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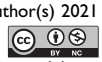

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Time for a paradigm change? Incorporating transnational processes into the analysis of the emerging European health-care system

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Summary

Health services have long been insulated from the process of European integration. In this article, however, we show that we are witnessing their re-configuration in an emerging EU health-care system. The article uncovers the structuring lines of this system by focusing on three interrelated EU-wide processes influencing the integration of national health-care systems into a larger whole. First, the privatisation of health-care services following the constraints of Maastricht economic convergence and the EU accession criteria; second, health-care worker and patient mobility arising from the free movement of workers and services within the European Single Market; and third, new EU laws and country-specific prescriptions on economic governance that the EU has been issuing following the 2008 financial crisis. The article shows that these processes have helped to construct a European health-care system that is uneven in terms of the distribution of patient access to services and of health-care workers' wages and working conditions, but very similar in terms of EU economic and financial governance pressures on health care across EU Member States.

Résumé

Les services de santé sont longtemps restés à l'écart du processus d'intégration européenne. Cet article montre cependant que nous sommes en train d'assister à leur reconfiguration dans un système de soins de santé européen émergent. L'article met en évidence les lignes de force de ce système en se concentrant sur trois processus européens interdépendants qui ont une influence sur l'intégration des systèmes nationaux de soins de santé dans un ensemble plus vaste. Tout d'abord, la privatisation des services de santé à la suite des contraintes découlant des critères de convergence économique de Maastricht et d'adhésion à l'UE; ensuite, la mobilité des travailleurs de la santé et

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celle des patients dans le cadre de la libre circulation des travailleurs et des services au sein du marché unique européen; et enfin, les nouvelles lois de l'UE et les prescriptions spécifiques par pays en matière de gouvernance économique que l'UE a édictées suite à la crise financière de 2008. L'article montre que ces processus ont contribué au développement d'un système européen de soins de santé qui se caractérise par l'inégalité, tant dans l'accès des patients aux services qu'en matière de salaires et de conditions de travail des travailleurs de la santé, mais aussi par une grande similarité entre les États membres de l'UE en termes de pressions économiques et financières de la gouvernance européenne sur les soins de santé.

Zusammenfassung

Die Gesundheitsdienste waren lange Zeit vom Prozess der europäischen Integration entkoppelt. In dem vorliegenden Artikel zeigen wir jedoch, dass sie sich in einem neu entstehenden EU-Gesundheitssystem neu konfigurieren. Der Artikel zeigt die Strukturierungslinien dieses Systems auf, indem er sich mit drei ineinandergreifenden, europäischen Prozessen befasst, die Einfluss auf die Integration nationaler Gesundheitssysteme in ein größeres Ganzes haben. Es geht zunächst um die Privatisierung gesundheitlicher Dienstleistungen unter Druck der Maastrichter Konvergenz- und der EU-Beitrittskriterien; anschließend um die Mobilität von Pflegepersonal und Patient:innen aufgrund der Freizügigkeit von Arbeitnehmer:innen und Dienstleistungen innerhalb des Europäischen Binnenmarktes; und drittens um neue EU-Gesetze und länderspezifische Vorschriften zur wirtschaftspolitischen Steuerung, die die EU in Folge der Finanzkrise 2008 herausgibt. Der Artikel zeigt, dass diese Prozesse zum Aufbau eines europäischen Gesundheitssystems beigetragen haben. Dieses ist in Bezug auf den Zugang von Patient:innen zu Gesundheitsdiensten und auf Löhne und Arbeitsbedingungen immer noch sehr ungleich. Trotzdem ist der Druck auf die Gesundheitsvorsorge infolge der Steuerung der Wirtschafts- und Finanzpolitik durch die EU in allen Mitgliedstaaten fast identisch.

