

# **Coping with Permanent, Aggravated Austerity in European Health Systems**

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# Argument

1. The **mandate of the European Union over health policy** is an indirect but highly effective one.
2. In light of the current fiscal crisis, this mandate has turned the EU into a crucial driver of **health system reform**.
3. This situation has consequences for what we call the **crisis of the welfare state** and for the study of its politics.

Based on a literature review of recent scholarship.  
Obviously work in progress.

# Limits of EU health mandate

- **Explicit treaty provisions** make MS responsible of health care delivery, Council unanimity is required (Art. 207 TFEU), and harmonisation is ruled out (Art. 168 TFEU, ex-Art. 152(5) TEC) (Hervey and Vanhercke 2010)
- **Jurisprudential limits** to the treatment of *public* health services as economic in nature (e.g. *Watts* 2004)
- **Institutional diversity** of health care systems limits convergence of services and provision of goods to *beta-convergence*

# Gradual involvement

- Since 1957 – **Public health objectives** (Arts. 6, 168 TFEU) through small-budget initiatives and OMC-generated cognitive harmonization
- Since 1998 – **Negative integration** over ‘spot markets’ related to patient mobility, professional mobility, state aids and insurer competition (Greer and Jarman 2012)
- Since 2010 – **Economic surveillance** of health expenditure as the largest component of MS expenditure

# Institutional shifts

- Remapping of human health expertise within EU institutions (DG SANCO + MARKT, ENVI) (de Ruijter 2016)
- Private interest representation of major incumbents (service providers, e.g. Franco-German complementary sickness funds via AIM) in Brussels (Greer 2009)
- Variable integration of EU dimension within national health departments / ministries / services, depending on initial strength of departmental autonomy (Greer 2010)

## Domestic reforms

- Top-down structural reorganisation of health systems at all levels of governance (state and providers)
- Managerialism and competition mechanisms within purchaser and provider markets (e.g. UK, Major + Blair)
- Limited privatisation of health risks through patient cost-sharing (Hacker 2004, Gringrich 2011, Jensen 2011)

Very general reform trends that apply to Bismarckian and Beveridgian health systems alike (Rothgang *et al.* 2010)

## Reform context

- **Permanent austerity** since mid-1970s, even though health care expenditure continued increasing (Pierson 2001)
- **Aggravated austerity** since Global Fiscal Crisis (2008–9) and Sovereign Debt Crisis (2009–10)
- **Severe cuts in public spending** followed by cuts in private health care consumption (primary care, pharmaceuticals)
- Currently – **Negative or null growth** in real health care expenditure since c. 2010 (Morgan and Astolfi 2015)

