



Why  
public  
health  
care  
is better

# Abstract

Access to good, quality health care is a basic human right and is best guaranteed if the services are organised by public authorities that are democratically controlled. Increased corporate involvement in health services provision and financing and increased corporate capture of health and development governance are worrying trends because corporate interests are generally not aligned with the public good. The primary aim of corporations is to make profit, instead of guaranteeing health for all. Moreover, corporations are not accountable to claim holders; they are accountable to their shareholders. In contrast, the human rights-based approach makes states or governments the primary duty bearers. Case studies show that only collective action lead by social movements can bring about sustainable policy change towards health for all.



Viva Salud is a Belgian NGO that originated from the conviction that every individual has a right to health. This is why we support the expansion of social movements fighting for the right to health in the Philippines, Palestine, the Democratic Republic of the Congo, Cuba and elsewhere.

**[www.vivasalud.be](http://www.vivasalud.be)**

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# Why public health care is better

<b>0</b>	<b>Introduction</b>	<b>4</b>
<b>1</b>	<b>Health is a human right</b>	<b>6</b>
1.1	Inequality makes sick	
1.2	When people have to pay for health care	
<b>2</b>	<b>Setting the scene</b>	<b>11</b>
2.1	Privatisation: what's in a name?	
2.2	An ideological cure worse than the disease	
<b>3</b>	<b>Commercialisation of health care: what are the risks?</b>	<b>16</b>
3.1	Privatisation triggers higher inequality in access to care	
3.2	Privatisation is often more expensive in the long run	
3.3	Privatisation isn't more efficient	
3.4	Privatisation doesn't lead to better quality	
3.5	Privatisation leads to less public control	
3.6	Privatisation leads to a lower availability of health workers and deteriorating working conditions for them	
<b>4</b>	<b>History on our side: why public health care is better</b>	<b>31</b>
4.1	Which health care system do we want?	
4.2	Successful civil society campaigns	
<b>5</b>	<b>Conclusion</b>	<b>40</b>





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# Introduction

Health indicators are traditional benchmarks to measure development. Half of the Millennium Development Goals are directly or indirectly linked to health. Most of the more recent Sustainable Development Goals also refer to health targets. This is not a surprise: nearly all political and humanitarian interventions influence the health of a population. Nevertheless, health and access to health services remain a challenge.

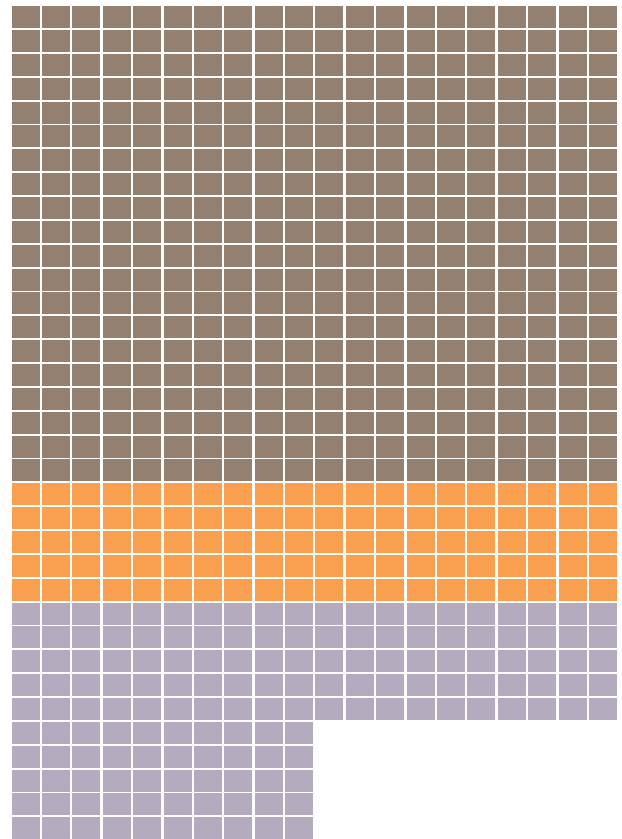
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**At least 400 million people in the world do not have access to one or several essential health services.**

**Each year, 100 million people are thrown into poverty.**

**150 million people are in financial difficulties due to personal expenses incurred while accessing health care.<sup>1</sup>**



Despite the strong evidence that our health is constituted by factors on which we as an individual do not have direct control, we witness a shift in discourse from collective to individual responsibility. Related is the way health is rephrased as a profitable entity by liberal actors, and how the influence of private actors in health policy and health service delivery is increasing.

We, and a growing number of citizens and social movements, see this as a worrying trend.

It is without any doubt true that private companies take up a role that cannot be ignored in health services and health policy shaping nowadays, but we can't approach this as a given fact without addressing the historical change in power relations that brought this about. If private involvement is a reality, then it is certainly not a neutral one.

There's method in the madness. The current economic system needs to expand ever more in new areas to make profits in order to avoid new

crises. By consequence, it also tries to expand the market in health and health care in different ways, accumulating wealth in few hands while depriving people from basic services.

It is important to see the commercialisation of health as part of a wider neoliberal agenda that subjects all spheres of human and environmental interactions to a market logic. From a human rights based approach, we have to debunk the idea that the market is an environment where health care can thrive.

We are convinced that the struggle for the right to health should be done collectively. In the last chapter we will focus on the potential of social movements to push duty bearers to realise this right.

We hope this paper can add to the existing evidence and the growing impact of those movements in opposing the commercialisation of health and the privatisation of health care.



# Health is a human right

Most nations in the world have recognized the right to health. Our health is affected by the conditions in which we grow, live, work and die. Being able to go to a doctor is only one factor. However, people with the least financial capacities to pay for health services, are the most likely to be in need of them at a certain point in their life.

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The right to health is enumerated in a series of international and regional human rights instruments. Most notable is the Universal Declaration of Human Rights (1948), whose article 25 recognises the right of everyone 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”<sup>2</sup>.

But the right to health was defined even earlier, in the 1946 Constitution of the World Health organisation (WHO) as “a state of complete physical, mental and social well-being and not merely

the absence of disease or infirmity”<sup>3</sup>. In 2000, the UN Committee on Economic, Social and Cultural Rights issued a legally binding interpretation of the right to health, incorporating all dimensions to the human right to health.<sup>4</sup>

When something is recognised as a fundamental human right, this implies that states have the duty to protect, promote and secure the conditions necessary to fulfil this right.<sup>5</sup> On the other hand, citizens have the right to organise themselves to claim their rights.

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## 1.1 Inequality makes sick

All these treaties stress that **the State has the prior responsibility** to take all appropriate measures to ensure equality of access to health care services, to diminish health deficiencies among the population, to eliminate discrimination in the field of health care and to make sure its citizens live, grow, age, work and die in the most healthy conditions attainable.<sup>6</sup> All services, goods and facilities must be available, accessible, acceptable and of good quality.

Secondly, these treaties point to the fact that health care alone cannot be responsible for better population health.<sup>7</sup> There are many interrelated factors that influence health, including socio-economic class, education, housing, occupational status and conditions, access to nutritious food, and gender, among others. These are termed ‘**the social determinants of health**’ (Dahlgren & Whitehead, 1991). In fact, as the graph below shows, there is powerful evidence that **the main factors affecting our health are those socio-economic conditions**.

