Manifest of the European network against privatization and commercialization of health and social protection.

Brussels 7th of February 2014

Table of contents

The health of the European citizens is at risk!

Austerity, the response of the European Union to the crisis (the negative effects of which on economies no longer requires proof) threatens the sick, the health of the population and health care personnel; but also the entirety of social protection mechanisms of the States and particularly the funding of health systems.

"The European Network against the Privatization and Commercialisation of Health and Social Protection" has struggled for years against the dismantling of health and social protection systems, and the dangerous consequences thereof.

These social protection mechanisms played a fundamental role in the development of the well-being of Europeans following the second world war.
Today, the degradation of the health of a substantial part of the population of European States, which varies depending on the countries, was met with and continues to give rise to significant problems, particularly in the south of Europe.
Currently we are seeing a rapid development of private care provision to replace non-commercial public services. The commercial sector has seen explosive growth since the beginning of the financial crisis. Two recent examples:
The German company Fresenius purchased 43 hospitals from the Rhön-Klinikum AG company in September 2013, becoming the absolute European leader in commercial clinics with 175,000 staff worldwide. Germany has been the scene of one of the largest hospital privatisation waves in Europe. Between 1995 and 2010 the proportion of private hospitals has doubled to 33%, while at the same time the total number of hospitals has been reduced by 11%, according to the Federal Statistical Office Destatis.
The French Korian group, which specialises in commercial retirement homes, underwent a merger in September 2013 with the Medica group, becoming the absolute European leader in "grey gold". Even if certain countries like France have long had substantial commercial health care sectors, the German and French multinationals have undoubtedly upped the pace, and the leaders of industrial health care trusts are dreaming only of increasing profits even further.
Health was a common good for the entire population, but has become the object of a competitive market in Europe.
This is the object of this "manifesto": to warn the people of Europe and health care professionals about the consequences of a privatisation/commercialisation policy and to address the governments and European election candidates for 25 May 2014.
This "manifesto" is the fruit of many months of work within the Network. A questionnaire was distributed on a large scale within over 15 European countries
The idea was to collect specific and verifiable information allowing us to shine a light on the com-

mon mechanisms within various countries, as well as the local particularities. This dealt simultaneously with the health status of the population, the degradation of social coverage, privatisation and commercialisation of funding and health care.

But most significantly health care agents were gathered from each of the countries with the ability to analyse the situation, to highlight resistance and possible alliances in order to act together in the defence of a solidary and universal health care and social protection model. We will then ask them to distribute this analytical framework and to adopt it at a local and national level. The idea is not only to address the national candidates for the European elections of May 2014: “what health care model do you defend, within what Europe?”, but most importantly to raise awareness among citizens and the voting public regarding social choice pertaining to health care.

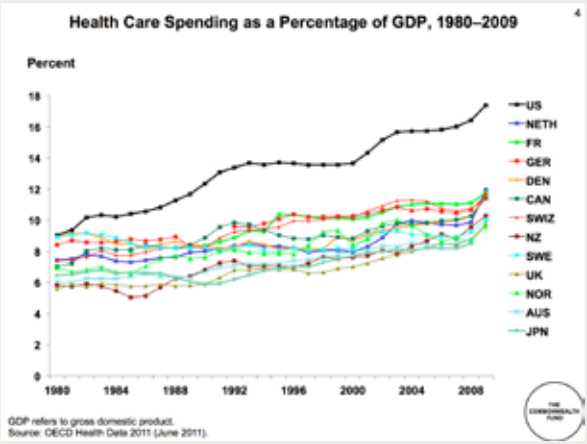
We have chosen health as the point of entry for this effort in the field of analysis, information and mobilisation for three reasons.

Health concerns us all. Whether we are professionals or beneficiaries, our interests converge.

The mechanisms perverting the system are easily identified as to their specific consequences for all. But they can also be more generally applied to the social model in which we live.

Finally, it has been scientifically and economically proven that the system we defend, non-commercial, solidary and universal, is vastly more efficient than the commercial private system.

The dogmas of a liberal economy cannot be applied to health, as health is not a piece of merchandise!



Comparison between US and other countries.

The evolution of health care spending USA / other countries 1980-2009 (percentage of GDP). Source OECD

1. Social protection, it works!

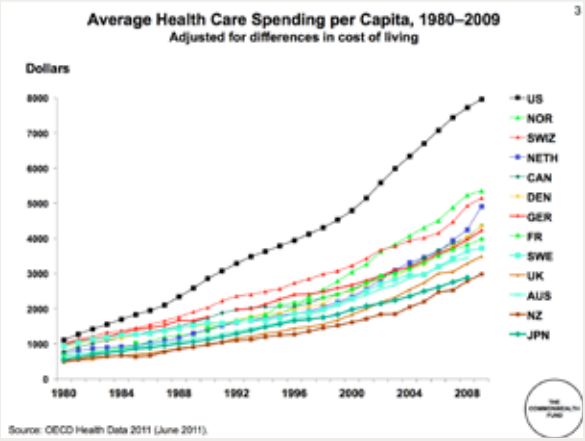
From 1945 until the beginning of the 1970s: extension and construction of public health services and the welfare state.

Progressively, in the aftermath of the second world war, the countries of the European Union adopted a system for the protection of health, the scope of which continued to increase, and included until recently all residents within a territory.

The collective financing of this spending, either via the State (the Beveridge model), or via social security, has allowed for a solidary financing, accessible to all, as well as a global and notable evolution: continuous improvement in the health of the European population.

Public policy, within the context of the reconstruction of a Europe ravaged by war, allowed not only the adoption of one of the most efficient health care systems in the world, accessible to all, but most importantly for improvements in **the key determining factors for health**: access to housing, food, education, employment, culture, development of transportation, agriculture, … When you know that a population's health is 75% dependent on these factors, you understand the importance of a global vision for health and social protection. **Prevention policies** appear as long-term investments which are vital to the improvement of the health and wellbeing of the population (hygiene, struggle against alcoholism, newborn care, …).

"The spirit of 45", to quote director Ken Loach, was indeed the cause for a considerable improvement of living conditions, thanks to the key role of non-commercial public services.



Comparison between US and other countries.

