



OUR HEALTH IS NOT FOR SALE

EUROPE - 7 APRIL 2018

European action day against the commodification of health

In view of the European elections in May 2019, we launch the campaign:

ALL FOR HEALTH

ONE YEAR TO SAY NO TO THE COMMODIFICATION OF HEALTH

#health4all

Join us to say that our health is not for sale!
Distribute this flyer before the 7th of April
Join the actions in your city/region
In the week of the 7th of April, hang a white sheet with your message against the commodification of health at a window of your home, health centre, work place
Take a picture and share it on social media with the hashtag #health4all



More info:
Facebook: Réseau Européen Santé - European Health Network
Twitter: @EUHealthNetwork
Website: europe-health-network.net

Health commodification is on its way...

Postponement of care

A growing proportion of the European population is being forced to postpone or even simply abandon care.

We talk about “barrier-abandonment” when a person is faced with an environment of constraints that do not allow them to access the necessary or desired care. This becomes the case when the system of social protection and the organisation of health care provision is no longer accessible to all, particularly for budgetary reasons.

The financial reasons that cause people to renounce care consist of a range of factors that are often intertwined: the price of care; the level of reimbursement and the patient’s personal share (on patient charge/out-of-pocket/co-payment) which vary according to the type of social protection and the quality of coverage; the person’s level of income; and the availability of financial resources at the time of need, in particular when the individual must advance the costs themselves. These costs often have to do with resources (income, reserves, allowances) and other non-medical expenses, especially fixed costs related to care. In the case of renunciation for financial reasons, indi-

viduals most often renounce specific care, with a variable frequency depending on their social situation.

For people in precarious situations, renunciations frequently involve medically necessary care resulting in undiagnosed conditions, late diagnosis, or chronic unmanaged diseases that can lead to complications (diabetes, high blood pressure, cardiac malformation, etc).

The complexity of health care systems and reimbursements, the lack of awareness of social rights, restrictions on reimbursements of benefits and medicines, unannounced fee supplements...these are all factors that amplify the postponement of treatment.

Reforms in the organisation of care (e.g., hospital restructuring) and the scarcity of supply in rural areas are further reducing accessibility, especially for vulnerable populations who are forced to postpone or abandon care.

Source : <http://www.irdes.fr/Publications/2011/Qes169.pdf>

Private health insurances

While the majority of OECD countries grant their citizens access to health care, this right is increasingly threatened, on one hand, by cuts imposed by austerity measures and implemented by States, and, on the other hand, the market interests of insurance companies and private health-care providers.

As citizens struggle more and more to access health care due to financial barriers (e.g., the increase in co-payments), private insurance companies come into play offering the individual protection that the State no longer guarantees. While this may seem to be a solution to ensure access to care and protect individuals and families from catastrophic healthcare expenditures, we know from the experience of the United States that this is not the

case. These private insurance plans thresholds that patients have to meet before either being eligible to receive reimbursement (deductible) or for costs that exceed the maximum amount the insurance plan will pay (maximum benefit).

Moreover, private insurance fosters inequality: while in public systems there are redistribution mechanisms (e.g., in tax-based systems the rich pay more while the poor usually need more service), with private insurance those who pay more gets more and better services. This means a complete turn-around from solidarity-based systems and the idea of health as a common good towards a vision of health as a commodity that individuals and providers negotiate on a private market.

Multinational pharmaceuticals industry

Pharmaceutical lobbying claims to spend at least €40 million a year at the European level, which is 15 times more than the public health lobbying expenditure of civil society. Pharmaceutical groups' profit margins, almost 20%, are amongst the highest of all industries.

Both marketing and lobbying at the European level and in the Member States of the Union result in citizens having to buy their medicines at increasingly higher prices. It is therefore up to patients and national healthcare systems to pay the prices imposed by multinational pharmaceutical companies, a policy supported by our governments!

How is this possible ?

Our governments have set up a research and development model that allows a pharmaceutical company to set prices through the patent system without having to take into account the real cost of developing and producing a patented drug.

