

The European Network*

**calls on citizens,
health and social workers
and users of health services**

**to join and organize actions
all over Europe!**



For our health!

- 1. Ensure adequate funding for public and non-commercial health services**
- 2. Protect the population against commercial abuses**
- 3. Guarantee financial, geographical, temporal and cultural accessibility**
- 4. Boost health democracy**
- 5. Improve social, environmental, ecological and gender determinants of health**
- 6. Orient medicine policy at the service of the population**

* European Network against the Privatization and Commercialization of Health and Social Protection

More information regarding the European actions and the European Network:
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**WITH THIS DECLARATION WE COMMIT OURSELVES TO
DEFEND AND GENERALIZE**

**A HEALTH SYSTEM AND A SOCIAL PROTECTION THAT ENSURES
ACCESSIBLE, RELIABLE, QUALITY AND NON-COMMERCIAL
SERVICES FOR THE ENTIRE POPULATION**

**WITH SUFFICIENT AND SOLIDARITY BASED FUNDING
TOWARDS A TRULY SOCIAL EUROPE**

The principles we stand for

Health is a state of **physical, mental, social, cultural and ecological well-being**, not just the absence of disease or infirmity.

Health and social protection are **universal human rights** that must be considered in its broadest and most comprehensive aspects, including the determinants of health.

Therefore, the right to health and social protection requires action not only by the health sector, but also by many **other social, environmental and economic sectors**.

Political choices, whether European or national, must be made to ensure that **the entire population, whatever their geographical area, has access to accessible, reliable, high-quality, non-commercial and democratic local services financed by a system of solidarity**.

That is why, in my role as an elected member of the European Parliament, representing European citizens, I undertake to oppose the dismantling of health and universal social protection systems through the following axes

- ▶ **1. For our health: ensure adequate funding for public and non-commercial health services in the Member States**, guaranteeing a system of social protection that is inclusive, public and universal and offers accessible, high-quality services;
- ▶ **2. For our health: protect the population against commercial abuses**, because health and social protection are common goods and are not for sale;
- ▶ **3. For our health: guarantee financial, geographical, temporal and cultural accessibility to health for all populations**, without restriction of any kind, taking into account local realities;
- ▶ **4. For our health: boost health democracy** by involving civil society, workers and beneficiaries in defining the objectives and means of health policies;
- ▶ **5. For our Health: improve health by addressing root causes such as the social, environmental, ecological and gender determinants of health;**
- ▶ **6. For our health: orient medicine policy at the service of the population and not of multinational pharmaceutical companies.**

Name & signature



For our health, ensure adequate funding for public and non-commercial health services in the Member States,

guaranteeing a system of social protection that is inclusive, public and universal
and offers accessible, high-quality services

The role of Europe

The 2008 economic crisis deeply modified the way European institutions intervene in healthcare systems on a national level.

While it was initially a question of exchanging best practices, economic policies are now prescribed via the European semester. The European Commission can even go so far as to give formal notice to a State to take decisions—with financial sanctions in case of disobedience.

The imposed prescriptions relative to healthcare aim primarily for a "clean-up" of public finances. They advise, for instance, to reduce the costs of institutional care, the costs of reimbursements for care and the costs of hospitals and retirement homes. The official goal is to improve the efficiency of public expenditures.

These European pressures also prompt national governments to reduce their public expenses relative to our social protection (old-age pensions, unemployment, health), among other things. Expenses in the field of public/collective services (education, childcare, care of disabled and elderly persons, transport...) or even of infrastructures are also on target.

At the same time States are reducing social welfare contributions (seen as an obstacle to competition) when they are funding social security.

An example: 1st prescription within the European Semester for 2018-2019

For **Belgium**: *make sure that the nominal growth rate of primary public expenses netto does not exceed 1,8 % in 2019, which corresponds to a structural yearly adjustment of 0,6 % of the GNP; use exceptional receipts to speed up the reduction of the public debt ratio; pursue reforms of pensions and contain the expected increase of expenses relative to long-term care; pursue the integral implementation of the 2013 cooperation agreement relative to the coordination of budgetary policy at different levels of power; improve the efficiency and the composition of public spending at all levels of power so as to make available resources for public investment, in particular by reexamining expenses.*

For **France**: *make sure that the nominal growth rate of primary public expenses netto does not exceed 1,4 % in 2019, which would correspond to a structural yearly adjustment of 0,6 % of the GNP; use exceptional receipts to speed up the reduction of the public debt ratio; reduce expenses in 2018 and fully precise the goals and new measures necessary in the context of Public Action 2022 so that they are converted in concrete measures reducing expenses and gaining efficiency in the 2019 budget; progressively standardize rules of various pension regimes so as to strengthen the equity and sustainability of these regimes.*