The evolution of health care spending USA / other countries 1980-2009 (sum per inhabitant). Source OECD

Within the diversity of the types of organisations in the different countries, we find a series of characteristics common to these non-commercial public services.

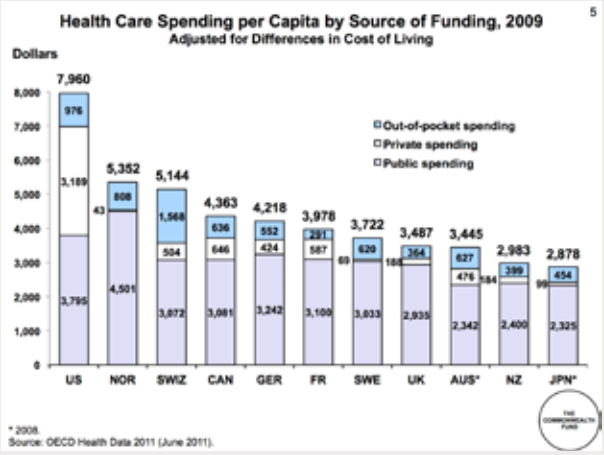
The societal goal of these services is without a doubt a major element. The goal is the wellbeing of the population. This may never be subordinated to the payment of shareholders, for instance.

This objective can only be achieved if **accessibility** to all is guaranteed, and therefore the universality of coverage. This accessibility must be assured at the financial, cultural, geographical, and administrative level, in a timely fashion. Universal coverage can be attained only if finance and coverage are completely separated: any resident must have access to quality services!

These services have been **financed** in a solidary manner, either via a social security mechanism (most often linked to work), or by the State (via taxes): this is a collective financing based on solidarity, and not linked to risk. Whether you enjoy good health or not, whether you are young or old, whether you live a risky lifestyle or not, … this has had no influence on your contributions or your participation in the financing.

Historically these services have been delivered by **non-commercial operators**[1]. Most often by public operators from local or regional authorities (municipalities, Regions, …), sometimes via central financing (NHS in England, for instance), sometimes also by independent non-profit operators, acting within a delegated public service mechanism, certified and financed for this purpose by the public authorities (Non-Market in Belgium, for instance).

All these operators have been subjected to **democratic control**, set up by the public authorities under which they operate. There are numerous variations to this external control within the various countries, but this usually translates in standards either for "input" (standards for infrastructure, personnel, organisation, qualification, …) or "output" (quality of provided service, health status of the population, …).



5

Comparison between US and other countries. Health care spending per inhabitant, per source of financing.
Blue: paid by the patient
White: private financing
Mauve: public financing

But this external control has been performed in numerous countries by a willingness of the beneficiaries to participate and by internal control, through the involvement of health care professionals. Numerous mechanisms for transparency complete this mechanism.
It is within this spirit that a specific **"management"** could be developed, aiming to involve human, financial, material and organisational resources for the purpose of achieving the objective, i.e. the wellbeing of the population, while guaranteeing good working conditions.
By means of sufficient investment, organisations are held to uphold the **quality** of provided services. Within a context of limited means, numerous mechanisms have been put in place in various countries which motivate these operators to aspire to true **efficiency**. When it comes to health, efficiency comes from a good fit between the provision of and need for care, specifically through the development of primary health care. But also from a planning and programme imposed by public authorities. And finally from social standards.
It is thanks to this model that the European Union today has enjoyed one of the highest life expectancies in the world, a level of health that is the envy of the world, with a relatively modest cost for society.

However, this was before the crisis struck…

2. Commercialisation advancing rapidly

Before Europe, southern countries served as guinea pigs.

The commercialisation of health and social protection systems did not come about in the current crisis 2007-2013.
With the financialisation of the global economy in the mid-1980s, the countries in the Global south were confronted mostly with a repayment of sovereign debt and were subjected to structural adjustment programmes by the International Monetary Fund (IMF), the World Bank (WB) and the powers in the North. In a quasi-systematic manner, privatisation plans for health and social protection were put in place. This has led to disastrous health situations particularly in Sub-Saharan Africa, but also in South America. Close links between IMF, WB but also the World Health Organisation (WHO) and neoliberal policies have been demonstrated in numerous countries. In addition, in places where democratically elected governments sought to put in place universal social protections, destabilising and pressuring measures were regularly implemented.[2]

Eastern European countries looking for a social model.

With the collapse of the USSR and the soviet model, health systems in the East of Europe were dismantled in the name of "less State". Drastic financial restrictions, which hit health systems but also the entirety of social protection mechanisms (pensions, unemployment, …), have led to a significant deterioration in the health of the population. The entry of these countries into the EU, including their economies into the European market, but also with liberalisation as the golden rule for all aspects of society, has resulted in massive exclusion of the population from any social protection systems worthy of the name. The State no longer provided a minimal "safety net", the value of received support shrank compared to the cost of living, on the basis of European standards. The new "very wealthy capitalists" did not settle for reduced health care, but had the wherewithal to seek care abroad.

The absence of a broad and solvent middle class certainly helps explain why, for several years, private care provision (which did not exist at all in 1990) still remains small compared to public care provision. The Czech Republic was without a doubt the European country that saw the fastest current development of its private hospital sector. The latter boasted over 30% of beds in 2006, while it had none before 1990. This progress was achieved particularly through the voluntary privatisation of state hospital infrastructure, permitted by the law for the reform of territorial administration of 1 January 2003. Today: all central and eastern European countries are involved in coordinated privatisation and commercialisation policies.

Another policy is possible.

The negative evolutions described above are not unavoidable. Health remains a political choice, both in the south and in the north. Even though the south has served as a guinea pig for austerity measures, outstanding examples on the matter can also be found there. Within a period of under ten years, Thailand has put in place an impressive reform of their health system. Preferring public health care to financial interest of pharmaceutical giants, the country successfully utilised every legal recourse available to do away with the monopoly position of multinationals and to import affordable medication or produce it themselves. In Costa Rica, a poor nation in central America which chose to abolish its army, the health situation was improved spectacularly. With the progressive implementation of universal social security and a robust system of primary health care, the underprivileged found access to adequate health care. Before the war, the Malian government had offered certain medical interventions for free, particularly targeting pregnant women: from 2005 to 2009, the rate of caesarean births was doubled. The proportion of births taking place in maternity wards grew from 53 to 64%. Other African countries, including Burkina Faso, Sierra Leone, Niger, Benin and Senegal, are following this lead. Within a year, the abolition of medical costs for minors and pregnant women in Sierra Leone has increased access to child health care by 214%, and lowered maternal mortality by 61%. In 2006, 47% of Salvadorians had no access to health care.

