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Toward an Integrated European Healthcare Space?

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TITLE:

Toward an Integrated European Healthcare Space?

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ABSTRACT:

While health services have long been insulated from the process of European integration, this article shows that we are witnessing their re-configuration in an emerging EU healthcare space. The article uncovers the structuring lines of this space by focussing on three interrelated processes that contribute to linking national healthcare systems into a larger EU-level one: 1) indirect vertical pressures linked to the rise of a new capitalist accumulation regime and the constraints of both the Maastricht economic convergence and the EU accession criteria; 2) horizontal market pressures linked to the free movement of health services, workers and patients within the European Single Market; 3) direct political pressures linked to new EU laws and New Economic Governance prescriptions that the EU has been issuing since the financial crisis of 2008. The article shows that these processes have helped constructing a European healthcare space that is uneven in terms of the distribution of access to services by patients and of wages and working conditions of healthcare workers, but similar in terms of economic and financial governance pressures within and across EU member states.

KEY WORDS: Health systems, European integration, healthcare, privatisation, labour mobility, patient mobility, new economic governance, methodological nationalism

Introduction

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

In this article, we look at health services from a transnational European perspective. In doing so, we enlarge our analytical lenses at two levels. First, we look at the European dimension of healthcare policies not only in cross-border care, but also in other areas, such as healthcare expenditure and healthcare privatisation. Secondly, we look not only at the macro level of control over healthcare resources or policymaking, but also at the meso level of European-wide configurations of healthcare employment and of access to health services. It is, indeed, in these areas that we can see the concrete impact of EU interventions on health services.

Whereas the EU integration process has not led to a harmonisation of health systems (Schmid et al. 2010), spill overs from regulations in other policy fields must be considered; most particularly the deleterious impact of the Single Market and EU competition rules on public services (Leibfried and Starke, 2008; Morton, 2011). But even these critical scholars continued to frame this impact as a discrete, national-level issue. In the same manner, if some analysts acknowledged the Europeanisation of public health policies (e.g. in relation to AIDS), they still thought that this process would preserve national prerogatives in health policy making (Steffen, 2012).

This analytical focus on the national level reflects a more engrained 'methodological nationalism' in comparative social sciences (Wimmer and Glick Schiller, 2002; Erne 2019). Scholars in the varieties of welfare state traditions (Esping-Andersen, 1990) considered that institutional arrangements, rules, and understandings underpinning various welfare state regimes have been modelled by national political forces and nation-building processes. Extrapolating to health services, it is thus the national level that is key to understanding the specific way in which such services are delivered, from both employment and access to services perspectives.

This article argues that, contrary to these views, services in Europe are being re-configured within an emerging European healthcare space, characterised by systemic links between initially discreet elements. These systemic links integrate national healthcare systems into a larger whole. To understand European healthcare systems and the larger space of which they are part, we must assess their 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 healthcare space by assessing first the specific role that healthcare plays in contemporary societies and economies (section 1). Then we examine three interrelated systemic links that contribute to the creation of a European healthcare space: indirect vertical pressures linked to the rise of a new capitalist accumulation regime as well as the fiscal constraints of the Maastricht convergence and EU accession criteria in the 1990s and 2000s (section 2); horizontal market pressures linked to the free movement of health services, workers and patients within the Single Market (section 3); and direct political interventions through new EU laws, the EU's New Economic Governance (NEG) prescriptions, and the enforcement of bilateral investment treaties (BITs) since the financial crisis of 2008 (section 4). The article concludes by arguing that these processes help construct an increasingly uneven European healthcare space in terms of the distribution of patients' access to services, of healthcare workers' wages and working conditions, as well as of financial control and policymaking both among and inside EU countries.

Healthcare as a productive and reproductive sector

European countries offer universal healthcare coverage through either national health service (Beveridge) or social healthcare insurance (Bismarkian) types of healthcare systems (Schmid et al., 2010). The emergence of universal healthcare access as a political goal in Europe must be placed, however, in the larger perspective of the role played by the healthcare sector in society.