For **Spain**: *make sure to respect the EU decision 2017/984 of the Council requiring Spain under appropriate legislative procedure concerning excess deficits, including by adopting measures aiming at reinforcing the budgetary frame and the frame of public procurement at all levels of administration: make sure that the nominal growth ratio of public primary expenses netto does not exceed 0,6 % in 2019, which corresponds to a yearly structural yearly adjustment of 0,65 % of the GNP; use exceptional receipts to speed up the reduction of the public debt ratio.*

For **Italy**: *make sure that the nominal growth rate of primary public expenses netto does not exceed 0,1 % in 2019, which corresponds to a structural yearly adjustment of 0,6 % of the GNP; use exceptional receipts to speed up the reduction of the public debt ratio; reduce the burden of taxation of the workforce, in particular by reducing tax expenditure and by reforming exceeded cadastral values; double the efforts in the fight against underground economy, in particular by strengthening the compulsory use of electronic payment thanks to a reduction of legal thresholds for cash payment; reduce the share of old-age pensions in public expenses so as to create margins for other social expenses.*

Our priorities

- The **needs of the people regarding social protection** must be defined as a priority in the **budgetary controls** of Member States.
- The budgets of Member States must

make it possible to face health challenges for today and tomorrow (ageing of the population, impoverishment, chronic, mental and occupational illnesses, etc.).

Alternative political choices are concretely possible:

- Place European solidarity on the agenda, to be expressed by a fiscal and social harmonisation as well as by the fight against tax evasion.

This will enable each State to finance its public politics. The economy must meet the needs of the majority rather than supporting the profits of a minority.

- Implement progressive tax systems all across Europe.

This is a question of, among others,

- implementing a harmonisation of corporate tax in all Member States and establishing minimum tax rates
- taking coordinated measures against the multiplication of intellectual property tax regimes ("patent boxes"). There is indeed no evidence that tax advantages for big pharmaceutical companies have any positive effect on innovation. On the contrary, they encourage tax competition among Member States.
- Enforce on a European level health standards and standards of staff and social protection corresponding to people's needs.
- Harmonise upwards, at European level, salaries and work conditions so as to make possible a true freedom of movement for professionals.



For our health

protect the population against commercial abuses

because health and social protection are common goods
and are **not for sale**

Commercial abuses

The reduction or freezing of public spending on the health (and social) sector has an impact on salaries, on the reimbursement of care and on investment levels (in infrastructure, equipment, etc.).

And when public spending is withdrawn, the private, for-profit sector enters, which opens the door for two-tier medicine and commercial abuses:

- **subcontracting**, which most often affects auxiliary services (e.g. cleaning, security, IT, catering, etc.) but also all medical and technical services (lab, RX, etc.)
- **privatisation**, which may be formal (change of legal form) or not (mergers, cross-ownership, privatisation of a public service or a public company, public-private partnership, etc.)
- **the increase in operation costs** with the personal share (out of pocket) of the beneficiary increasing for care, medicines, hospitalisation... which allows for the development of commercial insurances
- **privatization** of buildings, installations, equipment, etc.
- the use of **mechanisms to increase users' choices** of service provider and/or service quality. These include "service vouchers" (for personal care and home services), personal budgets (in particular in the field of care for people with disabilities or loss of autonomy), and the introduction of special premiums to provide a better quality service and faster access to it.
- **new management strategies**, i.e., the use of private sector management methods such as the selection of the cheapest offer at the expense of quality, the introduction of performance indicators and quality ratios, or market comparison ("benchmarking")...
- an increase in **social dumping** due to competition between health care institutions. The regulatory framework is crumbling and staff is becoming an adjustment variable in terms of both number and cost given the proportion of the budget it represents

Who benefits from commercialization?

Health expenditure is higher in a commercial system, such as the United States where 16.4% of GDP is spent on health care, unlike a system that is still largely public and/or not for profit as in France (10.9% of GDP), Belgium (10.2% of GDP), Spain (8.9% of GDP) or Italy (8.8% of GDP)¹.

In the United States, citizens' health expenditures are huge, but the health "performance" outcomes (in terms of life expectancy, morbidity, etc.) are at the same level as a developing country!

The private sector's control over entire areas of health care services further weakens the implementation of public health policies. And integrating the broader determinants of health becomes impossible since the private sector requires immediate profitability and a return on investment.

