Realizing Health During Crisis: Case Studies of European Austerity

Patrick Walsh
Science, Technology, and International Affairs Program

Mentor: Prof Emily Mendenhall
Coordinator: Prof Joanna Lewis

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# Table of Contents

Acknowledgements .................................................................................................................................. 3  
Abstract ............................................................................................................................................... 4  
Introduction ......................................................................................................................................... 5  
Analytic Framework ............................................................................................................................. 9  
Case Studies Introduction ...................................................................................................................... 13  
Case Study 1: France ............................................................................................................................ 13  
Case Study 2: Italy ............................................................................................................................... 19  
Case Study 3: Spain ............................................................................................................................... 28  
Synthesis .............................................................................................................................................. 37  
Genesis of Human Rights Frameworks ................................................................................................. 38  
Neoliberalism and the Right to Health ................................................................................................. 44  
Contemporary Neoliberal Decisions on Structuring Health Systems .................................................. 46  
When Neoliberal Austerity Harms Health: Populations in Crisis ....................................................... 50  
Conclusion ............................................................................................................................................ 52  
Appendix: Methodology ......................................................................................................................... 54  
Bibliography........................................................................................................................................   58
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Abstract

This thesis utilizes a framework of state obligations toward progressive realizations of health by realizing how social, political, and economic influence the population's health in four European countries. My primary question is: Have states successfully prioritized the health of their people when facing financial hardships? This is to ask if the policy, political, and economic decisions countries make during periods of economic recessions prevent or facilitate the retrogression of health outcomes, particularly when states select austerity measures. I investigate three case studies using population health, health expenditure, and health capacity data from France, Italy, and Spain to answer whether this state's decisions to intervene in economic crisis with austerity measures were met with good population health.
Introduction

In a 2013 article from Reuters, Italian security guard Daniele Iamilli is quoted as saying, “Never before have policies so impoverished the people” (O’Leary, 2013). The so-called “pitchfork” protests across Italy after the 2008 financial crisis represented a swelling of anger and frustration with the country’s trajectory in the austerity reforms the government used in dealing with the economic crisis and its subsequent impact on public services and social welfare programming. A student protest in Rome against a conference with government ministers stated, “our university isn’t a catwalk for those who peddle austerity” (Cinelli, 2013), meaning that they did not want their institution to provide a platform for those who slashed services. This discontent did not emerge out of nowhere and was advanced through popular expression throughout Italy in response to individuals navigating the post-recession access to social service and healthcare.

The Italian government took extraordinary steps to cut essential services that impacted human life and spurred deep resentment and anger among Italians. For instance, steps were taken that increased taxes on individuals and reforms to the pension system, impacting overall Italian take-home income (Petrelli, 2013). Cuts in social spending, such as the 1 million euro decrease in the National Health Fund, adversely “impact[ed] on the ability of families to cope with the continuing recession,” through the imposition of user fees and service cuts (Petrelli, 2013). Already, there was a documented rise in waiting time for routine and specialist health visits that have risen since the imposition of these austerity measures (Evening Courier Editorial Staff, 2018).

The Great Recession reverberated throughout the world starting in 2007, but countries like Italy—where austerity was a response to the financial crisis—were disproportionately afflicted in long-term strife. Italy was already experiencing significant economic and financial deficits when the Great Recession began. Government deficits were felt among citizens with rising healthcare costs that led to differentials between revenue and spending in regional health systems, causing some in Italy people to delay or avoid care because they were expected to pay more out-of-pocket than before (de Belvis et al., 2012). Already in 2007 before the crisis, Italy initiated the “Piani di Rientro”—which translates as “financial recovery plan”—and regions
throughout Italy adopted such plans to combat rising deficits, an ailing economy, and increasing overspending in the healthcare sector (Arcà, Principe, & Doorslaer, 2020). The central government identified these problems and sought to solve them by having regional municipalities in Italy implement solutions as a decentralized delivery of care. Ten out of 20 regions implemented them, albeit with different policies (Arcà, Principe, & Doorslaer, 2020), causing uneven effects on a disgruntled public.

When the Great Recession hit, these financial recovery plans received heightened scrutiny, both by the public as a whole and by the central government. Already, these plans were seeking to include more controls on the spending of Italian regional expenditures, which became an overall goal in other areas of Italian response to recession. Implementation plans and questions on regional sovereignty against the central government persisted. Healthcare programs were subject to intensive oversight and regulation from the central government that viewed this sphere as a potential means to achieve different austerity goals on reducing spending (de Belvis et al., 2012). Even despite these measures, health outcomes suffered. A 2012 study demonstrated a myriad of problematic health outcomes: declining quality of nutrition and rising mental and behavioral ailments (de Belvis et al., 2012). A 2020 analysis went further, citing a three percent rise in avoidable deaths among men and women (Arcà, Principe, & Doorslaer, 2020). Health capacity was also decimated, where hospital budgets and preventative medicine investments faced reductions in their spending that rippled through the health (Arcà, Principe, & Doorslaer, 2020; de Belvis et al., 2012).

Italy is not an outlier for high-income countries dealing with economic recession, particularly in the last 40 years. Global forces ideate through a health system. There is a more significant connection of individual experiences of such health systems to these international forces that similarly impact the national level (Sparke, 2016). Economics, laws, and politics shape the health of populations between nations as well as within countries. We can understand how these forces manifest among nations in the economy and the health profiles of its citizens (Sparke, 2016). The health of populations can similarly be understood by analyzing disease burdens: who is sick with what, where, and why? The health system is another way to evaluate how good the government is at meeting the needs of their citizens: identifying how people receive healthcare, for what, how often, and where. When this system is in shock through a
crisis, each of these questions can be tackled through the lens of the resilience of both the population and the health system.

However, health crises that align with financial problems have a history. As a governing ideology, neoliberalism seeks to proliferate market forces, which influences who precisely a government would prioritize during a crisis and how that prioritization would take a more market-based approach (Sparke, 2016). This directly impacts health, especially when governments perceive health as a commodity or expendable resource. Neoliberal prioritization in the health system contrasts with the right to health, highlighting the individual sovereignty and inherent value each individual holds by virtue of their humanity. Austerity measures can and often do conflict to assure the right to health to everyone in a government’s jurisdiction. In principle, the right to health should influence a government to seek to guarantee and protect these rights during crisis, despite potentially enormous costs. Yet, austerity measures exemplify how governments prioritize systems that undervalue the value of human life to advance an economic or state goal.

How do state policy decisions during economic recession affect health outcomes? This thesis will investigate the state's obligations to prioritize progressive realizations of health amidst financial crises. I use these case studies of Italy, Spain, and France during the Great Recession of 2008 to explore the financial crisis and how and why governments respond with austerity. With a particular focus on austerity, I ask: How do austerity measures facilitate recovery? More specifically, I ask: how are austerity measures reflected in the recovery of health systems and embodied in health outcomes? Through the case studies, I will evaluate whether state decisions to intervene in economic crisis with austerity measures contributed to good population health.

I focus on these three case studies because of their experience with economic recession, varying neoliberal responses that privatized or otherwise limited health services in different ways, and their potential alignment toward achieving the right to health. Compared on a spectrum, Spain endured the most drastic austerity in response to a significant recession, followed by Italy to a slightly lesser degree; France experienced less austere cuts to their system and was able to stave off some of the significant impacts of the recession itself more significantly than the other two case studies (Pavolini et al., 2014; Bozio et al., 2015).
Their relative similarities allow for comparison between each that offers insights into where a country lands on that spectrum of austerity and its impact on health outcomes for mental and behavioral ailments. Furthermore, these three case studies offer relative comparability to each other that can reduce the confounding factors that result in differences. Total land size, population total, population spread, governmental systems, and geographic locations are like each other in the three countries (CIA, 2021a; CIA, 2021b; CIA, 2021c). Additionally, their shared experience in the European system, particularly by being subject to EU policy solutions and austerity strategies, means that their membership in these intergovernmental systems does not sway significantly from each other. Therefore, I can focus on the policy solutions and derived motivations of the European system and each government, rather than attribute differing trends on the simple presence or not of such an intergovernmental organization.

Was it the chicken or the egg? Working at the intersection of economics, health, and government spending statistics is not a simple task because the variability inherent in what, when, and how the crisis unfolded and because the austerity measures rolled out are hard to quantify in the model (Note & McKee 2020; Ford et al. 2018). For instance, a poor economy preceding the financial crisis may be more potent in causing negative health trendlines amidst crisis than austerity (Note & McKee 2020; Stuckler et al. 2009; Partington, 2019; Inman, 2018). Similarly, the preexisting strength of health systems may influence life and death before, amidst, and after a crisis more than the crisis itself. Nevertheless, in this thesis, I have tried to disentangle what matters in population health and governmental recession response policy in times of crisis. In doing so, it is necessary to begin with the rights to which individuals in our world hold and international adherence and recognition of these rights in building and sustaining their health systems.

Throughout the thesis, I draw on Mann’s framework on the intersection of human rights and health (Mann et al., 1994; Mann, 2006). On the one hand, I operationalize the ideal of a human rights approach by way of endorsement of progression toward equity in accessibility, affordability, acceptance, and quality of health care. Suppose governments wish to pursue human rights and to elevate health outcomes immediately. In that case, moral frameworks must take precedence during challenging periods such as economic recession, where unemployment, uncertainty, and financial instability reign. On the other hand, I explain how neoliberalism fundamentally changed the health sector over the past 40 years, weakening the state’s ability to
respond to crises. In some ways, austerity was the only tool governments perceived available to them amidst the financial crisis.

In what follows, I introduce the analytical framework I have used throughout the analysis. Then, I present the three case studies and note trends among each. I subsequently introduce the genesis of human rights frameworks, explaining what they are and where they came from. I then shift to explain what a right to health and what governments are doing with it to highlight the concept of progressive realization of health. Contrasting with an emphasis on the right to health, I explain neoliberalism as a theory and economic policy—I explain how this influences health systems, including how they were designed, implemented, and orchestrated. Then, I lay out the arguments about why neoliberal austerity harms health. I use this argument to illustrate how austerity measures worsened health systems and health outcomes in places where austerity measures were more compared to places with fewer restrictions, as seen with the case studies.