Since 2009, the government of El Salvador took a gamble on health, most notably increasing the budget for the Ministry of Public Health from 1.7% to 2.5% of GDP. Since then, infant mortality was lowered and the country met the Millennium Goal for the reduction of maternal mortality.

During the second decade of this century, Venezuela also increased its social spending by 60.6%, for a total of 772 billion dollars. This policy reduced inequality by 54%, while poverty dropped from 70.8% in 1996

Public underinvestment … and financial globalisation.

The beginning of the 1990s marks a change of direction for public policies within many European countries; towards a reduction of public means, a reduction of the proportion of taxes or social security contributions.

This is the starting point of underinvestment, of an insufficient provision of care and a lowering of quality. At this time, Germany, the Netherlands and Switzerland reformed their sickness insurance system and introduced competitiveness regarding pricing and "a free choice" of insurance providers.

At the same time, population ageing greatly increased need, but this increase was not met with a satisfactory response from public services.

The negative impact on accessibility has been enormous. Geographically: elimination of neighbourhood institutions, mergers, … created distance for beneficiaries. At the financial level, the financial participation of patients was increased dramatically: where free health care had been achieved, it was compromised with the introduction of "moderator tickets", partly paid by the beneficiary, … At the same time, the insufficiency of public care provision lead to longer queues, sometimes promoting corruption.

Long-term investments such as education, prevention and action on determinants of health were the first to suffer from such policies.

For years now, "commercial" entities have been knocking on the door of health services. Phar-

to 21% in 2010, and extreme poverty plummeted from 40% in 1996 to 7.3% in 2010. In ten years, through taxation, the government amassed 251.7 billion dollars, wealth which it chose to redistribute. In this way, social security was able to cover twice the number of citizens compared to 15 years prior; all while still reducing public debt at the same time, from 20.7% to 14.3% of GDB; economic growth in turn was maintained at about 4.3% annually. Comparative research on Argentina, Cuba, Peru, Indonesia and Russia show that even in times of crisis, the refusal to commercialise health care allows for the preservation, or even promotion, of the health of the population. These countries were losing between 14 and 42% of their GDB in the mid-1990s. under these circumstances, only a political choice for the strengthening of the non-commercial health care system, with a focus on primary health care, was able to prevent a drop in the most fundamental health indicators as infant mortality and life expectancy.

J. Akazili and C. Soulary «Un défi pour les pays du sud». Le Monde diplomatique, January 2014, http://www.mondediplomatique.fr/2014/01/AKAZILI/50021

Amanda Bloom, Universal Health Care in El Salvador (Les soins de santé pour tous au Salvador), Global Health Check, 2013 : http://www.globalhealthcheck.org/?p=1318

The Achievements of Hugo Chavez. An Update on the Social-Determinants of Health in Venezuela, Counterpunch, 2012 : http://www.counterpunch.org/2012/12/14/the-achievements-of-hugo-chavez/

De Vos, Pol, AnaiGarcía-Fariñas, AdolfoÁlvarez-Pérez, Armando Rodríguez-Salvá, MarianoBonet-Gorbea, and Patrick Van Der Stuyft. 2012. "Public Health Services, anEssential Determinant of Health During Crisis: Lessonsfrom Cuba, 1989-2000." TropicalMedicine& International Health 17 (4): 469–479.

maceutical companies, producers of medical materials or equipment have received a significant part of means which should have been implemented for the wellbeing of the population, instead of for the benefit of their shareholders. Authorities remain very passive in the face of such medical marketing which, in certain countries, is more and more taking on the shape of corruption.

Within this context, within all countries of Europe, the management and operation of hospitals have been changed towards an industrialisation of the health care process. The introduction of financing to the activity allows one to finance a hospital based on the number of procedures and consultations. However, patients do not get to choose their illness. Through the perversion of this system, in the long term patients with unprofitable pathologies are having more and more difficulty in finding the correct standard level of care from specialised care structures…

The insufficiency of public financing leads many directors, even public ones, to outsource a range of activities, such as logistics (kitchen, maintenance, laundry…), but also diagnostic activities (radiology, laboratory, …).

A new trend appears regarding the "accountability" of patients, firstly in private insurance. Premiums are adapted on the basis of risk, particularly on the basis of lifestyle elements (tobacco, alcohol, sedentary, obesity, …). We are also beginning to see public mechanisms that are adopting the same principles, financially penalising patients who smoke or engage in violent sports participation,for instance.

In countries where it exists, the "solvent" population (middle and upper classes), not satisfied with the care provided by public services, demand high-quality care… if necessary at an elevated price. Thus is developed, initially, commercial health care provision not financed by social coverage contributions.

In certain countries (like the UK), commercial operators even gain the possibility to access public financing. The financing of the activity, based on cost per illness, therefore results in a selection

of more profitable illnesses and the specialisation of health-related commercial and multinational groups towards more lucrative pathologies, leaving the less "profitable" pathologies and patients to public operators.

The turning point of Maastricht: Europe taking care of Health!

The treaty of Maastricht vigorously reconfirms the founding principles of the European Union which are free competition and free instalment of business.
When Europe claims it has no competence in the field of health[3], and when Europe declares that the Treaty of Lisbon does not impose privatisation and commercialisation of health, Europe is partially right, in theory. But in fact, Europe has a massive influence on the framework within which the States may implement social and health protection policies. The Court of Justice uses these two founding principles as the basis for its judgments, for lack of a sufficient protective framework. With what right does a State prevent a service provider from establishing its place of business on its territory? How does one justify a different treatment for operators performing the same services?
Following the liberalisation of services in 2006 (Bolkenstein Directive), Europe attempted to define Services of General Interest which could be excluded from the general principles of free competition and free selection of place of business: topics of discussion here were non-economic services of general interest, explicitly excluding health care, certain social services, childcare, family support, … However, this limited list left many activities in a state of legal uncertainty.