Keywords

Health systems, European integration, health care, privatisation, labour mobility, patient mobility, new economic governance, methodological nationalism

Introduction

It is often assumed that the European Union (EU) plays only a minor role in health-care governance (Lethbridge, 2013). A number of analysts, however, have started to dispute this assumption, pointing to the rise of an EU health-policy regime (Greer and Jarman, 2012) or even a federal European health-care union (Vollaard et al., 2016). In 2010, a Deputy Permanent Representative for Health in the Council of the EU already observed a 'silent revolution' in European health-care policy (De Ruijter, 2019: 1). The EU's new health policy, however, is 'more about markets than about individual or aggregate health outcomes' (Greer and Jarman, 2012: 260) and goes beyond the traditionally acknowledged areas of EU intervention, namely, public health issues or health and safety in the workplace (Lethbridge, 2013; Smismans, 2004).

In this review article, we look at health services in the EU from a transnational perspective. In doing so, we broaden our analytical approach on two levels. First, we look at the European dimension of health-care policies not only in cross-border care, but also in other areas, such as health-care expenditure and privatisation. Secondly, we look not only at the EU's impact on health-care resources and policies, but also at Europe-wide configurations of health-care employment and

access to health services. It is, indeed, in these areas that we can see the concrete impact of EU interventions on health services.

The EU integration process has not led to a harmonisation of health systems (Schmid et al., 2010). Spillovers from regulations in other policy fields must be considered, particularly the deleterious impact of the Single Market and EU competition rules on public services. Even so, critical scholars continued to frame health care as a discrete, national-level issue (Leibfried and Starke, 2008; Morton, 2011). Similarly, others have acknowledged the Europeanisation of public health policy (for example, in relation to HIV-AIDS) but think that this process is still likely to preserve national prerogatives in health policy-making (Steffen, 2012).

This analytical focus on the national level reflects a more ingrained methodological nationalism in comparative social sciences (Erne, 2019; Wimmer and Glick Schiller, 2002). Scholars in the welfare state tradition (Esping-Andersen, 1990) considered that the institutional arrangements, rules and assumptions underpinning various welfare state regimes were modelled by national political forces and nation-building processes. Extrapolating to health services, comparative welfare-state scholars viewed the national level as key to understanding the ways in which such services are delivered.

This article argues that health services are being re-configured within an emerging European health-care system. We define 'system' as a set of regular interactions and interdependent relationships that integrate initially discrete elements (in this case, national health-care systems) into a larger whole. To understand the emerging European health-care system, we must therefore assess those transnational interconnections with a direct bearing on the provision and funding of health services at national and local level. Concretely, we aim to uncover the structuring lines of the emerging European health-care system first by assessing the specific role that health care plays in contemporary capitalist societies (Section 1). Then, we examine the European scale and EU policy underpinnings of three interrelated mechanisms that contribute to the creation of a European health-care system: health-care privatisation following the fiscal constraints of the Maastricht convergence and the EU accession criteria in the 1990s and 2000s (Section 2); intra-EU health-care worker and patient mobility arising from the free movement of workers and services within the Single Market, most notably since the EU's eastward enlargement in the 2000s (Section 3); and political interventions through new EU laws, the EU's New Economic Governance (NEG) prescriptions, and the enforcement of bilateral investment treaties (BITs) since the 2008 financial crisis (Section 4). We conclude by arguing that these processes are helping in the construction of an uneven European health-care system in terms of the distribution of patient access to services, health-care workers' wages and working conditions, and financial control and policy-making, both among and within EU countries. Thus, this review article aims to offer a new perspective on the nature and scale of health care–related processes in the EU.

Health care as a productive and reproductive sector

European countries offer universal health-care coverage through either a national health service (Beveridge) or social health-care insurance (Bismarckian) types of health-care system (Schmid et al., 2010). The emergence of universal health care in Europe must be placed, however, in the broader perspective of the role played by the health-care sector in society.

To assess this role, we move from varieties-of-welfare perspectives (which focus on national-level institutions and processes) to perspectives that allow us to consider larger transnational processes. Marxist analysts, such as Navarro (1976), saw health care as being at the core of capitalist processes; not only as an area of production (of services) but also one in which the reproduction of the labour force takes place. In the 20th century, however, the liberal profession of

medicine established in the 19th century became increasingly unable to deal with the increasing fragmentation of work and of workers themselves. Socialised health care emerged, at least in Europe, in response to this challenge, whereby the state stepped in as a guarantor of 'the reproduction of labour needed for the system' (Navarro, 1976: 215).