The European Union's free trade and investment treaties with other countries around the world require the liberalisation of services. These treaties both ensure commercial investment in profitable segments of health services and protect monopolies.

In **Spain**, geographical accessibility is threatened by budget cuts as non-urgent health transport risks becoming a paid service following the Royal Decree of 16/04/2012 which replaces the universal health system with public health insurance.

In **Ireland**, 9 years of economic problems have increased unemployment from 4 to 15%. Health care, in the hands of religious organizations, has seen the number of staff reduced by 12,000 carers and 941 beds. Medicine reimbursement has decreased by 100 million euros and waiting lists have increased from 6 to 12 months.

In **Greece**, the impact of neoliberal policy has been dramatic for public health. 1.1 million people have lost their jobs and 3.3 million live in poverty and are socially excluded.

In the **Netherlands**, the private market has taken over public health. Public insurance has been replaced by private insurance companies because a profit motive for insurances was prioritised. As a result, 50,000 public health workers have lost their jobs.

Within the **United Kingdom** it is the English NHS which has been the main testbed of privatisation since 1984. Three devolved administrations are running different models of the National Health Service (NHS) in Wales, Scotland and Northern Ireland. Scotland and Wales have scrapped England's market system, and largely eliminated privatisation. Even in England, despite setbacks, less than 10% of NHS-funded services are now delivered by the for-profit private sector, private hospitals have barely grown, and many privatised contracts and contractors have failed. The NHS has been defended so far by long and hard campaigning by civil society, and huge support from the public, but still faces real threats.

¹ Statistics of 2013 of the OECD on health, published in 2015

In **Italy**, pro-competitive measures started in the 1990s. Hospitals have become "health care companies" with business practices. Budget cuts have increased patient costs, and vulnerable socio-economic groups are struggling to access basic care. As in other countries, supplementary and private insurances are gradually replacing the universal system. Some sectors have introduced private insurances, complementary to the universal system, into employment contracts.

In **Belgium**, the traditional nursing home sector is increasingly placed in the hands of commercial groups, such as Korian or ORPEA, and turnover huge profits. Home nursing services are listed on the stock exchange. The nursing needs of the Belgian population, especially at the level of home care, are increasing for socio-demographic reasons. While hospital stays are shortened, savings made at the hospital level are not then injected at the extra-hospital level.

Our priorities

- Revise the directives on public services and procurement, applying strict rules on quality and accessibility while excluding commercial operators for all sectors essential for health and well-being
- Ensure that free trade agreements respect the social determinants of health and include social, labour and environmental clauses.
- Preserve the social protection in the face of the appetites of private for-profit insurance companies. Health systems must be financed exclusively by public social protection.
- Enable public operators to maintain all logistic services in the non-commercial sphere, as well as products, services and equipment essential for quality health services (medicines, research, medical equipment, prostheses, etc.)



For our health, guarantee financial, geographical, temporal and cultural accessibility

Different levels of accessibility to care should be considered, the most obvious being the economic aspect as it permeates all the other aspects.

What forms of accessibility are we talking about?

Financial accessibility

In a socialized or state system financed by contribution or by tax, a rule can be applied of "each one contributes according to his/her means and receives according to his/her needs".

Financialized systems on the contrary tend to evaluate the contribution depending on the risk and offer services limited to a "care basket".

In most European countries, the socialized portion is shrinking while the portion of private for profit insurances are growing. The portion of care paid "out of pocket" by people needing care is constantly growing. A person who has a basic health insurance does not receive healthcare of the same quality as someone who has a complementary insurance.

This is two-tier medicine (or even more) inherent to the commercialization of social protection. Wealthier citizens are able to pay for quick, regular and high-quality healthcare provided by private commercial companies while the others must satisfy their needs with what the underfunded public services can offer.

A direct consequence of this is that some must postpone, if not give up, healthcare. The most striking examples are to be found in optical care, dental treatment, prosthesis and medical devices.

People in precarious situations are frequently compelled to give up medically necessary care: diagnoses which are not made or are made too late, chronic diseases which are not treated, all leading to possible complications (diabetes, high blood pressure, heart defect, etc.).

Geographical accessibility

The dominance of profitability and the demands relative to reducing the public debt, the dogma of "free and fair" competition are at the origin of reforms of the healthcare organization (such as hospital restructurings) as well as of the shortage of health services in rural areas. A reversal from an organization based on accessibility depending on isochrone curves is necessary– i.e., a common will to organize healthcare in such a way that no one lives further away than one-hour distance from a high-quality care unit and not farther away than half-an-hour distance from a maternity ward.

The concentration of activities through the specialization and merging of units contributes to moving services offered farther away from the beneficiaries.