Here’s where inequality comes in. The final report of the World Health organisation’s Commission on the Social Determinants of Health<sup>8</sup> states that health and disease are not distributed equally in society, and that disease disproportionately affects those who have less access to resources such as food, clean water and environment, education, safe and stable jobs and solidarity-based welfare systems.

Our health is thus determined by the social position we find ourselves in. As a consequence, **people with the least financial capacities to pay for health services, are the most likely to be in need of them** at a certain point in their life.

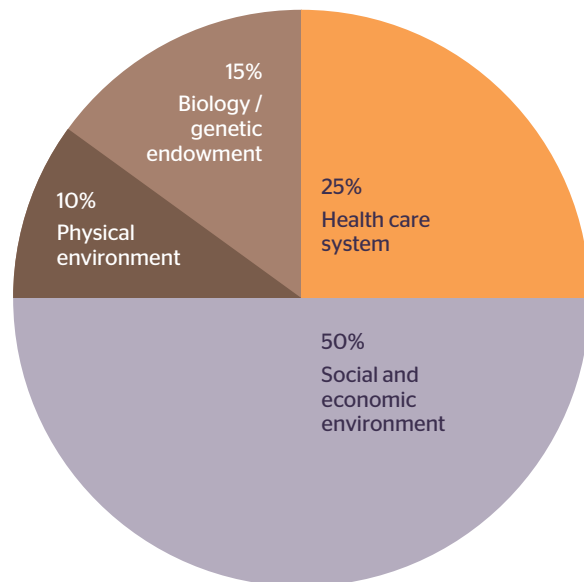
The economic and political system in place shapes the conditions for these social determinants of health to be improved, for example by its environmental and housing policies, food and drug prices and access to water. Reducing the unnecessary disease burden is primordial. On top of that, recent research points to the importance of overall equality in societies for health outcomes and well-being.<sup>9</sup> To come to a

structural solution, health advocacy should **not** only focus on the factors that impact health, but on the processes that determine their unequal distribution within society.

The essence of the right to health can be summed up as the following: health is a matter of social justice.

### Estimated impact of determinants on health status of the population

Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002



## 1.2 When people have to pay for health care

Although health care services can only play a limited role in the overall health of population, its accessibility remains a major determinant.

The **medical poverty trap**, a **concept** developed by Margaret Whitehead, well describes the consequences of user fees on poorer households.<sup>10</sup> A user fee is the part patients have to pay 'out-of-their-pocket' when making use of health services.<sup>11</sup> This can be the full cost of the service provided, or a partial contribution as part of a larger insurance scheme.

When sick, households often encounter financial barriers for their cure. And here is the trap. They have to make difficult choices: either they

postpone the care - risking a worsening health situation - or they end up **impoverished due to catastrophic health expenditure**. The latter option often leads to households having to sell livestock or cut down on food or education expenditures. This does not only happen in systems that rely on user fees: for example, in insurance-based systems such as the US, catastrophic health expenditure is a reality also for those who are insured. Also in Belgium, one in ten people postpones treatment because they cannot afford a doctor, even if the coverage system is considered as universal.



## What is a health system ?

The WHO defines a health system in a country as the sum of all the organisations, resources and people whose main objective is to improve health. Health systems are generally composed of subsystems: a public system financed by taxes or social contributions; a private not-for-profit system (run by associations, charities, NGOs, etc.); and (in almost countries) a private profit-making or commercial system. In some contexts they also include systems of traditional medicine and the informal sector. One important characteristic of most health systems is thus the large number of actors and interest groups.<sup>12</sup>

This nurse works in the Al Awda hospital in Gaza city. The hospital is run by the Palestinian Union of Health Work Committees, supported by Viva Salud. The Health Work Committees offers free treatment to the most deprived groups. Educational and cultural activities help raise awareness on health issues and the rights of citizens.



## Universal Health Coverage, the solution?<sup>13</sup>

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The WHO is promoting Universal Health Coverage (UHC) as the new mantra for health policies in developing countries. It is understood as a financing arrangement (an “insurance”) ensuring people can access the health services they need without incurring a financial risk.

Whilst this would definitely be an improvement for a lot of people in the world, this model directs attention from the quality and availability of health services to the mere financing aspect of it. As part of these reforms, public funding has been retained but steps have been taken to isolate the purchasers from the providers. This adds to the dangerous idea that health care can be treated as any other commodity, allowing the entrance of private insurance companies.

However, the WHO recognises that Universal Health Coverage requires a strong, efficient, well-run health system; access to essential medicines and technologies and a sufficient capacity of well-trained and motivated health workers.<sup>14</sup> Vivian Lin, health systems director at the WHO regional office for the Western pacific reported that “financial risk protection alone is not enough”, and that “without the availability of quality health care, Universal Health Coverage is meaningless”.



## 2

# Setting the scene

In the health care sector, privatisations come in all shapes and shades. Essential is the way care is transformed into a commercial relationship between a supplier and a buyer, and the making of profit is made possible. This is often accompanied by legislative changes<sup>15</sup>. If private involvement in health care is a reality, then it is certainly not a neutral one. We explore the historical change in power relations that brought this about.

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## 2.1 Privatisation: what's in a name?

It is important to note that generally speaking 'private' actors cover a very large group. Private providers can be both formal for-profit entities such as independent hospitals, individual care workers working on a self-employed basis, informal entities that may include unlicensed providers or street-market vendors of medication, and not-for-profit providers, such as community and social organisations, non-governmental organisations, etc.<sup>16</sup> In this paper, when we use the term 'private sector', we refer to all kinds of private-for-profit actors.

Commercialisation generally refers to the process of applying market principles to the functioning of policies and systems.

Actual privatisation starts once the financing and implementation of health services, policies and the production of health-related products is done by private-for-profit actors, instead of the government or another public body.

Public-private partnerships, or PPP's, are a specific form of privatisation and are "long-term contracts under which the private sector builds and sometimes runs major infrastructure projects or services traditionally provided by the State, such as hospitals, schools, roads, railways, water, sanitation and energy"<sup>17</sup>.

Applying a corporate approach to the governance of a health institution, even without direct collaboration of private actors, can be considered as a form of commercialisation, since its priorities and indicators will be redefined along economical and managerial terms.<sup>18</sup> An example is the use

of 'diagnostic related groups' as a way to monitor the performance of a hospital in economic terms. These groups associate each condition with the cost of its treatment.

Mechanisms leading to the emergence of private-for-profit actors in the health sector are plural.<sup>19</sup> Most known are:

- Opening up the health sector to new players by liberalisation of public markets, for example via trade agreements
- Decentralisation or regionalisation of health governance, leading to a modification of funding
- Unmet needs due to austerity, giving opportunities to private providers to 'fill the gap'
- The application of entrepreneurial functioning to smooth the transfer towards actual privatisation (human resources management, creation of indicators, quantitative over qualitative)
- 'Partial' privatisation by outsourcing specific services to the private sector, such as cleaning, catering or imaging services
- The encouragement of private investments in health care services by public-private partnerships
- A change in political angle from societal to individual responsibility
- The promotion of private insurance, both as a basic as well as a complementary amenity

*Those opposed  
to the welfare  
state never  
waste a good  
crisis*

McKee and Stuckler 2011

## 2.2 An ideological cure worse than the disease

The debate on the role of the State in health care has always been interwoven with the way health is defined, be it explicit or not.