Fresenius and Co

This is how multinational Fresenius was able, initially, to become the unchallenged commercial leader in dialysis within Fresenius Medicare, before becoming today's European leader of Commercial Hospitals via its Helios branch.
Parallelly, in France, 70% of the 50 groups of less severe illnesses are treated by commercial clinics. 70% of the 50 most severe interventions (transplants, cardio-thoracic interventions, acute leukaemia, etc.) are conducted by the public sector.

Commercial quality?

In the Netherlands, the Inspection for Care has submitted highly critical conclusions pertaining to the quality of care provided in private clinics.

Youth without hope

The Spanish unemployment rate reached a record level of 25.1% in August 2012. More than one young person in two is unemployed and has very little chance of finding employment.

Did you say “State Aid?”

Benefiting from this framework, profit-seeking operators considered subsidies as “state aid”, falsifying free competition.

They have instituted trials within the States, demanding more market share.

They dream of making this colossal financial treasure comprised of social protection and health services, which are still mostly dependent on state financing or social financing within social security systems.

Protective social standards, collective agreements, civil servant status, right to work, minimum wage, have been denounced as obstacles to the free selection of a place of business.

They demanded the application of European treaties, wishing to “eliminate any obstacle to a free and non-falsified market” and “the enlargement of the public markets directive”, thereby preparing for “the great integrated transatlantic marketplace”, where multinationals will be freed from any hindrance to competition.

However, on the one hand it is the States which defined the modalities for the European construction, and on the other hand it is the Commission which implements multiple European health programmes – policy plan 2007/2013, including a White Paper from the European Commission, but also the “new programme 2014-2020 – for the struggle against inequality and the promotion of innovations in the field of health”.[4]

This White Paper defines a strategic action framework for the EU within the field of health over the coming years. The strategic approach for the EU 2008-2013 “Together for health” claims to provide a general framework founded on the strategic principles and objectives for the improvement of health within the EU.

Toxic remedy

The people of Greece, Spain, Portugal, Poland or Lithuania know about toxic remedies. The White Paper specifies them: “Globalisation implies that problems and solutions in the field of health cross the borders and often have inter-sector consequences”, or “A precise community framework will also contribute to the promotion of dynamism and the viability of health systems by providing particulars on the application of community law on health care services and by providing the Member States with aid in the domains where economies of scale resulting from a coordinated action may constitute an added value for the national health systems”. On this basis, while reaffirming the autonomy of the countries in putting in place or maintaining a specific social protection model, Europe was able to impose upon all, but mostly upon those countries hardest hit by the crisis, remedies aimed at the single services market.

When Europe gets involved

But Europe does not stop there. Europe implements other mechanisms which strongly influence the social protection model. Indeed, European commissioner Lazlo Andor proposed in February 2013 to solve the problem of financing social services by creating “social impact bonds”: a system according to which a private fund invests in a social project. And whereby, if certain results are obtained, the State pays out a return on investment to the private fund. According to the Commission itself this mechanism “promotes participation of private capital in the financing of social programmes in exchange for financial advantages obtained from the public sector when the programme is concluded”. Social impact bonds therefore allow financial players to obtain money which should be utilised to respond to the needs of the population under the impulse of the European Commission.

And Europe perseveres: according to the Euro Plus Pact, the “viability of retirement, of health care and social benefits” can be linked to “the level of debt”.

Moreover, the budgetary pact or Treaty on Stability, Coordination and Governance (TSCG) demands the return to 0.5% of public deficit and to 60% of debt on GDP within 20 years. In the name of “competitiveness” and the reduction of labour cost, the EU seeks to reduce the spending cost for health and social protection.

The European Union also directly intervenes in the health policies of states. This intervention even becomes a direct injunction as in the case of Greece where the troika (European Central Bank, IMF and European Union) demanded that health spending stays below 6% of GDP, and in the case of Portugal where € 670 million were withdrawn from the national health system (even though health is considered an internal matter of governance for the states).

Under the cover of free competition and free selection of place of business, a network for gathering patients with profitable pathologies is being set up, whereby the “free choice of the patient” (which is nevertheless presented as a dogma for the promotion of liberalisation) has been phased

out. And in the name of accountability, less profitable patients are paying a veritable tax on their illness for the sake of profit for multinationals.

Crisis, austerity and health…

Poverty is very detrimental to your health!

One of the principal consequences of the crisis is the rise of unemployment, poverty and insecurity which have a major impact on the health of the population.

According to the OECD (Organisation for Economic Co-operation and Development), in Greece available family revenue has decreased every year between 2008 and 2012[5]: 2008 -2.3%; 2009 -0.4%; 2010 -11.4%; 2011 -10.7%; 2012 -10.8%.

Currently 26.5 million people within the Union are unemployed (19.2 million in the euro area), or 10.9% of the active population (12.1% that of the euro area). This European evolution is all the more worrying considering that it is accompanied by a deepening of the divide in unemployment between the south and the periphery of the Union on the one hand and the north of the euro area on the other hand. The gap between the two zones reached 10 percentage points in 2012, an unprecedented level.[6]

The European Union also has 124.5 million poor, or one fourth of the population!

In 2012, a quarter (24.8%) of the population was on the verge of poverty or social exclusion, that is 124.5 million[7] people (compared to 24.3% in 2011 and 23.7% in 2008).

The crisis affects all health systems.

In the United Kingdom*, the government has allowed enterprises to enter the health care system by progressively effectuating a range of profound legal changes for the purpose of allowing the introduction of capital. The government justifies this with the requirement for alternative investments following budget cuts. In 2012, the law on health and social protection set April 2013 as the end of the famous British National Health Service, opening the doors to a mixed financing system and health care focused on the company.

In Portugal*, the measures of the Troika have led to the lowering of salaries, pensions and unemployment benefits, and a general increase in taxes. As other important parties of the public sector which have been privatised, the National Health Service is under attack from all sides. Medical costs borne by patients have risen considerably, leading to a drop in primary consultations of 900,000.

In Italy*, measures favouring competition were introduced in the 1990s; hospitals have become "health care companies", with commercial practices. Today, budget cuts (over € 20 billion in savings since 2010) strongly impact the sector, leading to the increase in the costs borne by the patient and a reduction in accessibility, particularly for vulnerable socioeconomic groups. In a recent poll, 21% of households have declared a reduction in health spending, 10% put off surgical treatments for financial reasons, 26% declared increased emergency spending due to the increase in co-payments.