I conclude that austerity hurts not only systems but also people in measurable ways.

**Analytic Framework**

This framework seeks to demonstrate the dependence that favorable economic conditions, underlying perceived goals of a system, and the policies and expenditures pursued have on each other. Figure 1 illustrates the framework by which this analysis subscribes. It is judging whether countries were able to progressively realize health during economic crisis, and I dissect each case study, as well as my discussions on human rights and neoliberalism, to achieve this.
This framework has six main components. The first four components are what comprise the pyramid.

Firstly, the ‘progressive realization of health’ block is what, I argue, should serve as the human rights foundation for a health system. This is due to this foundational status as a human right for all that prioritizes its position within the decisions and policies of a health system (UNGA, 1976; Alston & Quinn, 1987). While there are policy, political, and logistical decisions that must be made about health systems, such as the WHO’s 6 Building Blocks for a health system, there ideally should be an underlying motivation for how and why the health system exists and a rationale for why decisions are made in specific ways. This block is in principle, as actual implementation and integration of this right into decisions about health systems are not uniformly motivated by this right in both historical and contemporary cases (Hafner-Burton and Tsutsui, 2005). The building blocks, the right to health, or whatever metric by which one can measure a health system’s structure can be mapped out, but to get there, governments must commit to progressively realize the health of their population. This is to say that not all these metrics can achieve immediately. Still, there must be a consistent and prolonged effort to realize them so that governments continue to make operational policy decisions that bring them closer to these ideals. Without this underlying idea, no matter how much governments spend or how stable
economies are health outcomes may still suffer because those resources are not spent, or the economy is not positioned to progressively work toward better health outcomes and more equitable health systems. Decisions then are not made to progressively realize health but rather for other motivations.

Secondly, the ‘government health & social welfare expenditure’ block represents how much countries spend on programs designed in these sectors, demonstrating a mechanism by which countries can promote the progressive realization of health. Understanding how a government spends its resources is critical to understanding whether those resources are constantly improving and innovating the health system. This block also dually represents a tangible means to measure governments' health social welfare policies. While not necessary that this block be increasing, this block is essential to understand in relation to its other components in this framework. If the progressive realization of health block is too small, this block may fall over, as it does not have enough to balance the entire pyramid, taking the health outcomes block with it. This is because, as noted previously, without adequate commitment to progressive realization, these resources would simply be moved around the health and social welfare system without aiming to achieve the right to health. Additionally, combined with the economic stability block, hold up the positive population health outcomes block, representing these two conditions that are essential to maintain overall positive health outcomes in each population (in this thesis, a country).

Thirdly, the ‘economic stability’ block represents an overall period within a country that is beneficial to people’s health. This is relevant because numerous prior analyses have demonstrated the negative impact of economic recession or instability on people’s health (Stuckler & Basu 2013). It also holds significance due to the premium that neoliberalism places on economics and market forces as a prism through which all other sectors are evaluated (Sparke, 2016). Simultaneously, health and social welfare resources may be considerable if an economy is still suffering or in recession; there remain significant negative impacts on health outcomes. Yet, a stable economy also produces beneficial health outcomes, including longer life expectancies. Therefore, when the health and social welfare expenditures block is not commensurate with the economic stability block, positive health outcomes could be sacrificed, particularly for the elderly or due to an overall lack of service to a large population. In this
graphic, that scenario is represented by the economic stability block being far larger than its peer, resulting in the positive population health outcomes block falling off from the pyramid entirely.

Lastly, the ‘positive population health outcomes’ block refers to overall health metrics in the country and is vital due to the evaluative nature of the metric. When this falls off the pyramid due to some imbalance of the factors described in this analysis, then that represents a flailing in these positive outcomes. This means that positive population health outcomes, in my analysis, are dependent on all three of the other blocks in order to remain positive (Stuckler & Basu, 2013; Lynch, 2020).

The two other components refer to the interaction of these blocks and are largely process-based components. The first process is the impact of an economic recession, represented by the arrow. A recession, by nature, removes the protection that economic stability affords to health, which is demonstrated by the removal of that block from the pyramid. The second process then looks at what will happen to the ‘positive population health outcomes’ block now that economic stability has been removed. This is to say that one of three conditions necessary to sustain positive population health outcomes has been removed, and it is one that directly impacts those trends in the first place. The question raised by this process is whether government health and social welfare expenditure, as part of the larger health system, will be enough to sustain positive population health outcomes without the added benefit of economic stability. Geometrically, the question becomes will the ‘government and social welfare expenditure’ block offer enough of a base to prevent the ‘positive population health’ block from losing balance or topple over, now that the economic stability block has been removed entirely? This also depends on whether these expenditures have enough balance on the progressive realization of health blocks to sustain this balance. In other words, are the expenditures and resources pursued with enough intention to progressively realize health, rather than wanton spending, that they continue to ensure balance without the economic stability block?

This is how I will seek to analyze the case studies selected and each of the requisite block components in the first place.
Case Studies Introduction

Major European systems offer exciting case studies to investigate how countries respond to crises, particularly by their recent experiences coping with the impact of concurrent crises: the late 2000s global financial crisis and the European debt crisis in the early 2010s. These include France, Italy, and Spain. The case studies analyze and discuss the relationship between population health data, health personnel data, and government health expenditure data in France, Italy, and Spain. The global forces of neoliberalism and human rights impact how countries respond to crises of an economic nature and structure their health system to respond to crises in the first place. However, what is similar among all three countries is the application of austerity measures that limited services, often social and health services. The motivations for these policy levels find their roots in the neoliberalism culture, tracing back to the 1980s (Sparke 2017).

Case Study 1: France

Heralding a population of 68 million, France is governed through a presidential-parliamentary system that balances the party politics of a Parliament alongside the authority of an executive (CIA, 2021b). Although the national level considers and implements significant amounts of policy decisions, regional and local authorities comprise the policy and regulation sphere of French governance. In the health sector, this is best exemplified in regional health agencies (ARS) that, since the 1990s, have grown in prominence in the governance and execution of public health services and coordination of overall service delivery (Chevreul et al., 2015).

The French case study offers an insight into how a country that saw the most negligible relative economic impact and that dealt with lost governmental revenue primarily through the increase of taxes rather than the cutting of services (although services still received cuts) fared in its health outcomes (Bozio et al., 2015). This case study traces the development of coverage and public health programming in France, followed by an analysis of the recession and the policy responses that impacted the health sector. I then close with a review and commentary on the French expenditure and mental and behavioral health outcome data.
France attends to the healthcare of its population through multiple different insurance schemes and mechanisms known as statutory health insurance (SHI); being state-run, SHI is subject to oversight and regulation by the national government, yet still operates a sizable chunk of the health system overall as an entity separate from national political leadership (Chevreul et al., 2015). Eligibility for the program slowly developed over the decades, starting with employees in 1945 and then extending to the unemployed in 2000 (Tikkanen et al., 2020). Voluntary health insurance for care still exists but is primarily used for supplementary coverage for items not covered by SHI or the universal health coverage (CMU) established in 2000 for those not eligible for SHI (Tikkanen et al., 2020). Reforms before the recession had increased the overall prominence and responsibilities of each ARS across the country, to the point where expenditures started growing and cost-controlling measures were considered (Chevreul et al., 2015).

The 2008 recession, however, had an impact on how France sought to administer its health system overall. Compared to other European countries, France had tightened budgets. Rather than limited spending, they sought to increase taxes and other measures to account for the revenue they usually take in that they lost (Bozio et al., 2015). Overall, France experienced a more resilient response to the recession; out of the three case studies selected, France stands out as the country that heralded less impact of the recession and fewer subsequent austerity measures imposed (Bozio et al., 2015; Karanikolos et al., 2013).

Examining how this resilience was demonstrated through expenditure first, I turn to Current Health Expenditure (CHE) measures nationally. As seen in Figure 2, per capita, France presents a positive CHE growth steadily from the beginning of the century, until that trend began to falter in 2008. This seems to have broken the previous positive trend into a plateau of total CHE after 2008. The trend after 2008 remains relatively consistent, around $4,500 per capita, but it does not continue a trend started in 2000 that increased the total CHE from a little over $2000 to nearly $5000 in 8 short years.

Figure 3 breaks down the government’s share of the financing because although there is primarily a publicly funded system (noted in Figure 4), private health spending still exists in France (Tikkanen et al., 2020). The GGHE-D per-capita data demonstrates a remarkably similar
trend of total CHE, albeit at a reduced per-capita cost of around $500. Supplementing this information with Figure 4, it is consistent with the other two target countries that their distribution of funding between public and private generally remained the same, with no significant changes in that ratio over the 18 years from 2000 to 2018. Accordingly, this suggests that the overall trend is driven by both the GGHE-D and private, as CHE moves similarly to the GGHE-D per capita. The size of the private sector funding does not significantly waver in its ratio to the public sector funding.

Figure 2. French Current Health Expenditure (CHE) per Capita in US$
Figure 3. French Domestic General Government Health Expenditure (GGHE-D) per Capita in US$

Figure 4. French Source of Current Health Expenditure by Percentage
- Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE)
- Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)
When reviewing the health metrics in France, overall trends are identified to be discussed later. For the in-patient diagnoses in Figure 4 per 100,000, the range between which the total diagnoses relate is 360 – 395. While a small range, this metric being per 100,000 means that France's total population has significant swings of mental and behavioral ailment prevalence. Thus, we see a negative trend up to 2003, which is replaced by a more positive trend that significantly increases in magnitude come 2008. A declining trend is then reached once more in the early 2010s, returning to similar in-patient diagnoses as 200, despite substantially more male diagnoses than female diagnoses.