Functionalist sociologists such as Talcott Parsons (1982) saw medicine as serving to ensure the social equilibrium through the regulation of deviant behaviour. By contrast to Parsons, Marxist analysts such as Navarro (1976) saw medicine as serving not so much society in general as the interests of the capitalist class, given that medicine's transformation of social problems into individual ones contributes to the legitimation of capitalism. Moreover, care is at the core of capitalist processes where not only production (of services) but also the reproduction of the labour force (as fit present and future workers) takes place. The rise of liberal professional medicine in the nineteenth century moved care from the non-capitalist, unwaged domain of domestic and folk care to the capitalist playing field of entrepreneurial

doctors (Federici, 2004; Turner, 1995). In the twentieth century, however, this arrangement was challenged by the increasing fragmentation of work and of workers themselves, resulting from the joint process of concentration of capitalist accumulation and specialisation. Socialised healthcare came, at least in Europe, as a 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 inspired by the work of Karl Polanyi (2001[1944]) moved the focus of attention from the sphere of production to that of exchange. Polanyi saw the rise of welfare states (of which modern healthcare systems are part) as one moment in the double movement of commodification and de-commodification of land, labour, and money in society. Socialised healthcare, and its aim of universal coverage, can be understood in this perspective as a manner to counterbalance the destructive potential of an unhinged labour market in which workers would be left to provide for their reproduction only through recourse to the market (Esping-Andersen, 1990). More recently, critical studies on globalisation and economic restructuring (Bieler and Morton, 2018; Silver, 2003) combined classical historical materialist approaches centred on class relations with world-system approaches in drawing attention to the global but uneven character of capitalist expansion. These studies have thus highlighted the global scale of the expansion of capitalist relations into the area of social reproduction, including healthcare (Lethbridge, 2011). We draw on these approaches to uncover the structuring lines of the emerging European healthcare space. We therefore pay attention to both the sphere of exchange - (i.e. access to health services), and the sphere of production (i.e. employment in health services). In doing this, we seek to unearth the EU-wide configurations of employment in and access to healthcare, as well as their link to policy-making processes.

Indirect vertical pressures: towards healthcare privatisation

Socialised healthcare has been increasingly challenged since the 1970s' crisis by repeated attempts to privatise healthcare systems around Europe. We adopt an encompassing view of healthcare privatisation, as covering the various processes that lead to a higher involvement of private interests in the provision and funding of health services.

Traditionally, healthcare privatisation has been referring to the rise of private funding and provision of healthcare, as illustrated by increases in private insurance and in the number of private clinics and hospitals. However, a more encompassing perspective on healthcare privatisation (Andre and Hermann, 2009) should also include two other processes, namely: a) the marketisation of publicly funded healthcare through new public management (NPM) measures, and b) the progressive disengagement of state responsibility from the provision and

funding of services. NPM measures include the introduction of internal markets through purchaser–provider split, performance indicators, benchmarking, and new case-based methods of hospital financing (Clarke et al., 2000; Schulten, 2006; Mihailovic et al., 2016; Bündnis Krankenhaus statt Fabrik, 2020). The disengagement of state responsibility for the provision and funding of services 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 healthcare units, in restrictions in publicly provided care through the definition of minimum service baskets, or in allowing private facilities to contract services with national health funds. Both NPM and state disinvestment have fuelled the rise of private involvement in healthcare delivery. Internal markets may serve as a preparatory stage for the later transformation of public healthcare units into private ones; and outsourcing of services directly clears space for private expansion in the sector.

NPM measures, state disengagement from healthcare provision and funding, and the active encouragement of private endeavours in healthcare funding and delivery had been observed in all European countries already before the introduction of the EU's New Economic Governance (NEG) regime in 2011 (Clarke et al., 2000; Maarse, 2006; Andre and Hermann, 2009; Schmid et al., 2010; Erne 2018). A pan-European study found that 'the share of private involvement in the healthcare 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 (MS) at the time of the study showed trends of privatisation and liberalisation affecting their healthcare sectors (Eurofound, 2011: 11).