*Starting at the article to appear "Fiscalpolicies in Europe in the wake of economic crisis. Implications on health and health care access." Elias Kondilis, Chiara Bodini, Pol De Vos, Alexis Benos and Angelo Stefanini.

Austerity policies degrade the health of the population and the public health services. The loss of employment and the fear of loss of employment have destructive effects on the mental health of the people concerned.

Surveys conducted in different countries show the increase in the number of suicides and attempted suicides. The number of suicides in persons under 65 years of age has increased within the European Union since 2007. In countries which joined the EU in 2004 or afterwards, suicides peaked in 2009 and remained at a high level in 2010. For those who joined the EU before 2004, an increase is observed in 2010. In England, the increase in suicides between 2008 and 2010 is to a significant degree associated with the increase in unemployment. The result was 1,000 additional deaths.

Simultaneously, the intensification and uncertainty of work have dire consequences for the health of the workers. Widespread suffering at work leading to the exposure of service providers to dangerous situations, an increase of musculoskeletal issues and work accidents and, in the gravest of cases, to suicide or attempted suicide.

The drop in revenue and increase in the number of persons living under the poverty line have a tremendous impact on the determinants of health (poor nutrition, unsound housing conditions, …), but also on the accessibility of health care (financial accessibility, travel, …).

In Catalonia: in 2010, 50,705 patients were on the waiting list for a surgical intervention. Today there are 89,000 (in 2011 there were 80,540). Patients hospitalised through emergency services increased from 64.9% to 67% in 2011.

Also in Catalonia, geographical accessibility is under threat: with budget cuts, 'non-urgent' medical transportation is at risk of simply becoming paid transportation following the Spanish Royal Decree of 16 April 2012 which replaced the universal health system with public health insurance.

Still in Catalonia, there was an increase in co-payment from 40 to 60% in the price of medication for employees and 10% for pensioners.

In Spain, the national drug plan saw its budget halved between 2009 and 2013.

In Lithuania for instance, geographical distribution of specialized care is highly irregular, which renders them virtually inaccessible in certain provincial areas.

In Lithuania, waiting times for specialized care and programmable operations have recently exploded!

When financing is commercialised…

In Spain, private financing grew to 25% in 2012.

In the Netherlands, new laws pertaining to health put in place complementary private insurance financing, covering care packages. The insurers select the risks, and therefore, the premiums are very low for young people, but very high for older or sick people. There is a risk that preference will be given to the more profitable care and richer patients. Those who do not have the means to pay will have to wait longer, and are at risk of receiving lower-quality care.

Austerity is very detrimental to health care!

The DEXIA group is the bank that was the subject of a structured loans scandal which led to the indebtedness of numerous local communities and hospitals in Europe, and knows better than anyone:

"Everywhere hospital reforms strive for the objective of a rationalisation of care provision, by means of three key tools: the territorialisation of hospital competences, the modification of the financing method of hospitals and the recomposition of hospital care provision. But the intervention modalities are different as there are as many hospital maps as there are countries"[8]. On the other hand, the public/private partnerships, set up around the world starting in 1995 under the impulse of the World Health Organisation (WHO), are becoming commonplace in Europe, along with budget control measures and a ban on public deficit.

Austerity policies pushed by the European Union and implemented by State governments result in a massive reduction of public and solidary funding of health systems and social protection systems. This is what the OECD has to say on the matter:

"The drop in health spending within all countries of Europe can be explained firstly by the crashed progression in public spending since 2009 – a progression which had on average been close to zero in 2010 and 2011. Private health spending has also slowed in many countries in 2010 and 2011, while household revenue stagnated or dropped back, but the drop was more limited."

In Greece, total health spending was reduced by 11% in 2010 and again in 2011, after an annual progression rate of over 5% on average between 2000 and 2009. These reductions are mainly due to significant cuts in public spending. Spain, Iceland and Ireland also went through two consecutive years of negative growth in health spending. Certain countries, such as Estonia and the Czech Republic, underwent drastic reductions in their spending in 2010, followed by a modest recovery in 2011. Other countries such as Italy and Portugal may have staved off budget cuts in

2010, but then proceeded to reduce public health spending in 2011.
In Portugal, public spending was reduced by 8% in 2011, after having remained stable between 2009 and 2010. [9]
Taking into account the very low level of progression for health spending within all OECD countries in 2010 and 2011, the share of GDP earmarked for health has dropped slightly in the majority of them. Health spending represented 9.3% of GDP on average within the OECD in 2011, compared to 9.5% in 2010. If we exclude investment spending, current health spending expressed in percentage of GDP went from 9.1% on average in 2010 to 9.0% in 2011. [10]
The data [11] on mortality of new-born infants indicated by the Hellenic Statistical Authority (ELSTAT) show that after 42 years of constant reduction in neonatal mortality (16.03/1000 in 1966 compared with 3.31/1000 in 2008), the years 2009-2010 saw a peak of 4.36/1000, which equals an increase by 32% between 2008 and 2010.
In France, one person in 4 claims to abandon care for financial reasons. In Greece 40% of the population is without social coverage (unemployed for more than one year, independent workers not having the means to pay their insurance, small enterprises going bankrupt, undeclared workers, irregular immigration).
Budget cuts also have a massive impact on prevention policies for public health, which is quickly manifested in a resurgence of "social" illnesses, health inequality, but also a secondary added cost in curative medicine.
Moreover, differentiating between care due to lack of means leads to an exacerbation of health issues, with sometimes dramatic and irreversible consequences for the sick, and represents an added cost for the health system. In Poland, prosthetic hip operations have a waiting period until 2020.

Privatisation epidemic among operators.