In Greece five out of eight psychiatric hospitals had to close, nearly a thousand

maternity wards in France... This decreases accessibility and creates so-called "medical deserts". The longer distances are also the source of expensive journeys to access care.

Temporal accessibility

While waiting times in the public sector grow longer, a "VIP" practice is developing which allows some to skip waiting lines through private but more expensive consultations. Depending on the speciality, the waiting time for an appointment can be as long as 9 months in a public hospital, but the same doctor can give you an appointment within a fortnight for a private consultation, which is of course more expensive. Waiting times for surgery are even longer.

Cultural accessibility

Knowledge of the existing offer of care and of the necessary procedures, of the language, health and hygiene practices... are elements restricting accessibility to healthcare.

The complexity of healthcare and reimbursement systems, people's lack of knowledge of social rights, the restriction

of the reimbursement of care and medicine, the unexpected additional fees... are all contributing to the postponement of healthcare.

The structuring of care via comparative normalization practices prevents adaptation of the system to the unique needs of the public.

Our priorities

The European Union must demand its Member States to ensure adequate funding for public and non-commercial health services, guaranteeing a system of social protection that is inclusive, public and universal and offers accessible, high-quality services

The European Union must aim to reduce social inequalities, in particular regarding health

Sanctions must be implemented for countries that exclude precarious groups from social protection and do not respect the principle of non-discrimination in access to quality healthcare

Activate European funds to promote proximity and non-commercial public health (such as FEADER/FEDER)



For our health, boost health democracy

by involving civil society, workers and beneficiaries
in defining the objectives and means of health policies

Health democracy

Before being a patient or a health professional, we are citizens involved in our environment, and impacted by all determinants of health.

A democratic health policy is a policy that starts from the needs of the population and allows for the population to actively participate in the organization of health systems and social protection.

We have the right and the duty to be actors in our health and this requires information, representation, modes of participation, modes of decision-making.

Populations should have every opportunity to participate individually and collectively in the planning and implementation of their health. This participation must represent the entire population, without discrimination on the basis of age, gender, disability, ethnicity or socio-economic status.

The evaluation of the health care system and its funding must be democratic and focused on health performance rather than financial results!

Patient participation

Patient participation has several advantages: better quality of care, better patient autonomy, better patient compliance with treatment, better management of resources, etc.

This not only refers to individual but also collective participation.

So, how is this organized in practice?

In the Netherlands, patient associations are long-standing and numerous. They can be specific and linked to a pathology or a disability or more general and focused on care at all levels and in its various aspects. They can also be in the form of platforms that bring together both types of organizations. Associations are considered to be "third parties" alongside health care providers and insurers. There are also patient councils (cliëntenraden) associated with the organisation of health care institutions. Funding is provided for the proper functioning of this system.

In France, a law organizes the participation of user associations through national and regional accreditation. Their role is only advisory. There is also the Collectif interassociatif des soins de santé, which brings together patient associations and other representative organisations (families, consumers, etc.) and plays a significant role in terms of consultation and decision-making. Although the legal framework exists, its application is not very effective due to lack of resources.

In Belgium, the movement of health service users was born about thirty years ago, first with specific associations (Fight against cystic fibrosis, for example).

Since its emergence, movement has become structured, and today there are two federations: the Ligue des Usagers des Services de Santé (LUSS) and the Vlaams Patiëntenplatform (VPP).

The funding of these associations is fragmented, not very structured and based on internal resources (fundraising, donations, or other contributions), private sponsorship. There are also public subsidies but especially for large associations. For example, the LUSS and the VPP are federally recognized and subsidized, which allows them to be present in different policymaking bodies.

What about accountability?

A common response from current authorities is that by making beneficiaries and/or providers financially accountable, care practices and "consumption" can be oriented.

It is necessary to create a mode of accountability of beneficiaries and providers within the framework of participatory democracy.

Prevention must replace guilt and the method of financing must avoid linking income to the number of interventions performed.

Our priorities

- Consider health democracy as a determinant of health
- Ensure a horizontal relationship with beneficiaries and collaboration between all relevant actors and disciplines

- Consider patients as partners
- Promote the development and recognition of patient associations
- Make patient participation a reality in democratic health systems...
 - in the relationship between patients and care providers;
 - in healthcare institutions where patients must be involved, as well as other stakeholders in decision-making in the various bodies and participate in the collective life of the institution;
 - at the political level, with institutionalized and permanent consultation mechanisms to be developed from bottom up, through systematic consultation of patients' organisations by the political authorities, prior to the implementation of new measures and their representation in the various decision-making and advisory bodies;
- Strengthen and develop prevention policies that are primarily collective
- Prohibit linking patient behaviour to access to care, including reimbursement;
- Make political decisions consistent with public health issues, excluding the intervention of for-profit lobbies.