A complementary perspective is inspired by the work of Karl Polanyi (2001 [1944]). He shifted the focus of attention from the sphere of production to that of exchange. Polanyi saw the rise of welfare states, of which modern health-care systems are a part, as one juncture in the 'double movement' of the commodification and the decommodification of land, labour and money in capitalist societies. Socialised health care, and its aim of universal coverage, can be understood in this perspective as a tool to counterbalance the destructive potential of an unhinged labour market, in which workers are left to provide for their reproduction through recourse to the market alone (Esping-Andersen, 1990).

More recently, critical studies on globalisation and economic restructuring (Bieler and Morton, 2018; Silver, 2003; Harvey, 2004) have combined classical historical materialist approaches with world-system approaches in drawing attention to the global but uneven character of capitalist expansion. These studies have highlighted the global scale of the expansion of capitalist relations into the area of social reproduction (Lethbridge, 2011). In following them, we have thus taken into account the European scale of new accumulation regimes in health care. This unveils the structuring lines of the emerging European health-care system by addressing both the sphere of exchange (access to health services) and the sphere of production (employment in health services).

Health-care privatisation

Socialised health care has been increasingly under challenge since the 1970s, with repeated attempts to privatise health-care systems around Europe. We adopt an encompassing view of health-care privatisation, as covering the various processes that lead to a higher involvement of private interests in health-service provision, management and funding.

Traditionally, health-care privatisation has denoted rising private funding and provision of health care, as illustrated by increases in private insurance or in the number of private clinics and hospitals. A more encompassing perspective on health-care privatisation (André and Hermann, 2009), however, should also include two other processes, namely, the marketisation of publicly funded health care through so-called 'new public management' measures and the progressive disengagement of the state from health-service provision and funding. New public management measures include the introduction of internal markets through the purchaser–provider split, performance indicators, benchmarking, and new case-based methods of hospital financing (Clarke et al., 2000; Mihailovic et al., 2016; Schulten, 2006). The disengagement of the state from health-service provision and funding is reflected in the outsourcing of ancillary and core health services to private companies; in the introduction of co-payments for services delivered in public health-care units; in restrictions in publicly provided care through the definition of minimum service baskets; and in allowing private facilities to contract services with national health funds. Both 'new public management' and state disinvestment have paved the way for growing private involvement in health-care delivery. Indeed, internal markets may serve as a preparatory stage for the later privatisation of public health-care units; and outsourcing services directly opens the way for private expansion in the sector.

New public management measures, state disengagement from health-care provision and funding, and the active fostering of private endeavours in health-care funding and delivery were already observed in all European countries during the 2000s (André and Hermann, 2009; Clarke et al., 2000; Maarse, 2006; Schmid et al., 2010). A pan-European study found that 'the share of private

involvement in the health-care sector is increasing, for example through a reduction in services covered by health insurance funds, more out-of-pocket payments, and an increase in private insurance and private hospital care provision' (Eurofound, 2011: 5). Twelve of the 27 EU Member States at the time of the study identified privatisation and liberalisation as trends affecting their health-care sectors (Eurofound, 2011: 11).

An analysis of health-care systems in OECD countries (Schmid et al., 2010) revealed increasing similarities between national health service systems (United Kingdom), social health insurance systems (Germany) and private health insurance systems (United States), and their convergence towards hybrid forms. For European countries, this convergence means that market competition has been considerably enhanced. Since the 1970s, in OECD countries, 'the public financing share tends to converge, while in service delivery privatization trends can be observed as a common pattern' (Schmid et al., 2010: 456). Public provision has decreased in nearly all 15 European countries in the study. This has led both to 'explicit privatisation', where states divest themselves of their facilities and transfer public hospitals to for-profit providers, and to 'implicit privatisation', including the move from in-patient hospital care, traditionally provided by public hospitals, to out-patient care, where private providers are more prevalent (Schmid et al., 2010: 459).

