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The politicization of healthcare in Europe

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The politicization of healthcare in Europe

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ABSTRACT: This paper addresses the topic of the politicization of healthcare in Europe and gauging to what extent it is a cause for concern. The aim of this work is to understand the trends of policymaking in Europe regarding healthcare, and whether the involvement of politics is a detriment or a benefit to public healthcare systems. It goes without saying, the structure and functioning of healthcare in Europe requires a significant degree of political activity. In order to achieve a solid level of understanding of how much political involvement is required, comparisons have been made with the British NHS, the Swedish decentralized healthcare system, and the Spanish Sistema Nacional de Salud. The result of such a comparison exposes a divide of discourse between the state's political and economic strategy and patient safety in all cases. However, it also reveals a limited amount of politicization creates a more responsive healthcare system. Controversially, this is supported by the current Covid-19 outbreak, which has put European healthcare systems to the test, and also raised questions on the standards of public health policy within individual states.

KEYWORDS: Healthcare Politics; Consumer Protection; Policymaking; European Healthcare; Governance

SUMMARY: Introduction. – 2. Healthcare in Europe. – 3. Policymakers vs. Patients. – 4. The Case of the NHS. – 5. The Swedish Healthcare System. – 6. The *Sistema Nacional de Salud*. – 7. An EU Healthcare System? – 7.1 Covid-19 and the European Response; 8. Conclusion

1. Introduction

Politicization of healthcare is the process, whereby which political discourse and rhetoric seep into the legislation and governance of healthcare, as well its functioning and efficiency. This phenomenon has made its appearance worldwide over the course of the last fifty years and is a process that experts don't expect to die down anytime soon. It appeared first in the years of public policy reform in mostly first world countries in the 70s that were adapting to rapidly growing socio-economic conditions. It is quite evident that a certain degree of political activity in needed in structuring and governing a healthcare system. Some scholars believe that the politicization of healthcare is a necessity, in that, with the latter being a system of social welfare, its management has to be a part of the political system. Contrastingly, others believe that by putting healthcare in the jaws of political discourse, there is a desensitization to the needs of the system and most importantly to the needs of the system's subjects – patients.

In Europe, there is a varying degree of politicization in healthcare systems, and this variation can be illustrated with the comparison of different European healthcare systems. For the purposes of this paper, the systems to be compared are that of the British National Health Service (*NHS*); the Swedish healthcare systems; and the Spanish *Sistema Nacional de Salud* (SNS). This comparison is dedicated to identifying what aspects and

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to what degree the political musings of government impact healthcare governance and efficiency. Additionally, one has to consider the influence of the European Union in national healthcare systems as it steadily develops its own independent structure of healthcare.

The World Health Organization (*WHO*) has defined healthcare governance as "…the attempts of government or other actors to steer communities, countries or groups in the pursuit of health as integral to well-being through the whole-of government and whole-of-society approaches." Do European political agendas allow for states to make this bid without purporting legislative measures that lessen the priority of their healthcare systems?

2. Healthcare in Europe

The general ethos of healthcare provision in Europe is built on two fundamental principles: equal access to healthcare; and cost-efficiency. Many European states have enshrined in their constitutions and in supporting decrees and legislation, the right to healthcare and the right to access it through a system that endorses equity. This tenet of accessibility and equality is a "like-minded" feature of EU member states, which in theory makes it easier for the Union to take on the role of support in setting out a common *Health Agenda*.

Europe is mainly characterized by two types of healthcare systems. The first is the *Beveridge* model, which is characterized, generally, by state ownership of healthcare facilities; universal coverage that is managed by state bodies (i.e. national or regional health authorities); and it is funded through general taxation. Examples of European states that use this model are the United Kingdom, Spain, Sweden and Italy. The concerns of systems that follow this model are of universal coverage, and establishment of some form of societal coherence. The second system of health care is the *Bismarck* model which is a social insurance system that is characterized by "payroll contributions" which are a form of state-mandated funding by the working population. This system is built on the concept of healthcare being associated more with one's occupational status, though this ideology has changed in the last century. Both these models dominate the European healthcare stage, not competitively but more so in a manner that is suited for each state[1].