Disease-specific interventions, or the classical humanitarian or needs-based approach to health, has long been the way to go. But the realisation that these interventions can only work if they rely upon broader basic health service provision<sup>20</sup> culminated in the 1978 Alma-Ata Declaration 'Health for All by the year 2000', promoting integrated health systems based on comprehensive primary health care, constructed with the participation of communities and intersectoral collaboration to address the social determinants of health.<sup>21</sup>

However, changing power relations on the international level made that this idea was quickly tagged as 'unrealistic' and 'costly' and that it was replaced by selective primary health care, with a focus on cost-efficiency and the promotion of specific interventions mainly for children and women.

Meanwhile, the leading global financial institutions, the World Bank and International Monetary Fund, were implementing their infamous Structural Adjustment Programs throughout the 1980s.<sup>22</sup> These programs were imposed on developing countries as a way of opening up new markets to foreign investors. Their market-oriented health reforms led to massive cuts in public health care expenditure in Low and Middle Income Countries, and to the privatisation of health care systems. The dramatic result was that by the turn of the Millennium most health care systems in developing countries were crumbling, with poor infrastructure, failing morale among

health workers and a rise in catastrophic health care expenditure by households, with a large proportion of out-of-pocket payments.<sup>23</sup>

Even after wide criticism, the starting point remained that the State need not provide services directly, but should play an enabling role, making the State more a manager of a broad range of service providers than a direct and active player. We still witness how private sector management is presented as an acceptable solution legitimised by the crumbling state of public health services.<sup>24</sup>

This logic completely ignores the duties of states connected to the right to health, and the fact that austerity<sup>25</sup> and market-oriented reforms lead to this situation. Also during the eighties, international institutions started funding partnership programs with private actors, mostly called 'philanthropists'. This meant a shift away from an international health agenda set mainly by public governmental actors within multilateral institutions. Often these corporate players have indirect interests in the pharmaceutical industry, health services or insurance companies. An approach that is still obvious today, in national, regional and global development policies. For example, the Bill and Melinda Gates Foundation is the largest non-state funder of the WHO, and its overall second largest donor after the United States of America. It is one of the driving forces behind public-private partnerships.<sup>26 27</sup>





In Cuba, the population has access to free medication with a prescription.

cc Julie S

## In the capitalist economy, medicine is an industry, according to David Himmelstein

How can health be profitable? David Himmelstein, professor of public health at the City University of New York, identifies four roles of health care systems in the capitalist economy<sup>28</sup>:

- Increase workers' productivity
- Maintain the domestic tranquillity and social stability needed for production and profit
- Create a market for the sale of commodities such as drugs and medical devices
- A commodity producing economy that is itself an important field for investment and profit
- As will be explained in the chapter on efficiency, you need a huge bureaucratic apparatus in health care to enforce inequality and extract profit. In 2017 there were approximately 30 times more managers in the US health system than there were 40 years ago.<sup>29</sup> For comparison: the number of physicians only doubled.<sup>30</sup> At the same time, there is a growing gap in life expectancy by income among the American population.<sup>31</sup>

## The National Health Service - from the good to the bad example<sup>32</sup>

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The UK health care system can be used as an illustration of how neoliberal thought and changes in power relations lead to the destruction of a well functioning health system.

Celebrating its 70th anniversary in 2018, the National Health Service (NHS) has long been the leading model of tax-financed, universal health care in Europe. The NHS, established in 1948, started from a widespread reform to the existing social welfare system. It was based on three core principles: it would be universal, comprehensive and free at the point of delivery.

The rational and responsive planning was aimed at redistributing health care resources and services across the country on the basis of need. While regional and district health authorities stood central in decision-making, all NHS organisations were directly accountable to the Secretary of State for Health.

Universal access to health in Britain has helped improve the health of the nation: life expectancy has increased by just over ten years for men and by more than eight years for women, while children are five times less likely to die in infancy than they would have been at the time of NHS' establishment. Moreover, recent comparisons of health systems in seven industrialised countries rated the NHS very highly on quality and efficiency of, and access to, care.

Simply put, NHS showed the world that publicly funded, publicly owned and publicly provided health care worked.

The turn came in the 1980s when Margaret Thatcher became prime minister and introduced private sector management principles to health care. This marketisation led to the introduction of a quasi-market and outsourcing in health care centred around competition and 'choice'. The NHS transformed from a unified comprehensive system to a sort of holding company 'franchising' health services out to various public and private providers.

Research show the devastating results, such as 'unnecessary and unjust premature deaths', the unavailability of services for patients who need the less profitable services, widespread hospital closures leading to increasing mortality rates and delayed care, and thousands of nursing jobs continue to be lost.

Though initiated by Thatcher, the privatisation of the NHS was always part of a broader move from a welfare state to a market state supported by a crowd of lobbyists- a process that continues today in the form of austerity and free trade agreements. The revolving door between NHS management and business positions are one proof of this. Neoliberal ideologues continue to hold prominent positions in government. Although there was public response to these reforms, it came too late due to misinformation and ignorance caused by politicians and commercial media. However, today we see how the NHS remains to be an important mobilising factor in the UK and is continuously high on the political agenda.



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# Commercialisation of health care: what are the risks ?

There are structural reasons why market logic doesn't lead to better health care for a society. Very often, the extraction of profit is at the expense of needed investments in infrastructure, research, health workers and equal access. We'll explain the reasons, starting from six often-used misconceptions.

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*Private provision naturally favours those who can afford.*

Oxfam, 2009

## 3.1 Privatisation triggers higher inequality in access to care

Introducing a consumer logic in health systems leads to the abolition of the principle of solidarity and human rights. As explained above, people with lower financial capacities are often forced to live in unhealthy conditions, consume unhealthy diets and are more subjected to psychical stress, which leads to even higher medical needs.

The main goal of private-for-profit entities is, as their name says, to make profit. This inevitably leads to compromising universal access to quality health care. Health services can be profitable in three ways: by charging user fees, by focusing on people that can afford to pay and by cashing in tax payer's subsidies.

The first option results in catastrophic health expenditure and worsening health conditions when people postpone care. User fees can be considered as a form of privatisation, since they are a shift away from redistributive public funding to private and individual sources. And, not surprisingly, research shows that the introduction of user fees has caused a reduction in access to care, hitting lower-income users the hardest.

The United Nations Research Institute for Social Development has summarised the experiences of user fees: "Of all measures proposed for raising revenue from local people this is probably the most ill advised. One study of 39 developing countries found that the introduction of user fees had increased revenues only slightly, while significantly reducing the access of low-income people to basic social services. Other studies have shown that fees reinforce gender inequality."<sup>33</sup> In 2006, Burundi, one of the poorest countries in the world, mandated free maternity services and

health care for pregnant women and children under 5. As a result, the country recorded a 43% reduction in infant and child mortality.<sup>34</sup>

The second option is also referred to as cream skinning. In a mixed public-private system the State generally remains responsible for patients with the highest needs and the lowest purchasing power, such as the unemployed, the elderly, the poor, people living in remote areas, and people with chronic diseases. This leads to a health system on two speeds: high-quality private services for those who can afford it, and slow, under-financed public services for those left behind.

