Economic policies and fiscal consolidation in Europe in the wake of the economic crisis
Implications for health and healthcare access

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Table of contents:

Economic crisis in Europe
Social consequences
Focus on Greece
   Economic crisis in Greece
   Social crisis in Greece
   Epidemiological and health crisis in Greece
   Health crisis and restrictive health policies in Greece: a lethal combination
Analysis
Conclusion
References
Figures and tables
   Figure 1: Average economic growth in G-7 since World War II
   Figure 2: Basic economic indicators, Greece 2001 – September 2012*
   Figure 3: Basic social indicators, Greece 2004 – September 2012
   Figure 4: Infant mortality rate, Greece 1990 – 2011
   Figure 5: Suicide mortality rates by sex and age group, Greece 2000 – 2010
   Figure 6: Problem drug users (heroin as primary substance of abuse) by age group, Greece 2006 – 2010
   Figure 7: Patients hospitalized in public hospitals, Greece 2000 – 2011*
   Figure 8: Prospected revenues from a 2% tax of financial wealth above 750.000 Euro, 1997 – 2011
   Table 1: Private health expenditure by type of service, Greece 1998 – 2010
“Those opposed to the welfare state never waste a good crisis” [1]

Economic crisis in Europe

Until recently, Europe represented the successful combination of stable and strong economies with strong social protection.[1] After World War II, internal and international power relations promoted the accelerated development of social security systems and national health systems that had been at the center of workers’ struggles over most of the continent. A strong US economy stimulated rapid world-wide economic growth, including in Europe. The 1950s and ‘golden sixties’ saw sustained economic development and growth in productivity. Salaries went up and social protection measures were further enhanced. The period 1945-1975 was called "the 30 glorious years" by the French liberal economist Jean Fourastié.

But from the early 1970s things began changing. Markets reached the point of saturation in many parts of the continent and profit rates started decreasing. The first signs of an overproduction crisis appeared. Times were changing. The OPEC decision to drastically increase oil prices exacerbated economic tensions, leading to a full blown crisis.[2] This was no cyclical recession, considered ‘normal’ in a capitalist economy. Since 1973, the global economy shows clear trends of long-term decline.[3] (Figure 1)

It was the start of the third structural crisis in the history of capitalism. After 1873, a first structural crisis affected the great capitalist powers. It ended with the mass export of capital and a clash for a share of the colonies, leading - in the end - to the First World War. The second structural crisis took place after the crash of 1929 and  

1 The methods and means, based on economic plunder and aggression, through which these strong capitalist economies were able to develop over the centuries, are not included in this analysis.
led to the outbreak of the Second World War. Now, this, the third structural crisis is manifest in all its dimensions.[4]

As the saturation of industrialized country markets became a constraint for further growth, fierce competition between transnational corporations forced them to cut costs and to find new markets. Over time this was done through different strategies: during the 1970s the South was the oxygen for getting rid of the overcapacity and massive exports eventually led to a stifling Third World debt. For decades, the interest on the debt ensured an important source of income for the big capitalist countries, while also providing the pretext for organized plunder through structural adjustment and neoliberal policies.

During the 1990s restructuring of transnational companies was the second strategy that was designed to shore up the faltering capitalist economy.[5] At home these firms were supported through tax reductions and privatization programs. Abroad, developing countries were forced to accept further liberalization, deregulation and privatization, providing transnational corporations an outlet for their excess goods and capital. The health sector was not an exception -- its profitable parts were increasingly privatized.[6][7][8]

These maneuvers masked the decrease of the purchasing power of Western economies, and most importantly of the US, whose consumption represented 25-30% of the aggregate global GDP.[9] This consumption needed to be maintained by increasing credits and debts in different ways, of which the most prominent was related to real estate -- the famous 'subprime debts'.

This third strategy was based on enormous growth of 'fictive capital' fueled by speculations (in stock markets, real estate, etc.).[10] This frenetic pace of money creation exceeded the capacities of the real economy to create the wealth needed to ensure its material basis. This strategy was the last throw of the dice, beyond which the global capitalist economy has been unable to invent new means to sustain even the illusion of growth.[11]
At the European level, important measures were taken from 1985 onwards. A common market was set up in 1990 and the Maastricht treaty was signed in 1992. Privatization of the public sector accelerated rapidly during the 90s. In 2002 the Euro was introduced. Not without fierce popular resistance, the Lisbon Strategy (intended to deal with low productivity and stagnation of economic growth in the EU) was developed in the first decade of the 21st century.