Developed by British economist Sir William Beveridge, the *Beveridge* model found its way through to a significant part of Europe, with states making the appropriate adjustments for the model to fit each individual system. Originally, the model was one of a centralized healthcare system that is governed by a national health authority, and this is the structure that built the British NHS. Alternatively, countries like Sweden and Spain have altered the model to fit into a decentralized system of healthcare. In Spain, healthcare decentralization is a constitutional tenet in which the healthcare system is largely governed by regional governments.

[1] J. KUTZIN, *Bismarck vs. Beveridge:Is There Increasing Convergence between Health Financing Systems*?, 2011.

Similarly, Swedish healthcare is decentralized but not at a constitutional level, rather at a statutory level which allows for the national government to enjoy a wider margin of appreciation of policymaking. This model is largely centered on the belief that health is a human right that should be affordable and accessible. Affordability is guaranteed by the state financing, through income tax, in which the government has the role of "single-payer". This financial arrangement allows for "managed competition"[2] by the state, which allows for lower price costs and "…benefits are standardized across the country[3]."

Contrastingly, the *Bismarck* model is a system of social insurance brought about by Otto von Bismarck in 1883. This model is built on the use of "sickness funds", a method of funding that is financed by both employees and employers. Unlike the *Beveridge* model, this model requires a decentralized system to work as it requires a collaboration between both private and public institutions. Regardless, the state still utilizes "managed competition", as seen in the *Beveridge* model, to allow a large degree of accessibility to healthcare but minimizing prices.

Over the past decade, the *Bismarck* model has seen a shift from "health as a labour right to health as a right of citizenship[4]", and while this change in dynamic is applauded, it has brought about significant problems for countries that utilize this model. The most obvious problem being, that a health system funded by the "sickness funds" of the working population will be put under a considerable amount of pressure when it adopts a policy of universal coverage. In order to alleviate this pressure and still provide universal coverage, many states have introduced subsidies from general revenue. The degree to which this is done, varies from state to state, and a clear example of this variance is Estonia.

Article 28 of the Estonian Constitution, states that every Estonian citizen and foreign resident has the "...right to the protection of health," and is supported by the *Health Insurance Act* and *Health Services Organization Act* which enshrine the right to healthcare. Additional decrees identifying healthcare packages and benefits have been passed. On a surface level, one would assume that Estonia has achieved universal coverage but statistics in the last decade have shown otherwise. The scope of coverage in Estonia is determined by which "entitlement" group one falls into, and as of 2018, there are over 50 groups one could fall in. However, even with a range of categorizations, there is still a significant number of Estonians without coverage. Those without coverage can be identified as those who are of the working age but do not contribute to social taxes. This ranges from citizens whose income does not fall within the tax bracket to citizens living abroad that do not pay taxes to unemployed citizens of a working age. Only 95% of the Estonian population is covered by health insurance and within this 95% is a percentage of citizens with limited coverage and care.[5]

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[2] L. B. MINOR, *Bismarck, Beveridge and "The Blues",* Baltimore, 2010.
[3] MIMI CHUNG, *Care Reform: Learning from Other Major Health Care Systems,* in Princeton Public Health Review, 2017.
[4] J. KUTZIN, *op. cit.*
[5] A. VÕRK, T. HABICHT, *Can people afford to pay for health care?,* 2018, http://www.euro.who.int/__data/assets/pdf_file/0004/373576/Can-people-afford-to-pay-for-health-careEstonia-WHO-FP-004.pdf?ua=1.

Like other public sectors, the health sectors of European states are constantly trying to adapt to socio-economic and political changes. In order to adapt, countries must reform their systems, and indeed, the healthcare system in Europe have been subject to significant reform in the past two decades[6]. Most of these reforms have been implemented at times of economic crisis, when the circumstances did not allow for the sustainability of existing healthcare regimes. However, while one sees how and why economic distress would call for healthcare reform, government prioritization has played a significant role in influencing health reform. English academic, J. Meadowcroft, states that « […]although the concept of market failure is well entrenched within the health policy literature…relatively little attention has been devoted to the prevalence of government[7].»