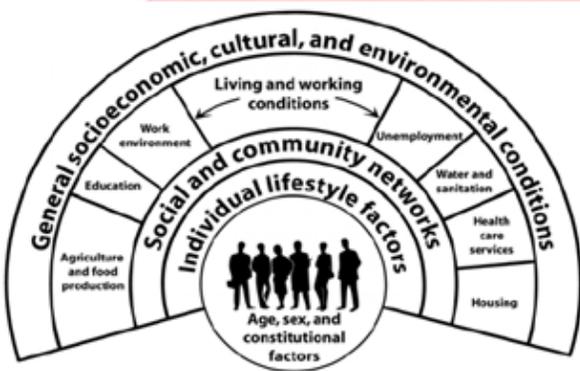


For our health, improve social, environmental, ecological and gender determinants

Determinants of health

Many interrelated factors influence health: not only factors such as age and gender but also socio-economic class, education, housing, employment status, working conditions, nutrition...

These are the "social determinants of health" (see illustration). Their influence on the health status of a population is much greater than health care itself.



This is where inequality comes in.

As a result, those with the least financial means to pay for health services are the most likely to need it at some point in their lives.

The current economic and political system shapes the conditions for improving these social determinants of health, for example through its environmental and housing policies, food and medicine prices and access to clean water.

To reach a structural solution, it is necessary to focus not only on the factors that have an impact on health, but also on the processes that determine their unequal distribution in society.

This includes, the right to employment and a decent income, the right to housing, access to drinking water and energy, equality between men and women (with particular attention to protecting women's health), the right to education, culture, clean air, nutrition, a protected natural environment, regulation of working conditions that protects employees and links employers...

In **Belgium**

Morbidity and mortality are very unevenly distributed.

According to a recent report of the European Commission on the state of health in Belgium, people with a higher education diploma live on average five (for women) to six (for men) years longer than people without a diploma, and also enjoy a longer life expectancy in good health.

And the more marked the socio-economic gaps are, the more the number of people suffering from mental illness, early pregnancy, psychotropic drug use, cardiovascular problems, etc., increases in a given territory.

Mortality before pensionable age is 2.3 times higher among the vulnerable than among the affluent.

Similarly, gender is a cross-cutting determinant in that it influences other social determinants (income, autonomy, education, etc.), but it has also to be specifically taken into account in policies relating to areas such as maternity, contraception, etc.

In Spain

According to the Office of the High Commissioner for Child Poverty, Spain is the country where inequalities have increased the most compared to other European Union countries.

In 2018, three out of ten children lived in poverty. (Foessa Foundation report <https://caritas-web.s3.amazonaws.com/main-files/uploads/2018/09/Ana%CC%81lisis-y-perspectiva-2018-digital-.pdf>)

The causes of this situation are easy to grasp: an unemployment rate of 24.1%, job insecurity, pensions "frozen" for years and reaching only €8,200 per year.

The consequences are significant. For example, 15% of the population cannot heat their homes in winter; thousands of people have been evicted for not paying their rent; many people can no longer afford to pay for the medicines they need.

Our priorities

- There is an urgent need to recognize the interconnections between environmental protection, the economic system and social justice in our societies.
- The EU has a central role to play in improving health by addressing root causes such as social, environmental, ecological and gender determinants of health.
- Member States and Europe must put in place an intersectoral approach to policies by assessing the health consequences of each decision in all sectors, in line with the WHO recommendation « health in all policies. » https://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf
- At the collective level, impose the analysis of health involvement on all social, economic, environmental, cultural and other policies.
- At the individual level, decompartmentalize the approach to health and contextualize it in our history and in our global environment (family, work, place of life,...).



For our health, orient medicines policy to the service of the population

Under the present system, drugs are developed, produced and marketed by commercial companies whose profitability takes priority over public health.

The pharmaceutical industry's monopoly position over medicines, granted to them through patents, and patients' growing expectations for access to new and innovative medicines force States to accept baseless financial conditions.

Public spending on medicines increased by 76% in European Union Member States between 2000 and 2009 due to the rising cost of medicines.

As a result, spending on pharmaceuticals has placed a great amount of pressure on the budgets for the social health system in all European countries.

At the same time, the profit margins of pharmaceutical lobby groups are constantly increasing, coming close to 20%.

These groups have become one of the most powerful actors in the economic sector.

