for funds for different objectives is addressed, the strategy outlines measures to improve access to European and national funds through increased capacity of administrators or inter-institutional cooperation. The internal absorption and the processing of the acquired European funds are not mentioned. This lack of (managerial) capacity regarding the use of funds can also be traced back to the criticism found in the CSRs and shows why the provision of the ESI was linked to ex-ante conditionality.

Lastly, human resource management (*RCD3*) must be addressed here. This paragraph regards measures to prevent the migration of health professionals as doctors and nurses and the training for health professionals also including the administration's staff. The prevention of migration is addressed once as one of the main strategic directions. Although it is regarded this important, no further objectives are included in the translated parts. The training of health professionals is more strongly elaborated. Training is planned in the fields of the digital information system, educating the doctors, nurses, medical staff continuously in their specialisations and in the topic of health literacy. Finally, employees shall be empowered by improving their work environment. Also, for this component, there is no alignment to resources or responsibilities.

In order to answer sub-question 3 *(What administrative capacity building measures are integrated into the Cluj-Napoca Local Strategic Development Plan for Health?)*, all the measures were included that were coded with a 0 or higher displaying a sufficient level of integration. In this, the following ACB measures are integrated: *RCD1.2, RCD1.4, RCD2.1, RCD2.2, RCD2.3, RCD3.2.* Consequently, this analysis provides two main insights. Firstly, the local government of Cluj-Napoca engaged in the development of a strategy in the health sector in which they have only limited competences indicating the local awareness regarding the seriousness of the topic. This strategy was developed in a tailor-made manner for the local situation based on extensive analysis. It was already published in early 2014, even before the national level. Crucially, the tailor-made analysis firstly provoked a systematic approach of thinking about a vision for the system. Secondly, the strategy mentions (0;0/+; +) 6 out of 9 ACB measures for the health system regarded as important by the literature. Moreover, the strategy addresses some of the RCs mentioned in the CSRs such as better human resource management, strengthening the efficiency and effectiveness of the system by investing and improving the use of resources. Altogether, this indicates an ambitious strategy, developed for the first time in this manner.

However, none of the objectives was attached with an elaborated planning including resources, responsibilities or accountabilities. Additionally, the strategy does not include a streamlined monitoring or evaluation plan regarding its practical implementation. This lack in addressing the level concrete organisational steps can seriously jeopardise the success of the practical implementation of the strategy. These are the crucial steps to ensure the administrative survival of the strategy after publication. If the visionary plans are not translated into actions, the strategy runs the risk to remain an empty shell. In chapter 5, these exploratory findings will be traced back to the theoretical expectations to subordinate them into the bigger picture of the analysis.

The document analysis, however, does not provide any reasons for this missing action -and implementation plan. Therefore, it is now of importance to explore how this implementation process was executed practically on the national and local level.

## 4.4 Process of Local ACB

This section presents the analysis of the data retrieved from the expert-interviews regarding the "process of local ACB". Subsection 4.4.1 includes the description of the main issues of the Romanian health system related to AC as they are identified in the interviews. This step is necessary to first introduce the context of the phenomenon: the turbulent environment surrounding the "process of local ACB" and "reform content". This step further serves as a control for the findings of the previous sections. Subsection 4.4.2 entails the presentation of the findings regarding the "process of local ACB" based on its operationalisation (A.1). Lastly, this section gives a respond to sub-question 4.

### 4.4.1 Turbulent Environment of the Health System

The issues and description depicted here were independently mentioned by the three respondents regarding the Romanian and particularly Cluj-Napoca's health system. Notably, patterns in single issue's occurrence seem to be present throughout the interviews. In this vein, each issue retrieved from an interview refers to the respective interview's transcript number. The outlined challenges are chosen due to their relatedness to administrative capacity. The transcripts of the interviews are available upon request under specific conditions.

The lack of human resources constitutes the first main challenge. The quality insurance authorities, as well as the other public health institutions, face crucial shortages of health care professionals negatively affecting the agency of managing the system. It also affects the accessibility and quality of healthcare. This issue is especially visible in the rural areas: "If you are going 30, 40, 50 kilometres away from Cluj-Napoca, there are some mountain villages, that have no access even to primary care. They don't have a GP in their village" (Interview II). The salaries of the professionals have been increased to incentivise these positions, but the migration into foreign countries or the urban centres did not stop because the work in the rural areas and in the "public health institutions (…) [are] not attractive at all" (Interview III). Interestingly, one interviewee additionally mentions that the hospitals cannot invest properly in medical infrastructure since most of the financial resources go to salaries. This indicates the weak managerial capacities of administering the health system in terms of human resource management and the efficient use of resources (Interview III).

The second main challenge regards the culture of quality evaluation of public health institutions in Romania. Particularly, the accreditation and quality evaluation of public hospitals is still "pioneering work" and "new" to the system's actors (Interview I). Consequently, the quality of the different hospitals cannot be ensured thoroughly and strongly depends on the managerial capacities of the hospital's manager or the facility's owner as the county's public health authorities to act in this regard engage by hiring professionals.

Cluj-Napoca, as a big "city under development" (Interview I) and "academic centre" (Interview III) with a classical medical university and well-equipped university clinics with a regional reach, however, does not face these problems, except for some areas like emergency medicine (Interview II). This could be one reason why for instance measures against migration of professionals are not addressed in the local health strategy of Cluj-Napoca. But due to the system's mismanagement, the lack of health professionals all over the country, and the weak infrastructure in more rural areas, the hospitals of Cluj-Napoca deal with problems of extensive inpatient care (Interview III) and informal payments due to long waiting lists (Interview I). This illustrates the strong link between planning and management capacities acting with needs-based foresight and the performance of the health system for the benefit of patients at all levels. A clear separation between a functioning urban system and a non-functioning rural area is not possible, as the example of Cluj-Napoca shows. The functioning of the interdependent parts of the system depends on well-trained administrators as the "backbone of the system" (Interview III).