Additionally, the European Union plays a significant role in the functioning of the healthcare systems of its member states. The EU follows a three-feature framework in its policy agenda for healthcare. The first being, it's production of public health policies that aim to ensure and secure the well-being of European society. *Articles 114, 153* and *168* of the Treaty on the Functioning of the European Union (TFEU) are the legal basis on which these policies are allowed[8]. An excellent example of a public health policy would be that of the *European Blood Directive*[9] which sets out the parameters in which the extraction, donation and use of blood should be carried out. The second feature is that of the application of the principle of free movement to national healthcare systems. The most renowned example and success is that the *Patients Mobility Directive*[10]. This directive is viewed as the instrument that consolidated the EU's dedication to keeping itself immersed in the discourse pertaining to European healthcare. This directive concerns patient mobility within the EU as a right in receiving healthcare treatment from other member states. Lastly, under *article 126* of the TFEU[11], the EU employs a system of budgetary surveillance which is the result of the financial crisis in 2008.

3. Policymakers vs. Patients

[6] Y. A. OZCAN, J. KUSHALANI, *Assessing Efficiency of Public Health and Medical Care Provision in OECD Countries after a Decade of Reform,* 2016*,* 325 – 343.

[7] J. MEADOWCROFT, *Patients, Politics, and Power: Government Failure and the Politicization of U.K. Health Care***,** in Journal of Medicine and Philosophy, 2008, 427-444.

[8] Consolidated version of the Treaty on the Functioning of the European Union (TFEU) [2016] OJ C202/1, art. 114 (approximation of laws), 153 (social policy), & 168 (protection of public health) TFEU.

[9] Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003 setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components and amending Directive 2001/83/EC, OJ L033, 2003, 30 -40.

[10] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, OJ L 88, .2011, 45-65.

[11] 1). Member States shall avoid excessive government deficits.
2.) The Commission shall monitor the development of the budgetary situation and of the stock of government debt in the Member States with a view to identifying gross errors. In particular it shall examine compliance with budgetary discipline

A significant part of this paper is to identify if the process of healthcare politicization presents any negative side effects in patient care. Politicization exposes the conflict between policymakers, healthcare professionals and patients. Policymakers follow the agenda of government which can either: prioritize the healthcare systems and instill policies that fall in line with health care concerns; or they can use the healthcare system as a crutch to support other areas of concern, like the economy (which happens to be the case in a number of countries). The *Californian Medical Journal* expresses this concern in an earlier publication, stating:

"[…] the large-scale financial involvement of government and others in personal health care made politicization inevitable, with the result that the sick or injured patient, who by law or circumstance is locked into a politicized system of health care, often becomes a helpless and hapless victim of political conflict…"[12]

This statement is further supported by other scholars who identify that the boundaries between healthcare professionals and policymakers are blurred, which essentially lead to a commercialization of the healthcare system and its services. Canadian scholar Derek Ritz states, « […] the providers' viewpoint…is defined by their care provision relationship with the patients and their supplier relationship with the payors. These relationships exist within the providers' contextual relationship with policymakers as regulated professionals[13]». This statement recognizes the role that the healthcare provider plays as a moderator. This in turn leaves patients vulnerable to the desensitized "health-industrial complex[14]".

The health-industrial complex has been identified as the health policy equivalent of the infamous "military industrial complex". This was a term coined by British scholar, E.J. Oliver in his analysis of the British NHS. This system of healthcare commercialization exposes a coalition, where national healthcare systems spend billions of euros, government taxation policies fund this expenditure and pharmaceutical companies gain from this.