The pharmaceutical lobby spends at least 40 million euros a year at the European level. That's fifteen times more than the lobbying expenditures of public health civil society groups.

Different mechanisms at the European level have led to the increase of public budgets for drug spending:

Protection of the economic interests of the

pharmaceutical industry through **free-trade and investment treaties**

During free trade and investment treaty negotiations, such as the TTIP and CETA among others, many provisions are drafted according to the pharmaceutical industry's wishes, for example: the exclusivity of clinical trial data or the strict information confidentiality requirements placed on companies with the threat of severe penalties for breach.

The arbitration tribunal proposed in these treaties is a very telling example of how the public interest is penalised to the benefit of multinationals' economic interests.

The granting of European subsidies via public-private projects

Under the impetus of pharmaceutical lobbying, the European institutions funded a public-private project of 5.3 billion euros that advantages the pharmaceutical industry (Innovative Medicines Initiatives).

Commercial companies generate profit margins from new medicines they develop using the results of research funded by Europe or the States.

Yet, the pharmaceutical companies can determine their preferred prices of drugs, although they were developed with the support of the European Institutions, without having to take into account the actual (lower) cost to them of production and development of a drug.

The patent system

The mission of the European Medicines Agency (budget of 330 million euros) is to evaluate and monitor medicines in the European Union in the interest of public health.

On several occasions the Agency has been accused of being subordinated by industry interests and of lacking transparency, contrary to its entrusted mission.

Surveys conducted in recent years show that only just over 10% of new medicines on the European market offer real advantages over existing medicines.

This means that 90% of new medicines provide almost no added value but the industry is still allowed to obtain new patents, thus preventing cheaper generic drugs from coming onto the European market.

Once an authorization for a new drug has been granted by the European Medicines Agency, the price and terms of reimbursement are fixed by the Member States' national authorities.

Currently, after a medicine is developed, its price is set in top secret agreements concluded between a country and the pharmaceutical company.

This opaque system removes pressure from the industry to reduce the public price of a product in the country where the agreement is signed and works in the industry's interest to not jeopardize price negotiations with other countries.

In this system, citizens have no control or information about the quality or cost of the drugs they are prescribed.

Such high prices affect overall reimbursements of health care systems.

To limit the inexorable growth of health

expenditures and under the pretext of making patients accountable, reductions are regularly announced: reduction of the coverage rate by health insurance of health expenses, reduction of hospital budgets, reduction in reimbursement of medicines and medical interventions...

These measures favour health system privatization through an increase of the private financing of health risks: the transfer of the charge of financing medicines and medical goods to supplementary health insurance has increased in all European countries.

In France it went from 5.3% in 1980 to 13.3% in 2015.

This year again, the French government has announced a billion euros in savings on medicine expenditure. However, laboratories do not necessarily lose. Currently, laboratories decide whether or not to produce certain drugs in sufficient quantities, causing shortages or imposing substitution with more expensive specialties.

Innovative medicines

There is a lack of collaboration on the European level around price-setting negotiations for medicines.

The multinational Gilead owns the patent for Sofosbuvir. Worldwide, 325 million patients are suffering from hepatitis C but many of them do not have access to this treatment because of the price.

The production cost for one Sofosbuvir treatment is 100€. The selling price is £30,000 in the United Kingdom, \$84,000 in the United States, 40,000€ in Belgium and 41,000€ in Italy and France.

The research for this treatment was conducted by a public university; the results were then purchased by Gilead.

The result for Gilead: after less than a year of marketing, all investment costs have been repaid.

In Italy secret agreements between the Minister of Health and the pharmaceutical industry are wreaking havoc on health care budgets.

The negotiated price for Sofosbuvir, prevents all patients suffering from Hepatitis C from receiving treatment while at the same time making the cheaper alternative treatments inaccessible.

Today there are long waiting lists for this treatment, varying greatly from one region to another, while for the purposes of public health, the widest access this treatment is essential in order to stop the epidemic and to prevent new infections.

In Belgium, since 2015, the costs of new treatments and innovative medicines threaten the balance of social security, with a budget overrun of 200 million euros every year.

This mainly concerns so-called "innovative" medicines negotiated directly between the cabinet of the Minister of Health and a pharmaceutical company via the Article 81 procedure.

This procedure allows the parties to conclude ultra-secret agreements without any democratic transparency while being very advantageous for the pharmaceutical industry.

As previously explained, a secret agreement in one country guarantees that negotiations in one country do not interfere with those another country in order for the company to obtain the maximum price for a medicine.