Increasing exports were crucial for sustenance of economic growth in Europe. Germany is the key exporting nation in Europe. It is also the strongest economic power in Europe, as well as the motor of monetary unification in the continent. Through its exports to the rest of Europe, Germany became the biggest beneficiary of the Euro. Its profits were gained at the expense of – mainly – the peoples in the south of Europe. The economic crisis in countries such as Greece, Italy and Portugal and the trade surplus in Germany are two sides of the same coin. Large swaths of national industries in Portugal, Greece and Italy, unable to compete with cheaper imports from Germany, have been wiped out.[12] Some of the important factors underlying the competitiveness of German exports have been its domestic policies – such as wage reductions and cuts in social protection measures. The wage reduction of the workers, imposed to improve their competitive advantage at international level, leads to a further decrease in demand, which deepens the crises. European austerity policies make populations pay, but don't solve the problem.[13][14]

Now these policies, adopted by Germany, are presented as examples that the rest of Europe should follow. Individual countries in Europe are, thereby, denied the scope of developing sovereign financial policies. National policy making space is further eroded as access to loans (not to support people in distress but to bail-out banks) are linked to fiscal measures that countries in debt are required to adopt. [15] Today’s crisis is used as an opportunity to break all resistances and impose an even more radical process of the same neoliberal ‘solutions’ which brought about the crisis in the first place. The privatization of lucrative parts of National Health
Systems and other public services has been a stated objective of the EU since many years. But today, as we describe below, this process is being aggressively pursued in several parts of Europe, including England, Portugal, Italy, and Greece.

The present recession in Europe is linked to the functioning of the capitalist system itself, based on the need for continued growth in a situation where the possibilities for increasing consumption are increasingly limited. The only ‘solution’ within the logic of present day capitalism lies in selling more to earn more to produce even more – a solution that gets short circuited when the purchasing power of the buyers is increasingly compressed.[16]

When overproduction occurs, surplus of capital follows. This excess cannot be used to increase production because it stands in contradiction to limitations in the growth of the market. This surplus capital, in search of high returns, then finds recourse in financial markets that were promoted by financial deregulation and the creation of new financial instruments. The whole bubble was encouraged even further through excessive credit stimulus, as granting credit is a way of creating money out of nothing.

In September 2008 the bubble burst. In the US, over two million house owners lost their homes as a consequence of the financial system being unable to sustain the credits provided on home loans.[17] A Cascading crisis resulted and across the world over 1,000 billion USD worth of bonds became virtually valueless. Big banks declared huge losses in large parts of the capitalist world. Several countries come to the swift rescue of their banks, governments from London to Berlin nationalized or bailed out the faltering banks.[18] In consequence, the (private) bank debt now becomes a problem of the state (i.e. of all of us), combined with an escalating economic crisis.[19][20]

From late 2009, fears of a serious debt crisis developed in many countries in Europe. In several countries private debts arose from a property bubble, and put the banking system under pressure (e.g. Caja de Ahorro - ‘Savings Bank’ - in
Spain). From 2012 onwards the EU organized a bailout of these banks. Over the same period, the slowing post-bubble economy led to a massive increase of public debt.[21] Moreover, the downgrading of government debt on the international markets led to a dramatic increase of interests on debt. Overall cuts in public and social expenses have been resorted to as a consequence of the high levels of government debts. These have, however, added to the crisis as they led to a further decrease in purchasing power.[22]

Social consequences

The actual European answers to the world-wide crisis are premised on the strengthening of market-mechanisms, combined with competition between countries to lower production costs, fiscal policies aimed at bailing out banks and corporations and ‘social dumping’. The inevitable consequences have been decreasing purchasing power of the population, decreasing public investments and a steady breakdown of social protection mechanisms.

In October 2012 the unemployment figure for the EU was 10.7%, an increase of 3.6% compared to 2008. Young people are affected the most. Of the potentially active population in the EU between 15 and 24 years, in September 2012 22.8% were unemployed.[23] In 2011 more than 24,2% of the EU population (near to 120 million people) was at risk of poverty, with women having a 2% higher risk than men. Having a job is no longer an insurance against poverty: 8.7% of the workers in 2011 were below the poverty line and 1/3rd of the poor were ‘working poor’. [24]

The dramatic public debt and the supposed ‘unsustainability’ of health and social security systems is used as an argument to push for further privatization. While the social consequences of the crisis (joblessness, housing problem, increasing poverty, etc.) are determinants for dramatically increasing health needs, healthcare is progressively transformed from ‘a human right to be ensured by the government’ to a commodity for those who are able to pay. Governments across Europe are colluding in the decision to transfer power and resources to private capital, and the tension between citizens’ interests and private capital are growing.
In the **UK** the government has allowed corporations to enter healthcare by implementing a series of incremental and far reaching legal changes designed to allow the entry of capital. These changes, justified as a necessary part of austerity and cuts, included the accounting and creation of corporate hospital trusts with new powers to charge, change in ownership and mechanisms for diverting funds to private sector, deregulation of staff and terms and conditions of service, privatization of services and staff. In 2012 the Health and Social Care Bill was published, which will end the NHS in April 2013 paving the way for a mixed funding system and corporate driven healthcare.[25]

In **Portugal** official unemployment reached 15%, but the reality is much worse. Troika-measures pushed towards decreasing salaries, pensions and unemployment benefits, with overall tax increases. Important parts of the public sector have been privatized. The National Health Service is in a crisis.[26] Co-payments went up drastically, causing a decrease of 900.000 first line consultations and half a million emergency consultations between January and October 2012 compared to the year before, while ‘rationalization’ of medicine use implied heavy price increases.[27] Privatization is underway and many health workers are losing their jobs.