Privatisation also leads to geographical inequities. As research shows, the private sector invests mostly in the more profitable specialised secondary and tertiary hospitals in cities. Rural areas and preventive primary health care are often overlooked.

### Solution:

**A unified public system can absorb these marginal costs and spread them across an entire population. A scoping study of the IMF reviewing 30 studies in developing countries found that government spending reduced inequality significantly.**





A Bengali public maternity. Nearly half of all Bengali women give birth without a health professional (Number: WHO) cc Julie S

## Two Filipino health systems<sup>35</sup>

Today, 8 people out of 10 in the Philippines report never having had a medical check-up or physical examination in their life. health care utilisation rates in the Philippines show worse access to health than the regional average.

The primary reason for the low coverage is a lack of financial means. Free health services are very limited and the poorest cannot afford medicines and treatment. This is not a surprise given that average costs of hospital admission are equivalent to 167.5% of the monthly salary of a minimum wage earner. Due to poverty, 6 out of 10 people die without ever having seen a doctor.<sup>36</sup>

There are large disparities in access to health services between different socio-economic groups in society. Coverage of health services in the Philippines is much lower among people living in poverty or who did not enjoy an education.<sup>37</sup> The poorest two-thirds of the population use public facilities, especially Rural Health Units and village health centres; in comparison only 10.6% of the richest quintile use these facilities, favouring private hospitals and clinics. However, the availability of public health services remains very poor in the Philippines, with large urban-rural disparities. At the same time, public facilities are often badly equipped and understaffed due to a lack of investments.

Many sectors are raising deep concern over the deteriorating health situation in the country due to the intensifying privatisation of health services. This has resulted in the further marginalisation of the poor due to costly hospital fees, reduction in the national budget for health, phasing out of charity wards of public hospitals, unregulated entry of private clinics and diagnostic and laboratory companies charging exorbitant fees, and the displacement of health workers and professionals.



## Two-speed queues in France<sup>41</sup>

In France, in medium-sized cities and in the public sector, patients have to wait several months for an appointment with a specialist such as an ophthalmologist or gynaecologist.

These queues have an impact on access to care, with a worsening of pathologies often treated too late, except for the well-off patient who can bear overcharging and will then go to private facilities with a much shorter period of care.

### 3.2 Privatisation is often more expensive in the long run

Mixed public and private health systems leave the public sector with diminished revenues and the responsibility to care for the poorest. In short: The weakened public sector bears the risks while the private sector gets the profit.

A recently published research of Eurodad, a European network of 46 civil society organisations, clearly shows how public-private partnerships, or PPP's, often appear to turn out to be more expensive than if the process would have been publicly funded and lead from the start.

Essential to PPPs is that the government gives strong guarantees concerning the expected generated profit to the private actor involved. These can, however, rather be defined as **insecurities inherent to economic systems**, instead of being called unexpected risks, such as "exchange rate fluctuations, inflation, prices and demand for the given service". Under World Bank-proposed PPP contracts, the State can even be liable for costs from strikes by workers.<sup>38</sup>

For example, to make an investment attractive, governments often guarantee above-average rates-of-return. If reality turns out different, it

is generally either the public side bearing the additional cost, or the corporate entity involved charging higher user fees for services than was agreed upon. Eurodad: "According to staff from the IMF Fiscal Affairs Department, 55 percent of all PPPs get renegotiated, on average every two years, and in the majority of cases, these result in an increase in tariffs for the users".<sup>39</sup> In the Democratic Republic of Congo, a consultation at the "Hôpital du Cinquantenaire" ended up costing between 20 and 25 dollars, while most members of the population live on 1.25 dollar per day.<sup>40</sup>

If not enough, private actors tend to demand higher guarantees in developing countries to compensate the higher risks of the often fragile or volatile settings.

#### **Solution:**

**Keeping investments public can avoid exploding costs due to the inherent instability of the market.**

## Scarce funds diverted in Lesotho<sup>42</sup>

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The World Bank's investment arm, the International Finance Corporation (IFC), advised the Lesotho Government on negotiations of a PPP in order to replace an old hospital. The private consortium agreed a 18-year tender for the construction and operation of the new hospital based on a 25% return on investment.

However, this turned out in a financial nightmare for the government: the new hospital is costing the government 7.6 times more than the one replaced, or the equivalent of 51% of the government's total health budget.

The exploding costs means that fewer resources are available to tackle serious and increasing health problems in rural areas where three quarters of the population live, and where investments in health services are lacking. In fact, where public funds were previously going towards providing primary health care services in rural areas, it is now used to cover the overly expensive private partnership. Above that, the Lesotho Government has proposed cuts to the budgets for agriculture and education in order to cover the exploding costs of the PPP.

## 3.3 Privatisation isn't more efficient

It is a common misconception that results in health care improve along with the amount of investments made. Lebanon has one of the most privatised health systems in the world and its health expenditure is more than twice that of Sri Lanka. However its infant and maternal mortality rate are two and a half and three times higher respectively.<sup>43</sup> The same comparison can be made between Cuba and the USA. Life expectancy in Cuba is 79 years, as in the United States. Infant mortality in Cuba is slightly lower than in the United States<sup>44</sup>. However, the United States' health budget per capita is up to 4 times bigger than Cuba's.<sup>45</sup>

Advocates of private sector investments often refer to advantages of privatisations such as more economic growth and job creation but they fail to bring along the evidence.<sup>46</sup> On the contrary there is evidence, globally, that systems that are not-for-profit do better on both cost-efficiency and quality. We understand "efficiency" as producing the best possible results with the available budget. A review of 132 studies comparing for-profit and not-for-profit hospitals and other health care institutions in the US, between 1980 and 2000, showed that non-profits were often superior on both terms<sup>47</sup>. More privatised systems are more fragmented and incur more transaction costs. In the Indian state of Tamilnadu, for example, pooled purchasing of medicines through a public sector entity has driven down medicine costs significantly and other states are engaged in duplicating the model.<sup>48</sup>

A review by UNDP's Global Centre for Public Service Excellence declares that there is no convincing evidence that either public or private health service delivery is more efficient. However, it showed that there is an "incentive to over-treat in private-for profit hospitals", a tendency absent in not-for-profit institutions.<sup>49</sup>

If the choice of treatment gets dictated by profit instead of medical need, this can lead to overly complex and often unnecessary treatments.

An important element in this debate is the **information asymmetry** in the health care 'market'. health care cannot be organised following a market oriented vision, since the 'consumers', in this case the patients, do not have enough knowledge to make informed choices. As shown in the case of Peru, this leads to patients being 'sold' unnecessary treatments out of financial motivations of the doctor or private institution. The information asymmetry is a strong counterargument to the neoliberal discourse that in private systems, patients have more freedom in choosing the services and doctors they prefer.

It can be argued that an array of private providers could offer these services if robust regulatory mechanisms impose conditions that oblige them to do so. But is often forgotten that those mechanisms come with a price. Oxfam calculated that monitoring and control mechanisms can go up to 20 per cent of spending from health budgets. The opposite situation is where government capacity is weak, and managing and regulating private providers becomes difficult, leading to even more inefficiencies and even cases of corruption.<sup>50</sup>

## Solution:

Public systems are more efficient because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment. A unified health system spends virtually nothing on competitive advertising.