One of the most visible indications of the extent of health-care privatisation in Europe is the growth of a lucrative market for the corporate, for-profit provision of health services. According to a Swedish study, the returns to private investors within the education, health-care and social services sectors have risen to 15 per cent, which is much higher than in other sectors (Lethbridge, 2013: 14). This market has expanded from ancillary services (such as catering, cleaning, building management and reception services) to high-technology diagnostic and treatment services, and to direct health-care provision with a growing number of European and non-European health-care multinationals operating in each area (André and Hermann, 2009). This process has affected countries not only on the EU's southern and eastern periphery, but also in its very core (Lethbridge, 2013). In the 2000s, the share of beds in private for-profit hospitals substantially increased, in Germany, for example, from 23 per cent of all beds in 2002 to 30 per cent in 2010, and in France from 20 per cent in 2000 to 23 per cent in 2010 (OECD, 2012: 76). Because of the growing importance of private health-care units and state disengagement from the funding of health services, out-of-pocket payments have also come to play a greater role. By the end of the 2000s, they had risen to 45.5 per cent of total health expenditure in Bulgaria; between 30 and 40 per cent in Hungary, Poland, and Romania; but also to 23 per cent in Spain and 28 per cent in Austria (Eurofound, 2011: 5).

In addition, private involvement in the management of public or collective health-care funds has been promoted in several European countries. Since the 1990s, Belgium, Germany, Switzerland and the Netherlands have enhanced the legal framework for competition between statutory sickness funds, nominally to make them more 'accountable' for their expenditure (Schmid et al., 2010). The next step has been to transform non-profit sickness funds into private insurance. After the Netherlands adopted managed competition between private insurers in 2006, the so-called Dutch model began to be heralded as a solution to financial constraints on health-care systems as different as those of Romania (Domnişoru, 2011) or Germany (Schmid et al., 2010). Despite being deemed by 'free-market' think tanks as superior to other EU health-care systems (Bjornberg, 2013), Dutch 'managed competition' has led to increased health-care spending and rising premiums for individuals, as well as to patient dissatisfaction with health services (Okma et al., 2011). Ironically, in these arrangements, health-care funds are still considered public, as the state retains responsibility for their collection and for population health-care outcomes. Nowadays, many companies are more interested in becoming direct providers for the public sector, where profits are more easily

guaranteed or, we could also say, in following the Dutch model of private management of public funds, rather than in investing in completely private schemes. This puts them in a position to extract profits while being shielded from the risks that they would incur in a totally free health-care market, as shown by the Irish (Oliver, 2005) and Romanian (Calin, 2016) examples.

The increasing privatisation of health services around Europe has been accompanied by a heightened segmentation of the health-care labour force, as well as inequalities of access among patients. These inequalities are reflected in the fact that health-care workers – other than doctors – face poor working conditions and remuneration, especially compared with employment requiring equivalent levels of skills and training in other sectors. This is particularly true for lower qualified care workers, such as those working in residential care for the elderly or in low-qualified tasks in hospitals and other care environments (Eurofound, 2011). All in all, the drive to reduce health-care costs has pushed the lower-paid segments of the health-care workforce into what many regard as a lack of career opportunities, stress and the threat of harassment and violence at work.

Conversely, the rise of private insurance and out-of-pocket payments has effectively made people's access to timely, quality health care more dependent on income and wealth (Albrecht, 2009). This is reflected in the fact that significant percentages of EU citizens declare that their care needs are unmet and that health care is unaffordable. In 2007, hence even before the financial crisis, the EU-27 average percentages of people reporting health care to be unaffordable was 21 per cent for hospital care, 35 per cent for medical or surgical specialist care, 11 per cent for family doctor or GP care, and as much as 51 per cent for dentistry (European Commission, 2007: 25–53; Thomson et al., 2012: 67). Interestingly, high percentages were recorded in relation to specialist and dental care not only for peripheral countries, but also for core and Nordic states.

