Austerity and the Unraveling of European Universal Health Care

ADAM GAFFNEY

A great human disaster is now unfolding in the many Eurozone countries that have agreed to slash spending, wages, and living standards to meet the demands of fiscal austerity. One facet of this story that has received far too little attention, however, is the effect of these measures on the health of these nations.

Austerity derives from the Greek *austēros*, for harsh or severe; but, in the area of health care, it has veered into the cruel: health expenditures dwindle, hospital budgets shrink, health care needs rise, and human suffering worsens. Suicide is on the rise; basic hospital supplies are missing; potentially life-saving surgeries are delayed; the rate of new HIV infections increases; drug shortages are ubiquitous; the prevalence of mental illness spikes. And these are just the obvious results.

The effects of austerity on health care are both immediate and long reaching. Deep cuts in public health spending clearly exacerbate the suffering caused by the prolonged economic depression. At the same time, the cuts contribute to a more pernicious, slow-moving, and decidedly political process.

For austerity is being wielded to initiate the unraveling of one of the great and humane achievements, indeed inventions, of modern Europe: the universal health care system. To understand why this is the case, let us take a brief look at how Europe came to have what it has today, before we return to the dangers of the present course.

Although the idea that all human beings, whether rich or poor, deserve health care can in some senses be traced to antiquity, it was only in the late nineteenth century, under the combined economic and political pressures of industrialization, working-class organization, and left-wing mobilization, that governments enacted forms of "social insurance." Under the government of Otto von Bismarck, Germany was the first to set up a system of "compulsory" health insurance, which obligated industrial employers to provide insurance for their low-paid workers. The health insurance system was funded and administered by workers and employers through the so-called "sick funds." The Bismarckian system is typically credited with initiating the European tradition of universal health care, and it certainly provided a model for other countries, as with Britain in 1911 and France in 1928.

The truly universal health care system, however, was in general a post–Second World War development and was usually the consequence of the work of labor and left-wing parties. Most Western European nations took one of two paths: gradual expansion of coverage until the system could fairly be called universal or the more abrupt creation of a truly socialized national health service. In Great Britain, the 1946 passage of the National Health Service Act brought about the British National Health Service. Financed through general taxes, it provided health care as a right, with medical services free at the point of service.

Most other nations, however, took a more incremental path. France, for instance, built upon its 1928 National Health Insurance system, passing successive pieces of legislation that covered larger and larger proportions of the population until, in 2000, the remaining 1 percent of the nation that was uninsured received coverage. Germany

likewise built upon its nineteenth-century Bismarckian system to create a system of truly universal coverage. Greece was relatively late to the game. In 1934, it established a Social Security Organization that covered urban and industrial workers, which was expanded to agricultural workers in 1961. But it was the 1983 legislation of the newly elected Socialist Party that put into place a National Health Service (NHS), founded on the principles of universal access. Along similar lines, Spain built upon a 1942 health insurance law with successive expansions of coverage. This culminated in the 1980s, when through a number of measures the Spanish Socialist Party converted the health care system to a tax-based system with universal access and a largely public provision of care.

No doubt, as they entered the twenty-first century, all of these systems had their own flaws, their own inefficiencies, even their own inequities and injustices. But for the first time in human history, the poorest individuals could avail themselves of some of the most advanced medical care in the world without worry that their illness would bankrupt their family, and without the stigma of charity. A true *right* to health care had been legislated into existence. Universal health care, from this perspective, represented a truly massive and historical achievement.

Needless to say, there has been resistance to these initiatives and programs from the time of their enactment. Margaret Thatcher tried to introduce market-based reforms into the NHS in the 1980s with so-called "managed competition," in which health authorities were to function as buyers of care from competing groups of providers. Overall, however, this was quite unpopular, and during the 1997 elections the Labour Party promised an end to managed competition and other Thatcherite reforms. Similar efforts occurred elsewhere. In the 1990s, for example, a conservative government in Spain managed to legislate certain "reforms" that, among other things, raised co-payments for care.

Still, the overall success of the universal model of health care was difficult to deny. It was clear that the United States, which lacked a universal system and which had worse outcomes despite paying much more, was not the model to emulate. And in 2000, when the World Health Organization issued its first ever ranking of the world's health care systems (albeit with controversial methodology), the two top spots went to France and Italy, with Spain in seventh and Greece in fourteenth. Although cost control was (and certainly remains) everywhere an issue, it was clear that those nations with a more market-based health care system, such as the United States, saw costs rise far faster. It was, in short, difficult to argue with success, and universal health care remained very popular among voters.