An analysis of healthcare systems in OECD countries (Schmid et al., 2010) revealed increasing similarities between national health service systems (UK), social health insurance systems (Germany), and private health insurance systems (USA), 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 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 (ibid.: 459).

One of the most visible indications of the extent of healthcare privatisation in Europe has been 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 education, healthcare, and social services sector rose to 15%, which is much higher compared to other sectors (Lethbridge, 2013: 14). This market expanded from ancillary services (such as catering, cleaning, building management, and reception services) to high technology diagnostic and treatment services, and on to direct healthcare provision *per se*, with a growing number of European and non-European healthcare multinationals operating in each area (Andre and Hermann, 2009). This process has affected countries not only in 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, for example, from 23% of all beds in 2002 to 30% in 2010 in Germany, and from 20% in 2000 to 23% in 2010 in France (OECD 2012: 76). Because of the growing importance of private healthcare units and of the state disengagement from the funding of health services, out-of-pocket payments also came to play a bigger role. By the end of the 2000s, they rose to 45.5% of total health expenditure in Bulgaria, between 30 and 40% in Hungary, Poland, and Romania; but also 23% in Spain and 28% in Austria (Eurofound 2011: 5).

In addition, private involvement in the management of public or collective 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 to make them accountable for their expenses (Schmid et al., 2010). The next step has been to transform non-profit sickness funds into private insurances. 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 strain in healthcare systems as different as in Romania (Domnișoru, 2011) or Germany (Schmid et al., 2010). Despite being deemed by free market think-tanks as 'superior' to other EU healthcare systems (Bjornberg, 2013), the Dutch managed competition led to increasing healthcare spending and rising premiums for individuals as well as patient dissatisfaction with health services (Okma et al., 2011). Ironically, in these arrangements, healthcare funds are still considered 'public', as the state retains responsibility for their collection and for the overall healthcare outcomes of the population. Nowadays, many companies are more interested in directly providing health services covered by public healthcare schemes, where profits are more easily guaranteed, or in managing public funds, like in Netherlands, than in investing in completely private insurance schemes. This puts companies in a position to extract profits while being shielded from the risks that they would incur in a totally free healthcare market.

The increasing privatisation of health services around Europe has led to a heightened segmentation of the healthcare labour force as well as inequalities of access among patients. These inequalities are reflected in the fact that healthcare workers, other than doctors, enjoy poor working conditions and remuneration, especially when compared to employment requiring equivalent levels of skills and training in other sectors. This is particularly true for lower-skilled 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 lower part of the healthcare workforce is plagued by a perceived 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 healthcare more dependent on their means (Albrecht, 2009). Significant percentages of EU citizens declare their care needs to be unmet or consider healthcare too expensive. In 2007, already before the financial crisis, the EU-27 average percentages of individuals reporting healthcare to be unaffordable was 21% for hospital care, 35% for medical or surgical specialist care, 11% for family doctor or GP care, and 51% for dentistry (European Commission, 2007: 25–53; Thomson et al., 2012: 67). Interestingly, high percentages were recorded not only for peripheral countries, but also for core and Nordic ones in relation to specialist and dental care.

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

Privatisation has also involved a vertical movement through which reform models, which aim to give more space to private endeavours in healthcare, are diffused among European countries. This diffusion has been promoted by several identifiable agents, such as private corporations, conservative think-tanks, and supranational organisations like the World Bank, the IMF, the American Chamber of Commerce, USAID (Stan, 2007) along with the EU (Leibfried and Starke, 2008). Healthcare privatisation has not yet been promoted through direct EU healthcare policy prescriptions, but rather as a possible solution to address the fiscal constraints created by the Maastricht convergence and the EU accession criteria. Even so, the

processes of EMU and EU accession had very much prefigured the direct commodifying EU interventions in national healthcare systems that followed the 2008 crisis. Before discussing them, we must first review horizontal market pressures on healthcare systems linked to the free movement of health services, workers, and patients within the Single Market.