Founded in 1978, the **Italian** National Health Service (NHS) represents a long lasting feature of the welfare system in the country. In line with the ‘80s-’90s global health reforms, pro-competition measures were introduced and users co-payments increased in the early ’90s; hospitals became ‘healthcare enterprises’, with the explicit goal of introducing business-like practices in healthcare organizations.[28] Today, budget cuts (over € 20 billion since 2010) are heavily affecting the sector, leading to increased user fees, removal of benefits (reduction in specialist care and drug prescription), and decreased accessibility -- particularly for vulnerable socio-economic groups.[29] In a recent survey, 21% of households declared a decrease in health-related expenditure, 10% had postponed surgical treatments for financial reasons, 26% reported increased expenditure in cases of emergency due to higher co-payments.[30] Combined with the effects of the crisis itself, the present fiscal
policies are likely to lead to a further deterioration of overall health indicators and increase inequalities in access to care and in population wellbeing.[31] Moreover, as government officials state that the NHS is no longer sustainable, reforms towards more ‘efficiency’ may well cover more radical privatization and marketization schemes.[32]

In Spain, the entitlement of the health system changed from universal to employment-based, and medicine copayments increased.[33] Combined with ongoing regional cost-saving policies, they have important consequences on the access, quality and out-of-pocket expenditure of public healthcare for a population that is increasingly jobless and impoverishing dramatically. National and regional governments use budget cuts targets to force privatization of the Spanish Health Service. While public-private partnerships are promoted,[34][35][36] extensive information is available regarding conflicts of interest, nepotism, monopolistic trends and "revolving doors" between government officials and private sector healthcare managers.[37][38][39]

While the German economic model is presented as a success story and an example to be followed, there is now evidence available that this approach is associated with increasing levels of poverty in Germany. 16% of the German population lives in poverty and almost 5 million workers have ‘mini-jobs’ with a salary of less than €400/month. The 8% increase in employment between 1996 and 2011 is due to a 1% increase of working hours, while the rest is related to mini-jobs without social security rights.[24] Today 26% of the jobs are precarious (temporary contracts, interim labor, obliged part-times). The number of working poor had reached 8 million in 2010, which is 23% of the country’s entire working population. Further, data indicates that half of all the low-wage earners ever had full-time jobs.[40] While in 1998 the poorest 50% of the population possessed 4% of German wealth, this figure further decreased to 1% in 2008.

In Belgium 15% of the population is poor and their numbers are growing.[24] Today, defenders of neoliberal policies harshly attack the Belgian social security
“wastage”. While trade unions are under fierce attack, regionalist divisionism is being promoted to break solidarity and resistance. But compared to the German model, between 2006 and 2011 Belgium had a higher increase in employment, which was also less fragmented than in Germany.[24] The number of working poor did not increase, while the figure almost doubled in Germany and increased even more in Spain or Greece. Even if the consequences of the crisis are being felt in a harsh and direct way, the Belgian case indicates the importance of solidarity transfers and of a strong social security system in times of crisis. It suggests that social models of redistribution and solidarity can – at least in the short run – better protect jobs, income and social security.

**Focus on Greece**

Since 2010 Greece has been the center of the world’s attention. The Greek economic crisis is held out as a lesson for the rest of the world, in terms of what needs to be avoided. The hardships faced by the Greek population are now being used as a threat against the people of Europe. Working people in the rest of Europe are being told that they will face a similar situation if their countries do not abide with the imposed austerity measures. In other words they are being told that “there is no alternative” to the sweeping erosion of social security.

**Economic crisis in Greece**

In November 2009 international financial markets and rating agencies started focusing on the negative results of the Greek government’s overall balance of payments. Through market speculation and media misrepresentation, public deficit and debt abruptly became ‘the cause’ rather than the symptom of the Greek crisis,[41][42] leading to a gradual downgrading of the country’s credit rating. In this situation, the Greek government agreed to borrow €110 billion in May 2010 and an additional €130 billion in February 2012 from the European Fund of financial stability in order to finance Greece’s external debt and to satisfy the country’s creditors, mostly German and French private banks.
According to the International Monetary Fund (IMF), the European Union (EU) and the European Central Bank (the so-called “Troika”), and repeated ad nauseam by the media, Greece’s misfortune is caused by a “way of living beyond its means”, as the country created a “ballooned welfare state” and offered too “generous payments” to its civil servants and “low retirement age pensioners”.\[43\][44] Uncontrolled government spending combined with inefficiency of state-owned enterprises and cumbersome business regulations that blunted entrepreneurship in Greece are claimed to have been the key factors for the Greek “public debt crisis”.\[45\] But the nature of this crisis lies far beyond this myth, advocated by the international financial institutions (IFIs).