## Commercialised health care systems often have very high transaction costs

- In 1999, 31% of health care expenditures in long-term care facilities in US went to administrative costs, While in the UK, the NHS, a unified public health system, in 1970s counted for only 5-6%<sup>51</sup>
- Medicare, the national health care program administered by the US federal government<sup>52</sup>, administrative costs' average only about 2 percent of total expenses. Many private insurers have costs up to six times higher.
- Competitive advertising can account for more than 15 percent of total expenses for private insurers<sup>53</sup>

## Unnecessary caesareans in Peru

The unnecessary caesareans practised in the private sector are a clear-cut and widely studied example. This procedure is performed in 80% of deliveries (an alarming percentage) and even 95% in some private clinics. For a caesarean, the doctor is able to charge a higher fee than for a natural birth. Furthermore, caesareans can be planned and generally do not take up nearly as much time. However, besides the financial extra cost, a caesarean brings along extra health risks for the mother. Doctors are spending less time on the delivery itself and more on expectant patients or at their private practices. In an overburdened system, time is money. (Commercialisation of health care in Peru, FOS, Health, a commodity?, 2016)

The Bengali government produces its own medication and provides them free of charge to its citizens. Patients only receive the exact amount of pills needed after consultation, to avoid wastage.

cc Julie S



## Does commercialisation leads to less wastage?

### Introduction of private insurance companies in Dutch health care

“Commercialisation in the Netherlands was intended to bring about a reduction in costs and yet premiums have skyrocketed in 10 years. They have gone from an average of 1,080 euros in 2006 to 1,260 euros in 2014. The question is: where does this money go and is it really spent on health care? Each year, health insurers spend some 500 million euro on advertising. Annual profits amount to over a billion euro. In total, health insurers have a reserve of 9.3 billion euro.

An appeal was made for a new form of basic public insurance. In March 2015, a group of general practitioners published a manifesto which, in the space of a few weeks, collected the signatures of approximately two-thirds of doctors actively practising in the Netherlands.” (Case by Doctors for the People, in Health a commodity)



## 3.4 Privatisation doesn't lead to better quality

It is often stated that commercial health care providers are more fit to offer better quality. However, if “qualitative care” is understood as “offering the best treatment according to the diagnosis, based on evidence and international treatment guidelines”, then this is not necessarily the case. A report of the World Bank states that the private sector generally performs worse on technical quality than the public sector.<sup>54</sup>

In the first place, public systems perform tasks that are not directly linked to providing care. A lot of these are linked to the importance of disease prevention, such as public awareness programmes, health education and immunisation programmes. These policies and tasks are often neglected in profit-based system. Out-sourcing health care to the commercial sector in China has led to a decline of less profitable preventative health care; immunisation coverage dropped by half in the following five years.<sup>55</sup>

Secondly, in order to make more profit, companies can decide to save money in the quality of the materials they use, and the training and availability of their staff, leading to care and treatment of less quality.

Thirdly, as stated above, quality should also be interpreted in terms of care-that-matters, meaning patients are not subjected to the risk of treatment if not necessary. There are documented cases where patients have been subjected to unnecessary or dangerous medical procedures simply due to greed. For example, MRI scans expose

patients to a certain amount of radioactive radiation.

In 2010, a report stated that waste accounted for thirty per cent of health-care spending in the highly privatised health care system of the United States of America. Next to unreasonably higher prices, administrative expenses, and fraud, more than half was the amount spent on unnecessary health care services.<sup>56</sup>

A commercial logic also leads to a biomedical bias, based on marketable products such as technology and medication, ignoring the importance of the health system as a whole. We've seen this trend clearly in the shift from primary health care to disease-specific interventions.

To end, competition on the health market can harm collaboration between different providers, often an important ingredient of good quality care, especially in relation to referrals between different kinds of specialists or between different levels of the health care system.

### Solution:

**Public services are in a better position to organise the quality of care provided in correspondence to real population needs.**



In 2015, Doctors for the People campaigned in front of the Belgian Ministry of Health for a health system where patients can visit the doctor free of charge

## Deteriorating quality of nursing homes in Belgium

This case is written by Stephen O'Brien, Doctors for the People<sup>57</sup>

In Brussels, Belgium, two thirds of the nursing homes are owned by commercial entities. The share of the 3 largest multinationals - Orpea, Armonia and Senior Living Group (Korian) - grew by 160% over the last 7 years, accounting for a third of all the nursing homes in Brussels in 2017.<sup>58</sup>

Nurses and caregivers of these commercial nursing homes have been denouncing the degradation of care caused by constant cost-cutting: reduction of food quality, less activities organised for the residents and less time spent with each resident. In certain cases, workers point to the increasing number of new residents that demand higher attention, such as persons with severe psychiatric conditions, but how the staff lacks specific training or time. These health professionals describe a "industrialization" of their daily work and a dehumanisation of the residents. They point out the profit-led management of these commercial nursing homes as the root cause of these negative changes.

Parallel, nursing home out-of-pocket prices have continued to climb: in the last 5 years, the number of nursing homes costing over €1700 per month has doubled, accounting for two thirds of the nursing homes in 2017.<sup>59</sup> This has had a particular severe impact on financial accessibility, knowing that the Brussels elderly population is distinctly poorer than the two other regions of Belgium. Twice as more 65-plus live on social welfare.<sup>60</sup>

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## 3.5 Privatisation leads to less public control

Outsourcing services to the private sector brings a loss of direct control, undermining the right and obligation of the State to regulate in the public interest.

Contracts with private providers can be considered as a threat to national democracy because they are often extremely complex and negotiated under 'commercial confidentiality', making it almost impossible for civil society and public authorities to exercise their right to participation.<sup>61 62</sup>

As stated above, these contracts can lead to extra opportunities for the corruption-minded. Fraud in the US-health care system is estimated to cost between \$75 and \$275 billion per year in 2017.<sup>63</sup> This number is rapidly rising: in 2009, the highest estimation accounted for 'only' \$21 billion a year.<sup>64</sup>

As to PPP's, few companies have the capacity to apply for the often relatively large-scale, public infrastructure or services projects. This reduces governments' choice and competition in tendering processes, which can also lead to a higher risk of corruption. Large multinationals also have more means and power to renegotiate contracts in their favour.<sup>65</sup>

### Solution:

**the State has the obligation to regulate in the public interest, and is thus more accountable. Corruption among public officials is a not-to-be neglected reality. But governments at any levels have more instruments for direct public scrutiny, both at the local as at the international level.**

# Greece – Or how the economic crisis was used to reform health sector towards increased privatisations

“Since the start of the economic crisis in Greece, the European Union, the European Central Bank and the IMF imposed radical austerity measures and other reforms, such as radical cuts of public expenses, drastic tax increases, reductions of unemployment benefits and the privatisation of public infrastructure. These austerity measures have affected all social indicators. In 2016, 35.6% of the total population was at risk of poverty or social exclusion while eight years earlier the same index was 28.1%. Historical evidence indicates that in times of austerity the public health system needs to be strengthened in order to avoid a sharp decline in the health status of the population. However, the EU's diktats in Greece forced the governments to continue to implement a health reform programme with the objective of keeping public health expenditure at or below 6% of a GDP (in 2007 Greece's health care expenditure was 9.6% of GDP). This has led to an increase of out-of-pocket expenditure on health care, with an increase of co-payments on medicines to up to 25,9%. Households are either forced into poverty in order to access health care services or they are forced to avoid accessing services. To understand who have been the real beneficiaries of reduction in public expenditure one needs to turn to the announcement in October 2017 which says that the debt of 100 public hospitals and other public health services had been bought by an Italian bank.”<sup>66</sup>

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## 3.6 Privatisation leads to a lower availability of health workers and deteriorating working conditions for them

In addition, outsourcing of health care provision to commercial investors is detrimental to the public sector by diverting away scarce resources, like health workers.