As for day cases, where we see a negative trend led to a positive direction for in-patient, a slightly different movement arises in Figure 6. This trend is that of constant increase, albeit at different rates depending on the period. Instead of in-patient, which fluctuated and returned to a similar total at the end of the two-decade period, day-cases substantially increased by nearly 100 cases out of 100,000. Different rates of change are present in the trend, with a rapid period of growth before the economic recession and the overall case numbers beginning to plateau after the recession. From a positive to slightly less positive slope, the day cases the rate is consistently increasing, differentiating itself from the rates in Spain.
Reviewing the expenditure trends of France, they are primarily like the trends of Spain and Italy. While the prevailing trend of increasing until the economic recession, and then stagnation in expenditures exist, it is of similar magnitude as well, facing a nearly 250% increase from 2000 to 2007 in CHE per capita in USD. Again, this is driven mainly through GGHE-D, as the trends are very similar in their overall movement and the relative steadiness of the source of funding that keeps private sector funding around 27 - 30%. These trends reveal a correlation of the stagnation with the onset of the economic recession and the imposition of some budget-saving measures that began in France during this period.

An interesting correlation between the in-patient and day cases can be seen before the recession, demonstrating some potential relationships between these metrics. In-patient cases declined from 2001 – 2003, only to rise at a slower rate than from 2003 – 2008. Day cases, meanwhile, increase from 2001 – 2003 and grow at a higher rate from 2004 – 2007. This correlation at first is a rise in day cases occurring with a decline in in-patient cases at the beginning of the period selected. Then, with the slower rise in in-patient cases occurring alongside a statistically faster trend in day cases during the same period. This potentially
demonstrates how cases could be shuffled from day cases to in-patient depending on when and where they receive their care from and how they receive care. Patients with mental and behavioral issues do not simply disappear, but rather a diagnosis can change or be perceived differently, which results in different means of treatment. Because these are metrics from hospitals, these are often severe cases of these ailments that are increasingly dealt with for day cases. However, this correlation is not a 1:1 ratio, as the raw numbers per 100,000 in the day patient and in-patient care is not equal, calling into question where some of these patients went if rates declined or where they came from if patients increase in France.

In-patient and day cases then display stagnation after the economic recession, demonstrating a correlation with that stagnation seen in CHE and GGHE-D. This indicates that for the expenditures and policy pursued by France during this period, they did see previously increasing trends turn with a slight stagnation that correlated with expenditure stagnation.

Case Study 2: Italy

Italy is a country in southern Europe that positions itself as a historical giant. However, the past twenty years have illustrated economic decline and a decaying safety net. With a population of over 62 million, Italy boasts a parliamentary style of government with an economy that is managed through regulations at the national level but local-level regional authorities that share governance responsibilities. (CIA, 2021a).

The Italian case study is crucial because it surveys a country that received a medium level of austerity measures. Relative to France, which had the least, and Spain, which had the most, Italy offers an example of how a country fares when this reduced level of austerity is applied, yet the government still experienced significant economic difficulty (Petrelli, 2013). This case study will evaluate the development of Italy’s health system, the impact of the recession, the response to the recession, and then delve into expenditure and health outcome indicators from the country.

The post-World War Two order in Italy saw the creation of the Ministry of Health in 1958, autonomous hospitals established in 1968, and the devolvement of hospital management and oversight to the regions starting in 1974 (Ferre et al., 2014). The most significant step toward formalizing a health system of integrated and coordinated care came from reforms in 1978 that
revolutionized the structure and criteria by which coverage in Italy was achieved. Dating back to the beginning of the 20th century, there were industry-specific insurance programs and mandates and guaranteeing of rights, cancer, tuberculosis programs, and worker insurance. However, the 1978 push to reform transformed insurance in Italy from primarily private industry to a publicly managed program (Ferre et al., 2014).

Law No. 833 of 1978 established Italy’s universal health care coverage, albeit for all legal residents and citizens of the country. This system, the National Health Service (SSN), sought to institutionalize a centrally managed, regionally administered system that, functionally, aimed to provide coverage to all of these and ensure other preventative measures that supported the health of the national populations (Ferre et al., 2014). Private insurance funds were eliminated in favor of this national system. According to a World Health Organization analysis of the system, the primary guiding principles of the SSN were “health dignity, health needs, and solidarity” (Ferre et al., 2014). Nationally, the government establishes and enforces the core benefits package that all are required to offer for free or with cost-sharing. Simultaneously, the regional health authorities were the primary guarantors of programming and partnership with local health units (locations of care, prevention, or health promotion).

Over the decades, the SSN has been seeking to integrate further cost controlling and performance management systems to better budget costs (Lega & Vendramini, 2008). This is part of a larger trend of cost-conscious reforms in Italy at this time and could have been motivated by neoliberal ideologies detailed later in this thesis.

When examining the trends in Italy, it is essential to discuss the context to which these trends have arrived. In the years after the initial economic crises in 2008, Europe dealt with several shocks to their economic system that reverberated from the intergovernmental systems down onto the national and sub-national levels. In Italy, initially, steps were taken that increased taxes on individuals and reforms to the pension system, impacting overall Italian take-home income (Petrelli, 2013). Further, cuts in social spending such as the 1 million euro decrease in the National Health Fund adversely “impact[ed] on the ability of families to cope with the continuing recession” through the imposition of user fees and service cuts (Petrelli, 2013). Already, there has been a documented rise in waiting time for routine and specialist health visits
that have risen since the imposition of these austerity measures (Evening Courier Editorial Staff, 2018).

This history of the health system and its corollary decisions during the economic recession impacted overall health outcomes. When examining Figure 7, there is a marked increase in per capita spending on health in the country, with both CHE more than tripling since 2000. This tripling of expenditures is also evident in Figure 8, describing GGHE-D. However, the first significant breaking of both trends arrives in 2008, correlating with the Great Recession. The spending continues with an overall negative trend that is not as strong as the previously positive trend of CHE and GGHE-D. This demonstrates that Italian spending on health experienced a notable plateauing that did not keep pace with prior growth of expenditures per capita.

This plateauing cannot be attributed to the private sector reducing expenditures in Figure 7, nor can it be attributed to private sector spending rising to account for reduced spending, as in the case of Figure 8. This is because Figure 9 demonstrates that, although domestic public sector spending was reduced, there was no significant change in the percentage of either private or public sectors. While there were slight fluctuations, these were not significant enough to explain the plateauing spending noted in current and governmental health expenditures in Italy.
Figure 7. Italian Current Health Expenditure (CHE) per Capita in US$

Figure 8. Italian Domestic General Government Health Expenditure (GGHE-D) per Capita in US$
Examining the health outcomes trends demonstrates a less significant impact of the recession than spending, albeit still a noticeable change.

The in-patient measure for mental and behavioral health in Figure 10 demonstrates a marked decline from 480 to 260 patients per 100,000 over 17 years. The drop does not significantly change during the economic recession. However, there seemed to have been an impact starting in 2012 that slowed down the more rapid decline of the in-patient diagnoses. Additionally, the gender breakdown does not offer any significant deviations from each other to indicate certain spending plateaus hurt different in-patient populations.

As for day cases in Italy in Figure 11, 2006 marks a change in a trajectory away from an increasing trend of day cases per 100,000, beginning a steady decline in cases from 120/100,000 in 2006 to 60/100,000 in 2018 for the total metric. This is interesting because it correlates with the Great Recession, like how the 2008 mark saw the expenditure trends begin to plateau. A reduction starting in the mid-2000s could refer to how diagnosis and staffing capabilities for
mental and behavioral ailments reduced throughout the recession to capture or treat fewer cases (Palese et al., 2014). Furthermore, Italy had already been experiencing reductions in in-patient cases since the 2000s. Yet, this trend of day cases breaking from a growth also comes at a similar time when reforms were being pursued prior to the recession that impacted overall staffing levels (Ferre et al., 2014). Consequently, while this may be an overall reduction in cases, it heavily contrasts with the current literature significantly that documents increases in mental and behavioral ailments during recession and in the recession recovery; this contrast instead suggests that overall capacity to detect these day cases in hospitals reduced during austerity-imposed cuts, rather than a reduction in prevalence (Gili et al., 2013; Petrelli, 2013).

![Figure 10. Number of Mental and Behavioral In-patient Cases per 100,000 in Italy](image)
The breaking of the trend from 2000 to 2008, which almost doubled the CHE expenditures and GGHE-D, then led to stagnant growth in total expenditures and domestic expenditures. This is correlated with these years of economic crises. While not directly attributable without deeper economic and legal analysis, later sections propose mechanisms by which the economic crisis produced these changes, such as through Troika-mandated changes.

Primarily in the European systems, where public sector funding dominates, as opposed to the American system, we may expect that private sector funding increases when public sector funding shrinks. This could be expected by a particular need in a health system to maintain existing infrastructure, even when services get cut. Hospital facilities still need to be maintained, staff still need to be employed, and other essential services would need to be provided. However, as noted in the literature review, hospitals did face steep cuts in service and staffing levels (Palese et al., 2014). The expenditures in the overall system remained stagnant, and the private sector funding also mirrored this stagnation. There was not an overall increase or decrease in the

![Figure 11. Number of Mental and Behavioral Day Cases per 100,000 in Italy](image-url)
share of CHE that the private sector held. As demonstrated in Italy's source of funding data, this percentage of expenditure by the private sector fluctuated around 10 – 15%. If anything, there was a slight decrease in the immediate years after 2008; however, this was a nonsignificant change that indicated that. This steadiness in the private sector funding rate demonstrates that, as public sector policy and political decisions lead to the breaking of the trend of increasing expenditures, the private sector also heralded a similar stagnation. If that nonsignificant decrease in private sector percentage of CHE were significant in that direction, it would have still meant that private sector funding decreased their share so that, despite a public sector decrease, there would be an even more significant decrease in the private sector. In summary, private and public sector funding stagnated, breaking a previously positive and rapid increase in 8 years.

The question essential to this analysis remains as to whether this stagnation in funding correlated with specific health outcome trends. In-patient and days in hospital trends reflect a consistently declining trend. Although these trends heralded some slight deviations, these were not significant enough to warrant commentary, as these changes could be attributed to collection measures. One such deviation is, perhaps, the slowing down of the decline after the years of 2011, creating a plateau-like trend that is declining not as rapidly as the trend before 2011. With these plateaus, one potential hypothesis is that the in-patient and day-case rates have reached a lower limit of some sort where despite tests and challenges to existing health infrastructure. These lower limits may be due to a basic normative level of these ailments that exist or the capacity to handle the austerity-struck level of care in long-term patient care. Indeed, these two metrics are related, so it is not a surprise that their trends are relatively similar. The plateau for both does occur after a similar plateau immediately after the CHE and GGHE-D, suggesting a corollary effect on the system after being subject to cuts and limits for several years.