Furthermore, unequal access to health services and labour market segmentation in health care are mutually reinforcing: separate areas of the sector are reserved for, respectively, disadvantaged and the most advantaged patients, with employment and working conditions in the two areas also showing disparities in terms of wages, workload, social prestige and so forth. Indeed, the general decay of publicly delivered health care under financial constraints may lead to parts of the population (usually the upper-middle classes) 'lifting-off' (Sampson, 2002) or opting out of public health care and choosing instead to pay for private care in hotel-like facilities. This process has been documented, for example in Romania (Stan, 2015) and in Italy for gynaecological care (European Union Agency for Fundamental Rights, 2013).

Privatisation has also involved the transnational diffusion of reform models aimed at opening the sector up to private health-care companies across European countries. This has been promoted by a number of agents, such as private corporations, conservative think tanks and supranational organisations, such as the World Bank, the IMF, the American Chamber of Commerce, USAID (Stan, 2007), but also the EU (Leibfried and Starke, 2008). The EU as well as a number of national governments presented health-care privatisation as a way of responding to the fiscal constraints established by the Maastricht convergence or EU accession criteria. Health-care commodification following the EMU and EU accession processes thus very much prefigured what ensued in the wake of EU interventions in national health-care systems after the 2008 financial crisis. Before discussing them, we must first review health-care worker and patient mobility arising from the free movement of workers and services within the Single Market.

Intra-EU mobility of health-care workers and patients

Since the 1970s, fiscal constraints imposed on the public sector have led, as in other sectors, to increased recourse to temporary migrant workers, initially mostly of non-European origin, to

access cheaper and more flexible labour (McGovern, 2007; Valiani, 2012). Like other developed countries, western European states thus became part of global health-care worker migration chains (Yeates, 2010). With the EU's eastward enlargements of 2004, 2007 and 2013, health-care worker migration chains started increasingly to include new intra-EU movements.

This was facilitated by the Directive 2005/36/EC on the recognition of professional qualifications, which harmonised minimum training requirements for nurses, midwives, doctors, dental practitioners, pharmacists, and veterinary surgeons, thereby creating a European health-care labour market and liberalising health service provision (Lethbridge, 2013). In turn, Central and Eastern European (CEE) countries started to experience a major loss of their health-care workforce to western European countries (Kahancová and Szabó, 2015; Stan and Erne, 2016).

East–west European labour migration shows a tendency towards short-term and temporary mobility. Several western European health-care facilities issue short-term contracts ranging from several weeks to several months to Polish, Romanian or Slovakian health professionals. Central and Eastern European (CEE) doctors have also been used to bridge gaps in western European 'medical deserts', such as in France and Germany (Wismar et al., 2011). Several CEE nurses have shifted towards the long-term care sector in western Europe. Central European countries such as Germany, Austria and Switzerland, but also southern European countries such as Italy, have registered substantial increases in Central and Eastern European nurses, care workers and informal home helps (Rogalewski, 2018; Galanti, 2018; Wismar et al., 2011). Migrant health-care workers are often employed in jobs below their qualifications and tend to receive lower wages than the local workforce. They are also more likely to work under difficult conditions, such as late or heavy shifts or in unregulated circumstances. For Perrons et al. (2010), east–west care-worker migration both results from, and contributes to, the social divisions within and between Member States, and hence it is intrinsically linked to processes of uneven development within the enlarged EU. Moreover, health-care worker migration, inasmuch as it is driven by state disinvestment in both home countries (in the form of depressed wages and outsourcing) and host countries (in the form of cost containment and privatised home care) also fuels the cross-border European drive to health-care privatisation.