An example of the risks the health-industrial complex poses to patient care and safety is that this competition limit access to public healthcare and increase costs. In 2007, a British nurse was diagnosed with breast cancer and was put on a treatment regimen that required the *Avastin* drug. However, this drug had yet to receive approval from the British '*National Institute for Health and Care Excellence'* (NICE)[15], for "market reasons". Now, if a treatment is not approved by NICE, then it cannot be administered under NHS insurance. Like many people would do, the nurse decided to fund this treatment through a private health institution. However, this put her at risk of having her NHS funded treatment revoked because she "self-fund[ed]" her *Avastin* treatment. The reasoning behind this was that, «co-payments would risk creating a two-tier health service

[12] M. J. CLINE, *The Politicization of Healthcare*, in California medicine, 2007, 58.
[13] D. RITZ, C. ALTHAUSER, K.WILSON*, Connecting Health Information Systems For Better Health*, Seattle, 2014
[14] J. E. OLIVER, *Fat politics*, 2006
[15] British government institution that provides policy guidance and sets national standards in the fields of healthcare, public health and social care.

and be in direct contravention with the principles and values of the NHS. (Templeton, 2007) ». In 2008, after public backlash, the British government rescinded the ban on co-payment, but this has not eased up the contention of resources between the NHS and pharmaceutical companies.

4. The Case of the NHS

«…[T]he politicization of healthcare via the NHS has not led to the realization of egalitarian ends but rather has empower, vested and organized interests at the expense of individual patients[16]». The United Kingdom and its healthcare system, the NHS, are one of the most noticeable examples of politicization of healthcare, after the United States.

British scholar, John Meadowcroft argues that political discourse surrounding the provision of healthcare in the United Kingdom is "endemic" to the national healthcare system. His argument is built on three key points: patient preferences; "dumbed-down" political discourse; and the dynamic between "special-interest groups" and policy makers[17]. For Meadowcroft, the problem surrounding the politicization of healthcare in the UK is that a blind eye is turned to the needs of society and the common interest. For example, it is the British government that lays out the healthcare budget and the NHS allocates it accordingly within its system. However, this budget set by the government needs to be defined by the current needs and goals of the NHS. Coincidentally, there is a struggle to identify these goals in a subjective manner *and* continuous strain on the NHS has led to a shortage of resources, thus further complicating the budget decision.

Evidence of the negative impact of healthcare politicization is that of Brexit. Campaigners for Brexit have pushed the narrative that the *Beveridge* model of healthcare is outdated[18] and that the NHS needs to be replaced with a system of health insurance. Fueled by their Euroscepticism and "anti-establishment" rhetoric, a significant number of conservative MPs and politicians have managed to sway stakeholders. In and of itself, Brexit has brought about a stark number of concerns for the average Briton. The concerns surrounding the NHS in light of Brexit are of the following: resources; patient care and mobility; and funding.

The resources referred to in the aforementioned list are that of staff and management employees working in the various sectors of the NHS. As of 2020, the NHS declared itself short-staffed of about 100,000 positions, with these positions ranging from administration staff to technicians to medics. These vacant positions represent a possibility of recruiting professionals from within the EU as the principle of free movement of labor[19] would allow. However, with Brexit, this possibility becomes less likely. In 2019, the Nuffield Trust

[16] J. MEADOWCROFT, *op., cit*
[17] J. MEADOWCROFT, *op., cit*
[18] F. O'GRADY, *How Brexit Could Affect Our Health Service*, 2019, https://www.tuc.org.uk/sites/default/files/brexit-TheNHS2.pdf.
[19] Consolidated version of the Treaty on the Functioning of the European Union (TFEU) [2016] OJ C202/1, art. 45 TFEU.

released a report which highlighted that « […] a net inflow of nurses from the European Union (EU) into the NHS has turned into a net outflow: between July 2017 and July 2018, 1,584 more EU nurses and health visitors left their role in the NHS than joined[20].» As of February 2020, there is an estimated 62,000 NHS staff that are EU nationals.

Additionally, Brexit put a specific demographic at risk, and that is pensioners living outside the UK, who rely on the S1 healthcare scheme. Prior to establishing a Brexit agreement, the healthcare status of over a million British citizens was undetermined. The S1 is an NHS healthcare scheme for British pensioners that allows them to receive reimbursed medical care in EU countries. The government solution was recommendations for pensioners to register into their host healthcare systems, but for a larger portion of them, the costs were too high. Alternatively, it suggested that at-risk-pensioners apply for private health insurance. However, there is the problem of costs *and* a number of British pensioners live with pre-existing health conditions that a number of private insurance companies either do not cover or charge extra fees for. Additionally, average UK citizens would have lost their access to reimbursed treatment within the EU because by leaving the EU, the UK will no longer have access to the "*European Health Insurance Cards"*. Without any system of reciprocity, British citizens were likely to be subject to higher insurance costs in the EU and vice versa for EU nationals within the UK.