Starting in 2007, the increasing trend since 2001 turned into a more prolonged decline when turning to day cases. This is interesting to note, as, while there were beginnings of the recession in 2007, there were not enough policy or economic impacts yet (particularly those that elapsed for multiple years that have effects). This initially suggests that the beginning of this decline could be attributed to causes that are not directly economic or policy-related. Therefore, this could indicate that the policy pursuing mental and behavioral ailments during this period successfully staved off an overall increase of diagnoses and strains on the systems. This
conclusion is supported by the decline and plateau of all three health outcomes metrics concurrently.

However, with in-patient cases and day cases decreasing since 2007, the question remains: where did these patients go? Evidently, there was an overall decrease in all trends, indicating an overall reduction in diagnosis.

As noted earlier, the first possible explanation could be the success of policy and expenditure spending, yet this would contradict what much of pre-existing literature notes and anecdotal evidence indicates.

The second possible explanation is changing diagnostic criteria that led to fewer diagnoses provided by clinicians and psychiatrists. However, two of the arguably most prominent classification mechanism in the mental and behavioral health field, the International Classification of Diseases (ICD) by the WHO and Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association, did not see changes in their diagnostic criteria until 2022 and 2013 respectively, with both prior revisions occurring before the focus period in the 1980s and early 1990s (WHO, 2018; APA, 2021). While not universally authoritative, particularly with the DSM-5 not being widely used outside of research purposes outside of the US, these two diagnostic classification systems demonstrate that, while there were changes in how mental and behavioral ailments were viewed, this did not reflect in a broad enough way to be reflected in the Italian trends (Frances, 2013).

A third possible explanation is, perhaps, the most consequential, as it ensures that the process behind collecting and reporting these metrics is also interrogated. With the plateau of expenditures and the apparent rise in mental and behavioral ailments brought on by the stress of economic crisis, it is unexpected to see this decline. Yet, with the plateau of these expenditures, with the imposition of other services fees, restrictions, and other social service cuts, this explanation posits that the capacity to report and capture overall cases diagnostically either reduced or stagnated (Petrelli, 2013). With fewer individuals able to receive care and heightened economic stress, particularly on more deficient individuals and families, they may not have been able to go to the hospital, afford medications or treatments that came with a diagnosis, or wait longer times ultimately resulted in inconclusive care. This bears the reminder that, although these metrics offer a glimpse into the diagnoses of these ailments, they are not always an authoritative
source of the population’s actual rates, particularly in the more subjective and nuanced mental and behavioral health field.

**Case Study 3: Spain**

With over 47 million, Spain is a parliamentary constitutional monarchy, with significant autonomy and authority delegated to each of the 17 autonomous regions (CIA, 2021c). This system of shared governance at the parliamentary level results in tangible tensions between the national and local levels, particularly in the healthcare space.

This case study is an example of how mental and behavioral health outcomes are impacted in a country that experienced significant austerity measures imposed on its population by national and European policymakers. The economic recession starting in 2008 hit Spain especially hard, where unemployment rose to 21.6% in 2011 in a few years (Bernal-Delgado et al., 2018). This impact was especially felt in the health sector, where regional health budgets declined, EU deficit targets were prioritized over service spending by law, and cost-sharing mechanisms were introduced that transformed a previously free system into one rife with user fees and out of pocket costs for the Spanish population (Bernal-Delgado et al., 2018). Consequently, this case study will trace the Spanish health system development, its policy responses to recession, and how these policy responses were reflected in the data on expenditures and health outcomes analyzed.

Beginning with the 1986 General Healthcare Act, the National Healthcare System of Spain (SNS) is a primarily publicly funded institution with several varied components. As a decentralized system, duties to attend to healthcare in the country are split between the national Ministry of Health (in conjunction with other national agencies) and the 17 regional health authorities administered by their autonomous provincial government (Bernal-Delgado et al., 2018; HealthManagement, 2010). Care coverage is provided through this public funding and administered mainly by public sector providers, with little to no out-of-pocket costs (Bernal-Delgado et al., 2018). Since the 1990s and early 2000s, a rapid period of changes changed vital parts of the system’s funding, delivery, and costs to reform identified issues.
These reforms consisted of a variety of integration of care coordination and personnel education; conversely, they also consisted of a significant decentralization that increased the prominence and responsibilities of the regional health authorities so that they had more capability to regulate and expand their services (Bernal-Delgado et al., 2018). While these were transformative in the system, dissatisfaction on behalf of the public persisted. However, studies suggest a diminishing share of the Spanish population felt the system needed additional funding over those years (Jovell et al., 2007). Still, public trust in the system was high, and a majority still felt a need for further reform and funding by 2006 despite the overall number reducing throughout these reforms since 1990 (Jovell et al., 2007). There were, however, gains in overall health outcomes since 1978, mainly due to emphasis on primary care within the Spanish health system; these reforms ultimately correlated with reduced infant mortality and increased life expectancy overall (Borkan et al., 2010).

The recession hit in the final quarter of 2008 with negative growth since the second quarter, with continued effects through the coming years (Dejuán, Febrero, & Uxo, 2013). Numerous factors influenced the magnitude of the recession, including the reverberations from the collapse of the American housing markets and financial system, and then the subsequent debt crisis in Europe; for Spain specifically, Spanish housing prices rose, and the implementation of the eurozone placed them within a more interdependent currency in the international system (Dejuán, Febrero, & Uxo, 2013).

The decentralized nature of the system heralded in differences in overall expenditures between regions, with some interdependence on neighboring regions on certain decisions to spend resources on services (Costa-Font & Moscone, 2009). This is important because it identifies a mechanism by which decisions to pursue austerity and spending reductions can ideate from the national level and proliferate among regional health authorities.

Once tax revenues and other revenue streams began to be challenged during the recession, the growth of both regional health authority budgets alongside the national system became untenable in the eyes of the Government (Bernal-Delgado et al., 2018). Subsequently, Spain decided to undertake significant cost reduction measures after the initial outbreak of the crisis, collectively referred to as the 2010 Stability Program. This program sought to centralize
the decision-making for the health system, particularly regarding overall expenditures, to stymie the growing costs that regional health authorities were accumulating in standing up and developing programs and service delivery (Bernal-Delgado et al., 2018). Additional reforms to reduce costs of the overall health system was to provide cost-sharing mechanisms with citizens and legal immigrants (as undocumented immigrant free care was ended as well); this meant that the Spanish population now had to pay out of pocket costs for different services, particularly pharmaceuticals, that shifted expenses from the government to the individual (Casino, 2012). Furthermore, as Gené-Badia et al. (2012) argue, policymaking on these cuts and cost-sharing schemes did not seem to consult providers and regional authorities already working in the system to evaluate their impact on the overall health of the population, resulting in ineffective coordination of cuts that were significant that culminated in the stunting of growth in health expenditures (and consequently, health services) overall.

The total CHE in Spain indicates a marked difference in the trendline from 2008 to 2009 (Figure 12). Following a nearly three-fold increase in overall CHE, that trend then peters out and experiences various bumps with a general downward trend. There does, however, seem to be a positive trend with the most recent data, and it remains to be seen how lasting this will be.

A similar trend to the total CHE can be observed from GGHE-D data in Figure 13, where there is a significant shift in the trend during 2008 – 2009. While the precise trend looks similar to the exact movement of the CHE, the y-axis is lowered on GGHE-D to highlight the differences in spending better. This means that, although the charts look similar, the GGHE-D has a minor difference between its data points than the CHE.

This similar trend between GGHE-D and CHE is not surprising, however, given that the percentage of private and public sector funding for the system remained steady throughout the entire measured period. This suggests that, when the overall expenditure decreased, so too did GGHE-D along a similar path, provided that the private sector funding did not fluctuate significantly year-to-year.

Figure 13 demonstrates, however, that the private and public sector shares of total CHE did not waver significantly throughout the entire selected period. Like the other two case studies, this demonstrates that the overall total funding was reduced. There was no compensation for this reduction from both the public and private sector sides; instead, they reduced tandem with the entire Spanish system stagnating previously growth seen in Figure 12.
Similar to Italy, Spanish trends in CHE and GGHE-D that led to a three-fold rise in these measures from 2000 to 2008 were broken come 2008 and 2009. In fact, with this, there does seem to be an overall negative trend, albeit with a less significant magnitude than the rise that preceded it. This demonstrates that the spending in Spain also stagnated after this initial rise, correlating with the outbreak of the economic recession and Spain’s particular strategy toward austerity and EU-imposed structural adjustments to their spending. A threefold increase to nearly $3000 per capita at its height in 2008 is a substantial investment in the health system in Spain, allowing for more resources to keep up with rising costs and more needs that may arise in the population.

Additionally, the private sector in Spain similarly did not significantly increase their share of spending materialize. This means that, overall, the spending driven by the public sector and government indicated this stagnation with a slight decline over time. This is further evidenced by the similarity in trends of each of these spending indicators. Even with both charts using the same Y-axis of Figure 14, they still hold a similar, although less powerful GGHE-D trend per capita. This trend demonstrates how the funding fluctuates during this year and reveals how the health system responded during this period immediately after the economic crises and subsequent policy responses. The demonstrable impact came after 2008, where stagnation and reduction in the trend began, as budgets are often set one to two years in advance, save for any immediate solvency issues or massive adjustment pursued by governments, which the Spanish government did not immediately seek at this time. While a positive trend seems to be materializing since 2015, it remains to be seen how lasting this will be, considering how COVID-19 may usher in new forms of austerity and structural adjustments to a scale similar or greater than for the Great Recession. Accordingly, stagnation with a slight overall declining trend from 2009 to 2014 demonstrates, for those years, how these policies were affected. Particularly with the European debt crisis coming to a troubling financial state in the early-mid 2010s, it is unexpected to see this increasing trend of spending back to levels previously seen in 2008 in the last five years.
Figure 12. Spanish Current Health Expenditure (CHE) per Capita in US$

Figure 13. Spanish Domestic General Government Health Expenditure (GGHE-D) per Capita in US$
For the health outcomes in Spain shown in Figure 15, the in-patient trends show a steady decrease from 2004 until 2013. For the female metric, this decrease ended in 2010, differing from the overall total and male population in-patient diagnoses. The period after 2013 then witnesses a generally positive trend, with some variance from the line of regression for this period.