The Romanian health system remains centralised with limited competencies for the local and county level following the historical trajectory of the centrally organised communist system (Interview III). The local and county's competences within the health system are moreover based on vague legislation which leads to highly constrained capacities of the administration and restricted feeling of responsibility resulting in limited local actions (Interview II). This directs to two further challenges of the system.

Firstly, although the needs of the different geographical areas differ significantly, they are approach alike by the national level. This produces situations in which well-equipped hospitals, highly specialised, are useless in their regions (Interview I). The public procurement system additionally contributes to this challenge of the inefficient use of resources, here with regards to e-Health systems: "They think that cheap is good but it's not. If you want to invest in something, you don't get the cheapest thing available" (Interview I).

Secondly, although counties or cities do possess the necessary resources, the limited responsibility hampers the investment in public health infrastructure since policymakers "invest these resources in things that are more visible, you know, like for the people that elect them and for their interest. Because if there are not forced or stimulated to invest in healthcare or the health system, they don't do it. Why should they, right?" (Interview II). Combining that with the lack of technical capacity at the public health authorities, this leads to a system that cannot adjust to the increasing challenges facing the health systems as the aging population and the high costs of digitisation. Consequently, as highly recommended by the EU, there is the need for reform. This, however, must be initiated politically.

This constitutes a further crucial issue. The political situation in Romania is considered highly unstable: "We had a very increased change in governments. So, you have one government after the other. So, a minister cannot do so much into 6 months or a year" (Interview II). This rapid turnover in government delays, for example, the political commitment and awareness for agenda-setting regarding the continuation of the necessary decentralisation endeavours as well as the implementation of the NHS 2014-2020 (Interview III). Additionally, the centralised system would require an evidence-based policymaking on the national as well as on the county and local level which is based on data collection and analysis for tailor-made decisions that fit the needs of the policy-target. However, this is barely the case: "Data analysis and use of data analysis, I think this is a problem in Romania on every part, in every sector" (Interview I). This also threatens the tailor-made adaptation of EU-driven reforms if these are blindly adopted (Interview I).

Moreover, the interviewees also indicate that the EU could do more to facilitate the existing reform endeavours in Romania for the benefit of patients. Especially, in the healthcare sector, not much improvement was reported since the EU accession in 2007 (Interview III). EU documents are further often used as a legitimacy argument to propose a law. Instead of using them "instrumentally" (Interview II).

Furthermore, the interviewees describe a lack of willingness and mentality to engage in change by the administrators in the city halls: "It's hard to work on their mentality because it's easier to work with what you know than to start with something. This is the fear of change" (Interview I). This challenge also constitutes a crucial threat to the implementation of the NHS 2014-2020 and the local strategy. Interestingly, this becomes clearly visible asking for the implementation of the NHS 2014-2020. According to the interviews, the implementation of the NHS 2014-2020 stopped after the governmental adoption of the health strategy (Interview II; Interview III)

without thorough evaluation: "I don't think there is an evaluation, at least a real one of the implementation systems" (Interview I). The Ministry of Health provides one monitoring report on its website dating back to 2016 (analysis of 2015) (Interview III).

Altogether, the interviews clearly show that the environment of the Romanian health system can be regarded as highly turbulent for ACB as expected on the basis of the theory. The challenges mentioned clearly underline that ACs such as knowledgeable personnel at all levels and institutional capacities in terms of clear accountabilities of and in the public health institution are key for the practical implementation of reforms (Surubaru, 2017; WHO, 2014). Moreover, political instability leads to a fractured political agenda undermining continuous reform endeavours undermining the administrator's actions (Rainey, 2014). Importantly, the willingness and mentality of the national and local administrators seem to play a crucial role in the (non-) implementation of the strategies (Dörrenbächer, 2017).

### 4.4.2 Planning and Implementing the Local Health Strategy

After having described the challenges of the system, it is now of importance to describe the information regarding the practical implementation of the local health strategy. The findings of the transcript's analysis are presented in the light of the operationalisation of "local reform content" (A.1) to answer sub-question 4.

Table 7. Process of Local ACB in Cluj-Napoca

| **Process Dimensions** | **Measurements** | **Level of Appearance in Planning (P)** | **Level of Appearance in Implementation (I)** |
|---|---|---|---|
| PD1 | PD1.1 Political Interference | - | + |
| | PD1.2 Discretion for Actors | + | - |
| PD2 | PD2.1 Incorporating external stakeholders | + | - |
| PD3 | PD3.1 Analysis of Status Quo before Planning | + | Does not apply. |

| | | | |
|---|---|---|---|
| | PD3.2 Monitoring or Support Systems in Place for Implementation | Does not apply. | - |
| PD4 | PD4.1 Clear Time Structure | 0 | - |
| PD5 | PD5.1 Formulation of clear, tailor-made objectives | 0 | - |

*Source: Coding of the Interview Transcripts*

Firstly, *PD1* is addressed. The process of drafting the entire local development strategy was conducted by the Faculty of Political, Administrative and Communication Sciences of the Babeş- Bolyai University, Cluj-Napoca. The respective Health chapter was drafted by the Department of Public Health. According to the interviews, there was high discretion (*P.PD1.2* +) for the actors drafting the strategy without being inferred politically (*P. PD1.1* -). The process was regarded as highly participatory (see *PD2*). However, after the draft was submitted, the city hall of Cluj-Napoca adjusted the strategy's priorities according to the political priorities of the local government (*I.PD1.1* +) (Interview III). Moreover, the interviewees wondered whether it was actually intended to implement the strategy (Interview II). It was a political decision to not attach an action plan (Interview III) leading to, to the extent explorable, no space for administrative action (*I.PD1.2* -). One interviewee assumes that the process was rather an "image exercise" for the city hall to show its openness (Interview II). Additionally, the time span 2014-2020 mirrors the EU funding framework. Important to mention, the CSRs were, however, not used to draft the document as the strategy was based on the WHO framework (Interview II).