In Spain, 236 out of 550 acute hospitals are now private hospitals.
In Lithuania, private hospitals are concluding contracts with health insurance funds.
In Navarre, accommodation of the elderly is now at 90% privatisation.
Currently **in Belgium**, 140,000 elderly persons reside in retirement homes.
The proportion of commercial retirement homes has risen from 45% to 57% between 2009 and 2010.
"The demand is rising, and retirement homes are popping up everywhere, as investors have sniffed out a good deal. In Wallonia, in addition to public or non-profit retirement homes (which each represent 25% of the market), half are already in the hands of private groups, and this figure is constantly rising. Renting rooms in a retirement home is much more certain for investors than renting offices. The lease is 27 years and the pool of potential tenants seems inexhaustible. The chief executive officer of Sicafi Aedifica, Stefaan Gielens, confirms that the potential for real estate investment in this sector is enormous. He specifies that a consultancy firm has calculated that 180,000 beds would be necessary within the 40 years to come, which represents a need for investments of almost € 15 billion". These investments are moreover quickly recovered as rooms are leased at a price of € 40 per day". (RTBV.be 8/8/2011)

The saturation of emergency services is a consequence of the difficult access to free and accessible care. Moreover, the abandonment of prevention policies leads to the resurgence and flaring up of infectious diseases (tuberculosis, HIV, malaria …).
Public hospital sectors providing access to care for all are themselves also victims of austerity policies. Their allowances are decreased and, faced with the competition of the commercial sector, they are forced to submit to the rules of profitability and productivity. The closing of care centres, local hospitals, elimination of beds, regrouping of services and restructurings create geographic distance between locations for care provision, and lengthening waiting periods for consultation and care.

Austerity reinforces private funding of health systems.

During the crisis and within many countries where austerity measures have affected social spending, the portion not borne by social coverage has grown tremendously. These austerity policies therefore shift the burden of financing care to the users; either by means of complementary insurance, or by means of an individual contribution to care (co-payment in Spain and Portugal). The result is that it becomes difficult or impossible for growing sectors of the population to gain access to care. The first to be affected are the people who are most socially vulnerable (the unemployed, irregular immigrants, single-parent households…). The personal participation of beneficiaries has, in certain countries, more than doubled.
Investment funds and other holdings have of course noticed the weakness of the system when there is public underinvestment. The selection of risk within an insurance mechanism allows private investors to gain a profitable market within a system that is losing momentum: that of complementary health insurance. The bigger the portion not covered, the greater the number of people

To be a woman in Greece

In Greece, the abandonment of all public health policies, as well as the impoverishment of large sections of the population (degradation of living conditions and individual and collective hygiene) have already resulted in the reappearance of infections which had disappeared, like malaria, the dramatic increase in tuberculosis, but also the 200% increase in HIV-positive persons. Within this context, Greek women are even more severely impacted, particularly by the disappearance of prevention policies, and by the inaccessibility of health care. The reproductive health of women was likewise affected by the crisis!
Acquis such as quality care lavished on pregnancy and childbirth, sexual education promoting sexual relationships based on equality, enjoyment and liberty, without masculine violence. The possibility to choose freely if one wishes to have children and under what circumstances, is henceforth a distant memory while free access to high-quality and cost-free childbirth and abortion as well as high-level family planning services and contraception are from now on the stuff of dreams… The right of women to make their own decisions pertaining to their bodies and to choose whether or not to have a child is constantly questioned, not by a ban on the right to abortion, like in Spain, but due to the impoverishment of women and the commercialisation of goods and services.
Moreover, knowing that measures are adopted and applied such as the repeal of collective agreements,

likely to purchase complementary insurance. The premiums however are adapted to individual risk, which guarantees the profitability of the system.
Such a mechanism was pushed to its utmost in the United States, into the realm of the absurd, as currently the insurance companies run the hospitals, on the basis of the same principle of risk selection. In Europe, certain mutual insurance companies have tried to provide compensation through complementary solidary insurances (without selection). In other countries however, temptation proved too strong, and these countries are now participating in the weakening of universal coverage.

Health care personnel pay for the crisis.

Greece, Ireland, Italy, Spain and Portugal have greatly reduced their health spending. And as the cost of labour represents on average about 70% of total health spending, numerous countries have imposed wage cuts for health care personnel (15% in Greece, 10% in the Czech Republic, between 5 and 10% in Ireland, 5% in Spain). Simultaneously, the countries hardest hit by the crisis have reduced the number of employees within the sector. In Spain for example, only 1 vacancy in 10 is replaced within the public health sector.
In Poland, “rubbish contracts”, sole proprietorships, have replaced employee contracts for many nurses. They are obligated to cumulate multiple contracts, and therefore greatly exceed 48H/week in order to obtain a decent salary. The flight of young nurses has caused the average age for nurses to be greater than 45 years of age!
Having a commercial private employer results in all cases in an increase in work pressure. Moreover, without minimal standards guaranteeing both quality of care and proper working conditions, the financing method by envelope or by pathology often turns labour costs into a privileged adjustable variable, leading either to a reduction of salary, or a reduction in the number of functions, or even both.

Women and health.

More and more analysts are denouncing the fact that women are doubly victimised by the crisis and austerity measures.

"The work of women is becoming more and more part-time, or in the form of short-term contracts with low salaries. Within sectors such as education and care provisions, sectors traditionally occupied by women, in the U.K. and Italy for instance, the salary has been reduced as well as the working hours and professional advantages." [12] The notion of "poor worker" is particularly appropriate for women obligated to accept employment that does not yield sufficient revenue to survive. The vast majority of single-parent households are run by women.

On the other hand, "A social and economic analysis leads to the expectation that women in Europe will need to take on more and more unpaid responsibilities, including caring for children, household work, community work and caring for elderly persons as their numbers increase and the care provision aimed at them is often inaccessible and very expensive. The middle classes in Europe have a habit of employing migrant women in order to transfer to them the responsibilities and duties pertaining to care. However, as the formal economy shrinks, these arrangements may very well change, because if active women lose their job and resume their domestic unpaid responsibilities, they could decide that it is no longer necessary or affordable to employ someone. According to a major Italian newspaper, Italian women are accepting with increasing regularity non-contractual domestic service and cleaning work, which until now had been reserved for migrant workers". [13]

The return home to provide "care" (activities which used to be performed within the family entity, and which have seen professionalisation after the war, including care and supervision of infants, elderly persons or persons with a disability, …) is taking place on a massive scale today in various countries in the south of Europe.

the reduction or abolition of a series of allowances set aside for collective agreements in order to facilitate the lives of women and the education of children. For example, the abolition of marriage benefits, nursery school benefits, child care benefits, vacation camp benefits, childbirth benefits and for multiple prenatal examinations as well as the reduction by 22% of care benefits for children during 6 months following childbirth, which equalled basic salary.