Crisis and Opportunity

The economic crisis of 2008 opened a historic window of opportunity for those who would move away from universalism. The long-growing and clearly unsustainable housing bubble—and all the economic distortions it had created—popped, to consequences worse than most had imagined, with punishing recessions and sky-high unemployment that have yet to resolve in such nations as Greece and Spain. These less competitive Eurozone nations, tied to a single currency whose masters had not read, or did not believe in, John Maynard Keynes's theory on the fundamental importance of monetary and fiscal expansion in times of crisis, were particularly crippled. Although Greece had had significant budgetary problems even prior to the crash, most other nations didn't. Indeed, despite all the later talk about the unsustainability of its welfare state, Spain was actually running a budget surplus before the crash.

Developing nations seeking "bailouts" are accustomed to the International Monetary Fund's "conditionality" demands for fiscal contraction, and in particular, for reduced social and health care spending. But now it was the newly indebted nations of Western Europe that were being asked to slash their public sector and undergo internal devaluation, this time by the so-called "troika"—the European Central Bank, the European Union, and the IMF. Those who had never been inclined to universal health care in the first place, and who had sought to chip away at it even when it seemed to be working

reasonably well, had a new and powerful ally. The attack on the European welfare state began in the "periphery."

Spain Steps Away

In Spain, talk about the "unsustainability" of universal health care rose in the early years of the crisis. While some cuts were going to be inevitable given the demands of the troika, the conservative "People's Party," elected to power in the Spanish parliament in November of 2011, went further. In the face of the demands of the troika to slash health care expenditures, the party proceeded to pass, by royal decree (thereby avoiding parliamentary debate), a new health care law that represented perhaps one of the largest changes in Spain's national health service since its establishment in the 1980s.

The law did several things, such as increase co-payments and limit the ability of illegal immigrants to access the health care system. Most radically, however, it quietly shifted the nation away from a truly universal scheme, financed through taxation, to a contributory one. Pensioners, for instance, could have access to the system only if they had contributed to it, while those over age twenty-one who had not contributed to the social security system needed to demonstrate an absence of income to obtain access to health care. In fairness, the system remained by and large a universal one, particularly if compared to, say, the United States. But the meaning of what had transpired was clear enough. "Spain's public health service is to shift from one that provides universal coverage through general taxation," reported Aser García Rada in the *British Medical Journal,* "to a system funded through social security contributions."

Crucially, however, these changes were carried out in conjunction with huge global spending cuts in health care. In Catalonia, for instance, as García Rada reported, the nationalist party, after its victory in the 2011 regional elections, moved quickly to reduce the health care budget by 10 percent, to cut the salaries of some forty thousand public health professionals, and to close a third of its hospital beds and 40 percent of its operating rooms. Waiting times for care rose, and the situation became so bad that surgeons at one university hospital offered to operate on cancer patients for free. Hospital management, however, citing the various other associated costs of operations, denied them this opportunity.

Mark Weisbrot at the Center for Economic and Policy Research estimated that in the United States these cuts would be comparable to a 25 percent reduction in total Medicaid spending. The reduced clinical activity, delays in payments, long waiting lists, and reduced health care investment will have two effects. First, the health of the population is likely to worsen. But second, these cuts have a certain self-fulfilling logic: as quality deteriorates, public support for the system declines, the system becomes more vulnerable to further attacks, and the cycle can restart. Universal health care in Spain has not been undone; its unraveling, however, has begun.

Mark Weisbrot at the Center for Economic and Policy Research estimated that in the United States these cuts would be comparable to a 25 percent reduction in total Medicaid spending.

"Humanitarian Crisis" in Greece

Greece entered the crisis in worse budgetary shape than Spain, and also with a less advanced health care system. The health of its population was therefore all the more precarious when austerity hit.

The cuts came hard and quick. With each bailout there were further demands for deep reductions in health care spending, with the IMF requesting a cut in public health spending from 10 percent of GDP to less than 6 percent. Health care spending—from both private and public sources—fell from $25 billion in 2010 to $16 billion in 2011. In 2011, the minister of health called for a 40 percent reduction in hospital budgets, despite a 24

percent rise in public hospital admissions between 2009 and 2010. And by 2012, Greece was estimated to be spending more on interest payments on its debt than on education and health care combined.

The common factor to all these reforms is that they take these nations' health care systems away from universalism, both in letter and spirit. Even more frightening, particularly for nations such as Greece and Spain, has been the fact that they haven't worked.

The results were soon evident. Doctors have reported shortages of basic hospital supplies, ranging from gloves to cotton wool. Nurses have complained about huge increases in their patient loads. Waiting times increased, with one physician telling the *New York Times* that breast cancer patients were waiting three months to have their tumors excised. Despite large increases in the rates of depression, spending on mental health actually fell by 45 percent. Significant reports of drug shortages came in from across the country. Co-payments for drugs were increased, while at the same time hospitals and pharmacies began demanding cash payments for drugs, so as to avoid the risk and wait for reimbursement.