Since the 1970s, European countries have also favoured transnational patient mobility. Western European patients started to use medical tourism as a response to inequalities and restrictions of access to health services in their own countries, for example, in dental care (Glinos et al., 2010). Given that medical tourism relies largely on out-of-pocket payments, it has thus bred the development, in the destination countries, of two-tier health-care systems that combine elite private health-care facilities reserved for medical tourists and wealthy local patients, with increasingly neglected public facilities for the poorer sections of local populations (Mainil and Stan, 2019; Whittaker et al., 2010). EU eastward enlargement spatially rescaled medical tourism from a global to an EU phenomenon, as western European patients started to discover the benefits of medical tourism closer to home, namely in Central and Eastern Europe. According to Mainil et al. (2017: 26), intra-EU health tourism (including wellness and spa tourism) had risen to around 5 million trips by 2015.

An important movement of patients, in addition to medical tourism, involves migrants using health care in their home countries. Given the rise in cheap airline flights in the 2000s, EU enlargement has led to a large transnational migration from Central and Eastern Europe to western Europe that involves work sojourns in the host country, combined with frequent visits back home. The main aim of such return visits is to reconnect with family and friends and take care of personal affairs back home, but they are also often combined with medical consultations, tests and treatments. Just like medical tourism, the more diffuse and informal transnational health-care practices

of CEE migrants in Europe are rooted in increasing inequalities of access (notably around ethnic and class divisions) in their host countries and in turn foster, through their reliance on private health services, increased inequalities of access in their home countries (Stan, 2015). Furthermore, even the use of the public European Health Insurance Card (EHIC), which gives mobile EU residents access to 'medically necessary care' covered by the public scheme in their country of residence, is increasing social inequalities between western European and Central and Eastern European states and across social classes (Stan et al., 2020). This is because 'EHIC patient outflows from Eastern to Western Europe result in a much higher relative financial burden for the budgets of Eastern European states than outflows from Western to Eastern Europe do for Western European countries' (Stan et al., 2020: 1). This contradicts the claims of Eurosceptic political leaders in western European countries that the opposite is true.

Patient mobility in the form of medical tourism and migrant workers' return medical visits thus actively contribute to a perverse cycle of increased privatisation and inequalities of access in both home and destination countries. In parallel, health care–worker migration is caught in a downward spiral generated by privatisation across Europe. The more public health-care services in Central and Eastern European countries decline, the more CEE working conditions deteriorate and the more health-care workers are inclined to move to western Europe, where they tend to be channelled into precarious jobs created by increasingly commodified health-care providers, notably in the elder-care sector (Anderson, 2012).

The EU's New Economic Governance in health care

Since the late 1990s, the EU has continuously increased its influence on national health services, first of all through several European Court of Justice (ECJ) (as it was then) rulings, which have framed patients as 'consumers', and corresponding new EU laws. Since 2008, they have been complemented by *binding* EU prescriptions on health care for Member States that have had to sign a Memorandum of Understanding with the EU and IMF, or have been found by the European Commission and Council to be running excessive deficits or excessive macroeconomic imbalances (Stan and Erne, 2019).

First, ECJ judgments to promote 'consumer choice' have facilitated European citizens' access to (private) health services in another EU country. This has undermined national states' prerogative of pre-authorisation of cross-border care and provided patients with 'a structure and judicial procedures through which to bypass the national system or challenge its decisions' (Martinsen and Vrangbaek, 2008: 178). These ECJ cases led to one of the most important EU interventions in the field of health care, the Directive 2011/24/EU on the application of patients' rights in cross-border health care (Cross-Border Care Directive). The Directive represents a compromise between the internal market and the principle of subsidiarity (Lethbridge, 2013). It recognises the EU principle of freedom of services, even if health care was excluded from the scope of the 2006 EU Services Directive, following huge transnational social protests (Crespy, 2016). The Cross-Border Care Directive also obliges national health services and statutory sickness funds to reimburse a range of cross-border care provided in both public and private units, even if they can still limit access to cross-border care involving overnight hospitals stays and expensive procedures. The Directive thus created a right to sell cross-border care without pre-authorisation, which may destabilise (Greer and Rauscher, 2011) and destructure (Martinsen and Vrangbaek, 2008) national health-care systems and their governance (André and Hermann, 2009). It thus opened the door for a single market in health care (Morton, 2011) and 'an increased obligation for Member States to