However, the day patients in Figure 16 offer a different result, with the regression indicating an overall positive trend that is weighted down by dips in the years of 2011 and 2013. Additionally, due to incomplete data from Eurostat, the year 2008 is omitted from this dataset, as well as the years 2000 – 2005. This, while a limitation, still allows for analysis in the years since the economic recession and debt crises, but this will make it more difficult to draw substantial conclusions about where the trend was going previously. While these dips are also substantial in this chart, representing a near 600% increase from 2013 to 2014 in diagnoses, with 2013 for all three metrics hovering around 50-day patients (per 100,000).
Figure 15. Number of Mental and Behavioral In-patient Cases per 100,000 in Spain

Figure 16. Number of Mental and Behavioral Day Cases per 100,000 in Spain
The correlations CHE had with health outcomes also merits discussion, primarily due to the correlation in recent years, but a significant correlation during the years immediately after 2008. The somewhat trend of in-patient, around the dates of the recession, did not change significantly, meaning that some policy decisions did keep people out of hospitals for mental and behavioral issues. While breaking this stable trend, it does return to the level seen in 2002-2003. One potential explanation could be a different way to count or collect this information was enacted from 2004 – 2007. Another could be that this year heralded more mental and behavioral issues overall, as the beginnings of the rumblings of the economic crises did have a significant impact on people’s mental health. This comes back to how governments collect and report this data while also generating a hypothesis that people who witness the beginnings of a national event like a recession and comparing that to its government response could be impacted. This hypothesis, however, is not mainly supported by the fact that the numbers drop back to the levels from 2004-2006, up until its significant rise in 2017.

Reviewing the information from the in-patient level does offer some interesting information, particularly by examining through the lens of gender. With the inpatient cases per 100,000, the general trend since 2004 is a downward regression, with some slight rise from 2015 to 2017. While it does not coincide directly with the economic recession, as it was started before its occurrence, the general trend of decreasing did seem to experience a more flattening of the curve, albeit this does not have a statistically significant strength as a deviation from the line of regression. Therefore, it does seem that Spain was able to stave off some increase in in-patient care for mental and behavioral health, yet this is still not clear whether it is due to capacity and limited services or a genuine continuation of the previously started trend that better treats and prevents these ailments.

However, the particular question the in-patient metrics raise is how the trends regarding male and female data. Through all of the charted period, the male in-patient numbers exceed that of females by 40 – 70 patients per 100,000, with the closest numbers coming through the 2010s. The total metric is between these two metrics, as inclusion of both of these in the population sampled means that it is averaged out more. This may relate to cultural perceptions of how males and females with mental and behavioral health are perceived. Thirdly, this may relate to diagnostic criteria perhaps being more easily applied to one gender than another. While these latter two options are not explicitly associated with austerity, Spanish limits of services at the
time may have heightened these considerations, allowing of the constricting of who could limit
which, invariably lessened the differential between the genders by the restriction of admissions
to more noticeably, less subjective ailments.

It is interesting to note this gender difference in the day-patient cases. While female
patients make up a slightly larger share of these cases than males, it is at a far smaller scale than
the gap for in-patient cases. This data, however, does offer a significant limitation to state
conclusive hypotheses explaining these results, as the 2008 data has not been reported to the
WHO, and there is no data prior to 2006, limiting this analysis’s ability to interpret trends
leading into the recession. The trend after the recession holds a positive upward trend. However,
there are significant deviations from this that contribute to the model’s variability. These
deviations in 2011 and 2013 decrease from the prior year by 70-100 patients per 100,000 and
100 – 150 patients per 100,000, respectively. It is interesting to note here that these trends are not
always consistently increasing or decreasing due to process issues. This could be revisions in
diagnostic criteria, alterations to reporting or collection capacities of state and localities, or other
individual measures. However, what makes these particular spikes stand out is that there are no
similar spikes in the different trends. If there were identical declining or rising spikes in other
metrics, this would suggest that the reduction could be due to declining patients rates or the
funneling of patients from day cases to in-patient. Since this does not occur, however, it raises
questions on where these day cases went? If there were no significant movement in mental and
behavioral health patients, day cases indeed would not have simply declined due to patient
movement. As we can see, the trends in expenditures hold steady at this point, and Spain was
subject to numerous user fees and fee-for-service payment models. This could have restricted the
care that individuals with these could have received, notably as these regulations are rapidly
shifted and moved depending on the priority and decisions by policymakers at that time.

Comparing this to in-patient care, this upward trend contrasts with the overall declining trend
of in-patients. This is interesting and not simply contained to the economic crisis period.
However, due to the lack of data prior to 2006, it is difficult to conclude whether this is a result
of the funneling of patients toward day care rather than in-patient care, or whether this is as part
of a longer trend of prevention and education on mental and behavioral ailments that result in
shorter in-patient cases.
Synthesis

The critical question here is what a trend, whether increasing or declining, represents for these metrics. This analysis takes a nuanced approach to this question. There are three primary means by which to think about this question. Firstly, an increasing trend could demonstrate an increase in the total number of cases in the country, allowing more interpretation of how the population responds to specific events. However, this does assume that these metrics are accurate and were not subject to scaling back of services, cuts, or reductions in these countries by austerity. Secondly, an increasing trend could also demonstrate the capacity of the healthcare system. This means that they reveal cases that the health system was able to treat and catch, indicating, particularly for mental and behavioral ailments, this is a measure of the capacity and strength of the system. An increasing trend with this lens would significantly impact how the system is treating and catching these cases. Thirdly, a rising trend could be a mix of both capacity and cases, requiring additional analysis comparing them with health capacity data to investigate how these countries experienced differences in service provision and quality over the years preceding and after the recession.

Additionally, the private sector share for these three target countries remains around 25 – 30%. This is interesting as it demonstrates how significant a share public sector funding has in the field and how movements of the government’s decisions on expenditures can impact the overall money in the health system. This can also be attributed to the direct public financing of healthcare in these countries, allowing for such a significant share of overall expenditures to be consolidated and driven by government spending.

Consequently, when reviewing these case studies, it is evident that there is a correlated impact between stagnation in health expenditures and health outcomes in mental and behavioral health. This analysis in each case study demonstrated the complication that arises when charting health outcome trends, as the literature suggests that declining capacity would be attributed to a reduction in capacity that has left it difficult to detect or otherwise treat mental and behavioral ailments resulting in them turning away from services (Stuckler et al., 2017; Palese et al., 2014). Furthermore, as highlighted in the introduction, individual behaviors may be changing because of perceptions in their health system, where people may have difficulty accessing services, paying for increased user fees for services, or frustration with declining quality standards (de
Belvis et al., 2012; Petrelli, 2013). These case studies clarify how governmental funding and policy decisions have a correlated impact on mental and behavioral health outcomes.

Thinking about shares of governmental funding, fluctuations, and decisions to stagnate overall growth of expenditures, particularly in Spain, is essential because of the central question of why would governments opt to make the deliberate policy decisions that would tighten his growth? And why, in the example of France, did decisions to stagnate growth still but not cut services to account for revenue gaps be made in the first place? I argue this is due to the tension inherent in contemporary policymaking between human rights frameworks relating to health and neoliberal ideological tensions that challenge or supersede the prioritization of the framework of the right to health in a health system. In the perception and decisions of the case studies, there were deliberate choices that impacted how human rights were de-prioritized in favor of neoliberal policy solutions that, at its core, diminished the emphasis of the right to health in health systems. When referring to the analytical framework, these case studies demonstrate how the core foundation of governmental funding and the progressive realization of health is not clear.

Subsequently, it is essential to consider how the right to health as a concept developed and proliferated in the international system, followed by the challenges that neoliberalism posed.

**Genesis of Human Rights Frameworks**

**What are Human Rights, And Where Do They Come From?**

Numerous international instruments such as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social, and Cultural Rights offer responsibilities and obligations for governance regimes regarding human rights (UNGA, 1976; UNGA, 1948). Philosophically, the fundamental rights of humans have long been debated. Still, the conception of human rights in the international system finds its roots in the aftermath of World War 2, where the promulgation of inherent rights of humans began to produce. After WW2, the violations against the rights of people were so egregious, from genocide to experimenting on people for medical research, that the international community determined some universal rights that people hold, regardless of the country in which they reside or the citizenship they hold. Over time, these rights have come to be defined in different ways by different stakeholders, such as applying a human rights approach to
identifying and resolving violations of individuals’ rights (Mann et al., 1994). Broadly, these rights as presently defined fall under two buckets: political and civil rights; and economic, social, and cultural rights. Some, like the United States since 1981, argue that the latter should instead be viewed as ideals that are in a “qualitatively different category” of rights from the former due to their perceived potential to be used as justification to violate civil and political rights that were already well established (Alston & Quinn, 1987).

As theoretical concepts, human rights offer intrinsic and inherent protections to every individual by virtue of their membership in our shared humanity. However, how these rights are actualized and operationalized is an entirely other domain that seeks to understand the real-world implications of inherent human rights. Moving these rights from written words in the United Nations repositories to the intentions and policies of governments and policymakers is a challenge in and of itself. Hafner-Burton and Tsutsui (2005) identify a “gap between states’ propensity to join the international human rights regime and to bring their human rights practice into compliance with that regime,” where government adoption of human rights treaties has also increased concurrently with violations of such rights until the 1990s. This demonstrates that human rights may find legitimacy in their identification and subsequent ratification in human rights instruments such as the Universal Declaration of Human Rights and other international covenants and agreements. Yet, in practice, ratification is not as clear-cut in immediately injecting a government with these rights as priorities, as violations persisted and persist in countries where they have been adopted.