In 2017, one billion euros was spent in Belgium for some 81 medicines covered by the Article 81 procedure.

This represents almost 25% of the total budget of medicines!

In France, drug prices are also rising sharply. The price of anti-cancer drugs has doubled in 10 years.

Opdivo (treatment of melanoma), refused in the United Kingdom because of its cost, has been accepted in France at 79,000€ per treatment.

The provisional price (before price fixing) of two new anti-cancer drugs is 300,000€ per patient.

The amount of spending on anti-cancer drugs went from \$24 billion in 2008 to \$80 billion in 2014, making oncology the most profitable therapeutic area for the

pharmaceutical industry today. The National Cancer Institute's 2017 projections expect to see between 6% to 8% growth per year.

Our priorities

- Essential medicines must be "accessible, available, affordable, of good quality and well-used to meet the needs of billions of people in Europe and around the world.
- In the case where a generic resource is available, it must be given priority through public procurement. When a drug is sold at an abnormally high price, the production of copies of drugs before the expiry of the patent should be made possible through compulsory licenses. And accordingly, the use of compulsory licenses should be facilitated.
- European institutions, such as the European Medicines Agency and the European Commission, must support the development of new models of research and development,

- production and distribution of quality products, such as principles based on "open science" and socially responsible licenses, in accordance with medical and societal needs, and not subject to the financial aims of pharmaceutical companies. International cooperation should be encouraged and public funding should be provided at the necessary level.
- Member States and European institutions must collaborate better to assess the value of a new drug, the cost of its development and access to all relevant information.
- Better determine the innovative nature and societal and therapeutic need in relation to alternatives already available on the market for medicines (e. g. generic and biosimilar medicines) in order to negotiate prices and ensure access to them at European level, without creating competition between countries.



The impact of EU policies on the privatisation of healthcare

Sabina Stan (DCU and UCD, Ireland)

The increasing privatisation and marketisation of healthcare services across the European Union (EU) is usually seen as the result of national politics and policies. After all, the EU has only limited legal competences in healthcare.

Over time, however, EU institutions have carved significant spaces of intervention in healthcare. Access to health services is now a European citizenship right, notably for people who travel or move to another EU member state. But there are also ever more EU prescriptions that put pressures on member states to contain or even cut public health expenditure, and prescriptions that favour the marketization and privatisation of healthcare, notably since the adoption of the EU's new economic governance regime during the Euro crisis in 2011.

Even so, the EU should not be seen as an agent 'out there' who single-handedly imposes policies on member states. The major EU institutions (Commission, Council and European Parliament) either directly draw on or are closely connected to national politicians and interest groups. Most initiatives proposed by the Commission have to be adopted by the Council and at times also by the European Parliament.

This means that EU healthcare policies should be an important target of labour and social movements' struggles against the privatisation of healthcare. Nonetheless, we should also acknowledge the fact that the actors behind European healthcare policies are situated at both EU and national levels.

Here, we will look more in detail at EU interventions in healthcare since the 2008 crisis.

The European Semester and prescriptions to privatise healthcare in Europe

In 2011, the Euro crisis led to the adoption of a "Six-Pack" of EU laws, which triggered the set-up of the European Semester (ES) as a new mechanism of macroeconomic policy coordination among EU member states.

The ES is allegedly aimed at preventing the occurrence of future crises in the EU by keeping MSs' debt and deficit levels under certain thresholds through the tight monitoring and surveillance of their fiscal policies and structural reforms.

Compared to the pre-crisis period's weak macroeconomic surveillance mechanisms, and in addition to incorporating the 'soft' social policy coordination under Europe2020 strategy, the post-crisis ES relies on stronger, more vertical interventions.

These include most notably an upgraded Excessive Deficit Procedure (EDP) and a novel Macroeconomic Imbalance Procedure (MIP).

The two procedures benefit from harsher sanctions (up to 0.2% of a MS's GDP for the EDP and 0.1% for MIP) and a more difficult mechanism (i.e. through qualified reverse majority) for the reversal by the Council of sanctions proposed by the Commission.

During the European Semester's annual cycle, each MS receives a number of Country Specific Recommendations (CSRs), which are adopted by the Council following proposals by the European Commission. CSRs basically offer a set of distinct policy prescriptions pertaining to fiscal policies and structural reforms, and are variously underpinned (in legal terms) by the EDP, the MIP or Europe2020 strategy.

The *constraining power* of prescriptions is *weak* if underpinned by Europe2020 strategy (at the latter involves no sanctioning mechanism) and *strong* if underpinned by the EDP and/or the MIP. The *strongest constraining power* is when policy prescriptions underpinned by the EDP and the MIP are made for MSs for which the EDP or MIP have been started (as the outcome of these procedures may include sanctions).

