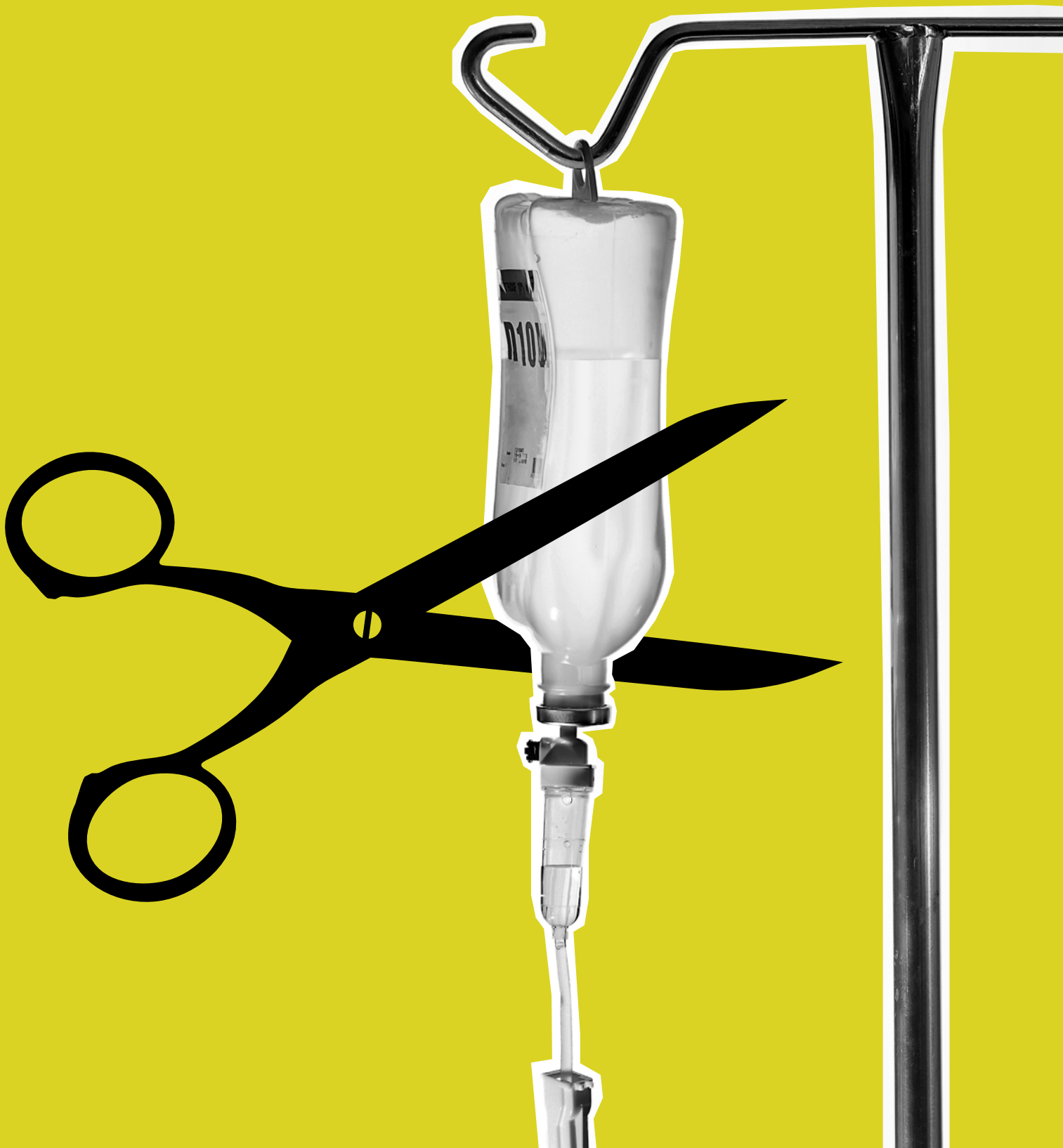


When the market

becomes deadly

How pressures towards
privatisation of health and
long-term care put Europe on
a poor footing for a pandemic



From hospitals to care homes, the evidence is mounting that outsourcing and private provision of healthcare has significantly degraded EU member states' capacity to deal effectively with COVID-19. The EU must reject the private sector lobbyists now whispering in its ear, and reverse course on the kind of economic governance which has accelerated healthcare liberalisation, instead putting public provision at the centre of its strategy. If it doesn't, more lives will be at stake.