Secondly, *PD2* is discussed. The planning and drafting phase was organised by the university in a highly participatory fashion (*P.PD2.1* +). Based on the employed framework of the WHO, the important stakeholders were identified and invited to several meetings and discussions to collect their opinions. In the implementation phase, which is the responsibility of the city hall, there was no incorporation of external stakeholders mentioned or experienced by the interview partners anymore (*I.PD2.1* -). Nor were any public documents published on the implementation for independent monitoring by civil society. Thirdly, regarding *PD3* a differentiation is made between an analysis of the status quo before drafting and executed monitoring during the

implementation or a final evaluation afterward. The former can be found in the Health chapter in terms of the extensive analysis of data regarding the local health system's performance and the local population's health indicators (*P.PD3.1* +). Regarding the monitoring or evaluation of the implementation of the strategy, no documents or indicators are available (*I.PD3.2* -). It is the respondents' assumption, that the implementation progress stopped after the planning phase. However, there are no information available which provide evidence for or against this assumption. The university's department responsible for drafting the strategy was also not involved in the implementation procedure nor informed about it. This furthermore leaves the question regarding the practical implementation of the strategy unanswered.

Fourthly, *PD4* is addressed. In terms of the planning, a need-assessment was conducted to explore the main issues and, on that basis, formulate visions that need to be addressed. This was done in 2013/2014 and objectives for 2020 were set as it was planned to be concluded in 2020 (*P.PD4.1 0*) As already analysed, no timely structured action- or implementation plan was attached to the strategy. In June 2019, there are no publicly available data suggesting that an implementation has been executed (*I.PD4.1* -). Lastly, *PD5* refers to the adaption to the local context. The Department of Public Health conducted an extensive analysis of the local health system based on the WHO's healthy cities framework which comprehensively includes measures for healthcare prevention, mental well-being and curative healthcare. By using the data and incorporating the local stakeholders, a fundament for the tailor-made objective setting was provided (*P.PD5.1 0/*+). However, streamlined and detailed indicators and action steps were not considered following a decision by the city hall, although they are necessary to address the shortcomings identified in the local system by implementing the strategy (*I.PD5.1* -).

In sum, and by that answering sub-question 4 *(How is the process of local administrative capacity building described and what are the main elements?)* the analysis of the "process of local ACB" provides strongly contradictory findings regarding the quality of the two process elements based on the process determinants. The process can be separated into two main elements: planning and implementation. First, the planning phase was executed by the Department of Public Health in an apolitical manner provided with discretion by the city hall. Also, the planning was timely systematically organised by incorporating external stakeholders and analysing local data to address the shortcomings of the systems with tailor-made objectives. Second, regarding the implementation, no information is publicly available. Based on the previous analysis, questions can be raised regarding the level of execution of the practical implementation. This might be the case due to decisions of both the local government and the

local health authorities not to implement the Health chapter or not to publish information about it. The information provided by the interviews thus allows to put the political will, the resources, and responsibilities for implementation into question.

Nonetheless, the successful planning process has shown the willingness and capacity of the local academia and the civil society of Cluj-Napoca to engage in change. Additionally, several visionary ideas have been raised to address the mentioned shortcomings which can be regarded as the first positive step. These analytical findings must now be discussed theoretically tracing back to the expectation based on the literature review to see to what extent these apply. Especially, the explored weak link between the EU's CSRs and the national and local actions must be addressed as it undermines the developed theoretical framework of a clear implementation process.

# 5. Discussion

In the following paragraphs, the exploratory findings are firstly traced back to the theoretical expectations made in chapter 2. This separation of analysis and theoretical discussion is done to avoid a too strong theoretical imprint of this exploratory analysis. The discussion of the expectations combined with the responses to the sub-question enable to answer the main research question in the conclusion. The theoretical expectations are addressed in numerical order.

Regarding expectation 1a (*The Semester increases the probability that national and local governments will participate in administrative capacity building as an essential EU requirement after EU accession)* two developments must be highlighted displaying increased endeavours of the Commission to improve the health system reform implementation including ACB measures. First, the poor quality of healthcare in Romania has been repeatedly stated raising a red flag and by that trying to build political awareness for engaging in reform. Second, as stated in the theory, the Member States are consulted by the Commission in the Semester cycle aiming to strengthen their commitment to the CSR's implementation since 2017 (Alcidi & Gros, 2017; Zeitlin & Vanhercke, 2018: 165). Nevertheless, the Commission faces enforcement constraints, especially since health is a national competence based on the Treaty of the Functioning of the European Union, Article 168 (7). The enforcement pressure as possible through pre-accession conditionality cannot be applied similarly after accession (Schimmelfennig, 2008). One post-accession enforcement tool available is, however, to link the adoption of reforms to the provision of ESI funds (Commission, 2019). This was done for the case at hand. Finally, the analysis shows that the Semester as a post-accession monitoring instrument can lead content-wise to the legal adaption of the reform components into a national and local health strategy, but not necessarily to their practical implementation. Consequently, this case might indicate the occurrence of decoupling between the planning resulting in an adopted local strategy and its practical implementation as analysed by Zhelyazkova et al. (2016). Also, the public cannot provide independent monitoring supporting the Commission in this regard (Falkner & Treib, 2008) since the completing of the strategy in Cluj-Napoca is not observable due to no publicly available documents (Interview III). This study cannot provide evidence whether the strategies are following the CSRs.