Horizontal pressures: the mobility of healthcare workers and patients

Since the 1970s, the segmentation of the healthcare workforce around Europe has led, like 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). As other developed countries of the world, Western European (WE) states have thus become part of global healthcare worker migration chains (Yeates, 2010). With the EU eastward enlargements of 2004, 2007 and 2013, healthcare worker migration chains started to increasingly include new intra-EU movements.

In 2005, Directive (36/EC) reformed the system for recognition of professional qualifications with a view to encouraging more automatic recognition of qualifications, but also to flexibilising healthcare labour markets and further liberalising the provision of services (Lethbridge, 2013). In turn, Central and Eastern European (CEE) countries started to experience a systematic loss of their workforce to Western countries (Kahancová and Szabó 2015; Stan and Erne, 2016). As a result, WE countries recruit more and more health professionals from the European free-movement area.

East–west healthcare worker migration shows a tendency towards short-term and temporary mobility. Several healthcare facilities in WE issue short-term contracts ranging from several weeks to several months to Polish, Romanian, and Slovakian health professionals. Several CEE nurses have been shifted towards the long-term care sector in WE. Central WE countries, like Germany, Austria, and Switzerland, but also southern WE countries, like Italy register substantial increases in CEE nurses, care workers, and informal home-helpers (Rogalewski, 2018; Galanti, 2018; Wismar et al., 2011). CEE doctors have also been used to bridge gaps in the WE 'medical deserts', e.g. in France and Germany (Wismar et al., 2011). Healthcare migrant workers are usually integrated below the original qualifications and experience lower wages than the locally trained workforce. They are also more likely to work under difficult conditions such as late or heavy shifts or in unregulated circumstances. We could say, therefore, that healthcare worker migration is participating in privatisation, as it is both generated by privatisation in departing countries and feeding into privatisation in receiving countries. 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 is hence intrinsically linked to processes of uneven development within the enlarged EU.

Since the 1970s, European countries have been favouring global 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 in large part on out-of-pocket payments, it has thus bred the development of two-tier healthcare systems in the destination countries, combining elite private healthcare 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). European eastward enlargement has spatially rescaled medical tourism from a global to an EU phenomenon, as WE patients started to discover the benefits of medical tourism closer to home - in CEE.

An important patient movement, additional to medical tourism, is that of migrants returning home for medical treatment. Given the rise in cheap airline flights in the 2000s, enlargement has led to a large transnational migration from CEE to WE that involves work sojourns of limited period in the host country, but also frequent visits back home during these sojourns. The visits' main aim is to reconnect with family and friends and take care of personal belongings back home, but they are also many times combined with medical consultations, tests, and treatments. Just like medical tourism, the more diffuse and informal transnational healthcare practices of CEE migrants in Europe are, the more they are rooted in processes of increased inequalities of access (notably around ethnic and class divisions) in their host countries. In turn, through their reliance on private health services, they fuel 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 of their country of residence, is increasing social inequalities between WE and CEE states and across social classes (Stan et al., 2020): EHIC patient outflows from CEE to WE result in a higher relative financial burden for the budgets of CEE states than outflows from WE to CEE do for WE member states, even if WE Eurosceptic leaders have recurrently claimed the opposite (ibid.).

Patient mobility in the form of medical tourism and migrant workers' return medical visits thus actively participates in a perverse cycle of increased privatisation and inequalities of access manifesting in both home and destination countries. In parallel, healthcare worker migration is caught in a downward spiral movement generated by privatisation across Europe. The more public healthcare services in CEE countries decline, the more CEE working conditions deteriorate and the more healthcare workers are inclined to move to WE, where they

tend to be asked to fill-in precarious jobs that have been created by increasingly commodified healthcare providers, notably in the elderly care sector.

Direct Vertical Pressures: EU's New Economic Governance Regime and Healthcare

Since the late 1990s, the EU has continuously increased its influence on national health services; first through several ECJ rulings which constructed patients as consumers, and through corresponding new EU laws. After 2008, they were complemented by binding EU prescriptions on healthcare for member states that had to sign Memorandums of Understanding with EU and IMF institutions, or member states that were found to experience excessive deficits or macroeconomic imbalances (Erne, 2012, 2018).