Maternity itself becomes a major gamble. The right to free maternity has become a luxury reserved only for the rich!

This is why the number of abortions and their cost are growing (€ 350 at a public hospital), resulting in a significant number of women turning away from hospitals, with grave risk to their health. Likewise, child abandonment is on the increase due to the increasing poverty of parents. For the first time since the Second World War, we are seeing an increase in prenatal mortality. The regression of vaccination, which is all but absent for poor children, is without a doubt a ticking time bomb for health!

Regarding childbirths, the cost for women has become unaffordable. The situation is even worse for pregnant women without social security, and for undocumented women, who are expected to pay the costs for all medical examinations and for hospitalisation for childbirth. If they wish to deliver their child (in a public maternity ward, € 600 for normal childbirth, € 1200 for a cae-

Moreover, health programmes for birth control are among the first to fall victim to budget cuts, resulting in the exclusion of a significant number of young women.

Austerity, health and immigration

Budget cuts in health systems in various countries result in the exclusion of care for residents who are not part of the social protection system. Persons with an immigrant background, but most of all refugees and undocumented residents, are being denied basic care. This is where humanitarian associations are supposed to pick up the slack. In Spain for example, the Royal Decree of 16/04/2012 effectively excludes immigrants with irregular status from access to care (save in case of life-threatening emergencies, childbirth, paediatric care).
In the midst of cultural isolationism and xenophobic sentiments, these populations are left to their own devices, and are seeing their state of health crumble on a massive scale and at a quick rate.

sarean section). And without even counting the price of doctors' visits during pregnancy and also prenatal examinations. This is the reason why many women arrive at the maternity ward without having had any prior medical examination!
For "… the non-Greek citizens of the European Union and citizens from third countries…", namely the undocumented immigrants and refugees as well as women without social security, a doubling in the cost of childbirth and medical care is expected (€ 1200 for normal childbirth and € 2400 for a caesarean section)!
The result is that many among them are rushed to hospital in the middle of the night with their newborn child in their arms so they would not have to pay the costs. Hospital administrations then threaten not to deliver the birth certificate, or to only deliver it after prior payment to the hospital.
This is how children are born in debt on the first day of their life, phantom children, undeclared children, who are born and yet they do not exist…

Conclusions

On the one hand, the crisis has directly affected the health of the population, on the other hand austerity policies put in place by governments in response to this are degrading the care and social protection systems, resulting in a deepening of the health and social crisis. This is the vicious circle in which the people of Europe find themselves trapped. The crisis, with the damage to health and society it creates, is increasing the need for health care and social protection, while austerity policies meant to resolve it reduce the possibilities for access to care.

This is confirmed by a study which appeared in The Lancet "even though recessions present risks to health, the interaction of fiscal austerity with economic shocks and weak social protection is what eventually seems to be exacerbating the health and social crises in Europe". [14]

The commitment of the WHO and the Member States in a resolution of the World Health Assembly 2009 entitled "Reducing inequalities through action on the social determinants of health" has remained an empty promise.

We note that the situation in Europe has taken a sudden turn for the worse. The WHO notes the damage done, but the States pursue a policy of austerity and aggravation of social health inequalities: "it is necessary, in addressing socially determined health inequities, to deal with the "causes of the causes". These include the unequal distribution of power, income, goods and services, globally and nationally, that results in unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing, healthy life." [15]

The transatlantic marketplace against people, against health and social protection!

The question of commercialisation of public services was brought up by the World Trade Organisation (WTO) in September of 1986 in Punta del Este (Uruguay).
In 1994, the General Agreement on Trade in Services (GATS) obligates States to create a competitive environment for public and private enterprises. In practice, this translates either into a reduction of subsidies for the former, or in the provision of specific aid for private enterprises.
The Multilateral Agreement on Investment (MAI) of 1998, which attempts to open up the possibility for multinationals to have States condemned, gave rise to widespread international manifestations. This was the first failure of "complete liberalism". Likewise, the struggle against the "Bolkestein directive" limited the scope of the directive of 12 December 2006, for Services of General Interest (SGI) which included health and social security and services of general economic interest, limiting internal state competition.
Last 14 June, the ministers of commerce of 27 EU States accepted a secret negotiating mandate from the European Commission. This mandate pertained to the negotiation of a transatlantic trade and investment partnership between the United States and the European Union (TTIP). The goal is to align rules on international commerce, customs tariffs, but also non-tariff standards (most notably a uniformity of environmental, health, social and security standards).
Contrary to what our governments would like us to believe, a "free trade" agreement does not imply doing away with "state, social or environmental obstructions" to trade, but does imply a decision for radical political changes in the operation of these markets.

The threat is significant, for the entire sector of health and social protection, that European standards will be lowered in order to have them correspond with United States standard which constitute one of the areas where the privatisation of the health and social system and social protection is highest in the world.
The uniformity of health and social protection standards, as we already know, will go against social security systems, against the universality of health services. The United States boast the most expensive health system in the world, allocating over 16% of their GDP to it, but also one of the worst systems among OECD countries due to the exclusion of 50 million Americans from access to care.

The discussions being held for a new European directive on public procurement and negotiations on the Transatlantic Trade and Investment Partnership can only further accelerate the commercialisation and privatisation of health systems, and exacerbate health and social crises.

The public procurement directive and the Transatlantic Partnership are likely to deal a fatal blow to Services of General Interest. This directive would mark a new step (complementing the one from 2006) in initially enhancing competition at the European level. With the start of negotiations towards a Transatlantic Partnership (for the purpose of constructing a marketplace between North America and the European Union), a competitive space is also opened at the global level.
What will then become of our models based on the objective of service for the population, on universal accessibility, on solidary financing, on non-commercial operators, on democratic control, on participatory management, on the quest for quality and efficiency within public planning?[16]

A sense of urgency concerning health in Europe, we demand the following:

Equal access to care, everywhere, for all, without any restrictions of any kind. Such a programme implies that the provision of universal health care, and therefore the accessibility thereof, must be independent of the individual ability of users to pay.
Because health is a common good, we must promote and restore **public and collective financing** as was the case for the principal social protection systems after the war. In order to strive towards solidary financing and universal access to health, we **must protect social protection from the greed of private insurance**. These health systems must be financed exclusively by **public social protection**, which alone is able to put in place and aspire to policies and practices which respect the right to health and provide all with equal access to health care.