Exploring the reasons for the lacking implementation of the developed reforms, following expectation 1b *(The lack of administrative capacities of the local administrative forces hampers the ability to achieve local structural change in-line with EU-standards in Cluj-Napoca)* it is

indicated that the lack of managerial capacity of the public health authorities through weak human resource capacities and lacking evidence-based policymaking on the central and local level hamper the local agency of engaging in urban structural change supporting the findings of Dossi (2017). This result is also directly stated in the CSR of 2016. The CSRs outline in detail the shortcomings of the system which are also predominantly mentioned in the NHS 2014-2020 and the Health chapter of the local strategy (see answers to *SQ2 & SQ3*). Nonetheless, the finding of Ganev (2013) that political elites seem reluctant to invest in ACB can be supported for the case under analysis since no measures for the implementation of the local strategies addressing the identified shortcomings in administrative capacities were planned or executed following a political decision. The unstable political situation on the national level additionally undermines the centrally organised system's capacity for continuous improvement by hampering administrative action's (Rainey, 2014; Vlădescu et al., 2016). The expectation can thus be supported.

Providing insights regarding expectation 2a *(The likelihood of effective local practical implementation of EU administrative reforms increases if the domestic administrative forces of Cluj-Napoca perceive political and public support including the provision of policy space.)* must be done alongside the separation of the process into a planning and implementation phase, respectively legal compliance and practical implementation (Zhelyazkova et al., 2016). The former, executed by the local university was supported politically by providing extensive space of action and allowing for the participation of the public's external stakeholder embodied by civil society organisations (El-Taliawi & Van Der Wal, 2019; WHO, 2014). These steps made it possible for the drafters to develop a well-scoped strategy according to the local needs. The existence of the ambitious strategy seemed to be in the interest of the policymakers. The information regarding the practical implementation was not publicly available which does not provide the basis to follow-up and excludes the public from executing public support .This explored process on the local level fits the results of Zhelyazkova et al. (2016) that diverging policymaker's interests and weak administrative capacity increase the probability of decoupling reform adaption and its implementation. Especially, administrative autonomy is under threat here (El-Taliawi & Van Der Wal, 2019). This weak link between the local government and the public can be regarded as historical heritage of the communist system leading to a lack of trust (Bădescu et al., 2004). In general, the local/ county public health authorities and politics do have a limited discretionary scope in the centralised health system for ACB constraining their ability and willingness to work on the shortcomings of the systems (Dörrenbächer & Mastenbroek, 2017).

This leads to expectation 2b *(The likelihood of effective local practical implementation of EU administrative reforms increases if the domestic administrative forces of Cluj-Napoca follow a well-scoped reform plan including the allocation of resources and monitoring instruments.).* No action plan including the attachment of resources, accountabilities or responsibilities was found. The strategy was built on an extensive local analysis leading to well-scoped objectives and ideas for the city. The lacking action plan, however, hampers the likelihood of effective practical implementation of the strategies according to the interviews and the theory (Heichlinger et al., 2018). Both findings also confirm earlier literature (Junjan, in Nemec and de Vries, 2012) regarding the main patterns of administrative reform implementation and ACBs in CEECs in terms of political control, motivational issues of the local administrators undermining the reform endeavours.

For expectation 3a *(The likelihood of effective ACB on the local level increases if the reforms to be implemented are carefully applied to the specific socio-economic context of the city of Cluj-Napoca.)* the analysis of "reform content" reveals that six out of nine measures which were identified in the theory (see sections 2.2 and 2.3) as important for local ACB, were mentioned. Measures that were missing such as combating the migration of professionals, do not constitute an urgent problem for the city. Also, measures to reduce the outpatient care dependence as addressed by the CSRs, are included by the drafters. Again, the lacking action plan jeopardises the implementation endeavours (Heichlinger et al., 2018). Therefore, it can be concluded based on this exploratory analysis that although the strategy perfectly identifies the problems of the local health system, effective ACB was not facilitated by the strategy.

This points to expectation 3b *(The likelihood of effective local ACB increases if the process is seen as a long-term endeavour, carefully monitored and evaluated by impartial bureaucrats equipped with the necessary resources.).* The literature on ACB mentions the loop of administrative capacity. Existing capacities strengthens the administration's agency to build administrative capacity (Heichlinger et al., 2014). In the case at hand, the lack of detailed-strategic planning capacity combined with the mentality of fear of change led to the non-implementation of reform endeavours that incorporated well-scoped measures for ACB resulting in little improvement of the local health system. The fact that administrative reform including ACB is a long-term endeavour cannot be neglected and must be also take into account here (El-Taliawi & Van Der Wal, 2019). Historical path dependencies are visible in the health system regarding high centralisation, lacking expertise and inefficient use of resources (Vlădescu et al., 2016). Additionally, the accession to the EU reinforced the problem of the

migration of professionals (Paina et al., 2016). Nonetheless, the strategies show that the capabilities for visionary and evidence-based planning are available, also within the civil society. This chapter has now put the explorative findings of the analysis in a theoretical spotlight. That final step enables to conclude the thesis by conflating the results and to finally answer the main research question.