integrate foreign [private] suppliers into the domestic health-care mix' (Martinsen and Vrangbaek, 2008: 182). These developments are all the more striking as they are complemented, as we have seen, by the spiralling growth of health-care privatisation resulting from types of patient mobility other than those implied in the Cross-Border Care Directive, namely, medical tourism and migrants' return trips to their home countries. Moreover, ECJ rulings conceive services delivered by national health systems as an economic activity. Thus, health services are, in principle, under the grip of EU internal market, public procurement and state aid law. Regulations in favour of public provision thus become 'exemptions' that need to be justified by invoking overriding reasons of general interest or public service obligations (Hatzopoulos, 2005).

Second, the EU's New Economic Governance regime, which the EU adopted after the financial crisis (Erne, 2012a, 2012b), put Member States' public health-care systems under further pressure. The curtailment and commodification of labour rights and welfare services became the major adjustment mechanism adopted to correct excessive macroeconomic imbalances and fiscal deficits. As health services account for a significant part of public expenditure – 15.3 per cent on average across the EU in 2016[1] – it is hardly surprising that health services have been targeted by commodifying New Economic Governance prescriptions, namely, those contained in the very constrictive Memoranda of Understanding for states that required bailout funding and in the constraining Country-Specific Recommendations (CSRs) issued to states deemed to be running excessive deficits or excessive macroeconomic imbalances. Health services have been targeted not only indirectly through prescriptions on public spending or labour relations (Greer et al., 2016; Jordan et al., 2020), but also directly by prescriptions on their level and organisation (Azzopardi et al., 2015; Stan and Erne, 2019). An in-depth analysis of New Economic Governance prescriptions on health care for Germany, Ireland, Italy and Romania from 2009 to 2019 has shown that most of them stipulated that the costs of health care should be pegged or even reduced, and health services further commodified (Stan and Erne, 2019). This echoed the Europe 2020 strategy of 2010, which, while acknowledging that health contributes to social cohesion and economic productivity, and aiming to ensure better access to health-care systems, also argues for structural reforms in health care (Lethbridge, 2013). Health care has thus become 'part and parcel of the EU's economic governance' (Baeten and Vanhercke, 2016: 3). This seems to be the case even for systems organised as national health services, which were previously considered to be shielded from the prevailing commodifying understanding of 'services' among EU competition lawyers (Martinsen and Vrangbaek, 2008).

In addition to the EU's New Economic Governance pressures, multinational corporations have started legal proceedings against some Member States to challenge national health-care policies that promote more universal, publicly delivered health services. The Slovakian and Polish cases described by Lethbridge (2013) show how EU internal market legislation and bilateral investment treaties (BITs) have been used to challenge national health-care policies that aim to reduce the role of the private sector. Indeed, when Dutch investors challenged the Slovakian and Polish reversal of health-care privatisation, they made the case before private BIT tribunals that awarded them millions (in the Slovakian case) and even billions (in the Polish case) of euros as 'compensation for lost profits'. The investors also obtained a policy commitment from the Polish government for further privatisation. Although the EU asserted its prerogative in settling intra-European BIT disputes, the BIT tribunal dismissed it in the Slovakian case, and, because of opposition from western European governments, intra-European BITs have not been terminated (Olivet, 2013).

1 Eurostat [gov_10a_exp].

As Hirschman (1970) showed with the example of education, once private provision of public goods is introduced, there is a downward spiral of user choice and sanctions in the form of an increased exit of wealthier users towards private services. The challenging of Member States by private companies through appeals to EU legislation and bilateral agreements points to a completely different level of sanctions involved in this privatisation spiral. Indeed, users' exit (manifest, as we have seen, in medical tourism and migrants' transnational health-care practices) is now complemented by the coercive voice and action of very powerful actors. It is in the geography of these sanctions (which seem to reproduce core–periphery divisions across Europe) that we can see at work the uneven character of health care in Europe and the European, and indeed global, institutional structures that have come to sustain it.