For example, we see rights articulated such as clause 1 of Article 25 of the Universal Declaration of Human Rights that read:

“1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control” (UNGA, 1948)

Yet, where medical care in the United States is increasing unavailable due to cost and lack of insurance by many or where cuts to social services in Greece have reduced the availability of security in the event of unemployment, there are still new violations of these rights that have existed for decades (Faust, 2019; Lynch 2020).
Additionally, article 20 of the UDOHR articulates the “right of peaceful assembly and association.” Although a signatory to the Declaration, a 2018 UN report highlighted increased labeling of human rights defenders as “terrorists” by governments across the world in an attempt to marginalize and outright discredit these individuals (OHCHR, 2020).

These rights, while enumerated, still face challenges in realization. Consequently, debates persist over how to realize best the rights found in these documents, with some commentaries looking at the prevailing instruments that have not succeeded in preventing human rights abuse, while others argue for the benefit of these instruments under their documentation and codification of these rights itself (Hafner-Burton & Tsutsui, 2005; Alston & Quinn, 1987; Braveman & Gruskin, 2003).

**What is the Right to Health?**

Internationally, virtually every country has submitted to the human rights regime set in international law, including the right to health. The right to health falls under the economic, social, and cultural rights bucket in the international rights regime. Health, and its establishment as a right, emanates from several human rights instruments. These include the Universal Declaration of Human Rights that establishes a right to a “standard of living adequate for [..] health and wellbeing,” and then further by the ICESCR’s promulgation of both the right to health and steps to be taken in article 12, and finally the definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” in the WHO’s preamble to its constitution (Yamin, 2005). A helpful way to think about the right that considers these historical framings and documents is the three obligations under the right to health articulated by Yamin (2005): “(1) to respect the right by refraining from direct violations (2) to protect the right from interference by third parties and (3) to fulfill the right by adopting deliberate measures aimed at achieving universal access to care.” The right to health is enshrined across multiple precedence and stipulations throughout many of these human rights agreements (UNGA, 1976; UNGA, 1948).

Whose job is it to uphold a high level of health? The ICESCR (article 12) argues that it’s the responsibility of the state to provide the “highest attainable standard of physical and mental health.” The Covenant further notes the provision of medical services during sickness as key to this right. (UNGA, 1976). Jonathan Mann and others have argued furtively for a robust
framework linking health to human rights over the last 30 years (Tarantola et al. 2006). In this framework, health and human rights are inextricably linked, despite distinctions between the scholarly and practical fields with little substantive engagement with each other.

On the one hand, doctors may concern themselves with the patient in front of them. On the other hand, human rights advocates focus on political and civic rights. Blending these approaches offer a direct link to the human rights instruments noted above and promote the right to health. Therefore, the goal is to link these fields fundamentally and advance the well-being of every human. Violations of human rights and public health separately impact each other. State health policies may infringe on an individual’s rights, such as the right to information for products with adverse health products (Mann et al., 1994). Conversely, it has been suggested that discriminatory inequalities of people hold an impact on mental and social wellbeing (Schwartz, 2017).

Therefore, intertwining conceptions of health and the pursuit of realizing human rights allows for the inclusion of an obligation to promote and protect the right to health. This has its origins in the notion that initial conceptions of human rights viewed these as relationships between the state and the individual – this is what the state has signed up to protect. They are the primary guarantors of these rights drawn from these international instruments. This idea of the state being the primary guarantor is what traditional interpretations of human rights theory in the post-World War 2 order have advanced, where rights are a relationship between the state and the individual (Mann et al., 1994). In reality, states have not always lived up to this guarantor status, even less so for rights to good health. While rhetoric and agreements in international forums have been consistent, implementing policies and structuring health systems that are framed around or about human rights frameworks are contentious. In the United States, the notion of putting human rights at the center of the health system would be a complete challenge to the profit-driven health system. In contrast, many European contexts maintain more equitable health systems that excise profit from notions of health, managing health as a social good. But measuring how and where a human rights framework is embedded within a health system can be tricky as accountability to the ICESR has been sparse (Chapman, 1996).

What is Progressive Realization of Health?
This thesis aims to survey how states succeed and fail to promote health as a human right. Thinking about achieving health as a human right has been increasingly challenging with the rise of neoliberal policies and corollary impacts of those policies in/on health systems. With this in mind, I will discuss the concept of progressive realization on how countries should protect rights in the first place. This includes both the mechanisms and underlying justifications.

The linchpin of the Covenant rests on this concept of “achieve progressively.” Specifically, the ICESCR establishes in article 2 that each State has an obligation to take steps “to the maximum of its available resources, intending to achieve progressively the full realization of rights recognized in the present Covenant.” (UNGA, 1976). The linchpin of the Covenant rests on this concept of “achieve progressively.” Its drafting process reveals the underlying intention and debates behind this concept: implicitly articulated throughout article 2 is this idea that progressive achievement meant at the earliest possible moment, subject to the means, resources, and programs available to states to guarantee such rights (Alston & Quinn, 1987).

Progressive realization refers to the implications of progressive achievement or the formation of policies that focus on or draw upon a more equitable structural framework. I turn to Baltussen and colleagues’ (2017) practical guidance on how nations could integrate progressive realization into their plans and organization of universal health coverage (UHC). This guidance posits that health authorities must first select the priorities of service they both desire and can provide for their citizens. Secondly, they must decide how precisely to implement these priorities in an equitable, accessible, high quality, and affordable way. These two choices, they argue, are thought to help the progressive realization of health by identifying tangible, incremental steps that can be taken to prioritize specified services and provide them. Fully realizing the right to good health and protecting that right through national policy choices requires thoughtful and strategic planning that draws from resources a state already has while imagining how to expand a health system once requisite resources exist (OHCHR, 2008). There must also be a focus on progressively realizing, in this case, a health system that emphasizes equity in both process and outcome (Hunt & Backman 2008; Braveman & Gruskin 2003). For example, health officials in West Java, Indonesia, sought to engage all stakeholders when developing their priority HIV/AIDS services as part of their five-year (2004-2018) strategic plan so that multiple voices and priorities were embedded in national strategy (Baltussen et al. 2017).
The notion of progressive realization was perceived by many as a process, which allowed for multiple interpretations and applications of the ideal. For instance, initial proponents of progressive realization sought to clarify that this language allowed states to ratify the Convention, provided that they were working as “a matter of good faith” toward the full realization of the rights. Others, such as the Lebanese representative to the negotiations, noted that this concept might “discourage immediate implementation…because a state would be able to say it was only bound to implement the rights in the Covenant progressively (Alston & Quinn, 1987). Nearly 55 years later, states waver in their commitment to this ideal, leading critics to propose a different enforcement mechanism entirely to ensure states adequately protect these rights (Chapman, 1994). Although more than 70 countries have recognized the right to health in their national constitution, and, at least on paper, many more have signed onto international agreements recognizing this obligation, countries actualize it in different ways, to varying degrees of success (Yamin, 2005).

An interesting debate in this context is whether inadequate health protection below that which is established the law on the books is within the confines of this right, even if this implemented standard is all that the country has the available resources for. A pair of decisions in the European Court of Human Rights held that should protections to the right to health solely exists “in theory” rather than “in practice,” the obligations to protect and progressively achieve health rights deriving from article 2 of the ICESCR are not satisfied (Calvelli and Ciglio v. Italy, 2002; Dodv v. Bulgaria, 2008). While not setting overarching international precedence or authoritative redress for states in which this type of in-name-only health access exists, these decisions demonstrate that countries’ perceptions of these obligations still are litigated and subject to varying interpretations (Mikolajczyk, 2019). This is important in my analysis because, while I argue that countries are obligated toward realizing these rights, governments may not uniformly agree on what these obligations are and if they are responsible for all aspects of the right to health.

This is where approaching health from a human rights lens shifts the construction of the concept of health. From this approach, as a human right, states have an obligation to promote good health for their population. This is due to the conventional understanding that rights primarily ideate in the relationship between the state and the individual, and this still holds with the expansion of rights discourse to include relationships between other institutions, like
multinational corporations, and the individual or their environment (Mann et al., 1994). So, by formulating our understanding of health as a right, it becomes incumbent on the state to facilitate the realization of this right; this means the inverse is true as well, that states then also bear the responsibility when these rights are either being actively violated or passively denied (Yamin 2005). Thus, I argue that progressive realization of the rights mentioned above insists that states work to fully realize these rights, and retrogression of progress toward guaranteeing these rights would represent a violation of this commitment.

While human rights are set in international law, economics and its associated neoliberal ideology find their roots through the nature of our globalized economic capitalist system (Sparke, 2016). This means that the health systems working within this system are also subject to both the ideology and the overall economic conditions in the world (Packard, 2016). Therefore, policymakers of health systems demonstrate how decisions made for financial or economic reasons can spill over into the overall population health of their country. Already, there have been conflicts over how countries prioritize and balance the forces of human rights and economics when governing their health systems, ultimately determining the health of their people (Lynch, 2020; Hunt & Backman, 2008).

Why states strive to realize health rights during recession can be observed before crisis strikes, or, in other words, if a right to health is embedded within the preexisting national health system built during economic stable periods. Accordingly, the most effective mechanism by which states can meet this obligation can be by building in services and pursuing a policy that seeks to achieve the highest attainable standard of health (Hunt & Backman, 2008; Braveman & Gruskin, 2003).

**Neoliberalism and the Right to Health**

As a governing ideology, neoliberalism constitutes a focus on “making market forces the basis of economic coordination, social distribution, and personal motivation” (Sparke, 2016). The product of the ideology finds its roots in the 1980’s structural adjustment programs (SAPs) advanced by leading international financial institutions that produced user fees, service cuts, and restrictions on health programs (Packard, 2016). Initially, the ideology and its associated programs were founded on colonial or neocolonial relationships, with SAPs often enforced on African and Latin American countries by Western-backed international finance institutions. Over
time, particularly after the 2008 financial crisis, similar programs (albeit re-branded) that allowed for austerity found their way to be enforced on European governments who, ironically, had a history of imposing neoliberal policies on other countries (such as the 2005 Gleneagles debt relief agreement) (Sparke, 2016). One facet of this is the pursuit for growth is the rhetorical focus on “investments in health” – in other words, this current establishment phrase notes that investments in health pay off, denoting profit, growth, and sound economics (Sparke, 2016). This, therefore, produces this singular focus on growth and all other ailments become secondary. Social welfare, healthcare, or education – all must be effective in pursuit of economic growth. As has been noted, this focus on economic growth and overall economic discourse in health has produced unfortunate consequences on national health. Tossing aside the human rights-based framework means that the health system as a structure does not solely serve the progressive realization of the right to good health.