In reality, public deficits and debt sharply increased only when the economy came to a stop,\[46\][47] reconfirming that the recession caused the deficits and not the other way around.\[42\] Figure 2 shows that, after 14 years of continuing economic expansion the Gross Domestic Product (GDP) in Greece started showing (close to) zero growth rates since the 4th quarter of 2007 and negative growth rates since the 3rd quarter of 2008. This sharp decrease in GDP growth rate led to a rapid increase of public deficit and a dramatic build-up of the country’s external debt within a period of less than two years (2007-2009).

The economic contraction in Greece was an outcome of Greece’s integration in the European Union, in a situation where it was relatively underdeveloped in comparison to the more developed (economically and industrially) countries in Europe. It was also fueled by the pressure imposed on the national economy by the global structural crisis.\[41\][48] The participation of Greece in the European Union and the Eurozone weakened the country’s economic competitiveness: cheap products were imported from Germany and other countries, destroying parts of the country’s productive assets, leading to a constantly deteriorating trade balance since the late ’80s, in favor of the more industrialized countries of Europe.\[41\][47] With the onset of the global crisis, from 2007 onwards, Greece was profoundly affected.
While evaluating Greece’s “over-developed and over-spending public sector”, one should point out that, compared to other European countries, it is actually less developed. Greek welfare state was always poorly funded and limited.[49]

While the public sector in Greece has never been a synonym for efficiency, the truth is that public deficits in the country were the result of declining state revenues rather than expanding public expenditures.[49] The dozens of tax-reliefs for the flourishing Greek shipping industry and the large sums of money from Greece that is stashed in Swiss banks are evidence that successive Greek governments have repeatedly reduced, avoided or failed to collect taxes from the top income brackets of Greek society.

**Social crisis in Greece**

IFIs have long been accused of prescribing macroeconomic policies to crisis-stricken countries that are directly linked to the deterioration of general socio-economic conditions.[50] These contractionary, fiscal consolidation programs usually include specific requirements for the debtor countries, such as strict inflation and fiscal deficit targets and public spending ceilings on wages, education and health.[51][52][53] These conditionalities increase the chance that loans received will finally be paid back.[51] The Troika’s loans to Greece wasn’t an exception to the rule. Austerity measures were imposed and public services were cut back, markets and professional services were deregulated, and an ambitious plan for liquidation of public assets was put forward.[54]

As Greece is now entering its 6th year of economic recession and the 4th year of harsh austerity, socio-economic conditions of the Greek population show clear deteriorating trends. As figure 3 illustrates:

- In the third quarter of 2012, 1.23 million people were unemployed (24.8% of the economically active population), an increase of 875,000 since the onset of the crisis.
• At that moment, the number of long-term unemployed (defined as those having lost their job for more than a year) amounted to 770,000 (14.1% of the labor force), 585,000 more compared to the pre-crisis period.

• In 2011, 3.4 million persons lived in households facing the risk of poverty and/or social exclusion (31% of the Greek population), 405,000 more than in 2008.

• In the same year, 28% of the Greek population (compared to 22% of the population in 2008) declared living in conditions of severe material deprivation, not being able to respond to basic needs such as paying their rent, eating a meal with meat, chicken or fish every second day, or keeping their home adequately warm.

Although reliable statistical data for the population living in conditions of abject misery/poverty are not available, qualitative evidence reveals an alarming trend in this most vulnerable segment of the population. In 2011, an estimated 20,000 people were homeless,[55] 12,280 more than in April 2009.[56] Evidence suggests that the current crisis has changed the profile of homeless people, since the number of “newly-homeless” (as a consequence of recent unemployment and poverty) has significantly risen.[55] More than 20,000 people in Athens and Thessaloniki were receiving daily food rations from non-governmental and charity organizations.[57]

**Epidemiological and health crisis in Greece**

In these conditions of severe socio-economic hardship, as described above, one would expect deterioration in the health status of large sections of the Greek population. International evidence from past economic crises indicates that in conditions of economic contraction and increased unemployment, infant mortality and mortality related to suicide, homicide, male cardiovascular disease and communicable diseases tend to increase.[58][59][60][61][62][63][64] Similar trends are expected for overall morbidity rates in Greece, as economic crisis is also associated with increasing rates of infectious diseases, malnutrition, alcohol abuse and mental disorders.[62][64][65][66][67]
Despite the fact that it is too early to draw definitive conclusions on the net effect of the ongoing crisis on population health, important signs of such an epidemiological/health crisis are becoming apparent in Greece:

- According to the latest Hellenic Statistical Service’s data (figure 4), infant mortality rate increased by 51% in 3 years (2008-2011), reflecting in the most direct way the sharp deterioration of socio-economic conditions in Greece during the years of the crisis.
- According also to the latest Eurostat data, suicide and homicide mortality in Greece increased by 11.5% and 40% respectively between 2007 and 2010 (from 2.6 and 1.0 deaths per 100,000 population respectively in 2008, to 2.9 and 1.4 deaths per 100,000 population in 2010).[68]
- In the male population aged below 65 years, relative increases of cause specific mortality are by far more intense. An earlier study, based on data derived from the WHO European health for the period 1997-2007, had already revealed that for the years 2008 and 2009 mortality rates for men under 65 years for suicide, homicide and infectious diseases were well above predictions based on the decade’s pre-crisis (1997-2007) mortality trends.[54] A more recent analysis (figure 5), with data derived from the Eurostat public health database for the years 2000-2010, shows that suicide mortality rates for males aged 30-34 and 50-54 years increased by 75% and 82% respectively between 2007 and 2010 (from 4.5 and 6.3 deaths per 100,000 population respectively in 2007, to 7.8 and 11.5 deaths per 100,000 population in 2010).

Regarding morbidity, several sources already highlight the sharp increase of mental disorders and infectious diseases incidence in Greece during these years of crisis:

- The results, for example, of three nationwide cross-sectional studies, conducted by telephone in 2008, 2009 and 2011, showed that the one-month prevalence of major depression and the proportion of the surveyed
population having attempted suicide in the month before the survey increased by 2.48 and 2.50 times respectively between 2008 and 2011.[69][70][71][72]

- According to data from the Greek Documentation and Monitoring Center for Drugs, the number of persons with problematic drug use (heroin as primary abuse substance)–rose by 11.6% between 2008 and 2010 (figure 6). In the sub-group of problematic drug users aged 35-64 years old, the relative increase was as high as 88%, indicating relapses associated with the ongoing economic crisis.

- Finally, economic turmoil seems to have had impact on the infectious diseases dynamics in Greece,[73]-- between July 2010 and December 2011 the country faced three infectious disease outbreaks (West Nile virus infection in Northern Greece; malaria in Southern Greece; and a still ongoing accelerated HIV-1 infection transmission, especially among injecting drug users).[74][75][76][77] In all three occasions the risks of transmission had not been addressed through prevention, due to the dismantling of services previously provided by national and regional public health agencies.[54]

Health crisis and restrictive health policies in Greece: a lethal combination

Historical evidence suggests that economic crises are usually associated with changes in the utilization and the demand of healthcare services.[66] Decreased household healthcare consumption, as a result of income drop, and a consequent increasing demand for public services can put an unbearable burden on government-funded health services during times of economic recession.[78] Greece seems to follow this pattern:

- According to our analysis (based on data derived from the Hellenic Statistical Authority’s household budget surveys) after ten years of increase (1998-2008), since 2009 private health expenditure started a sharp and ongoing decrease (table 1). More specifically, total private health expenditure in Greece, calculated in 2009 constant market prices, decreased by 16.2%
between 2008 and 2010 (table 1), reflecting households’ inability in times of crisis to purchase health services (and especially primary healthcare services) on an ability to pay basis.

- On the other hand, the demand for public healthcare services follows the opposite direction. According to our analysis (based on data derived from the Hellenic Statistical Authority’s annual hospital surveys and the Greek Ministry’s ESY database) the number of hospitalized patients in public hospitals increased by 37% between 2009 and 2011 (figure 7). Additionally, the average annual growth rate of hospitalized patients in public hospitals during the years of crisis was 4.9 fold higher compared to the rate in the pre-crisis period (average annual growth rate of hospitalized patients in public hospitals was calculated at 11.3% per year for the period 2009-2011, compared to 2.3% annual rate for the period 2000-2008).

In a situation of increased healthcare needs, where Greek households squeeze their demand for services directly related to their income and exponentially increase their demand for services in the public sector, successive Greek governments responded through restrictive policies: underfunding and downsizing of public health services, higher user fees and cost-sharing. Between 2009 and 2011 the total expenditure of the Greek Ministry of Health decreased by € 1.8 billion. But in 2011, only for outpatient services delivered during daytime hours in public hospitals, patients spent € 25.7 million on out-of-pocket-payments, services that were free at the point of use before the crisis.[54]

While Greek government or ex-government officials still argue that the economic crisis in Greece doesn’t constitute a threat for the population’s health,[79][80][81] a WHO report on the financial crisis and global health argued as early as in January 2009 that “some countries are at particular risk (…) and these include developed countries that have required emergency assistance from the IMF, where spending restrictions may be imposed during loan repayment”. [82] Today in Greece, the toxic combination of protracted economic recession and neoclassical adjustment
policies constitute a double threat to the population’s health and well-being. The first step for effectively confronting this double danger is to recognize it.