Brexit also brings economic uncertainty for the British economy considering that the EU makes up almost half the UK's trade deals. Trade relationships with the EU remain uncertain, and if the outcome is significantly drastic then government would be forced to make large budget cuts to public services like the NHS. Already in a financial bind, funding cuts to the NHS would greatly reduce resources, staff and service efficiency. Being a system reliant on taxation, the fallout of a no-trade Brexit deal would cripple the NHS[21]. In 2016, government spending for British healthcare amounted to £116.4 billion. This figure makes up almost 20% of the total UK spending. In March 2020, this figure has been estimated to be about £162 billion[22]. Healthcare spending is the government's second largest area of spending[23]. With each budgetary increase, follows a persistent deficit that does not ease up. This deficit has been caused by an increase in service, an ageing population and budget cut which just exacerbate the cycle. Proponents of Brexit argued that by leaving the EU, the UK would save an estimated £350 million a week (of monetary contributions) and that would be put towards NHS spending[24]. Ironically, this budgetary plan is now a remnant of coercive political rhetoric.

The struggle of the NHS continues with the Covid-19 pandemic. Like many other European countries, the Covid-19 pandemic has greatly exacerbated the weaknesses of the British healthcare system. Government

[20] L. ROLEWICZ, B. PALMER, *The NHS workforce in numbers*, 2020.
[21] F. O'GRADY, *op. cit.*
[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818399/CCS001_CCS0719570952-001_PESA_ACCESSIBLE.pdf, 2018.
[23] 2019, https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit.
[24] V. SIMPKIN, E. MOSSIALOS *Brexit And The NHS: Challenges, Uncertainties And Opportunities*, in *Elsevier*, 2017, 477-480.

failure to act quickly is a significant factor in this situation. On the 3rd of March 2020, the department of health and social safety released an action plan[25] to *contain, delay, mitigate* and *research.* It was only on the 23rd of March that British government announced a nationwide lockdown. Within these 20 days, the number of positives and deaths went from 51 positives and 0 deaths, to 5,687 positives and 281 deaths. On the 20th of May, the numbers were at 248,822 positives with 35,341 deaths. Healthcare professionals are adamant in their belief that such a late response to the crisis worsened the situation.

Furthermore, a system already straining under pre-existing problems is grossly ill-equipped to manage a pandemic. A key concern is that of the lack of testing and personal protective equipment (PPE) equipment for medical staff. While this problem is not exclusive to the United Kingdom, it makes an interesting example of state response to shortages. In mid-April it was revealed that the British government denied the EU-led PPE procurement, four times[26]. When it became known that Britain had taken part in the EU crisis meetings, it became somewhat evident that the government decision not to join this consortium was of a political nature. Following this publicization, the *British Medical Association* (BMA) released a survey[27], which found that more than half of NHS medical staff are working with a limited supply of PPE. Under the *Personal Protective Equipment at Work Regulations 1992,* all workers have the legal right to PPE. Considering the staggering 321 deaths of NHS employees, the governance of the NHS will most definitely find itself in a series of legal implications[28].

5. The Swedish Healthcare System[29]

Sweden provides for an interesting case study in analyzing the effects of healthcare politicization. The Swedish healthcare system is a decentralized system, in that the central government establishes general principles and guidelines pertaining to healthcare, and the regional councils, locally known as *landsting*, hold the responsibility of maintaining and facilitating healthcare to their counties. Being a "welfare state", Sweden finances its healthcare mostly through public funding from income tax (an estimated 83% of healthcare spending[30]), enabling universal coverage. In 2018, healthcare spending in Sweden made up 11% of the

[25] https://www.gov.uk/government/publications/coronavirus-action-plan/coronavirus-action-plan-a-guide-to-what-you-can-expect-across-the-uk.