First, ECJ judgments in favour of consumer choice facilitated European citizens access to (private) health services in another EU country. This challenged national states' prerogatives 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' (Marinsen and Vrangbaer, 2008: 178). These ECJ cases led to one of the most important EU interventions in the field of healthcare, i.e. the Directive on Cross-border Healthcare, which was adopted in 2011. The Directive represents a compromise between the internal market and the principle of subsidiarity (Lethbridge, 2013). It recognises the EU principle of the freedom of services, even if healthcare had been excluded from the scope of the 2006 EU Service Directive, following huge transnational social protests (Crespy, 2016). The Cross-Border Care Directive also obliges national health services and statutory sickness funds to reimburse cross-border care in principle, even if they can still limit cross-border access to health services in certain circumstances relating, for example, to public health. The Directive has also created a right to sell cross-border care without pre-authorisation, which de-stabilises (Greer and Rauscher, 2011) and de-structures (Martinsen and Vrangbaer, 2008) national healthcare systems and their governance (Andre and Hermann, 2009). It thus opened the door for a single market in healthcare (Morton, 2011), which led to 'an increased obligation for member states to integrate foreign [private] suppliers into the domestic healthcare mix' (Marinsen and Vrangbaek, 2008: 182). These developments are the more worrying as they are complemented, as we have seen, by the spiral growth of healthcare privatisation resulting from types of patient mobility other than those implicated in the Cross-Border Care Directive, namely medical tourism, and migrants' return trips to their home countries. According to these ECJ rulings and the Directive on Cross-Border Care, services delivered by national health systems are, more and more, considered as an economic activity. Thus, they are, in principle, under the grip of the EU internal market, public procurement, and state aid law. Regulations in favour of public

provision become hence exemptions that need to be defended by invoking ‘overriding reasons of general interest’ or ‘public service obligations’ (Lethbridge, 2013: 11).

Second, the adoption of the EU’s New Economic Governance (NEG) regime after the financial crisis altered the EU’s message to member states even further. The curtailment and commodification of labour rights and welfare services became the major adjustment mechanism to correct excessive macroeconomic imbalances and fiscal deficits. As health services account for a significant part of public expenditure, namely 15.3% on average across the EU in 2016 (Eurostat [gov_10a_exp]), it is hardly surprising that health services have been targeted by commodifying NEG prescriptions; namely those contained in the very constraining Memorandum of Understandings for states that required bailout funding, and in the constraining Country-Specific Council Recommendations (CSRs) issued to states that were deemed to experience ‘excessive deficits’ or ‘excessive macroeconomic imbalances’ (Erne, 2018). Health services have not only been targeted indirectly through prescriptions on public spending or labour relations (Jordan et al., 2020; Greer et al., 2016), but also directly by prescriptions on their organisation (Stan and Erne; 2019; Azzopardi et al., 2015). Between 2013 and 2017, 5% of all CSRs issued dealt with health services (Efstathiou and Wolff, 2018). Most of NEG prescriptions on healthcare for Germany, Ireland, Italy and Romania from 2009 to 2019 stipulate that the costs of healthcare should be pegged or even reduced, and health services be further commodified (Stan and Erne, 2018). The ‘Europe 2020’ strategy of 2010 echoes this by arguing for structural reforms in healthcare, while acknowledging that health contributes to social cohesion and economic productivity and aiming to ensure better access to healthcare systems (Lethbridge, 2013). Healthcare 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 had previously been considered among EU competition lawyers in need of protection from the prevailing commodifying understanding of ‘services’ (Marinsen and Vrangbaek, 2008).