Analysis

Contemporary events in Greece, and to some extent in the whole Europe, mirror today what has been happening in the developing world since the early 80s: unaccountable international financial institutions demanding “a pound of the people’s flesh in exchange for bailing out banks and rewarding speculators” through the so-called structural adjustment programs (SAPs).[83] SAPs were the practical tools used by the International Monetary Fund (IMF) and the World Bank (WB) to supposedly promote growth and development in poor countries strangled by the huge debts caused by the lending spree of ‘petro-dollars’ generated by the oil crisis. The strings attached for debtor countries to qualify for financial help were to implement the primary tenets of neoliberalism, i.e. promotion of free markets, privatization of public asset including health services, small government, and economic deregulation. SAPs produced many casualties and much collateral damage to public health through a number of pathways including cuts in basic public healthcare services; imposition of fees for healthcare services; cuts in other public sector services such as education and public works; unemployment caused by lay-offs of public sector workers and income declines resulting from wage cuts for those remaining; privatization of state industries that often led to layoffs; removal of state subsidies for essential services; and increases in social inequality and economic vulnerability.[84][85][86]

All this sounds very similar to what is happening in Europe today: the very countries that, through the IMF and the WB, promoted the SAPs in Africa and other poor countries are now suffering serious economic crisis and swallowing (a least partially) the same pill they once prescribed for the indebted countries. We see today a pervasive assault on European public systems in the best tradition of Naomi Klein’s “disaster capitalism” that “never wastes a good crisis to destroy the welfare state”. [87][88][1]
What makes the present reality of structural adjustment in Europe quite different from its earlier form in developing countries is today’s very different global context. WTO-sponsored and other similar international free trade agreements, for example, involve strongly binding commitments that might affect the prospects of reversing or correcting decisions made by current governments under pressure. Investment treaties, and possibly the EU Treaty itself, are being used by multinational companies to try and force the governments to pay compensation for reversing health privatization; moreover, international arbitration mechanisms could override public courts, thereby placing public welfare at risk.[89][90]

On the other side, the political ground is changing as the financial crisis in rich countries has apparently, to a certain extent, shaken market fundamentalism. It is ironic that present World Bank President, Jim Yong Kim, is the co-author of a book seen by many as one of the most sweeping indictments of adjustment and neoliberalism.[91][92] China, the new financial and political player in the developing world, may be seen as the first external challenge to Western hegemony. The ascendance of the left in a number of Latin American countries over the past decade represents a direct confrontation with the Washington Consensus. In rich countries, including Europe, new social movements - some of which emerged from the anti globalization movement - have joined to challenge structural adjustment, such as the People’s Health Movement.

European citizens are resisting SAPs through public demonstrations and different types of actions including violent protests – a reminder of the anti-IMF demonstrations of the 80s and 90s.

In the UK, the public campaigned for months for the abolition of the top-down reorganization of the NHS driven by the Health and Social Care Act. However, after months of protests that saw health professionals and citizens in the streets against the growing role of the private sector in the health service, when the act became law there was silence. In November 2012, a group of health professionals decided to create a new political party to challenge the health reforms at a political level.
The National Health Action party is set to challenge the privatization of the NHS and the fragmentation of care accelerated by the Health and Social Care Act and aims to restore the NHS to a service that provides publicly funded healthcare, free to all at the point of need.[93]

In Spain, the privatization initiatives and cuts in welfare was accompanied by a strong and unexpected resistance, not only amongst civil society, but amongst healthcare staff who are firmly defending the public healthcare system. A historic unity, linking all types of professionals (doctors, nurses, health workers) and hierarchical positions, primary healthcare with hospital based professionals, has made possible the organization in Madrid and other regions of a huge movement, called "marea blanca" (white wave), a prolonged strike and a massive mobilization on the streets with a vast media coverage.[94] A great variety of initiatives among civil society, together with healthcare professionals, have been born in recent years to reflect on what is possible and how to reverse the privatization policies of the public health system.[95] These initiatives range from advocacy groups, such as La Federación de Asociaciones para la Defensa de la Sanidad Pública (The Federation of Associations for the Defense of Public Health) and in Catalonia Dempeus per la Salut Pública and Centre d’Anàlisis i Programes Sanitaris (Center of analysis and health programs) up to neighborhood groups who decided to self-manage a Primary Assistance Center and civil platforms built along the 15-M movement giving notice of appeal to the court against budget cuts alleging that these cuts are killing citizens (Plataforma de Afectadas por los Recortes Sanitarios, Platform of people affected by healthcare cuts).[96][97][98][99][100]