Health expenditure accounts for a significant part of government expenditure (15.3% on average across the EU in 2016). It is then no surprise that healthcare has been importantly impacted by European Semester's policy prescriptions.

First, healthcare has figured not so much in the 'soft' prescriptions underpinned by Europe2020 strategy, but mostly in those more constraining prescriptions underpinned by the EDP and the MIP. Moreover, public health services have come under the remit of the European Semester not only through explicit healthcare prescriptions (i.e. those who mention 'healthcare' in their text) but also through prescriptions on public finances and/or public sector resources (e.g. regarding employment and wage levels in the public sector).

Several analysts as well as the Commission have presented the European Semester as having undergone a gradual 'socialisation' of its prescription and overall character.

This socialisation seemingly includes the increasing participation of 'social actors' (like the 'social' Directorates General of the Commission: DG Employment or DG Santé) in the drafting of CSRs, but also the increasingly 'social' (as opposed to economic or fiscal) character of the ES's policy prescriptions. Other analysts saw this 'socialisation' as being more problematic, given the pre-eminence of fiscal consolidation aims among prescriptions affecting social provisions and services (including healthcare), and the ambiguous formulation of prescriptions that could be seen as being oriented towards 'social investment' aims.

In order to evaluate the policy orientations of healthcare prescriptions in the European Semester, I have undertaken a study of 'healthcare prescriptions' for four countries, namely Germany, Italy, Ireland, and Romania. I started from the premise that these orientations have been built in time, starting most specifically during the troubled beginnings of the ES in the heat of the 2008 financial crisis and 2010 Euro crisis. Indeed, it is during these first few years that the EU legislation underpinning the post-2011 EDP and MIP (namely the Two- and Six-Packs of EU laws) was adopted.

Moreover, already in 2009, several countries both inside (i.e. Ireland) and outside (i.e. Romania) the Eurozone were submitted to the conditionality of EU/IMF funding. In doing so, these countries offered a testing ground for a series of interventions in areas (such as healthcare) which up to then have been seen as protected from direct intervention on the part of EU institutions. My analysis therefore dealt with healthcare policy prescriptions between 2009 and 2017.

These prescriptions were included in both Memorandums of Understanding with the Commission and the IMF (for Ireland and Romania, between 2009 and 2015), and in the post-2011 CSRs adopted by the Council for all four countries.

The analysis shows that, far from being ambiguous, healthcare policy prescriptions take a definite direction.

While the most prevalent prescription for the four countries has been the somehow vague invitation to 'increase cost-effectiveness in healthcare', this prescription has been directly linked (in the text of the documents) to a series of other prescriptions that go quite explicitly in the direction of a reduction of public spending in healthcare and/or the marketisation of the allocation of these resources.

Both types of prescriptions promote a diminished scope for public health services and the increase in private actors' involvement in the funding, delivery and management of health services.

In contrast, in the whole corpus of prescriptions analysed in the study, only a few, and also more recent, prescriptions could be seen as being more 'social'. Tellingly, these prescriptions are not only numerically marginal compared to the pro-marketisation and privatisation ones, but are also vague, imprecise, and lack the sometime precise targets of the latter. Finally, prescriptions pro-public health services have little constraining power, as opposed to most pro-privatisation ones' high constraining power.

Thus, we may conclude that, for the four countries analysed in the study, the European Semester has been a mechanism which generated prescriptions

pressing for the privatisation and marketisation of health services rather than for the reinforcement of the public character of their funding, delivery and management.

Conclusions

EU-related processes and mechanisms have led to increased pressure on public finances and public health expenditure either in an indirect, spill-over form (as during the set-up of Economic Monetary Union and the eastwards enlargement processes) or in more direct manners (as in the post-2009 MoU conditionality, and post-2011 EDP and MIP prescriptions).

In the last decade, the EU has thus moved on towards more direct interventions in healthcare in the name of fiscal sustainability. These interventions have also been predominantly directed towards the privatisation and marketisation of public healthcare.

The last few years' return to economic growth has been translated in most countries leaving the EDP and MIP, and the European Semester prescriptions becoming lighter and also more 'social'. The mechanisms are however in place for when the new crisis hits to re-tighten pressures towards fiscal discipline.

Given the history of the ES, it is most likely that this discipline will involve new rounds of healthcare privatisation. Or not. But for the latter to occur, we need the building of solidarity against the further privatisation of healthcare and corresponding retrenchment of its public character to continu