In addition to the EU’s NEG pressures, multinational corporations started legal proceedings against some member states to challenge national healthcare policies that promote more universal, publicly delivered health services. The cases of Slovakia and Poland described by Lethbridge (2013) show how EU internal market legislation and bilateral investment treaties (BIT) are being used to challenge national healthcare policies that aim to reduce the role of the private sector. Indeed, when Dutch investors challenged the Slovakian and Polish reversal of healthcare privatisation drives, they made the case before private bilateral investment treaty (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, due to opposition from Western European governments, intra-European BITs have not been terminated (Olivet, 2013).

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. However, private companies challenging member states through appeals to EU legislation and bilateral agreements points to a completely different level of sanctions involved in this privatisation spiral. Users' exit (manifesting, as we have seen, in medical tourism and migrants' transnational healthcare 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) where we can see at work the uneven character of healthcare in Europe and the European, and indeed global, institutional structures that have come to sustain it.

Unequal development and the rising European healthcare system

In the traditional varieties of capitalism view, analysts who emphasise the core-periphery divides within the EU often believe 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 the struggle to maintain their competitive advantage through cultivating the institutional recipe that allegedly made them successful in the first place.

This divisive view has, however, been invalidated in several sectors, including healthcare. Since the financial crisis and the enforcement of austerity reforms in southern and eastern Europe, it has become more and more visible that working conditions deteriorating in southern and eastern Europe can have a boomerang effect on the rest of Europe (Lehndorf, 2015). Thus, there is a need to go beyond the varieties of capitalism perspective on both labour relations and welfare (and healthcare) systems. The varieties of capitalism perspective comforts the view that there are 'welfare models' (like the Nordic one) that can ensure a better deal to its citizens in isolation from what happens to all the others, or again from corporate power. Therefore, varieties of capitalism studies ignore the integration of capitalist economies and welfare systems in Europe and globally (Crouch, 2009). In the area of healthcare, this integration is realised, as we have seen, through European-wide processes of healthcare privatisation, healthcare mobility and EU and BIT healthcare governance.

This article has shown that healthcare privatisation appears as the primordial driver behind the rise of the European healthcare space, and that the latter is moving in a direction where health services may be used to direct public money into private purses. Our study

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, doubled by the private appropriation of profits, tells us that this (re-)commodification mobilises the state, which is now, even more than before, '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 not only an agent of de-commodification but also one of re-commodification. To understand this, we need to go beyond Polanyi's model and investigate the role of class relations in healthcare. For Navarro, state nationalisation of care left class relations untouched, as it reinforced individualism while leaving unchallenged the supremacy of medicine and its upper-class membership. The emerging model of combining state funding with private management and delivery points to the continued relevance of the state as a guarantor of class relations; only now, healthcare configurations speak of the state 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' rising grip on healthcare delivery and funding and the possible dumping of their risks on state budgets. The dominated classes are the main contributors to funding these budgets.

Healthcare privatisation sets off a process whereby labour segmentation and inequalities of access on the one hand, and healthcare worker and patient mobility on the other, feed into one another in a perverse cycle. The fate of health services in Europe is therefore a matter not solely of work organisation, but also of how patient access is configured. As we have seen, patient cross-border movements actively participate in healthcare privatisation, and are thus a form of service outsourcing and delocalisation. Said in Polanyian terms, the de-commodification of labour performed by healthcare workers cannot be untangled from the de-commodification of services accessed by patients. Or, in Marxian terms, the regulation of healthcare service production (and healthcare employment) cannot be untangled from the regulation of health service distribution (and patient access to services). It is by looking at both these aspects in a transnational European perspective that this article has tried to paint the contours of what looks like an emerging, but increasingly uneven, European healthcare system.

The commodifying dynamics resulting from vertical and horizontal European integration pressures discussed above have, however, also 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 (namely the *European Network against Privatisation and Commercialisation of Health and Social Protection* or *Public Health – Europe*), following the realisation that healthcare systems in different countries

are affected by similar commodification processes. Although there is a growing awareness that commodified healthcare is not capable to respond to transnational health risks, such as the Covid-19 pandemic, it remains to be seen to what extent countervailing collective action will succeed in significantly reshaping the European healthcare space.

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