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Introduction

As COVID-19 swept the globe, with [over 26 million cases and 466,000 deaths in the European region alone \(as of 11 January\)](#), the capacity of healthcare systems to deal with the pandemic has been constantly in the spotlight. Long-term and elderly care provision has also come under scrutiny, as shocking proportions of COVID-19 deaths have occurred in residential care homes in many European countries – [up to 60 per cent](#) in the pandemic's first wave.

EU member states' health systems – both those based on employment-related health insurance and those financed via general taxation – have been subject to political and policy pressures that have encouraged the creeping privatisation of healthcare. In 2017 [Corporate Europe Observatory lifted the lid](#) on the ideological, corporate, and financial pressures – including from the EU-level – that have created conditions conducive to a growing role for private sector companies in this traditionally public service.

But squeezing profits for shareholders out of health and care services comes with risks: deteriorating working conditions, worse pay, reduced staff levels, greater workloads, more stress, and shortcuts in training and protective equipment, all of which affect safety and quality of care. Health inequality is exacerbated as private, for-profit providers 'cherry-pick' lower-risk and paying patients, whilst higher-risk and poorer patients, or those needing emergency care, remain reliant on public health service provision, which – due to austerity, and the increasing capture of public funds by for-profit providers – is badly under-resourced.

In the context of COVID-19, these trends have had disastrous implications for health and care systems' ability to handle the pandemic. Health budget cuts have led to understaffing and reduced total hospital bed numbers, while the rise of private hospitals goes hand in hand with a fall in intensive care beds, which are less profitable for companies. Profit-oriented care homes have kept their costs down by hiring too few staff, who are often poorly paid, inadequately trained, little or no sick-pay, and with no option but casual work at multiple facilities, contributing to the virus' spread.

Yet it hasn't always been this way, and it does not have to be. The shifts that have led to greater privatisation of healthcare, the casualisation of care work, and the erosion and underfunding of the public sector are the result of political decisions at national and European levels. For many people shocked by the state of these sectors when the pandemic hit, these shifts have slipped by largely unnoticed. COVID-19 has been a wake-up call for many, a reminder that we have a choice in how our vital public services are run.

This article considers both the EU policy pressures and the corporate lobbying that has promoted increased marketisation, commercialisation and privatisation of healthcare. Trends which contributed to health and elderly care systems in Europe being poorly prepared for the pandemic.

Some of our key findings include:

- The private hospital lobby is prolific in Brussels, using the pandemic as an opportunity to push its interests. Meanwhile, analysis shows healthcare privatisation has reduced countries' long-term preparedness for dealing with pandemics, *and* actually costs governments more than public healthcare.
- EU pressures to cut public spending have contributed to the commercialisation of the elderly care sector, as well as the healthcare sector, with catastrophic effects during COVID-19, particularly in care homes.
- The evidence against public-private partnerships in health is mounting, but a mindset shift is still needed. However, such a shift is unlikely if the Commission accepts help from firms like McKinsey (known for its role in increasing the privatisation of the UK's NHS) in its COVID-19 crisis response, while keeping the public in the dark about the details.
- COVID-19 is a clear example of the failures of the privatised model of healthcare and long-term care provision. The fight against this model is a fight for patients and workers, for the elderly and disabled, for justice, equity, and human rights. As plans for a European Health Union get under way, it is vital to safeguard the public not-for-profit nature of healthcare provision in Europe, and ensure that COVID-19 recovery funds are not siphoned off to for-profit providers.

1. Private hospitals use marketisation of healthcare to strengthen their hand

Healthcare may be a national competence, but the [EU has determined it as](#) an economic activity, and therefore subject to EU internal market rules (free movement of goods, people, capital and services; public procurement and state aid rules). The 'marketisation' of healthcare challenges the public nature of healthcare provision, opening it up to outsourcing, competition between different providers, public-private partnerships, and the sale of public hospitals to private investors.

Such reforms, as the [People's Health Movement \(PHM\) notes](#), are "undertaken under the guise of increasing efficiency and quality through competition and choice", but in reality have "contributed to a significant rise in inequities in health and healthcare access" and "weakened the public healthcare systems".