Unequal development and the emerging European health-care system

Analysts in the varieties-of-welfare tradition, who emphasise the divides between more or less successful institutional configurations within the EU, often assume that so-called more advanced countries and regions are shielded from the challenges affecting less fortunate parts of Europe. As a result, the only game in town for them would be to struggle to maintain their competitive advantage by cultivating the institutional recipe that allegedly made them successful in the first place.

This divisive view has been invalidated in several sectors, including in health care. Since the financial crisis and the enforcement of 'austerity' measures in southern and eastern Europe, it has become more and more evident that deteriorating working conditions in southern and eastern Europe can have a boomerang effect on the rest of Europe (Lehndorff, 2015). Thus, there is a need to go beyond the varieties-of-capitalism perspective on both labour relations and welfare (and health-care) systems. The varieties-of-capitalism perspective conforms to the view that there are welfare models (such as the Nordic one) that can ensure a better deal for a country's citizens in isolation from what happens in other countries, or from corporate power. They thus ignore the integration of capitalist economies and welfare systems in Europe and globally (Crouch, 2009). In the area of health care, this integration is realised, as we have seen, through Europe-wide processes of health-care privatisation, health-care mobility, and EU and BIT health-care governance.

This article has shown that health-care privatisation appears to be the primary driver behind the rise of the uneven European health-care system, and that health services are increasingly being used to divert public money into private coffers. This confirms Marxist and Polanyian accounts of capitalism's drive 'to convert public services into commodities to be bought and sold on the private market' (Navarro, 1976: 216). The continuation of public funding, together with the private appropriation of profits, indicates that this (re-)commodification has to some extent 'captured' the state, which is now, more than ever, 'footing the bill for the private sector' (Navarro, 1976: 216).

The result is a curious swing of the Polanyian double movement, in which the state is an agent not only of de-commodification but also of (re-)commodification. To understand this, we need to investigate the role of class relations in health care. For Navarro, the nationalisation of health-care services by the welfare state left class relations largely untouched, as it reinforced individualism while also leaving unchallenged the supremacy of medicine as a profession and its upper-middle class membership. The emerging model of combining state funding with private management and delivery points to the continued importance of the state as a guarantor of class relations. Nowadays, however, health-care configurations seem to indicate that the state is guaranteeing not so much the reproduction of the medical profession as a dominant class – as parts of it, such as junior doctors, are now also part of the professional precariat – as corporations' grip on health-care delivery and

funding, and the possible dumping of any risks on state budgets and on the dominated classes that are the main contributors to the funding of these budgets.

Health-care privatisation sets off a process whereby labour segmentation and inequalities of access, on the one hand, and the mobility of health-care workers and patients, on the other, feed into each other in a perverse cycle. This means that the fate of health services in Europe is a matter not solely of work organisation, but also of how patient access is configured. Indeed, patient cross-border movements actively contribute, as we have seen, to health-care privatisation, amounting to a form of service outsourcing and delocalisation. In Polanyian terms, one might say that the decommodification of labour performed by health-care workers cannot be disentangled from the decommodification of services accessed by patients. Or, in Marxian terms, the regulation of health-care-service production (and health-care employment) cannot be disentangled from the regulation of health-service distribution (and patient access to services). By looking at both these aspects in a transnational European perspective, this article has tried to outline what looks like an emerging, but increasingly uneven European health-care system.

The commodifying dynamics resulting from the systemic, economic and political European integration pressures discussed above have also, however, triggered countervailing collective action. The European Federation of Public Service Unions (EPSU) and some national unions and social movements have started to develop transnational networks (for example, the European Network against Privatisation and Commercialisation of Health and Social Protection or People's Health Movement – Europe), following the realisation that health-care systems in different countries are affected by similar commodification processes. Although there is a growing awareness that commodified health care is not capable of responding to transnational health risks, such as the COVID-19 pandemic, it remains to be seen to what extent countervailing collective and political action will succeed in significantly reshaping the European health-care system.

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