[26] https://www.theguardian.com/politics/2020/apr/22/uk-government-accused-of-cover-up-over-eu-scheme-to-buy-ppe.

[27] https://www.bma.org.uk/news-and-opinion/bma-survey-reveals-almost-half-of-doctors-have-relied-upon-donated-or-self-bought-ppe-and-two-thirds-still-don-t-feel-fully-protected.

[28] R. NIR, *Coronavirus: Could Government Face Legal Questions Over The Death Of NHS Workers During PPE Shortage,* in *The Conversation*, 2020. https://theconversation.com/coronavirus-could-government-face-legal-questions-over-the-death-of-nhs-workers-during-ppe-shortage-137020

[29] *Healthcare in Sweden,* 2020, sweden.se/society/health-care-in-sweden/#.

[30] A. H. GLENNGARD, *The Swedish Healthcare System,* in International Profiles of Health Care Systems**,** 2017, 145-154.

Swedish GDP and today, this figure has remained constant and steady, and the Scandinavian state has been praised for decades, for having one of the best healthcare systems in the EU and globally. Compared to the global standard, this is true, but Swedes believe that the current state of their healthcare system is not up to Swedish standards. Recent concerns over the stagnant economy and recent government policies have put into question the state of the healthcare system.

Swedish scholar Anna Lind observes that, «[…]although not specifically included in the constitution, rights to health care have acquired a semi-constitutional status in Sweden by a backdoor route.[31].» Under the *1982 Health and Medical Services Act,* Sweden encoded the principle of "equal access" to healthcare, as a statutory right. and the Act set out three principles of healthcare application that would ensure that the aforementioned would be achieved. The three principles are as follows: human dignity; need and solidarity; and cost-effectiveness. The principles of the 1982 Act were equally important to national and regional governments, but in order to ensure maximum efficiency and accessibility, the Act, formally gave the landsting responsibility for hospital services.

Following the 1982 Act, the Swedish government, following the wave of the "international public policy phenomenon", introduced the *Dagmar Reform* in 1985. This reform supported the policies enacted in the 1982 Act, particularly pertaining to the funding and management of health services. For example, the financing of ambulatory care was reoriented from fee-based service administered by central government to a fee-based service administered by the *landsting.* The reform also helped create internal healthcare markets based on the decentralized system of capitation and functioned on the principle of proportionality.

However, while the welfare state of Sweden's healthcare is lauded as being successful (rightfully so) it has faced a few setbacks in its decentralization. The separation of state government and municipal government has brought about a discrepancy in the efficiency of Swedish healthcare. While one would assume, it would be a linear incline, the reality is that it is a fluctuating progression. Different regions prioritize healthcare at varying degrees. For example, the county of Stockholm with a population of 2.3 million people would undoubtedly pay attention to healthcare services and provisions, as compared to the county of Gotland with a population of 59,000 people.

The case of Sweden is particular in outlining the focus and emphasis on patient care and the provision of "equal access" to healthcare. In this example, one sees a stark contrast against the British NHS which has shown that the process of politicization has significantly eroded the efficiency of the NHS. The Swedish system of decentralization has removed the possibility of healthcare being used as a political tool to leverage other areas of interests. The concerns previously outlined have come to the attention of national government and policymakers which naturally, has increased their intervention in healthcare policies. However, this

[31] A. LIND, *The Right to Health in Sweden*, in *The Right to Health at the Public/Private Divide: A Global Comparative Study*, 2014, 51 – 78 .

intervention has brought about notably constructive legislation pertaining to patient care and national funding.

6. The Spanish SNS

The Spanish *Sistema Nacional de Salud* (SNS) is a public healthcare system that follows the *Beveridge* model. It was organized under the 'General Health Law'[32] of 1986 which was the legislative instrument in ensuring the rights set out in articles 43 and 49 of the Spanish Constitution. In Spain, much like Sweden, healthcare governance is decentralized, and the authority of healthcare governance lies with the autonomous regions as stated in the preamble of the 'General Law' which reiterates this constitutional prerogative[33]. However, a rise in both socio-economic and political discord has encouraged national and regional bodies to find an equilibrium that allows for devolution while respecting "the national character of the healthcare system." Recent legislation pertaining to healthcare has been adopted to increase central government jurisdiction amid fear of economic turbulence.