# Morgan and Astolfi 2015

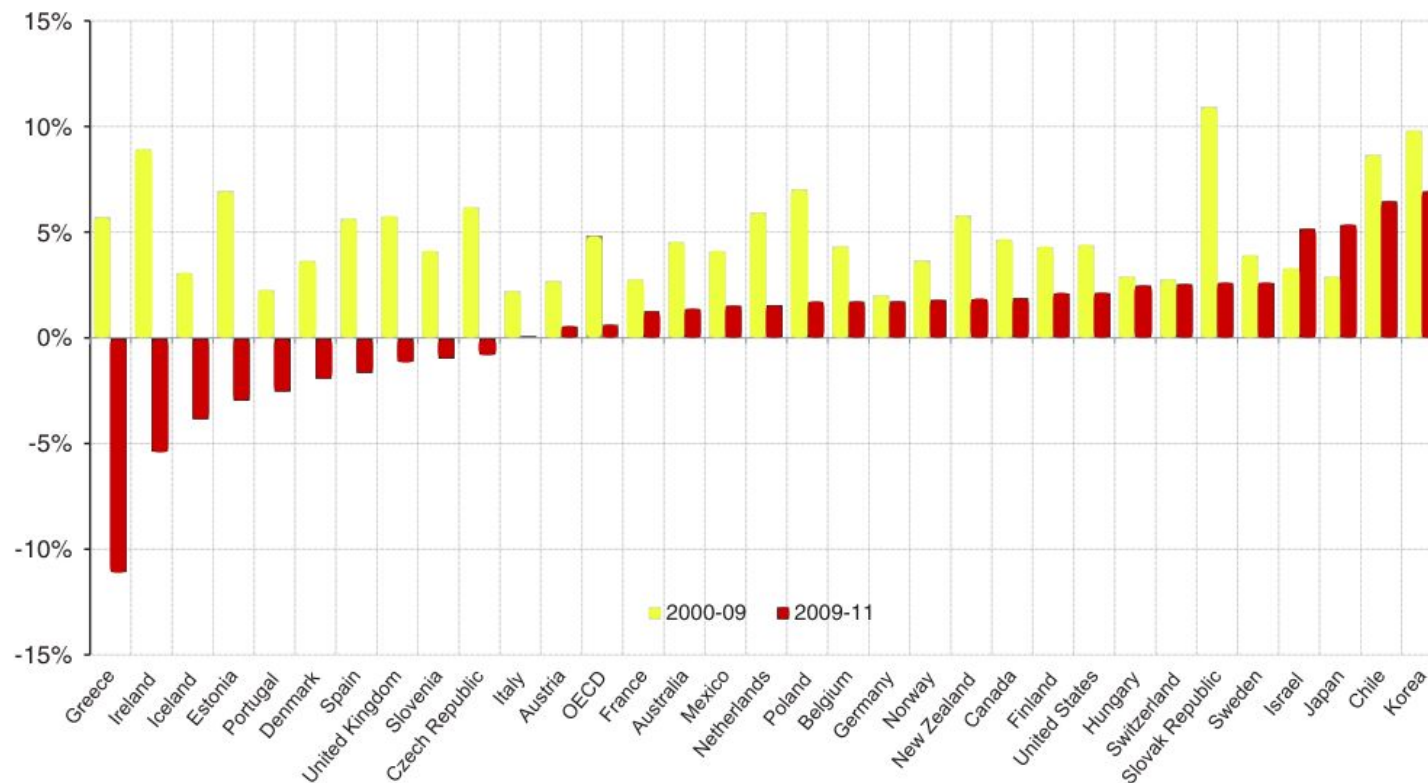


**Figure 1.** Average OECD health expenditure growth rates in real terms, 2000 to 2011, public and total

*Source:* OECD (2013).