# 6. Conclusion

This chapter summarises the results of the analysis based on the sub-questions, formulates an answer to the research question, proposes implications for further research, outlines limitations and strengths of the thesis, and lastly, presents policy recommendations.

The first sub-question asks for the theoretical state of the art in the field under investigation. The literature does not provide specific insights into ACB through the practical implementation of EU structural reforms. To have an employable theoretical framework which structures the analysis of the process of the practical implementation, it was decided to adapt to the EU policy implementation framework. Interestingly, the literature review showed that the distinctive research fields practical implementation, implementation of administrative reforms and ACB overlap in the determinants mentioned as important. These collaboratively provided the fundament for the operationalisations applied. Sub-question 2 structured the CSRs analysis which clearly outlined that the Commission acknowledges the interplay of administrative capacities and healthcare sector performance. It especially links the delayed implementation of the NHS 2014-2020 to the lacking administrative capacities of the system. The CRSs contain health system reform components that need to be addressed through the practical implementation of the public administration measures also contained in the CSRs. The third sub-question focused on the local health strategy on the meso-level. It revealed a well-scoped ambitious strategy integrating important measures for ACB in Cluj-Napoca as addressed in the CSRs and the theory. However, no action-plan including any operational steps for achieving the strategy's objectives was attached nor were any monitoring endeavours or evaluation plans for the implementation. This highly contrasting finding also coined the response for sub-question 4. On a highly participatory and evidence-based planning phase of the strategy followed the implementation phase where no data are available. This raises questions about the administrative capacities of the local authorities and the political will for implementation. The strategy should be concluded in 2020, but no practical implementation actions could be reported since the publication in March 2014.

Based on that the main research question of this thesis can be answered *(Which consequences does the practical implementation of EU health system reforms by local administrative forces have on the administrative capacity building in the health system of the city of Cluj-Napoca (Romania) under EU-post-accession monitoring from 2011 to 2018?).* First, following the exploratory findings of the analysis, it must be stated that that the implementation of the local health strategy most probably did not leave the theoretical stage of legal adoption in Cluj-

Napoca. The local administrative forces of the local health system possess only limited competencies in the highly centralised health system which constrains their possibility for implementation action. Therefore, also in a developed city in terms of healthcare, the central system undermines the agency for local structural change. Secondly, the local health administration strongly lacks autonomy from local politics, has weak managerial capacities in organising the local health system and limited expertise through mismanagement in human resources. Moreover, the data reported a mentality of fearing change within the administration. Additionally, no action plan for operationalising the strategy into administrative mechanisms was planned that could have provided orientation. Thus, as far as can be seen in this study, the characteristics of the local health administrative forces have had the consequence that no ACB was executed following the local health strategy.

In terms of the implementation procedure, it is highly questionable if the analysed NHS 2014-2020 and subsequently, the local health strategy are an implementation result of the CSRs that were theoretically identified as the source for EU health reforms. The local strategy was timely adopted before the national strategy and was built on a WHO framework without referring to the national strategy or the CSRs which just mentioned health firstly in 2013. The interviews additionally indicated that the EU documents are hardly considered content-wise by the administrators in the public health authorities. The Commission additionally faces monitoring constraints due to their limited capacities as well as faces the limitation that health is a national competence. Nonetheless, one indication of EU influence is visible. The time structures of both strategies mirror the EU-funding frames. This, however, could be a result of the post-accession monitoring tool used by the Commission relating the implementation performance of the Member States measured in the Semester to the provision of ESI funds (ex-ante conditionality). Nonetheless, as also outlined in chapter 5 and section 4.3, the process of ACB is a long-term endeavour that needs time in a system which is still shaped by its communist past. The participatory process of planning and formulating the Health chapter as well as the steady issue blaming by the Commission provoke crucial thinking of the actors that can manifest itself over time and result in incremental improvement of the system. In line with Dossi (2017) the Semester could in this regard display a common logical framework for urban structural change through structuring the process of local ACB. Importantly research, thus, needs to differentiate between the failure of short-and medium-term endeavours like strategies and long-term development through mentality change.

The following paragraph presents the limitations and strengths of this thesis. To begin with, three limitations of this study are named. First, more extensively discussed in the methodology part, the employed methods have limitations. The analysed data only allows for assumptions regarding the political will for and the execution of the implementation. This due to the missing interview with a local government employee and the publicly available monitoring data. Also, the language barrier resulting in manual document translations and the missing second round of coding for intra-code reliability constitute limitations to this study. Secondly, the thesis does not entail a comparison of the status quo of the local administrative capacities in 2014 and 2020. This would have been necessary to explore whether an implementation of the strategies has happened without informing the public. This controlling measurement would have served the data validity. However, no data was available for this step. Lastly, the restricted competencies of the local level in the Romanian health sector lead to limited local administration's action capabilities and resources. This in turn incorporates less research possibilities for investigating distinctive patterns of local action in this field.

To continue, three strengths of this thesis are outlined. First, the study made a multifaceted approach to explore this understudied topic. It used the Europeanisation theory with a special focus on the urban area in a multi-level governance context including the post-accession dynamics in CEEC. This was combined with the practical implementation and administrative capacity building literature. Consequently, this constitutes an innovative theoretical approach to explore ACB in this context. However, if theoretically unexpected findings appeared such as the assumed non-implementation of the local strategy, they were not excluded but further investigated. Secondly, two different methods of data collection were employed to analyse the issue from different angles. This approach provided the possibility to cross-check the results and provide a more complete picture of the situation by including documents from three levels of government and three interviews with experienced experts. Thirdly, the case-selection of a deviant case study enabled to clearly show the high interrelatedness of the different areas of centralised system. Although Cluj-Napoca is well-developed as opposed to most parts of Romania, the mismanagement on the central level due to the mentioned political instability and lacking capacities strongly affects the local practical implementation performance.