One example is how the presence of the private for-profit sector in a country or medical tourism industries in neighbouring countries are enticing health workers away from the public sector by offering higher salaries. This so-called internal and international “brain drain” leads to shortages of health staff in the public sector and in rural areas and undermines the availability and quality of health care.

In some countries, for example in the Philippines, health workers are being treated as commodities in trade agreements by deliberately promoting their export as a strategy to gain foreign exchange. Contrarily, countries that offer hefty incentives to retain health workers in the public sector or in rural areas have successfully promoted equitable service delivery.

Again, we witness a new split in health systems leading to a parallel understaffed public sector and a private sector with highly specialised personnel only available to those who can afford. It is a fallacy and a myth to believe that such a monetarist economic model and the ‘labour market’ in itself will overcome the work force deficits, and improve health status results.<sup>67</sup>

The never-ending search for higher profits often leads to harsher working conditions for health staff, like uncompensated overtime, higher working pressure and unfavourable contracts. Poor and insecure working conditions in their place have an obvious negative impact on the health of the workforce, also leading to poorer quality of care. Burnout, stress symptoms and even suicidal thoughts are rife in the health care sector.

### Solution:

**Availability of well-trained health staff is an integral part of the right to health, and can be claimed for by citizens. In a unified public health care system, competition amongst workers should be avoided.**





Cuban health workers take measurements of the community on the streets of Havana

## Cuba: the health worker at the centre of the community

Most Cubans have access to quality health care, free of charge. The family doctor plays a central role in the Cuban health care system. He or she has all the medical information relating to the patients for whom he or she is responsible and can therefore optimally adapt the provision of care to the specific needs of the patients.

A family doctor, a nurse and a social worker are collectively responsible for a certain number of inhabitants of a given territory. Half of their tasks consist of consultations and half of preventive home visits. This is how they know the living conditions of their patients and can therefore intervene on the social and ecological risks that determine their health.

While in many countries there are growing shortages of health workers, in Cuba there are 7.5 doctors per 1000 inhabitants. Even in remote parts of the country, patients have access to basic health care. By way of comparison: in Belgium there are 3 doctors per 1000 inhabitants.<sup>68</sup>

# The medical cost of freedom of movement in Croatia<sup>69</sup>

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Freedom of movement for services in the EU allows cross-border delivery of medical, dental, and other health services. While this offers a potential choice to patients, it also provides an opportunity to care providers, including those in the private sector, to recruit patients and health workers from across the continent. Such rules also promote 'medical tourism', essentially to service health needs of those who can buy care from the market, instead of addressing real needs of local patients. In Croatia, the government provides support for the development of medical tourism and public investments in medical tourism are disproportionately higher than the support to public hospitals. Many of the latter are in debt and are then accused of providing poor quality services.



# History on our side: why public health care is better

At the centre of the right to health is a well-functioning health system, which is available, accessible and acceptable to all without discrimination and of good quality. Health systems are constructed through the interplay of social forces, shaped by historical changes in power relations on the local and global level, and hence in a state of constant evolution. But citizens can be the main actor in this change.

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## 4.1 Which health care system do we want?

*Just as taxation tends to redistribute wealth; regulation tends to redistribute power. A democratic state controls and contains powerful interests on behalf of the powerless.*

George Monbiot, 2013<sup>70</sup>

According to the rights-based approach to health, a health system should go further than mere assistance and charity. At the centre of the right to health is a well-functioning health system, which is available, accessible and acceptable to all without discrimination and of good quality:

- **Availability:** A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programs
- **Affordability:** Financial accessibility
- **Acceptability:** culturally appropriate, gender sensitive, respect of medical ethics
- **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality<sup>71</sup>

Public health systems that provide comprehensive health care, free at the point of delivery, with a focus on prevention and are driven by community needs generally outperform the more commercialised health systems in terms of the above criteria. Research shows that a tax based single pooling system generates the most equitable outcomes. The abolishment of private, and even social, health insurance systems, would result in significant savings in terms of fragmentation, administration costs and advertising.

This health system reflects the need for broad targets incorporating social determinants that oblige and support actions to reduce inequities and mandate actions beyond the health sector. As stated in the Alma Ata declaration, comprehensive primary health care and population-centred health systems that build on community participation and empowerment are the way to go. In mixed service provision system, the public health care system should be strengthened to avoid passive privatisation.

However, as the example of community-based health workers in the Philippines shows, participation shouldn't be a substitute for the essential role of the State in providing health services. Popular participation and public services are complementary and any health policy should be based on these two realities.<sup>72</sup>

Filipino community health workers from the Council for Health and Development give a training to residents of poor neighbourhoods on how to recognize health problems