For Spain, maintaining the autonomy of its various healthcare insurance is important in achieving efficiency in healthcare. Pablo Avanzas, a healthcare professional in Spain shares the concern of a number of specialists and scholars in his belief that "…in order to maintain […] autonomy, the institutions need to have legal standing and a professional governing body that is independent and not politically colonized[34]." This statement echoes the concern of policymaking overriding genuine healthcare agendas.

In 2012, the Spanish central government passed the *Royal Decree-Law*[35] and it was hailed as one of the most important pieces of healthcare legislation in Spain. This was a provision that was introduced under economic pretenses but some of the autonomous regions felt that it held motifs of a political agenda. For example, under *art. 3* of the Decree, undocumented foreigners were not eligible for healthcare services. This was coming at a time when Europe was struggling under a heavy influx of migrants. Additionally, the Decree increased taxation for the SNS.

The Spanish SNS is undoubtedly a system that functions well and meets its own standards of *equity, quality* and *participation* and sets an international standard. Public opinion shows that the system is secure and reliable but recent reforms and political discourse has brought about the concern of priority of the SNS. The

[32] Ley 14/1986, de 25 de abril, General de Sanidad. – 'Article 1: 1. La presente Ley tiene por objeto la regulación general de todas las acciones que permitan hacer efectivo el derecho a la protección de la salud reconocido en el artículo 43 y concordantes de la Constitución.'

[33] *Título VIII* De la Organización Territorial del Estado*, C.E.*

[34] P. AVANZAS, I. PASCUAL, C. MORIS, *The Great Challenge of the Publish Health System in Spain,* in Journal of Thoracis Disease, 2017, 430 - 433.

[35] Real Decreto-Ley 16/2012, de 20 De Abril, de Medidas Urgentes Para Garantizar La Sostenibilidad del Sistema Nacional de Salud Y Mejorar La Calidad Y Seguridad de Sus Prestaciones.

example made with the *2012 Royal Decree-Law* goes to show that by moving healthcare from the health agenda, to the political agenda, the state puts the systems sustainability into question.

7. An EU Healthcare System?

The possibility of an EU healthcare system sees itself mimicking the decentralized systems of a number of its member states. While the European Union has a "supporting" competence in the field of health, it has over the years developed its own *Health Strategy* on the platform set up *article 168* of the TFEU. In its definition of its competence in the area of health, the EU has stated that, «[…] while EU countries define and deliver their national health services and medical care, the EU seeks to complement national policies by means of its Health Strategy». It is important to note, that healthcare as an integrate EU system has made a slow but steady appearance on the EU's policy agenda. While in theory, the concept of an EU healthcare system is enticing, underlying political tensions and socio-economic concerns emanating from member states limit its realization. It is a fragile concept that with enough pressure, from disagreement from member states, and uncertainty from policymakers, will collapse.

In 2014, the Commission released a communication on "effective and resilient health systems" which consolidated the Union's stance on delivering a competent system of integrated healthcare among the member states. This communication set out the agenda which aimed at the following:

1. Strengthening effectiveness
    a. Health system performance assessment
    b. Patient safety and quality of care
    c. Integration of care
2. Increasing accessibility
    a. Planning EU health workforce
    b. Cost-effective use of medicine
    c. Optimal implementation of *Directive 2011/24*
3. Improving resilience
    a. Health Technology Assessment (HTA)
    b. Health Information System
    c. eHealth

This agenda emphasizes the Union's dedication to their "supporting" role in the competence of healthcare. It is an initiative that enables the EU to have its freedom in its workings but is also meant to give member states a feeling of comfort that the Union is not encroaching on their jurisdiction in health. Eurosceptics

would argue that the EU present this agenda under the guise of a "reform recommendation" but really, it sets up a framework for Member States to follow, thus under undermining their competence. A contrasting argument is that the agenda pushes for a cohesive network of healthcare systems that promote the common aims of member states in providing the most accessibility and effectiveness. Furthermore, by creating this framework, the EU is able to minimize the impact of political discourse on healthcare performance.