This paragraph lays out the implications for further future research. Based on the limitations of this thesis, future research can make the second step in exploring the case under analysis by conducting further interviews with employees of the local government and local public health authorities involved in the ACB process. Additionally, a comparative performance

measurement can be conducted of the local health administration by future research to test the administrative capacities from 2014 and 2019. In this vein, the coding procedure could be repeated to control for the results and increase the intra-code reliability. Moreover, the analytical explorations reveal two main theoretical findings providing possible directions for future research. Firstly, the newly constructed operationalisations for "reform content" and "process of local ACB" (A.1) provided the possibility to explore the mechanisms of local ACB in Cluj-Napoca. Further research could apply these operationalisations in another context of local ACB to test their robustness in an explanatory-oriented design. Nonetheless, the policy sector's selection should be in line with Dossi's (2017) demand of choosing a sector without "urban" in its headline and considering the level of local competencies. Secondly, the theoretical approach of using the EU policy implementation mechanism to analyse the practical implementation of EU reforms in national and local strategies did not work out. This may have to do with the selection of strategies or the not yet known implementation mechanisms of the Semester (Zeitlin & Vanhercke, 2018). Future research could, therefore, test a different theoretical design to explore the implementation procedures of the Semester. One possibility could be to rather focus on concrete national and local policies that directly relate to the CSRs.

To conclude, based on the findings of this research and in line with statements made in the interviews, policy/action recommendations are presented for each level involved:

1. For the European Union:
    - Strengthen the facilitation endeavours for the practical implementation of the CSRs in Romania by providing continuous support, data, and expertise for the national and local governments to ensure the tailor-made adaption of the reforms in line with national characteristics.
    - Support the civil society and the universities by financial and idealistic means in a direct way to the extent possible to facilitate public control and support the enlargement of the public chamber of knowledge.
2. For the National Level, Romania:
    - Continue the decentralisation of the national health system to more efficiently incorporate local problem-solving capacity by strengthening the local administrations and by that enable needs-based investments.
    - Improve the use of data and more often conduct impact-assessments to foster evidence-based policymaking.
    - Open public health authorities for professionals other than physicians.

3. For the Local Level, Cluj-Napoca:
    - Strengthen the cooperation between the local government, the universities and the civil society through project collaboration in health prevention, and health literacy and organise events for young professionals interested in public health.
    - Develop an action plan including accountabilities, measurable indicators and monitoring mechanisms for the still relevant parts of the local health strategy.
    - Plan training and programmes for young health professionals to work in the more rural areas in order to decrease the strong dependency on inpatient care in the urban university clinics.

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# Appendix

## A.1 Table of Operationalisation

| *Phenomenon to be explored* | *Theoretical constructs of phenomenon* | *Construct's main determinants/ dimensions* | *Measurements* | *Data collection* |
|---|---|---|---|---|
| **Local ACB trough implementation of EU driven health system reforms** | **Process** of developing local development strategies and their implementation based on Semester | -Political support (PD1) | - How do national/ local politics participate/act in the local implementation/ strategy development process?<br>-How much discretion is provided for local actions? | - Interview with local experts |
| | | -Incorporating external stakeholder networks (local and EU-wide) (PD2) | - Which external partners within the local and European healthcare system were incorporated in the process (hospitals, pharmaceutical firms)? | -Interview with local experts |
| | | -Monitoring, support- and evaluation systems during and before implementation (PD3) | - To what extent is the process based on an evaluation considering the health system performance of the city? | -Interview with local experts |
| | | | - Are there any monitoring or support systems in place accompanying the process? If so, by whom are they run and how do they affect the further process? | -Interview with local experts<br>-Document analysis & interview with local experts |
| | | -Time structure (PD4) | - How is the process timely structured? Are their deadlines with particular goals being set? | |
| | | Adaption to local context (PD5) | - Formulation of *clear policy objectives and goals* based on the local health system's characteristics | -Document analysis |
| | **Content** of ACB measures for health system reform from EU to local level | --Implementation of proposed EU health system reform measures | - What are the main necessary reform components of the Romanian health system as addressed in the Semester?<br>-To what extent are the measures addressed in the national health system reform? | - Document analysis & Interviews with local experts |

| | | | | |
|---|---|---|---|---|
| | | -Institutional capacities (RCD1)) | -Measures for *tackling corruption in hospitals*<br>-*Monitoring to identify skill-and capacity gaps* in hospitals and health system administration<br>-Measures for *simplifying administrative health system structure*<br>-Measures to *improve local health infrastructure* (added based on CSR/NHS) | -Document analysis |
| | | -Bureaucratic capacities (RCD2) | - Development *of e-Governance tools* (electronic health record)<br>- Measures for *optimisation of internal process structures* (stationary and ambulant care) | -Document analysis |
| | | -Human resources instruments (RCD3) | - Measures *for steering the management of resources* (accountabilities, fund accession etc.)<br>- *Professional trainings* for healthcare professionals<br>- Measures for *preventing migration of health system professionals* (incentives, career development) | -Document analysis |

### 6.1.1 A1.1 Examples for the development of the operationalisations

*Reform content.* One example is provided to display the logic behind it. Referring to *RCD1* Institutional structures, the WHO proposes to put in place independent oversight for health system organisations as well as building an organisational structure which pays attention to responsible leadership. Heichlinger et al. (2014) propose measures to tackle corruption and to implement a socially and ethically responsible culture. Thus, one facet of *RCD1* are the measures taken on the local level to tackle corruption in the hospitals or the local health system administration which can include independent monitoring tools or the implementation of an ethical code of conduct.