At the same time, pharmaceutical lobbyists seek to influence European laws under the guise of representing experts and advisers with little transparency about meetings and their impact on legislation.

A discourse on the cost of developing "innovative medicines" created by the pharmaceutical lobby, induced the European institutions to start up a public-private initiative (IMI) between the EU and the European Federation of Pharmaceutical Industries and Associations (EFPIA). Through this initiative, €2.6 million of European taxpayers'

money has largely gone to EFPIA for research and development of medicines. EFPIA is the largest pharmaceutical lobby group in the European Union, bringing together the largest multinational pharmaceutical companies.

After the development of a new medicine, ultra-secret agreements are concluded between a State and a pharmaceutical company in order to fix its price in that country. This opaque system allows industry to avoid reducing the retail price of a product in the country where the agreement is signed and to also avoid jeopardizing price negotiations in other countries.

As a result, citizens no longer have any control or receive any information on the quality and cost of drugs prescribed to them. At the same time, cost-saving measures are being imposed on healthcare professionals and patients throughout Europe to compensate for the ever-increasing margins of pharmaceutical companies.

There is a need for better collaboration between EU Member States to assess the value of a new medicinal product. Member States must join forces with the European institutions to negotiate tariffs and to access all relevant information (costs underlying prices and clinical information) in order to determine better prices (innovative nature in relation to the alternatives already available). To preserve a non-commercial health care model that is accessible to all, we must move towards another model that no longer generates Big Pharma monopolies that curb competition between generic and biosimilar products.

Outsourcing or subcontracting

In hospitals, logistical or support functions such as kitchen, sterilization, laundry, cleaning, technical maintenance, IT, and others are progressively outsourced to private companies.

Technical services such as clinical biology or medical imaging are also outsourced through a grouping treatment activities.

The reason commonly cited for outsourcing or subcontracting is to allow for other costly investments. However, there has been a shift towards the commercial private sector, where the primary social purpose of «health» activity no longer has a place.

Market logic is deployed widely with a concern for immediate profitability.

We are witnessing the imposition of well-defined rules: reducing personnel costs to the minimum by increasing their versatility, reducing raw material costs even if quality is no longer present.

The patient is supposedly the central concern, but managers do not care much about the quality of services, food, environment.

Imposing cost-saving measures can also have an impact on the safety and health of workers.



Health and social protection are not for sale...

nevertheless, health commodification is on its way throughout Europe

Cuts or freezes in public spending in health (and social) sectors have an impact on :

- salaries and working conditions of nursing staff,
- reimbursement of benefits and medicines,
- levels of investment (infrastructure, equipment, etc.)
- ...

Under the guise of “therapeutic freedom”, health commodification limits the ability of public authorities to choose a service provider or high quality of service.

Privatization

- Formal privatization/change of legal form of public service or public enterprise
- Privatisation of infrastructure: private companies purchase buildings through private financing initiatives or contractual or institutional Public-Private Partnerships (PPPs) (e.g. for the construction of buildings, facility management, etc.)

Direct competition between public/non-profit operators and commercial operators, through imposed public procurement and concession procedures.

Increase in operating costs: the share remaining to be paid by the beneficiary increases for care, medicines, hospitalisations...

Vouchers for personal services or budgets (especially relating to care for people with disabilities): an allowance is given to the beneficiary, who chooses his or her provider, at cost price. This puts non-profit providers in direct competition with commercial providers.

Private for-profit health care providers impose themselves and take over the most profitable activities

Subcontracting of services

- first auxiliary services (e.g. cleaning, security, IT, catering, etc.)
- medico-technical services (laboratories, RX, ...)
- housing, with private care hotels attached to hospitals

Use of private sector management methods («New Public Management») such as selection of the cheapest offer at the expense of quality, introduction of performance indicators, quality ratios, market comparison (benchmarking),...

Decentralisation/Regionalisation: solidarity is reduced to a smaller area, which prevents solidarity between richer and poorer regions.

Private insurance is invading the social protection market. Introduction of special premiums to provide better service and faster access to care.