It is the entirety of the population which must ensure the management, defence and improvement of health. The manner of **participation of the socially insured** and of the users must be determined in order **to set up democratic health services**. Their performance must be evaluated in terms of health and not financial results, and be supported by sufficient resources to achieve this goal.

In order to improve care, the underlying causes must be addressed, such as the **social determinants of health.** We demand the improvement of health through the existence of a set of actual rights for the entire populations, **the right to employment and decent income, the right to housing, the right to drinking water and energy, equality among men and women, the right to education, to culture…**
We demand from the European governments, from the Commission, from the elected officials of the European Parliament that they reformulate, put in place, and aspire to policies and practices which respect the right to health and provide all with equal access to health care. For this purpose, **massive investments must be made in public health, prevention, promotion of health, primary care.**
To preserve the common good that is health, **not a single euro of public money may finance the commercial sector of health services, as health is not a commodity.**
Europe must not only allow each State to continue to protect its social welfare and health mechanisms from the rules of the marketplace, but also encourage them to correctly finance these mechanisms. Europe must also allow public operators **to maintain the entirety of logistical services within the non-commercial domain**, as well as the products, services and materials which are essential to sound health services (medication, research, medical equipment, prosthetics, …).

To do away with health inequality means to put an end to misery, to unemployment, to insecurity and to the exclusion of the 125 million poor in Europe, by including European minorities such as the Romani, migrant workers from outside of the community who are today falling victim to miserable living conditions and whose human dignity is compromised.

The European austerity policies are harmful to health and exacerbate the situation of the people. The implementation of a European programme for the preservation of health, for social action and for social protection intends to put an end to austerity plans being applied everywhere in Europe. Health and human rights must prevail over financial and profitable logic.

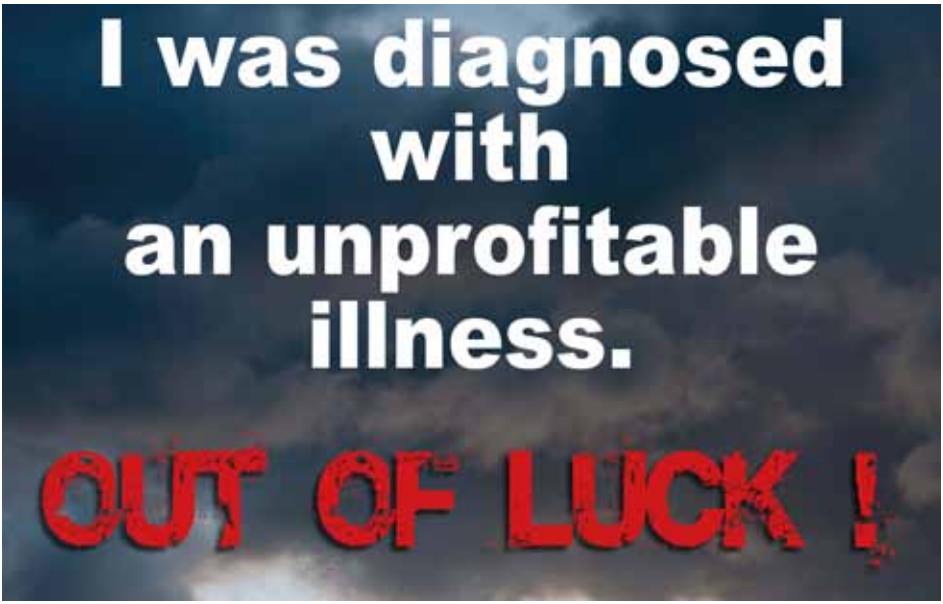
Moreover, the idea is to put in place, at the initiative of the European Union, a **programme for the repair of the damage dealt to the health of the populations in question** by these policies, to restore the accessibility and quality of care, particularly in those countries where a restriction plan is being imposed as a condition for the obtainment of European financial aid.

A {Distinction???} must be made between finance and health. The European population is not responsible for sovereign debt. This debt is therefore illegitimate. It is neither health nor social protection that require reductions, cuts, amputations. Finance and the economy must be at the service of the wellbeing of the population, and not the other way around.

We demand an immediate halt in the negotiation of the "Transatlantic Partnership". Social and environmental standards must be harmonised from the top, and permanently aspire to improve the health of the populations. The States must continue to put in place standards applying to health operators, most notably a non-profit objective.

Health and social security must be protected from all attacks. Health and social security must be withdrawn from "public procurement".

1. In the rest of this document we will discuss public service both for public operators and non-commercial operators providing official public services.
2. See on this matter the records of the conference in Antwerp in December 2013 http://iahpeconference2013.wordpress.com/presentations/
3. This was the response given during the meeting of the European Network and the European Commissioners on 14 March 2013.
4. http://www.eu2013.lt/en/news/unions-program-to-reduce-health-inequalities-promote-innovation-in-health-
5. Source: OECD database on health 2013.
6. Source: comptes-protection-sociale-2011 DREES 2013.
7. Eurostat communiqué of 5 December 2013.
8. Dexia / Hope publication, November 2009.
9. Source: OECD database on health 2013.
10. Source: OECD database on health 2013.
11. BONOVAS S & NIKOLOPOULOS G (2012). High-burden epidemics in Greece in the era of economic crisis. Early signs of a public health tragedy. J Prev Med Hyg, 53, 169-71.
12. The impact of the financial crisis on women in Europe and the West. Windy Harcourt; AWID.
13. Corriere della Sera, 9 May 2009.
14. Financial crisis, austerity, and health in Europe. The Lancet, 27 March 2013.
15. 60th session of the WHO Europe EUR/RC60/TD.3 Moscow Sep 2010.
16. Cf. supra p. 6.



Our Health and social protection are not for sale !

RE : European network against privatization and commercialization of health and social protection.
Sebastian Franco - chaussée de Haecht, 53 1210 - Bruxelles - Belgique - Février 2014