Simultaneously, access to public health services was sharply limited. The loan agreements that Greece has signed with international lenders have resulted in major changes to the health care system. Greece had not had a fully universal system of health care even prior to the crash. Individuals and their employers would contribute to a government-supported fund, and these individuals thereby received access to the public health system. Those who lost their jobs received benefits for a year and thereafter could still receive some treatment if unable to afford health care. But under the new deal, Greeks had to start paying for more of their health care costs out of pocket once their benefits expired. At the same time, the ranks of those without benefits swelled, creating a dangerous situation.

Reliance on "street clinics" and charitable care, which previously had been used primarily by illegal immigrants without access to the public system, became more common. One charitable clinic, as reported in the medical journal *Lancet*, described a rise in the proportion of Greeks that utilized its services from 3 percent to 30 percent. Reuters carried a story about another clinic that relied on donated drugs, run by volunteer doctors and nurses who saw sixty patients a day.

This, of course, was all occurring at time when the social, medical, and mental health needs of the population were expanding rapidly. A 2012 study suggested a more than doubling in the rate of major depression in Greece between 2008 and 2011, particularly among the young and those, not surprisingly, in financial distress. Reports of rising suicide rates in 2011 were particularly concerning given Greece's traditionally low rate. The government's public health agency reported significant increases in new HIV infections. Illegal drug use became more prevalent. The deputy health minister described a large "new category" of homeless—those unemployed by the crisis and evicted thereafter.

Other European countries made similar, if less dramatic, cuts. Portugal, for instance, pushed through a large increase in co-payments as part of an agreement with the troika. Co-payments were also introduced in Italy, while the Italian Health Pact of 2011–2012 required a reduction in the number of hospital beds and admissions.

The common factor to all these reforms is that they take these nations' health care systems away from universalism, both in letter and spirit. Even more frightening, particularly for nations such as Greece and Spain, has been the fact that they haven't worked. Slashing public sector spending has, as widely predicted, merely intensified the recession. Unemployment thus remains at Great Depression levels. As GDP falls further, so too does tax revenue. With no headway made in deficit reduction, countries need more bailouts, the troika demands more cuts, and social services such as health care deteriorate further.

Austerity has been both an economic and human disaster, and it only remains to be seen how many lives are ruined—or indeed, lost—before the responsible parties recognize it.

Although universal health care was a relatively recent achievement, it quickly came to be considered an intrinsic feature of the European welfare state. It is not, however, immutable. Universal health care everywhere arose through the process of political struggle, and it can be similarly unmade. It was generally the creation of parties of the Left, and was more likely to emerge, and to emerge earlier, in those countries with a strong tradition of labor unionism. As the balance of power shifts, it is not only possible, but indeed probable, that those elements that were fundamentally opposed to universal health care from its very conception will emerge to challenge it.

The greatest bulwark against these challenges remains its broad popularity, and it is for this reason that the attacks do not come head on. The best analogy in the United States is with Medicare and Social Security, also popular programs entirely discordant with the political philosophy of the Right. The right wing uses the cause of cost-containment and deficit reduction, combined with allegations of inefficiency, to chip away at the margins of these programs, to promote privatization and reductions in benefits, while at the same time avoiding a frontal rhetorical attack. Similarly, those who would undo universal health care in Europe begin by increasing the barriers to access (such as increased user fees or the denial of care to illegal immigrants), by cutting expenditures and reducing quality, by subtly changing the system away from universalism with changes in financing or benefit eligibility. Not to recognize that such measures could amount to the first step in a long process of unwinding the right to health care would be a dangerous mistake.

There is yet another mistake that we must avoid. Perhaps because we wish to avoid self-congratulation or complacency with the status quo or perhaps because every system has faults and inefficiencies and imperfections, we can sometimes fail to recognize a true advance or accomplishment. Even as we try to improve it, we should accept the historical importance of universal health so that we can understand what we would lose were it to end.

You don't need a doctor to know that there are not many things worse than suffering from a serious illness or injury. One thing that is worse, though, is suffering while knowing that effective care for that condition exists, but is inaccessible or unaffordable; or suffering and receiving some treatment, but at the cost of bankruptcy; or suffering while knowing that the illness could actually have been prevented with better, or earlier, care. True universal health care confers an individual right to be protected from these terrible eventualities. It is therefore all the more urgent that we both protect and expand it.

Adam Gaffney is a board-certified internist, a fellow in pulmonary and critical care medicine, and a member of Physicians for a National Health Program.