*Process of local ACB.* An example of the operationalization process is presented: Political support (*PD1*) refers to two measurable determinants asked for in the interviews and retrieved from the documents: (1) policy space, namely the discretionary scope for local administration provided for in the NHS and (2) the extent to which the experts involved in the process perceive political support or have experienced political interference in their actions. In general, the use of this concept aims to presents the process and analyse the environmental factors influencing the local ACB.

## A.2 Coding Tables

### A.2.1: Table 1. Issues of the Romanian health system raised in Semester CSRs 2011-2018

| **Time of CSR** **Health system issues** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** |
|---|---|---|---|---|---|---|---|---|
| Inefficient Hospital Network | - | - | - | - | X | X | - | - |
| Informal Payments | - | - | - | X | - | X | X | X |
| Funding | - | - | - | X | X | X | X | X |
| Lack of AC | - | - | - | - | - | X | - | X |
| Poor Quality Provision | - | - | - | - | X | X | X | X |
| Use of Resources | - | - | X | X | X | X | - | X |
| Inpatient Care Overload | - | - | X | X | X | X | X | X |
| Management of Facilities | - | - | X | X | - | - | - | - |
| Shortages of Professionals | - | - | - | - | - | - | X | X |
| Accessibility Inequalities | - | - | X | X | X | X | - | X |
| Referral System | - | - | **X** | - | **X** | - | **X** | - |

*Source: Summary of the coding for the CSR for Romania*

### A.2.2: Table 2. Issues of the Romanian public administration raised in Semester CSRs 2011-2018

| **Time of CSR** **Public administration issues** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** |
|---|---|---|---|---|---|---|---|---|
| Weak AC | - | - | X | X | X | - | X | - |
| Management and control systems of fund absorption | - | - | X | X | - | - | - | - |
| Excessive bureaucracy | - | - | X | - | - | X | X | - |
| Inconsistent legal framework | - | - | X | X | - | - | X | X |
| Low degree of professionalism | - | - | - | X | - | X | - | - |
| Corruption/Independence | - | - | - | X | | X | X | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Human Resource Management | - | - | X | X | X | - | - | |
| Public procurement | - | - | X | X | - | X | X | X |
| Strategic planning | - | - | - | - | - | X | X | X |
| Weak implementation | - | - | | X | X | X | X | X |
| Structural weaknesses | - | - | | - | X | X | X | - |

*Source: Summary of the coding for the CSR Romania*

**A.2.3: Table 3. CSRs for Romanian Health System 2011-2018**

| **Year of CSR** | **CSR: Health System** |
|---|---|
| 2011 | None. |
| 2012 | None. |
| 2013 | *CSR 3*- Pursue health sector reforms to increase its efficiency, quality and accessibility, in particular for disadvantaged people and remote and isolated communities. Reduce the excessive use of hospital care including by strengthening outpatient care. |
| 2014 | *CSR 3*- Step up reforms in the health sector to increase its efficiency, quality and accessibility, including for disadvantaged people and remote and isolated communities. Increase efforts to curb informal payments, including through proper management and control systems. |
| 2015 | *CSR 3*- Pursue the national health strategy 2014-2020 to remedy issues of poor accessibility, low funding and inefficient resources. |
| 2016 | *CSR 3*- Curb informal payments in the healthcare system and increase the availability of outpatient care. |

| | |
|---|---|
| 2017 | *CSR 2*- In healthcare, shift to outpatient care, and curb informal payments. |
| 2018 | *CSR 2*- Improve access to healthcare, including through the shift to outpatient care. |

*Source: Country-Specific-Recommendation 2011-2018*

**A.2.4: Table 4. CSRs for Romanian Public Administration 2011-2018**

| **Year of CSR** | **CSR: Public Administration** |
|---|---|
| 2011 | None. |
| 2012 | None. |
| 2013 | *CSR 6*- Strengthen governance and the quality of institutions and the public administration, in particular by improving the capacity for strategic and budgetary planning, by increasing the professionalism of the public service through improved human resource management and by strengthening the mechanisms for coordination between the different levels of government. Significantly improve the quality of regulations through the use of impact assessments, and systematic evaluations. Step up efforts to accelerate the absorption of EU funds in particular by strengthening management and control systems and improving public procurement. |
| 2014 | *CSR 7*- Step up efforts to strengthen the capacity of public administration, in particular by improving efficiency, human resource management, the decision-making tools and coordination within and between different levels of government; and by |

| | |
|---|---|
| | improving transparency, integrity and accountability. Accelerate the absorption of EU funds, strengthen management and control systems, and improve capacity for strategic planning, including the multi-annual budgetary element. Tackle persisting shortcomings in public procurement. |
| 2015 | None. |
| 2016 | *CSR 3*- Strengthen the independence and transparency of human resources management in the public administration. Simplify administrative procedures for business and the public. |
| 2017 | *CSR 3*- Adopt legislation to ensure a professional and independent civil service, applying objective criteria. Strengthen project prioritisation and preparation in public investment. Ensure the timely full and sustainable implementation of the national public procurement strategy. |
| 2018 | *CSR 3*- Increase the predictability of decision-making by enforcing the systematic and effective use of regulatory impact assessment and stakeholder consultation and involvement in the design and implementation of reforms. |

*Source: Country-Specific-Recommendation 2011-2018*

### A.2.5 Argumentation binary coding EU structural reforms.

For the analysis, only topics that appeared at least twice in the documents were used to ensure that these problems were of medium or long-term nature. It was decided to keep the coding at this binary level, as the CSRs are mainly problem-oriented in order to further improve the system. This means that although the strength of the wording or the wording itself may vary, it is more decisive whether a problem is mentioned or not. Nevertheless, it must be pointed out that even if a problem is not explicitly mentioned in the document, it can still exist in practice. Finally, some issues have been mentioned differently over the years or in different contexts within the sections on AC or HS. However, as these are fundamentally existing problems within the system and the formulation or contextualisation of these issues is under the influence of the changing focus of the CSRs, it was decided not to differentiate these further.