The underlying notion of neoliberalism and health is that health should be commodified as part of the creation of economic benefit. This is imperative within the neoliberal model so that, when push comes to shove, services can be cut or restricted in the name of reducing government deficits and promoting economic growth (Viens, 2019). These policy prescriptions provide an example of how the neoliberal ideology opts to respond to economic hardship, with many of the proposed austerity solutions spilling over into the health sector, adding to the lineage of the commodification of health that finds root in the late 1970s and early 1980s SAPs for debt-stricken countries (Pfeiffer & Chapman, 2010). The drivers behind austerity can be domestic. However, due to the interconnections on the global economy, the International Monetary Fund (IMF) and the World Bank Group (WBG) hold a leading role in advising how States ought to respond to economic crises. These international institutions promoted a 1990s economic policy package known as the “Washington Consensus” that has since received critical reception and was met with mixed records of success due to their variability in application and results measured from their policies. (Stuckler & Basu, 2013). This policy package includes conditional rules, such as privatization, reductions in health and social services, and deregulation of finance and trade industries, placed upon a state to recover from economic recession or debt, and have come to represent how neoliberalism as an ideology can be translated into actionable policy steps that come to be known as part of a larger austerity regime today (Sparke, 2016).
Drawing inspiration from Sparke’s compliments to the theory of biological sub-citizenship, I argue that neoliberal policy has disenfranchised people from their right to health entirely, seemingly abandoned by their state (Sparke, 2017). While the initial goals in the health system may have been to protect this right, the infusion of neoliberal austerity cuts and restrictions introduced differing priorities to the national government, whether by choice or by imposition of external institutions. In the current prevailing economics and health environment, not all people have the same level of “citizenship” in protecting individual health. Therefore, differing outcomes in health produce biological sub-citizens with the resources and innovations of their health system extracted and subsequently benefit others deemed as “biological citizens” – in other words, those with wealth, power, and status in our society. This is a critical part of the theory initially advanced by Rose and Novas (2005). This exploitation and extraction occur from numerous different institutions, yet their impact has been ballooned during the 2007-08 financial crisis, and international organization’s requirements before assistance were granted (Leider et al., 2014; Sparke, 2016).

Contemporary Neoliberal Decisions on Structuring Health Systems

In the global economic system, as it stands today, the health system under pressure may also be subject to pressure by market forces, particularly during economic recession. This is through policymakers' political and moral choice to respond with austerity and additional neoliberalism measures that cut or otherwise restrict services (Stuckler et al., 2009; Stuckler & Basu 2013).

As an advisory source on health system structuring, the World Health Organization’s Health System Building Blocks offers six core components that comprise an effective system, complete with various associated indicators. They are as follows: (1) service delivery, (2) health workforce, (3) health information systems, (4) access to essential medicines, (5) financing, and (6) leadership/governance (WHO, 2010). These blocks are a few frameworks through which we can view health system strengthening for the highest attainable standard of health. Each requires significant investment, both monetary and attention-wise, to create an integrated, effective system. From the WHO’s perspective, each of these serves to structure and subsequently modify a health system. Yet, in this constant progression, a health system should be aimed to achieve the right to health.
Consistent progression also involves the inclusion of equity, considerations of social determinants of health, and the universal offering of services without discrimination (Lynch, 2017; Braveman & Gruskin, 2003). The building blocks and human rights approach reinforce each other, where greater implementation of, say, health information systems may strengthen rights previously overlooked or injection of progressively better health delivery standards may improve the health system’s functioning as a whole (Hunt & Backman, 2008).

With these blocks in place, either entirely or partially, a state is not immune to the strain placed upon the entire system and society-at-large during economic recession. This is where the health system as a whole begins to bend, and the response to that bending is what makes the difference between buckling under the pressure and protecting the population from health retrogression.

Approaching this phenomenon from a human rights perspective beckons the question: have health systems been set up to guarantee these rights? If so, how do they? If not, what then are they set up to do?

Table 1 demonstrates broad categories of how health systems are set up, with the primary distinguishing sources of resource supply, public-private structure, and regulation of access to care. By understanding the types of health systems as demonstrated by Riebling, Ariaans, & Wendt (2019) and Wendt (2009), we can have a better comprehension of how, in these cases, OECD countries can structure their systems and why these systems succeed or fail at guaranteeing human rights related to health. Furthermore, as noted in Timothy Faust’s (2019) explanation of the American health care system, health systems can arrive at these categories through cascading choices by independent stakeholders without a centrally planned design (although successful systems reform often is achieved through a coordinated and integrated design).
Table 1. Comparison of 5 clusters of health systems and their distinct features drawn from a composite of frameworks from both Reibling, Ariaans, & Wendt, 2019; Wendt 2009.

<table>
<thead>
<tr>
<th>System</th>
<th>Supply</th>
<th>Public-Private Structure</th>
<th>Access Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply and choice-oriented public systems</td>
<td>Public &amp; Private</td>
<td>Regulated Social Insurance</td>
<td>Free choice</td>
</tr>
<tr>
<td>Performance and primary care-oriented</td>
<td>Public &amp; Public</td>
<td>Government</td>
<td>Cost-sharing</td>
</tr>
<tr>
<td>public systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulation-oriented public systems</td>
<td>Public &amp; Private</td>
<td>Regulated Social Insurance</td>
<td>Regulatory limits</td>
</tr>
<tr>
<td>Low-supply, low-performance mixed systems</td>
<td>Public &amp; Private</td>
<td>Government</td>
<td>No cost-sharing, low out-of-pocket expenses</td>
</tr>
<tr>
<td>Supply and performance-oriented private</td>
<td>Public &amp; Private</td>
<td>Private financing</td>
<td>Deductibles limit</td>
</tr>
<tr>
<td>systems</td>
<td></td>
<td></td>
<td>High out-of-pocket expenses</td>
</tr>
</tbody>
</table>
Healthcare systems are often one of the most direct pathways through which an individual’s health is impacted, for better or worse. This includes the lack of service, which demonstrates the state’s inability to realize this human right. Reibling and colleagues (2019) offer a typology for how these systems are structured in practice, differentiated by questions of financing, access, regulation, private sector involvement, and purpose. Table 1 demonstrates the myriad of choices that policymakers and, in many countries, the private sector face when constructing and realizing their health system in the frame of Riebling Ariaans and Wendt (2019). At the center here is how health is constructed in each system – that is to say, how policymakers, politicians, general populations, and countries regard the relationship between their populations’ health and the right to health. Whether national leaders view health as a right and take seriously their obligations toward progressively realizing it can be reflected within the construction of the system, particularly during a crisis. The rationale behind certain systems choices is immersed in the political and ideological realm, with debates over how these measures take the government’s role (Glencross, 2018; Leider et al., 2014). Thus, as the construction and implementation of a health system are political, its response to crisis is as well. What complicates clashes of ideologies within national policymaking bodies, through which states exact some sovereign authority over creating and maintain their system, is that this debate is not limited to the politicians and policymakers in the room (Gostin et al., 2019). Interest groups, international bodies, trade associations, and medical-related businesses all place their imprint too on the health system of a country (Shiffman, 2019; van Olmen et al., 2012). This imprint can be rhetorical, on service delivery and its associated material and financial needs, and influence on the creation and maintenance of the system.

Despite the seemingly immediate effects of the latter two influence mechanisms, it must be noted that rhetoric and popular discourse shape how the problems of health inequity themselves are viewed and thus shape what policy responses, for political leaders, are available at their disposal. Framing problems in a health system as caused by individual irresponsibility, maldistribution of resources, violations of human rights, or privatization results in drastically different policy levers to pursue remedies (if any) while also attracting certain stakeholders to influence system creation (Lynch, 2020). This is especially pertinent during economic recessions, such as popular demonstrations against economic stimulus in the United States in the immediate aftermath of the 2008-9 global financial crisis.
Furthermore, the structural factors at play in the health system similarly reduce the available policy levers while also affecting the priorities of the overall system. Transformations occurring since the late 1980s toward neoliberal ideologies in public services, which prioritized market forces, financial profit, and economical solutions to social and other problems, severely impacted how these health systems foundationally responded to these economic crises. As part of this transformation was how policymakers and institutions responded to the 2008 economic crises, which reflected this prevailing neoliberal policy consensus that then impacted how the crisis was spoken about while also dealt with. Yet, there were significant ramifications for this decision that came to influence the health outcomes of the populations throughout Europe, but particularly in these three case study countries.

**When Neoliberal Austerity Harms Health: Populations in Crisis**

In agreeing to slash public health services and shift care costs to patients to recoup enough funds to pay back their debts to international and European countries, the lack of services in Greece produced numerous health concurrent crises, such as an HIV epidemic among injecting drug users from 2011 to 2013, the re-emergence of locally transmitted malaria since 1970, and homeless populations and undocumented migrants experiencing significant unmet needs (Karanikolos & Kentikelenis, 2016). Previous analyses by Marina Karanikolos and Alexander Kentikelenis (2014; 2016) directly attributed these crises to the impact that programmatic and budgetary cuts imposed on the Greeks by the so-called ‘Troika’ -- the European Commission (EC), the European Central Bank (ECB), and the IMF.