In Greece an important grass root movement for the right to healthcare is growing. It has multiple targets. Firstly, massive gatherings of people are closing public hospitals' administration offices, obstructing the recently introduced obligation for patients to pay a 5 Euro entrance ticket to the outpatient departments. In parallel, a solidarity movement has developed towards people that are excluded from any health insurance scheme because of their unemployment. Solidarity clinics are growing in number all over the country.[101] Declaring their
distances to a charity approach, they gather health workers and other volunteers to provide primary care to people in need. The aim is to combine solidarity and mobilization of both health workers and patients against the implemented policies, integrating these activities in the movement for the right to health. More recently this same movement is mobilizing against the government’s decision to close down public hospitals. In Thessaloniki a broad movement was able to force the government to postpone its decision to close a hospital.[102]

In Portugal people’s resistance is intense and diverse. Since the onset of the crisis, four general strikes and a series of national mobilizations of all sections of the population have taken place. In July 2012 more than 80% of the doctors went on strike.[103] On the 15th of September 2012 hundreds of thousands took to the streets in all big cities of the country.

Conclusion

Awareness of health as a public good and a new realization of the need to operationalize human rights obligations - for governments, but also for international financial institutions - has prompted lively interest among academics as well as activists. This is becoming a motor to engage in the defense of the public sector and celebrate a new health commons. The German civil and human rights activist who has filed a charge at the International Criminal Court at Den Haag for suspected crime against humanity is a striking example of new avenues that are opening for activism.[104]

As the experience in the developing world has exposed, SAPs have constituted an assault on the public sector as an essential source and guarantor of population health and welfare. As affirmed by the Universal Declaration of Human Rights and translated into a binding commitment by the International Covenant on Economic, Social and Cultural Rights, social and economic rights are human rights whose implementation and survival require, as not sufficient, but necessary prerequisite, the role of a robust public sector and government. In this view, structural adjustment’s systematic dismantling of public services such as healthcare,
education, and social safety nets may be seen as a war on the poor whose effects can be measured by examining excess mortality and morbidity rates and other health indicators.

In order to express in practical terms a right to health in the structural adjustment era, a health system should be seen as a commons, not as a market, where priorities are set for the public good, risk is shared, and health providers are accountable to their communities. As Meier has put it, “rather than relying solely upon an individual right to medical care, envisioning a collective right to public health, a right applied at a societal level to address underlying determinants of health, would alleviate many of the injurious health inequities of globalization.”[105] This is the time to defend and expand public services and ensure public investment in education, health, infrastructure. Social needs are huge and require housing programs, nurseries, transportation, healthcare, educational services, and cultural development.

But who pays? The state is in debt, and public debt is extremely high. A tax on high incomes and large fortunes could be a first step. In Europe, 3.2 million families possess a financial wealth of € 7,800 billion.[106] A tax on financial wealth of the richest 2% could yield € 100 billion per year (figure 8). There is a need for European solidarity: if the tax goes where it is being collected, it will further favor the richer areas. Affluent areas also have a responsibility towards poorer areas. But this is mainly the responsibility of the rich of these rich areas and not of the poor. There are moments in history when the social logic must take over. In the late nineteenth century, parliament was opposed to the prohibition of child labor for these very arguments: they were the perfect size to work in the mines. The labor movement imposed a social logic, and that changed the minds of the majority in Parliaments. It is high time to follow the elementary logic that collectively produced prosperity be used to improve living conditions of all. A more fundamental solution is inevitably linked to a radical transformation of society. We need an economy that is not driven by profits for the few, but by the fulfillment of the needs
for the many, embedded in a global ecosystem approach to protect future generations.

The European crisis is based on structural overcapacity in the economy, in a world of fierce competition and search for maximum profitability. The strangest thing is that there is "overproduction", even though most basic needs are not met. This economy only supplies solvent demand, while the poor are excluded, although their needs are huge. Another logic is needed, as only public powers can provide an alternative to profit and competition. A public logic can focus on production in function of social needs. This implies the need of a certain level of public planning: the industry can develop what will best serve the population, not what is most profitable. Such a program could be facilitated through the nationalization of strategic sectors as energy and finance, so they would serve the public interest and not those of shareholders and managers. These concrete measures are a necessary step to maintain public services, to develop a public policy towards affordable and safe housing. This approach is the only possible to ensure health care for all.

The crisis imposes us to rethink the society in which we live. The choice is between deepening the market economy causing crises of overproduction and stagnation or a society based on the satisfaction of the global needs, for those who can pay and for those who can't but who have as much right to a decent life and to material goods that the world can produce. This is the time to explicitly present these two options.