## Empowerment by health workers in community-based health programmes in the Philippines<sup>73</sup>

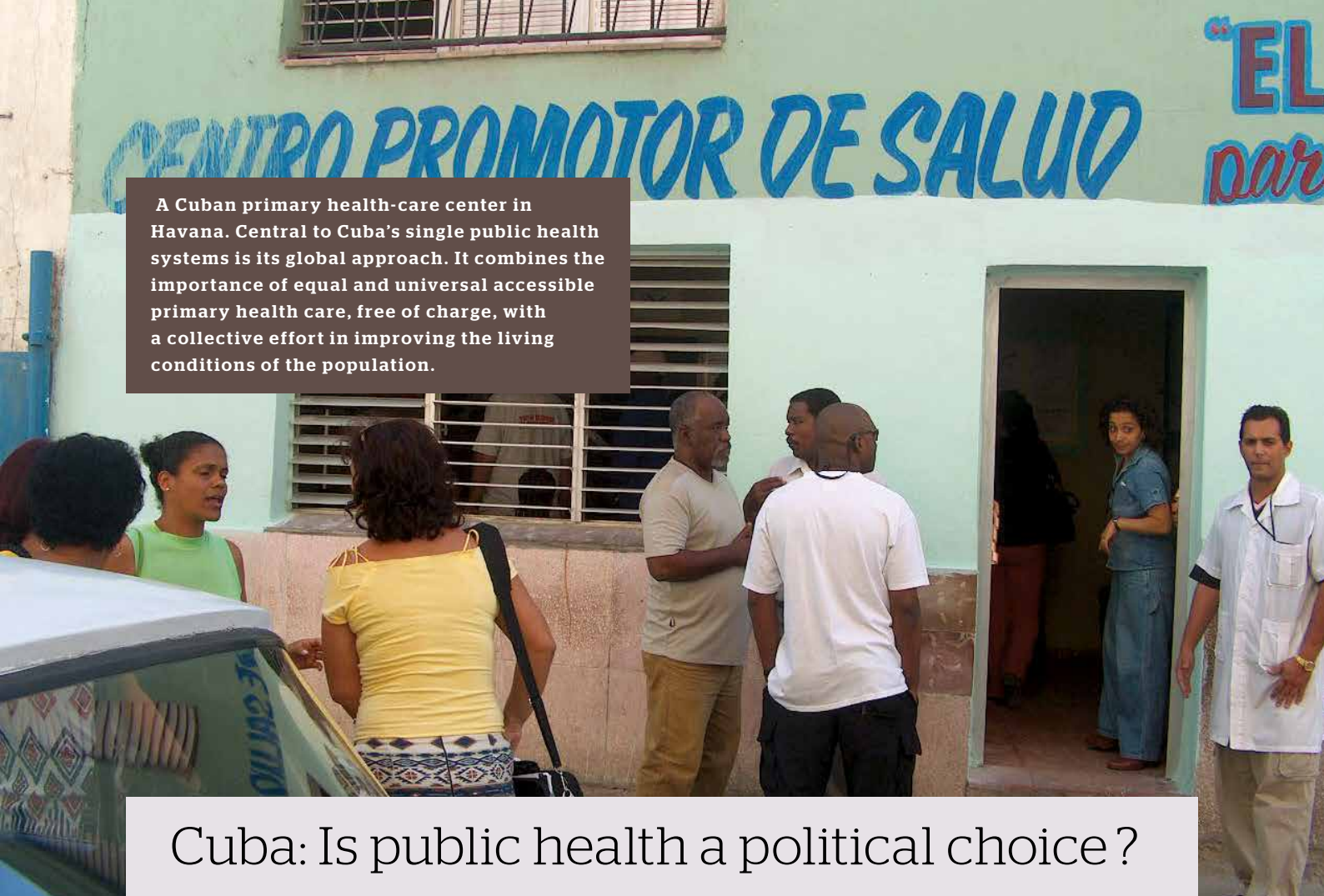
Documented by the WHO<sup>74</sup> as an example in the global effort to strengthen health systems and ensure positive health outcomes for the rural majority, community health work programs marked the international health scene in the 70s and 80s. Community Health Workers (CHW) are for example a key component of the primary health care perspective in the Alma Ata Declaration. What makes community health workers unique, is their special relationship with both the community and the health system, regardless of setting or location. As a member of the community where they work, the role of a CHW has to be understood to go beyond basic health care for the most vulnerable members of a population, and extend to what can be described as community development. Their aim is to support the process to improve social conditions to all community members. However, nowadays, the focus of their role shifted to service 'delivery' and the debate surrounding their dual role became marked by technical issues; neglecting the important transformative potential and element of empowerment for society as a whole of community health workers.



Community-based health programmes in the Philippines have been set up all over the archipelago to provide farmers and ordinary men and women with basic medical training; these skilled “barefoot doctors” can then treat the most common ailments in their communities. Working closely with social movements in their country, they help people to claim their right to health from the government. These programmes are now coordinated by the independent Council for Health and Development.

Based on many years of experience, they apply a few basic principles that may also be useful for other health workers committed to changing processes addressing social justice. Here are three:

- One must realise the basic difference between community-oriented health care coming from elsewhere and community-based, and eventually managed, health care. The former promotes dependence while the latter promotes empowerment. Remove health professionals from the clinic and go to where the people are. Equip them with the knowledge, skills, and attitude for community practice.
- Acquire a deep understanding of the socio-cultural-economic-political context of health issues. This can be done by integration, social investigation, and actual integration in the lives of people in the community. One becomes a health service provider, a teacher, an advocate, a coordinator, a leader, manager, and a student of the people.
- As a primary health care practitioner, we must give emphasis on disease prevention and tap into the potential of the people, as well as their wealth of experience. We must look at the people not as beneficiaries, but as partners in development.<sup>75</sup>



A Cuban primary health-care center in Havana. Central to Cuba's single public health systems is its global approach. It combines the importance of equal and universal accessible primary health care, free of charge, with a collective effort in improving the living conditions of the population.

## Cuba: Is public health a political choice?

The improvement of health indicators can be attributed to the economic and social upheavals following the 1959 Cuban revolution. An improvement in general living conditions and some major social achievements (such as: a house for each family, guaranteed income, better education, etc.) have been the basis for a healthier population.

Universal access to health care and prevention are the foundation of the Cuban health system. After the 1959 revolution, private clinics and the pharmaceutical industry were nationalized and integrated into a single system for the whole country under the administration of the Ministry of Health. The country has been divided into health zones, with one polyclinic per zone and the decentralization of health care to the communal level. Patient orientation and communication between providers at different levels of the health system goes generally without problems.

Health care in Cuba is a national priority and is the responsibility of the State. Even in times of crisis, the government budget for health care has been maintained at 10% of Gross National Product (GNP). Cuba strengthened its public health system, especially primary care. Health services became a priority and remained free, the number of general practitioners tripled and prevention got more attention.<sup>76</sup>

Cuba remains true to this recipe: health care is exclusively entrusted to the public authorities and privatization is prohibited by law. Since free and high-quality health care is guaranteed for the entire population, there is no demand for private medicine in Cuba. While during the 1990s the other countries of South America were concocting drastic reforms and privatisations in the health care sector, under pressure from the IMF and the World Bank, Cuba stubbornly insisted on maintaining the exclusively public function of the health care system. Cuba is one of the few countries that is not a member of the IMF or the World Bank.

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## 4.2 Successful civil society campaigns

To achieve universal access to public, comprehensive health services of good quality, action is needed. Citizens have the right to ask better and more accessible health care services to their political representatives. Even more, there are examples of organised citizens succeeding in demanding policy change, such as those illustrated below.

As explained in the first chapter, a lot is at stake on the international level. Corporate powers have different means to change health policies in their favour.


Citizens organise themselves against the impacts of these policies in different ways.

For example, solidarity clinics in Greece have been opened. They connected with the movement in support of migrants, further universalising their claim for health for all. When social revolutions in China, Cuba and Iran put health

and social demands on the agenda, they often achieved impressive results. In Latin America too, social struggles in countries such as Brazil, Costa Rica and Nicaragua led to greater political attention being paid to public health.<sup>77</sup> After the severe cholera epidemic in 1866, Belgian trade unions demanded the authorities to start extensive clean-up programs, public infrastructural works, and the development of a system of public water distribution and public bath houses to improve the sanitary conditions in the working-class areas near factories. This stopped cholera and tuberculosis.<sup>78 79</sup>

Alliances for health, in all its dimensions, are being built in different parts of the world on various scales. These raise the real possibility of the emergence of a political force capable of transforming society.



A photograph of a protest in Brussels, Belgium. In the foreground, a person wearing a large, realistic mask of an elderly woman with white hair and glasses is speaking into a red and white megaphone. The megaphone has a green circular sticker with text in French and a green banner that reads 'FAITE AVEZ AUX RICHES' and 'UNE L'avenir a son syndicat'. In the background, other protesters wearing green clothing and hats are visible, along with a building and a banner.