While this is just one of the most prominent case studies of how austerity produced by neoliberal austerity agendas harm health outcomes, there are countless examples of similar imposed austerity measures across continents that show similar impacts in these three case countries. In Italy, with costs introduced for 2012 – 2014 amounting to 8bil (euro) of the public sector public health services, there is a rise in unmet needs for medical examinations for the bottom and middle-income quintiles of the populations, with 12% reporting unmet medical needs in the bottom quintile in 2012 (Petmesidou, Pavolini, & Guillén, 2014). This is especially true for elderly populations in this bottom quintile in Italy and demonstrates how these populations in Italy have found increased difficulties obtaining routine medical screenings that are essential in preventative care. A qualitative study of Spain’s healthcare workforce in Valencia reveals how
austerity and the privatization process they were witnessing extremely concerned them and noted the increases in cuts to referrals and early discharges that ultimately harmed their patients (Cervero-Liceras, McKee, & Legido-Quigley., 2015). Those surveyed noticed and identified a potential political agenda behind the privatization of their services; neoliberalism is a core part of this political agenda that seeks to privatize and reduce public expenditures, to the point where those operating in the system report that this harms those they seek to serve. In France, rising unemployment, reduced governmental funding for health and social services, and other economic crises faced by the countries produced poor access and overall difficulty in navigating the bureaucracy of the health services, particularly for the most vulnerable, such as recent immigrants, as noted in Sargent and Kotobi (2017).

Prominent scholarship documents neoliberal ideology as a producer of poor population health (Lynch, 2017; Stuckler & Basu, 2013). As neoliberal ideology drives notions of austerity, it is no surprise austerity can hurt a country’s social and biological health profile. Austerity has been associated with numerous health outcomes, such as suicide (Reeves, McKee, Stuckler 2014; Kentikelenis et al., 2014), immunization (Packard, 2016), infectious disease (Karanikolos & Kentikelenis, 2016), and access to care (Ford et al. 2018). A review of the European populations in countries with many austerity measures imposed even showed increases in homelessness and food insecurity, demonstrating a negative trend on conditions that exacerbate suffering and ill-health (Stuckler et al., 2017). Overall, the conditions in which healthcare is provided are being strained significantly. Palese et al. (2014) demonstrate a clear example of direct austerity and its impacts on associated health systems. The study surveys nurses across Italy from 2010 to 2011 whose employers were experiencing cost-containment measures and cuts to expenditures overall imposed directly from the repercussions of the 2008 recession. They report alarming trends, which are consistent with the myriad of studies noted above. Stress in their clinics has increased. More patients are reporting significant social problems. Nurses are receiving increased workloads and fewer resources to do so, and students are having more difficulty with clinical placements. This snippet of the health workforce in Italy and their self-reported increasing of problems and disturbing trends represent this larger trend of neoliberalism: these services receive cuts and reductions that ultimately harm care. How these nurses report their jobs changed are some of the many mechanisms by which neoliberalism ideates from cuts at the top of an organization through to the lived experiences of patients.
Furthermore, austerity hurts the health workforce during crisis, including physicians, nurses, clerical managers, and policymakers. Healthcare workers’ stress can be exacerbated by perceptions of austerity to affect how they perceive their government supporting their work. If the crisis is related to health, such as a disease outbreak, national support is critical despite the financial crisis. Yet, other crises can escalate health burden when the crisis may be perceived negatively by healthcare workers. For example, nurses in Italy cited austerity as the source of increasing workloads, stress, and patient numbers, underscoring how reducing finances allocated to the health system can profoundly impact those who work within (Palese et al., 2014; Cervero-Licera 2015; Lynch 2017). This points to a larger issue on how these austerity measures are received by the workforce directly affected by those in the healthcare sector and often have to continue to execute their services despite the measures.

**Conclusion**

This thesis revolves around the duties of a government to its population during economic recession. In this analysis, that obligation is the progressive realization of the right to health. Primarily, this is pursued through how countries structure and implement their health systems, particularly where they choose to allocate funds. During economic instabilities the last two decades, health systems have seen pressures exerted on them by the rising toll that an economic recession may be taking on their populations’ health. With the rise of neoliberal ideological focus on market solutions to these problems, policymakers may view that obligation to the right to health in a different lens. This thesis subsequently aims to look at how this obligation and austerity have impacted the three case study countries, as they can compare trends between each other. The main course of analysis is whether the policy solutions, whether austerity or increasing health budgets, were enough to sustain the progressive realization of health.

In this field of study, numerous analysis has focused on the negative impact that economic downturns have on a population and have also focused on policy solutions have deepened that negative outcome. Both of these focuses demonstrate that this field is growing, and there is an increased need for further research on how exactly these mechanisms might work. My thesis fits into this by looking at policy solutions to stem the tide of adverse health outcomes. Using a human rights lens, it is evident that governments have this obligation to stem the tide of
negative health outcomes during economic recessions to work towards progressively realizing the right to health constantly. It has been important to focus on the intentions behind certain policy actions, which has been why this analysis has also concentrated on neoliberal drivers of policy. Combining analysis on human rights, neoliberalism, population health, and government expenditures, this thesis offers a synthesis of existing literature from multiple angles and three case studies by which these larger forces play out in people's lives.
Appendix: Methodology

The methods used in this thesis consisted of statistical analysis of population health, health capacity, and health expenditure from France, Italy, and Spain from 2007 to 2013.

These countries were chosen due to their similarities in geography, governance style, political leanings, and health system structure, and their differences in levels of austerity applied during this period. This period was subsequently chosen because of the global financial and localized European debt crises that these countries had to weather while also administering to their health system.

It is important to note that, in this methodology, there will not be a direct cross-country comparison of data values. This is because each country differs in its methods for definition, reporting, diagnosis, and collection. Any such difference between data points would be subject to bias due to various means of collection and compilation. Therefore, the primary means of comparison will be through comparing the overall trend lines of countries longitudinally. This allows for using the standardized means of collecting and compiling data within each country and then only comparing how these data points changed year-to-year.

The question that will be evaluated in these statistics will be the following: did health outcomes either (1) stay on the same trendlines, (2) create a positive trend-line, or (3) break previously positive trendlines? This will demonstrate how these outcomes changed when regressed against the spending of governments. The focus of this study will be on correlation and will not investigate causality. The correlation of a trend could suggest that the governments have successfully progressively realized health through their spending. Regardless, the health outcomes had these trends, and correlations may reveal how they interact.

Source of Information

Population health data is from the statistical office of the European Union, EuroStat, and is broken down by the second level of the Nomenclature of Territorial Units for Statistics (NUTS 2), which measures at the regional level within a country. Population health data demonstrates how these populations fared during this period. Health capacity is sourced from the same datasets and used to measure how countries are utilizing their expenditures and offers a glimpse into how populations might access healthcare.
This data on health outcomes and health capacity metrics were drawn from the Eurostat, which is the primary official statistical agency for the European Union, collating information on each of its Member States related to, among other items, health outcomes.

Eurostat was selected for this information for multiple reasons. Firstly, the data is organized in a gendered breakdown, allowing for review and analysis on the trajectories of outcomes on this basis, when applicable. Secondly, the data includes national total and regional totals utilizing the Nomenclature of Territorial Units for Statistics (NUTS) 2 classification. As set up by Eurostat in the 1970s, NUTS is a standardized means of organizing the statistical data received from Member states to reflect better, harmonize, and frame how this data reverberates down to the local level (European Commission, 2021a). The classification has received multiple revisions since its conception, but the system “generally mirrors the territorial administrative division of the Member States” (European Commission, 2021b). NUTS 2 in France, Italy, and Spain demonstrate the country's territorial division so that each NUTS 2 region generally is administered by an overarching local government and the national government. Thirdly, Eurostat, as an arm of the European Union, collaborates directly with the national statistical institutions of Member States (or other national entities with this portfolio), who collect the data and then report that information directly to Eurostat, who attempt to harmonize and standardize methods and visualizations of the data (European Commission, 2021c). This, however, does represent a limitation, as direct comparability between total numbers in Eurostat metrics should not be directly compared, as different methods of collection exist between each of the national statistical institutions of Member States.

The data on health expenditure and shares of spending in health are sourced from the WHO’s Global Health Expenditure Database (GHED). The database “provides internationally comparable data on health spending” for much of the world since 2000 (WHO, 2021). This source was selected for its comparability of metrics between the three target countries. This is achieved through direct collaboration between the Member States and GHED. WHO aims to revise and update the database annually when new information about these expenditure and accounts metrics is received (WHO, 2021). To better understand comparable trends between countries, this database serves an essential purpose in this analysis by measuring and reporting the same metrics that, although they cannot be numerically compared, can be approximated by their longitudinal trends and responses to the 2007-2008 financial crises.
Selected Metrics

Table 2 explains why each health expenditure metric was utilized to create the figures in each case study.

Table 2. Health Expenditure Metrics and Justifications For Their Selection

<table>
<thead>
<tr>
<th>Name</th>
<th>Reason Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Health Expenditure (CHE) per Capita in US$</td>
<td>This offers a top-level overview of how much money is put into the health system of a given country, standardized into a per-capita metric so that trends are normalized to reduce differences due to budget size or population size.</td>
</tr>
<tr>
<td>Domestic General Government Health Expenditure (GGHE-D) as % CHE</td>
<td>This percentage demonstrates the level to which the public sector provides toward the overall health expenditure in a country. This then allows a view of the total CHE, where the funds are sourced from. When paired with the metric of “PVT-D as % CHE,” it should equal 100%. This metric offers insight into how impactful specific budgetary changes were on the overall CHE when measuring austerity.</td>
</tr>
<tr>
<td>Domestic Private Health Expenditure (PVT-D) as % CHE</td>
<td>This percentage demonstrates the level to which the private sector provides toward the overall health expenditure in a country. This then allows a view of the total CHE, where the funds are sourced from. When paired with the metric of “GGHE-D as % CHE,” it should equal 100%.</td>
</tr>
<tr>
<td>Domestic General Government Health Expenditure (GGHE-D) per Capita</td>
<td>This metric demonstrates how much of the public sector spending is on health. The strength of utilizing the per capita metric is that it offers comparability between countries to indicate how these trends can be measured against each other.</td>
</tr>
</tbody>
</table>

These metrics can be categorized into three broad categories: those that demonstrate comprehensive resources, those that show governmental priorities, and those that illustrate the impact of economic recession.
As a measure of health outcomes, the mental and behavioral health diagnoses are categorized by day cases (per 100,000), and in-patient (per 100,000). This allows for comparability between countries while also providing information on the length and type of visit over this period. Additionally, they are broken down by gender and NUTS 2 region.
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