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welfare state analysis.

Interestingly, social investment policy reforms have been enacted and defended by both by conservative and progressive coalitions, even in economically hard times. Broad support for social investment, I believe, is rooted in the fact that, despite deepening inequalities, aspirations of modern familyhood have come to converge over the past two decades on the desire of adult men and women to work and raise children, an aspiration shared by low-income and middle-class groups alike. Of course, social investments will inevitably miss out on protecting the most vulnerable groups. For this reason, adequate minimum income protection remains a critical precondition for an effective, inclusive welfare state.

In the face of the raging Euro crisis, social investment can no longer be dismissed as a ‘fair weather’ policy when times get rough, as was the case during the Lisbon era. European policy makers are confronted with a truly existential—economic, political and social—interest in addressing prevailing trade and competitiveness asymmetries by forging viable economic adjustment strategies that do justice to the important macro-economic returns of the social investment perspective. Because of ageing, human capital cannot be allowed to go to waste through semi-permanent inactivity, as was the case in the 1980s and 1990s in many mature continental European welfare states. For these reasons, social investment must be anchored in a euro zone macroeconomic and budgetary governance to support durable growth in the real European economy. However, there is a real risk that a balanced set of social investment objectives will be lost in the drive for front-loading (pro-cyclical) austerity in times of large-scale public and private deleveraging, conjuring up a spectre of a lost decade for Europe, worse than the one experienced by Japan since the early 1990s.

The EU needs a New Deal between countries which are in better budgetary shape and have pursued social investment strategies more consistently in the past, and countries which have been less consistent with regard to social investment than one may have wished and therefore experience dramatic budgetary situations. The macro-economic policy regime that is required is one wherein all governments pursue budgetary discipline and social investment over the medium and long run, and are effectively supported therein. To convince the larger European democratic publics, in terms of political legitimacy, consistent with norms of social fairness, such a macro strategy should be tangibly based on a well-articulated vision of a ‘caring Europe’, caring about people’s daily lives and future social wellbeing.

Health Effects of the Crisis in Southern Europe
Julia Lynch and Isabel Perera
University of Pennsylvania

The relationship between economic downturns and aggregate population health remains a subject of academic controversy. Recessions have been found to reduce mortality through a combination of reduced traffic accidents and air pollution, declines in smoking and fast food consumption, and increased quality of nursing home staff.¹ At the same time, events associated with economic crises, like job loss and housing disruption, have profound negative health consequences

on those who suffer them. The economic crisis in Europe thus seems likely to have significant negative effects on human health, particularly in the most economically distressed Southern European countries where direct experiences of severe economic disruption are widespread. And while the most dramatic effects of the crisis in the short term may be cuts to health care spending, longer-term disruptions to the social welfare systems of these countries are likely to have more profound health consequences.

Early results of research on the effects of the sovereign debt crisis on health have revealed strong negative effects in Southern Europe. For example, Stuckler et al. (2011) found immediate, large increases in suicides among young people following the onset of the crisis. Kentikelenis et al (2011) reported a 17% increase in suicides in Greece between 2008 and 2009, along with a doubling of the rate of homicides, and increases in heroin use and new HIV infections. There is risk in attributing the suicide numbers directly to the crisis in an econometric sense, but anecdotally, there can be little doubt that the sharpness of the economic downturn, particularly in Greece, has been catastrophic. Elsewhere, the health effects of the crisis have been less dramatic, but equally troubling. In Italy, the prevalence of suicide also rose following the crisis, along with increases in mental health disorders and diseases of poverty (e.g., tooth loss) and declining consumption of fresh fruits and vegetables and time spent exercising. In Spain, despite universal health insurance, the crisis has prompted reductions in utilization of health care.

The most obvious explanation for the negative health effects of the crisis in Southern Europe is cuts to health care budgets. Health spending, which make up between six and 12 percent of GDP in European countries, is an easily identifiable target for austerity-minded governments. Indeed, across Europe, the steady increase in real health care spending relative to GDP since the 1960s slowed after the crisis. The so-called “crisis countries”—Ireland, Estonia, Greece, Spain, and Italy—have seen real cuts to health budgets, however. In Greece, health budgets were cut by 25% in 2010 alone. In Spain, the Autonomous Communities, which run the health care systems, were the deepest cuts have occurred. Catalonia, for example, reduced its health care budget by 6.8% from 2010-2011, suspending investment, closing primary care facilities in rural areas, and...
reducing hospital beds, and laying off health care and other personnel. In Italy, significant new patient copays have been introduced, and the central government has exerted strong pressure on the regions to reduce health care spending and cut hospital beds.