As part of this marketisation, private for-profit providers seek what they call a level-playing field with public providers; in other words, a slice of public funds. This is partly because for the private healthcare model to be profitable (beyond just the wealthiest minority of paying clients), it still requires public funding – since often, those most in need of healthcare are least able to pay the 'market price' for it.

The European Union of Private Hospitals (UEHP), a lobby group active in Brussels with a mission to promote an "internal market in the field of healthcare", a [lobby budget](#) of €200,000–€299,999 (2019), and a seat on Commission's eHealth expert group, is a big proponent of this argument. UEHP's members are national associations of private hospitals, rather than corporations directly, but its [board of directors](#) includes [French private](#)

[hospital group ELSAN](#) (whose [2018 revenues](#) were €2.1 billion). [UEHP's Vice President](#) is from the German private hospital association BDPK, [whose board includes](#) the [Chief Executive](#) of German private hospitals company Asklepios (whose [2019 revenues](#) were over €3.5 billion).

Five months after we shone a light on UEHP's close relationship with the European Commission and lobby events at the European Parliament [in June 2017](#), UEHP held an event and [networking lunch](#) in the Parliament, [in collaboration with](#) the centre-right EPP group, to launch its new 'factbook'. The message of the UEHP factbook [was that](#) "private hospitals in Europe do not create inequality"; rather, inequality is created "by the financing system".

According to UEHP, inequality only arises if the public sector refuses to pay private hospitals for patients' care, leaving patients to face high [out-of-pocket payments](#). And that, it insists, is the fault of public sector gatekeepers, not the private hospitals! Thus UEHP argues that [it is](#) "essential that the system treat the private and the public hospitals on an equal basis". This is a core lobby demand of the private hospital group – they want public money to cover private hospital patients, thereby diverting more taxpayers' money away from chronically underfunded public hospitals to profit-making private ones.

[Coverage of UEHP's event](#) by a lobby outfit called Health First Europe (whose [secretariat is run](#) by lobby consultancy Instinctif Partners; [UEHP is also a member](#)) notes that although a "significant decrease in hospital beds is observed in several EU member states... the hospital private sector has increased from 17,56% to 20,45% of total EU beds (from 2007 to 2015)". This dynamic is important, because while national and EU-instigated (see Part 4) austerity measures cut public budgets to healthcare, resulting in public hospitals being closed or sold to private companies, private hospitals (as well as PPPs and PFIs – see Part 3) flourished.

UEHP argues that it is "essential that the system treat the private and the public hospitals on an equal basis."

However, in the context of COVID-19, one vital difference must be noted: private hospitals prioritise the most profitable patients, for example concentrating on chronic illnesses and day surgeries, rather than [emergency care or intensive care units](#) (ICUs). So when the pandemic hit, the increased proportion of private hospital beds could do nothing to offset the overall decrease in hospital beds – and particularly ICUs – in many parts of Europe. And, as [studies have shown](#), higher hospital capacity (in beds per 1,000 people) is significant in lowering COVID-19 mortality.

Italy's overall number of acute¹ care beds is below the EU average, and the number of acute

beds per 1,000 people [dropped](#) significantly from 7 in 1990 to 2.6 in 2015 (see also Part 4). The [Commission cites](#) figures for Italy that 68 per cent of all acute hospital beds are public, 4 per cent private not for profit, and 28 per cent private for profit (OECD 2012). But, as a [New Statesman investigation](#) (see Box 1) noted, of 5,300 intensive care beds in Italy, just 800 were in private hospitals. So while private hospitals have nearly 30 per cent of total acute beds, they have only 15 per cent of ICU beds. [When it came to COVID-19](#), *New Statesman* observed, "private hospitals' capacity to contribute to the response was minimal. They were, indeed, used to leaving such things to the public hospitals."

Box 1: How pro-private health policies ill-prepared Lombardy for COVID-19

Lombardy – Italy's richest region – made headlines around the world in the first wave of the pandemic as hospitals overflowed, military trucks collected bodies from hospitals, and medical staff described the situation as akin to "[a world war](#)". A [New Statesman investigation](#) in April 2020 described doctors blaming a healthcare system "in which private and public clinics compete for taxpayers' money".