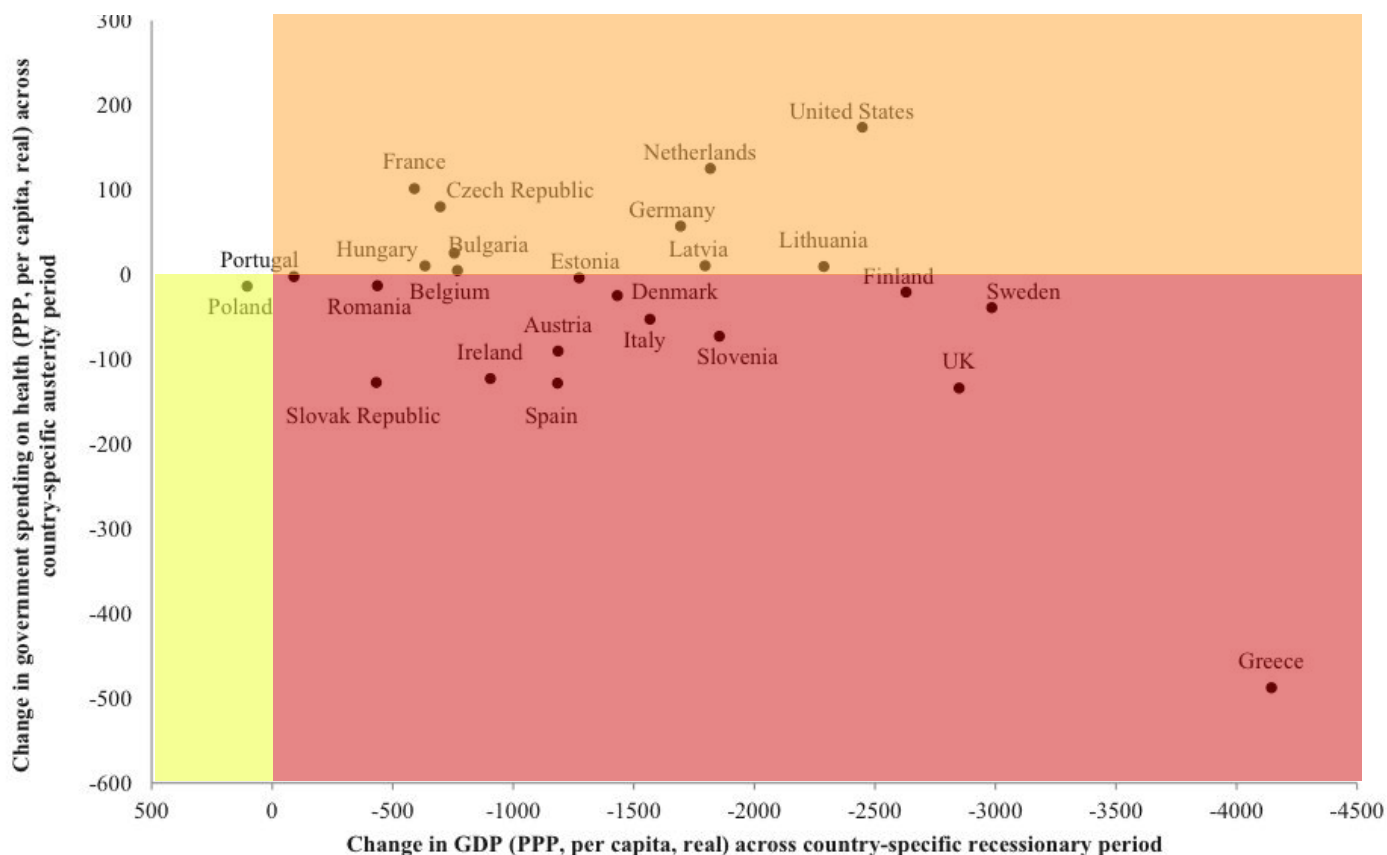


# Morgan and Astolfi 2015



**Figure 2.** Average annual growth in health spending across OECD countries, 2000–2011  
*Notes:* Growth rates for Australia, Denmark, Japan, Mexico and Slovak Republic refer to 2009–2010. Growth rates for 2009–2011 are not available for Luxembourg and Turkey. Growth rates for Chile calculated using the Consumer Price Index (CPI).  
*Source:* OECD (2013).

# Reeves et al. 2014



**Fig. 1.** Change in GDP and change in government spending on health across country-specific recession and austerity periods. Cross-national variations in healthcare spending, by country-specific recession and austerity periods, 24 EU countries and the United States. *Notes:* Source: WHO Health expenditure database 2013 edition, EuroStat 2013 edition. Recessionary- and austerity-periods are defined in detail for each country in Web Appendix 1. Recession is defined as declining GDP (adjusted for inflation and purchasing-power) in consecutive years. Austerity is defined as declining government expenditure (adjusted for inflation and purchasing-power) in consecutive years. Data on small populations (i.e., Malta, Luxembourg, and Cyprus) excluded from the graphic. The US is included in this figure as a comparison but is not included in the other analyses in this paper.

# EU involvement

- ECB + IMF **macroeconomic conditionality** for bailed-out MoU countries, e.g. Greece
- SGP + (TSG)EMU + European Semester **fiscal surveillance** for non-MoU countries, e.g. France
- **Structural funds** might be redirected to objectives above per 2014–20 ESIF rules (Baeten and Vanhercke 2016)
- Consequence – COM now operates as a **failed fiscal state** trying to cover MS expenses without means of taxation (see also Greer and Jarman 2015)

# Political consequences

Let's give our NHS  
the £350 million the  
EU takes every week



Vote Leave

[voteleavetakecontrol.org](http://voteleavetakecontrol.org)



# Political consequences

- Current reforms are not carried by broad consensus, but by minimum-winning elite coalitions (Pierson 2001)
- Increased risk of health care politicization through us-versus-them 'Euroclash' politics (Fligstein 2008)
  - *Rich vs. Poor*
  - *Elite vs. People*
  - *Citizens vs. Foreigners*
- Adversarial politics having no known positive effect on income growth, the situation is potentially self-defeating

# Thank you for your attention

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**Statement of interest:** if you know someone who works on the consequences of permanent, aggravated austerity for **social care policies**, and on the role of the EU in this context, please let me know.

(Bibliography available per request.)