Dutch scholar A. Hemerijck, states that «[…] those who are [politically] responsible for healthcare at the domestic level are faced with a "double blind" from the EU level». While member states have considerable freedom to frame their healthcare systems, there is a limit to this freedom which is defined by the influence of EU legislation. This "double blind" is a situation that a number of member states are apprehensive about, so as a means of alleviating this discomfort, EU policymakers take more cushioned approaches to their health policies. These approaches, as summarized in their health agenda, from system assessments to logistical planning to an integrated health system.

Within the EU, the correlation between law and politics makes evident the aforementioned tensions between the legislation coming down from the supranational level of the EU and the reception at national level. As previously mentioned, the narration of an integrated system is fairly new, but national courts and the ECJ have been instrumental in assessing its scope and margin of appreciation. Over the course of this discourse, there has been an insistence on "objective public interest" that ECJ has progressively recognized.

7.1 Covid-19 and European Healthcare

The Covid-19 global pandemic has undoubtedly put national healthcare systems and the organization of the EU to the test. In the United Kingdom, the government's inability to act decisively has put the NHS under unprecedented pressure, adding on to its preexisting problems. Sweden, surprisingly, has taken an approach opposite to many of its European counterparts. Instead of issuing a nation-wide lockdown, the Swedish government announced precautionary recommendations for citizens, and re-allocated funds into the healthcare system. In Spain, the state decided to issue the *Royal Decree 463/2020,* which evolved healthcare competences back up to the central government as a means of monitoring and dealing with the crisis cohesively. The late reaction of the European Union has brought about the discussion that its system of crisis management and *also* institutional response needs to be reformed. This criticism comes from the memory of the failed handling of the migrant crisis, and the current health crisis. Being such an interconnected entity, the European community *needs* to have a politically decisive supranational body to avoid this scattered degree of crisis management.

When there is the possibility for a crisis, that jointly affects all European states, there is the need for a collective response. The reason being, a crisis, such as the Covid-19 pandemic, affects European states at the domestic level, the supranational level and at the international level. It exposes the need for the EU to have a more solid role in public health and healthcare systems. At the domestic level, the health systems of member states are pushed to their limits where they're struggling with a lack of medical supplies such as testing kits for the hospitals and PPE for medical staff as seen in the NHS example.

The initial reaction of European states was one clearly driven by panic and fear of institutional collapse. Closed borders and the imposition of export restrictions manifested a possible reality for Europe. Advocates for the EU viewed such acts as those which promote nationalist and populist ideology in a time when European solidarity is needed most.

8. Conclusion

Politicization in healthcare is not an obvious feature. General healthcare governance by the state is present in all legal systems. However, the difference that one finds, is the degree to which political agendas impact it. A prime example being that of the NHS and the various political factors that significantly impact its governance and functioning in a negative manner. Alternatively, the Swedish and Spanish systems enjoy a relatively stable governance, and this is largely due to their devolved systems of healthcare. An express example of this success is when one takes a look at the Covid-19 responses of each individual state. While Spain has been the most affected out of the three, government action and coherence has proved to be more effective as compared to that of the UK. Even presently, in the ongoing crisis, British government and the NHS are receiving criticism both internally and externally in its crisis management. Sweden alternatively maintains a seemingly placid but firm control over its healthcare system during the pandemic. While its death toll is still increasing, there's been a steady decline in the pace of its positive infections.

There is a hesitance among member states in supporting the creation of an EU healthcare system. While EU integration is continuously encouraged and aimed for, the plausibility of conferring such a fragile and imperative duty on to EU institutions is weak. European states are still very much holding on to their sovereign prerogatives and competences. In crises, the European geopolitical sphere calls for an integrated system of healthcare that mirrors those of Spain and Sweden.