## A.3 Data Appendix

| *Level of Analysis* | *Type of Document* | *Name of Document* | *Retrieved from:* |
|---|---|---|---|
| *EU Structural Reforms* | Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on the National Reform Programme 2011 of Romania | https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52011SC0825 |
| | Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on Romania's 2012 national reform programme | https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52012DC0325 |
| | Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on Romania's 2013 | https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52013DC0373 |

| | | |
|---|---|---|
| | national reform programme | |
| Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on Romania's 2014 national reform programme | https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52014DC0424 |
| Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on the 2015 National Reform Programme of Romania | https://ec.europa.eu/info/sites/info/files/file_import/csr2015_romania_en_0.pdf |
| Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on the 2016 national reform programme of Romania | https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1486055100657&uri=CELEX%3A52016DC0343 |

| | | |
|---|---|---|
| Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Romania | https://ec.europa.eu/info/sites/info/files/2017-european-semester-country-specific-recommendations-commission-recommendations_-_romania.pdf |
| Country Specific Recommendations | Recommendation for a COUNCIL RECOMMENDATION on the 2018 National Reform Programme of Romania | https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1558000585933&uri=CELEX%3A52018DC0422 |
| National Implementation Strategy | Strategia Nationala de Sanatate 2014-2020 | http://www.ms.ro/wp-content/uploads/2016/10/Anexa-1-Strategia-Nationala-de-Sanatate-2014-2020.pdf |
| National Implementation Strategy – own translation | National Health Strategy 2014-2020 | Available upon request |

| | | | |
|---|---|---|---|
| *Reform Content* | Local Strategic Document | Strategia Municipiului Cluj-Napoca în domeniul sănătății | http://cmpg.ro/wp-content/uploads/2014/03/Strategie-sanatate-Cluj-18-martie-2014.pdf |
| | Local Strategic Document – own translation | Local Health Strategy of Cluj-Napoca | Available upon request |
| *Process of Local ACB* | Interview Transcript | Interview 1 | Available upon request under specific conditions |
| | Interview Transcript | Interview 2 | Available upon request under specific conditions |
| | Interview Transcript | Interview 3 | Available upon request under specific conditions |

## A.4 Interview Guide

| WHY | # | Questions |
|---|---|---|
| - Understand position within local system | | Could you describe your function at work? |
| | | What is the function of your organization within the local administrative system of Cluj-Napoca? |
| **EU and Cluj-Napoca** | | *There are no right or wrong answers. Please elaborate your own thoughts and wherever possible provide examples based on your daily work.* |
| - Understand the role of EU for the city development of Cluj-Napoca since accession<br>- Gather knowledge about local perception and clash between EU and Romania on national level and how it affects the local level<br>- Understand if there is local awareness of post-accession monitoring | 1 | How would you describe Cluj-Napoca's health system development since 2007? |
| | 2 | Which tasks pertain at local level for the local health care administration to support the provision of health care in Cluj-Napoca? |
| | 3 | What are the current main challenges of health care administration of Cluj? |
| | 4 | To what extent and which tasks pertain at local level for the implementation of EU driven health care reform? |
| | 5 | To what extent does the EU monitoring measures trickle down to the local level and how is it addressed by your organisation? |
| | 6 | How does your organisation communicate and work with other local or European stakeholder of the health system (hospitals, health NGOs) If yes, please elaborate this cooperation? |
| | 7 | To what extent does your organisation communicate and cooperate directly with the EU? |
| | 8 | Do you recognise conflicts between the national government and the EU? How do these conflicts affect the work of your organisation? |
| **Process of implementing administrative capacity** | | |
| -Understand how the ACB was organized, why so and by whom? | 9 | How would you describe the process of developing and drafting the local strategic development plans for the local health care provision? |
| | 10 | Which actors have been involved in the process? To what extent shaped political interests, the process? |

| | | |
|---|---|---|
| -Understand to what extent non-bureaucratic forces influences the process<br>-Gather knowledge about the challenges which appear on the local level in ACB | 11 | What kind of participation forms were used in the process? To what extent have for example hospitals been involved in the drafting? |
| | 12 | What were the main challenges/ conflicts during the draft stage? |
| | 13 | To what extent would you describe your organization capable of developing and implementing such strategies in terms of sufficient tools, resources etc.? |
| | 14 | Up to now, are there major differences between the planning and the implementation? |
| | 15 | What are the main challenges you face in implementing the local strategic development plans? |
| | 16 | Is the implementation process monitored and evaluated? Is yes, by whom and how? |
| **Content of local health system reform**<br>-Collect additional, complementary information regarding content besides document analysis<br>-explore the degree to which EU reform content are applied on local level<br>-gather information about possible priorities or contentual focuses | 17 | On which basis did you draft these plans (EU recommendations, National health strategy etc.)? How would you describe the function that EU documents played in the development of the strategy? |
| | 18 | What are the concrete measures for administrative capacity in the local health system administration to curb informal payments, improve the local capabilities and strengthen human resources? |
| | 19 | What measures do you consider as most important for administrative capacity building in the local health care system? And why? |