To argue for a health commons will therefore guide health workers and activists toward new ways of engagement and resistance: the struggle to protect and invigorate the public sphere. As incited by Stuckler and McKee: “There is an alternative: public health professionals must not remain silent at a time of financial crisis.”[107] Mobilization by civil society that encourages public debate and raises political consciousness will demystify and counteract the given orthodoxy. The challenge is to develop strategies for activism that can lead to broader social change.[108]
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Figures and tables

Figure 1: Average economic growth in G-7 since World War II

Source: GDP growth calculation (in 1990 International Geary-Khamis dollars) based on Maddison’s Historical Statistics (http://www.rug.nl/research/ggdc/data/maddison-historical-statistics). Maddison was reknown for his historical statistical series, and an adviser to the OECD. He was recognized as a specialist on long term statistics (with Paul Bairoch), and published part of his work with OECD.
Figure 2: Basic economic indicators, Greece 2001 – September 2012

Note: (1) Gross Domestic Product – GDP (2) GDP growth rate expressed as % change compared with previous year (3) the figures for 2012 cover only the first three quarters (Q1-Q3) of the year.
Figure 3: Basic social indicators, Greece 2004 – September 2012

Notes: (1) The figures for 2012 represent the average number of unemployed and long-term unemployed during the first three quarters (Q1 – Q3) of the year (2) Long-term unemployed are defined as job seekers for one year or more in the labour force (3) People at-risk-of-poverty and/or social exclusion reflects the share of the population which is either at risk of poverty, or severely materially deprived or lives in a household with a very low work intensity (4) People severely materially deprived reflects the share of the population that cannot afford at least 4 out of the 9 following items: pay arrears on mortgage or rent payments, go one week annual holiday, meal with meat-chicken-fish every second day, face unexpected expenses, have a TV, have a telephone, have a car, have washing machine, keep their home adequately warm.

Figure 4: Infant mortality rate, Greece 1990 – 2011

Note: Infant mortality rate (IMR) expressed as the number of deaths of children less than one year of age per 1,000 live births.

Figure 5: Suicide mortality rates by sex and age group, Greece 2000 – 2010

Figure 6: Problem drug users (heroin as primary substance of abuse) by age group, Greece 2006 – 2010

Note: for the year 2007 data weren’t available by age group.

**Figure 7:** Patients hospitalized in public hospitals, Greece 2000 – 2011

Sources: Authors’ calculations based on data derived (1) For the years 2000-8 from the Hellenic Statistical Authority’s annual hospital survey (available from: [www.statistics.gr](http://www.statistics.gr)) (2) For the years 2009-2011 from the Greek Ministry’s of Health and Social Solidarity ESY-net database (available from: [www.yygka.gov.gr](http://www.yygka.gov.gr)).
Figure 8: Prospected revenues from a 2% tax of financial wealth above 750,000 Euro, 1997 – 2011

Revenues from a tax on the financial capital of the richest Europeans, 1997-2011 (billions of Euros)

Source: calculation based on data from CapGemini and RBC Management (earlier Merril Lynch).
### Table 1: Private health expenditure by type of service, Greece 1998 – 2010

<table>
<thead>
<tr>
<th>Type of service / Survey Year</th>
<th>1998/99</th>
<th>2004/5</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>1,031.72</td>
<td>1,369.77</td>
<td>1,633.09</td>
<td>1,542.80</td>
<td>1,525.89</td>
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<tr>
<td>Medicines</td>
<td>N/A</td>
<td>1,128.96</td>
<td>1,353.16</td>
<td>1,275.22</td>
<td>1,299.11</td>
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<tr>
<td>Therapeutic devices</td>
<td>N/A</td>
<td>240.8</td>
<td>279.93</td>
<td>267.09</td>
<td>226.30</td>
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<tr>
<td>Outpatient care</td>
<td>3,811.95</td>
<td>4,515.30</td>
<td>4,329.52</td>
<td>3,923.91</td>
<td>3,186.24</td>
</tr>
<tr>
<td>Medical care</td>
<td>1,311.93</td>
<td>1,600.92</td>
<td>1,487.19</td>
<td>1,331.01</td>
<td>1,062.87</td>
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<tr>
<td>Dental care</td>
<td>1,878.19</td>
<td>2,140.46</td>
<td>2,092.06</td>
<td>1,947.64</td>
<td>1,574.18</td>
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<tr>
<td>Other outpatient</td>
<td>621.82</td>
<td>1,547.83</td>
<td>1,501.04</td>
<td>1,290.53</td>
<td>1,097.43</td>
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<tr>
<td>Inpatient care</td>
<td>683.23</td>
<td>988.98</td>
<td>1,065.32</td>
<td>1,162.65</td>
<td>1,178.86</td>
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<tr>
<td>Public hospitals</td>
<td>167.88</td>
<td>278.351</td>
<td>293.28</td>
<td>299.18</td>
<td>336.61</td>
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<tr>
<td>Private hospitals</td>
<td>515.35</td>
<td>710.63</td>
<td>772.53</td>
<td>862.98</td>
<td>841.77</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,527.07</strong></td>
<td><strong>6,874.04</strong></td>
<td><strong>7,027.93</strong></td>
<td><strong>6,628.88</strong></td>
<td><strong>5,890.99</strong></td>
</tr>
</tbody>
</table>

Notes: (1) Private health expenditure expressed in million euros (€), 2009 constant market prices (2) Data not available – N/A.