A trade unionist protests against the retirement age of health workers in Brussels, Belgium

## The European welfare system is a product of struggle

Health coverage schemes in Europe were designed as welfare payments during sickness and later integrated into entitlements for health care. For example, in post-war France, waves of strikes brought about more social advantages, the minimum wage and a shorter working week.<sup>80</sup> European countries introduced compulsory sickness insurance for workers beginning in Germany in 1883. Other European countries opted to subsidise the mutual benefit societies formed by workers. The primary goal of these programs in Europe was income stabilisation and protection against the wage loss of sickness, rather than payment for medical expenses, which came later. However, this period was also characterised by rising discontent among the working class. The introduction of these schemes can be understood as a way of buying their political allegiance.<sup>81</sup>





Congolese youth organize an action on World Health Day

## Congo - inhabitants keep the local infirmary running

Lubudi Luka is a popular district with more than 13 000 inhabitants in one of the least prosperous municipalities in Kinshasa. It is a swampy zone where the population lives in rural conditions with hardly any electricity or access to water. The households therefore use the rivers as water supplies and the streets as waste storage. Water-related diseases, such as cholera, typhoid, malaria, hepatitis, diarrhoea and other health problems are a daily reality.

A survey conducted in November 2015 showed that a large proportion of the population identified the lack of care as one of the main causes of mortality. More specifically, the residents turned to the infirmary 'Lubudi', where a shortage of personnel could not guarantee continuous care. Moreover, there was no midwife working in this place, so many women decided to give birth in poor and unhygienic conditions.

The public health committee and the women's movement of our partner Étoile du Sud appealed to the health workers of the district, the medical staff of the sickbay 'Lubudi' and the district head to raise the problem and to propose a collective alternative.

This consisted of the local residents taking on the maintenance and administration of the local infirmary 'Lubudi', which freed up resources for the recruitment of a midwife. In the meantime, the sickbay is kept open thanks to a collaboration between the community relays (health workers at district level) and the person in charge of the local health committee with the support of the local women's movement of Étoile du Sud.





Filipino activists protest outside of the Fabella hospital in the Philippines, that the government wants to replace by a commercial centre.

## Save Fabella Hospital – Philippines

The Fabella Hospital, Dubbed as “baby factory”, is a maternal and newborn tertiary hospital where mostly poor mothers from the Filipino capital and nearby provinces come to give birth because of its affordable service. The World Health organisation recognised the hospital as a role model for its essential newborn care programs, which have been proven to reduce infant morbidity and mortality.

However, the building hasn’t been renovated in a long time due to a lack of public investments. The government uses its current bad state as an argument to close the hospital and replace it by a commercial centre. The closure is set to displace its ordinary employees as well as an average of 1,000 patients per day.

Viva Salud’s partners send out an appeal to resist the government’s privatisation plans. The appeal provided a real popular protest. Pregnant women, together with nursing staff and many other worried Filipinos, took action day after day. In June, the management tried to pull out the hospital’s equipment. But the group barricaded the gates of the hospital. A few months later however, the group was surprised to see government soldiers carrying high-powered firearms doing the job. The use of soldiers to take out the equipment was clearly an attempt to intimidate the protesters. But fear is not in their vocabulary as they confronted the soldiers, and demanded that the latter present a copy of an order to pull out the equipment from the hospital. The confrontation prompted the hospital director to hold a dialogue with the protesters. As a result, he was compelled to order the soldiers to unload the equipment and return them to the hospital.

In March 2018, the combined effort of the large Filipino movement against privatisations led to a big victory: the House of Representatives approved the ‘Anti-privatisation of Public Hospitals, Health Facilities and Health Services Act’. This bill bars the Health secretary or any other person from initiating, causing or approving the privatisation of any public hospital, public health facility or public health services.<sup>82</sup>

Manifestation against  
the commercialization  
of health care in  
Belgium, 2018



5

## Conclusion

The majority of countries in the world agreed to take all possible measures to fulfil the right to accessible and qualitative health care for their population. However, anno 2019, this is far from achieved. Even worse, many national governments and international institutions direct health policies along a market-led approach. Privatisations have been brought up as the solution to national health systems' funding shortages. But numerous case studies and comprehensive research shows that health outcomes get worse when the pursuit of profit comes in.

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*A radical  
change  
of approach  
is needed.  
Health is a  
human right.*

**1. Privatisation triggers higher inequality in access to care.**

Private hospitals have to make a profit, so they focus mainly on people who can afford it. This creates the risk of a health system at two speeds. On the one hand, high-tech and specialised care for the rich and, on the other hand, simple public health care for the less well-off. This despite the fact that it is the duty of public service providers to provide care to everyone, without distinction.

**2. Privatisation is often more expensive in the long run.**

Unexpected costs, such as rising interest rates or expensive energy prices, are usually passed on to the government or the patient in private hospitals. An Oxfam study calculated that a public-private hospital in Lesotho costs the government three times more than the public hospital it replaced. Under some contracts, the company can even sue the state for costs related to protests of employees.

**3. Privatisation isn't more efficient.**

Public systems are more efficient because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment.

By contrast, in the United Kingdom, the number of managers in the National Health Service tripled since the introduction of a market logic. In the Netherlands, private health insurers spend 500 million euros per year on advertising campaigns.

**4. Privatisation doesn't lead to better quality.**

In today's market logic, private institutions will focus on the treatments that are financially interesting, instead of those that benefit the patient the most. In Peru, private hospitals are much more likely to choose a more risky Caesarean section than a natural birth, because the doctor can charge more.

**5. Privatisation leads to less public control.**

Negotiations between private players often take place under strict rules of confidentiality. Public control is therefore very difficult, which makes the risk of corruption increase. Engaging funds from the private sector opens the way for corporate involvement in policy shaping.

**6. Privatisation leads to a lower availability of health workers and deteriorating working conditions for them.**

Commercial companies take the scarce resources, such as health workers, away from the public sector. This so-called "brain drain" leads to shortages in the public sector and in more remote areas. Moreover, the drive for ever higher profit margins often leads to poorer working conditions, unpaid overtime and higher work pressure. Burn-out and stress symptoms are very common in the health sector.

# The alternative exists

This paper starts from the positive side. All over the world, social movements and governments make efforts to change their health care system for the benefit of the population.

- **Universal access to quality health care is a feasible political choice.**

Countries that prioritise people's well-being and choose to invest in making health care accessible to all achieve better health outcomes. Even countries with low expenditure on health have been able to build strong health systems.

- **Need, not wealth.**

The only proven route to realise this is cancelling all fees for health care and essential medicines, and increase public investments in well-trained staff, nearby health facilities, and prevention and health promotion programs. A unified public system does not have the disadvantageous contradictions brought by the fragmentation and competition that characterises mixed private-public health systems.

## **What the international community can do.**

Reinforcing countries financial capacities to cope with a potential budget increase should also be a focus of the international community and international institutions, for example by:

- stepping away from imposed budget restrictions in public services
- regulating pharmaceutical companies' monopoly positions
- cancelling debt
- fighting large-scale tax evasion
- excluding health services from trade and investment agreements

Due to globalisation, the vast majority of people in the world are subjected to very similar economic realities, forces and dynamics: environmental degradation, the global competition of workers, attacks to and exclusion from social protection schemes and a growing inequality between social classes to name but a few.<sup>83</sup>

This global emergency situation represents an unprecedented challenge for humanity. Since health and other societal challenges are very interconnected, the struggle for health can function as a major unifying factor in the mobilisations required to address these issues.

**We hope that this paper can be a support for those social movements standing up for social justice.**



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We love to hear from you!

Contact us with your feedback,  
or in case you want to organize a  
workshop based on this research.

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