Real health system reforms could mitigate the effects of austerity-induced cuts. Such reforms might involve cutting care that is not cost-effective, reorganizing and consolidating health care supply, leveraging monopoly power to lower pharmaceutical prices, exempting vulnerable groups from new user fees, maintaining public investments in prevention and mental health. But in post-crisis Southern Europe, health system “reforms” have been driven largely by Finance Ministries or external actors, not Health Ministries. This has led to a mentality of cutting fast, and wherever possible, reducing the supply of care even when it is needed, suspending investment, and increasing patient cost-sharing. This has led to reduced utilization of both high- and low-value care due to increasing patient costs, insufficient supply and increased waiting times. The most likely to reduce care use are the unemployed, and those who have experienced income declines.7

But while health care systems have been targeted for cutbacks everywhere in Southern Europe, the type and extent of cutbacks varies. For instance, increases in user fees in Spain have been minor in comparison to those in Italy. Spanish authorities have levied a small fee for pharmaceutical copayments. Italian authorities, on the other hand, have raised copayments for ambulatory care, non-urgent care, and some diagnostic services. Perera (2013) finds that these differences in contemporary cost-sharing arrangements are due to policy feedbacks resulting from the differing historical trajectories of the medical care delivery systems in the two countries and the party affiliations of those who built the new National Health Services (NHS) in these countries in the late 1970s and 1980s.8 In Spain, Socialist Ministers of Health leveraged the existing public infrastructure of medical clinics and social insurance to build a universal NHS. In contrast, Liberal Health Ministers oversaw the implementation of the “conditionally universal” Italian NHS, which proceeded from a system of principally private practice and private pay.9 As a result, Italian citizens became more amenable to user fees in the NHS than their Spanish counterparts, and were thus less hostile to the more recent, austerity-driven copayment hikes. This suggests that cutbacks to universalistic and residual pillars of the welfare state may be characteristic Southern European austerity measures,10 but they are also influenced by context-specific factors, with varying consequences for health outcomes. (Indeed, such contextual variety may help explain why there is not more agreement on the effects of economic downturns on population health more generally.)

Whatever the variation in health system retrenchment following on the crisis, the more important effects on population health over the medium to long term will depend on how well Southern European countries are able to rebuild their labor markets, housing markets, and systems of social care. In normal times, variation in health care accounts for only a small portion of variation in mortality.11 Far more important are the “social determinants of health,” which include living and working conditions and the economic and social resources available to individuals and commu-

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7 Lusardi, A., Schneider, D., & Tufano, P. (2011). The Economic Crisis and Medical Care Usage. NBER.
A perennially high unemployment rate will almost certainly have negative consequences for health. Austerity in social services, combined with grim housing prospects, means that Southern Europeans will struggle to access social supports and obtain decent living conditions, both of which are critical to protecting human health. Already, the housing bubble has forced many Spaniards to move to abandoned buildings. These buildings pose a number of housing-related health risks, such as indoor air pollution, temperature extremes, and inadequate ventilation. Communicable diseases are prone to spread in poor living conditions, and home injuries are also a risk. Many Southern Europeans will also suffer from economic insecurity due to housing debts, which is correlated with mental disorders overall. Even more alarmingly, by 2009, relative child poverty rates in Spain, Greece and Italy were approaching those in the US—a striking development given substantial declines in the median income in those countries during the crisis. The combination of shocks to the current generation of young adults unable to find work, and ongoing distress to a generation of children growing up in poverty, bodes ill for Southern Europe.

Will Welfare Systems Pay for a Crisis They Did Not Engender, or Be the Way out of It?
Bruno Palier
Sciences Po, Centre d’études européennes

Confronted with the crisis in 2008, the main reaction of governments in 2008 and 2009 has been to ‘let automatic stabilisers play’ through unemployment insurance and job subsidies, all leading to enormous increases in public deficits and debts. Since 2010, the number of austerity packages increased in Europe in order to deal with the sovereign debt crisis and to reassure the financial markets. The measures adopted by governments in Europe, as well as European institutions’ recommendations, are mainly of three types: reform of social policies, privatizations, and freezing of salaries and reduction of the number of employees in the public sector. The social policy reforms are probably the most important ones, social spending cuts are planned and structural reforms imposed: rise in retirement age, more flexibility of the labour market, reduction of unemployment benefits in order to make work more attractive, mandatory work for people receiving unemployment assistance, and strengthened competition in health and social services.

Austerity Plans Hit Social Policies First

Social spending is at the frontline of austerity plans. In addition to budget cuts, structural reforms are implemented—often as a result of pressures coming from European institutions, joined by the International Monetary Fund and the European Central Bank in the case of Greece, Ireland and Portugal. Such reforms include increased labour market flexibility, raising of the retirement age, and strengthened competition in services including health and social services.

In many countries (including Germany, Portugal, Romania, Denmark, Ireland, the UK, Spain, and Greece), plans have included the reduction of unemployment benefits and the assistance for the

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