The system in place when COVID-19 hit was "skewed in favour of the private sector" as patients were eligible for care in either private or public facilities, giving private clinics the best of both worlds, receiving both insured and uninsured patients, "foisting the burden of the free treatments on the taxpayer, [at a higher cost](#)". As a result, privatisation had boomed: the share of public funds captured by private facilities jumped from [30 per cent](#) to [50 per cent](#) between 2010 and 2020.

Over the same period public facilities waned, even as they were forced to compete for public funds against private "rivals that offered 'customer first' patient experiences – better bedlinen, better food, more in-ward entertainment – over the less market-friendly considerations of community healthcare". Community healthcare, which plays a crucial role in an epidemic and helps to keep people out of hospital, was depleted by "years of 'patient-focused' care" that made trips to hospital the go-to whatever the illness. When COVID-19 hit, this enabled its rapid spread through hospitals which, soon overwhelmed thanks to a reduced number of beds, sent symptomatic people home to spread the virus further, and even discharged COVID-19 patients to elderly care homes, with devastating results (see Part 2).

One academic [described](#) what happened in Lombardy as "the logical endpoint of a system" which had allowed profit "incentives to distort healthcare priorities over a long period of time". [Commentators in Italy](#) have condemned Lombardy's health system for putting "profit over prevention", and transforming "health into a commodity". As the *New Statesman* investigation concluded: "preparing for a pandemic involves spending money in the hope that it is not needed. This is something that only the public sector, freed from the motive of profit, can accomplish".

¹ / Acute – or curative – care beds are a subgroup of total hospital beds, defined as all hospital beds which are regularly maintained and staffed and immediately available for the care of admitted patients ([Eurostat](#)). Intensive Care Units (ICUs) – or critical care beds – are a specialist type of acute bed, for the most seriously ill patients; ICUs have additional equipment and more medical staff.

In February 2019 UEHP met with then Commissioner for Health, Vytenis Andriukaitis; according to [notes from this meeting](#), UEHP complained that “access of private hospitals to EU funds is uneven, varying between MS [member states]”, and claimed that “private hospitals are more efficient than the public ones”. Whether such assertions will be taken at face value has a lot to do with the underpinning ideology; but as our [2017 report highlighted](#), much of the Commission shares a neoliberal ‘business is best’ approach. The European Observatory on Health Systems and Policies has also [noted that](#) while “the desire for greater efficiency in healthcare motivates a great deal of decision-making, the routine use of relevant efficiency metrics to guide decisions is often lacking”.

The assertion that private hospitals are more efficient, however, is not borne out by the evidence. The European Foundation for the Improvement of Living and Working Conditions (EUROFOUND), an EU agency, rebutted this [in a 2017 report](#) on the hospital sector, which recognised that “policies that favour the role of private providers and which aim to diminish the role of the public sector tend to have, as their rationale, gains in efficiency and a reduction in public expenditure”. However, no “conclusive evidence was found on which type of hospital is more efficient”.

What EUROFOUND did find was that private hospitals offer fewer types of treatment, that patients “in private hospitals usually have conditions requiring treatments that are more profitable than those provided in public hospitals”, and, that patients “in private hospitals with complications tend to be transferred to public hospitals”. Combined, this dynamic keeps public hospitals doing the more complex, expensive, and ‘unprofitable’ care, including emergency and intensive care (see Box 2). Meanwhile private hospitals are free to cherry-pick patients whose treatments are cheaper/more profitable, and if complications do arise, they can simply pass the patients back to the public purse.

At a big picture level, [OECD data](#) from 2019² on national health spending indicates that the supposed greater cost-efficiency of private, for-profit healthcare

compared to public healthcare is more fairytale than fact. The US spends vastly more on its highly privatised healthcare system than EU countries spend on their more public healthcare systems:

- As a percentage of GDP, US total healthcare spending (government/compulsory, voluntary and out-of-pocket³) is 16.96 per cent. That’s double the EU27 average of 8.26 per cent, and over a third more than the EU’s biggest spender Germany, at 11.65 per cent.
- In US dollars per capita, the US spends a total of \$11,072, more than three times that of the EU-27 average of \$3800 per capita.
- Even when you break it down to government spending and compulsory health insurance only, the US spends 14.38 per cent of GDP (or \$9387 per capita) compared to the EU-27 average of 6.13 per cent (or \$2872 per capita). Even Germany, Europe’s biggest government spender on health, spends only 9.9 per cent (\$5648 per capita).

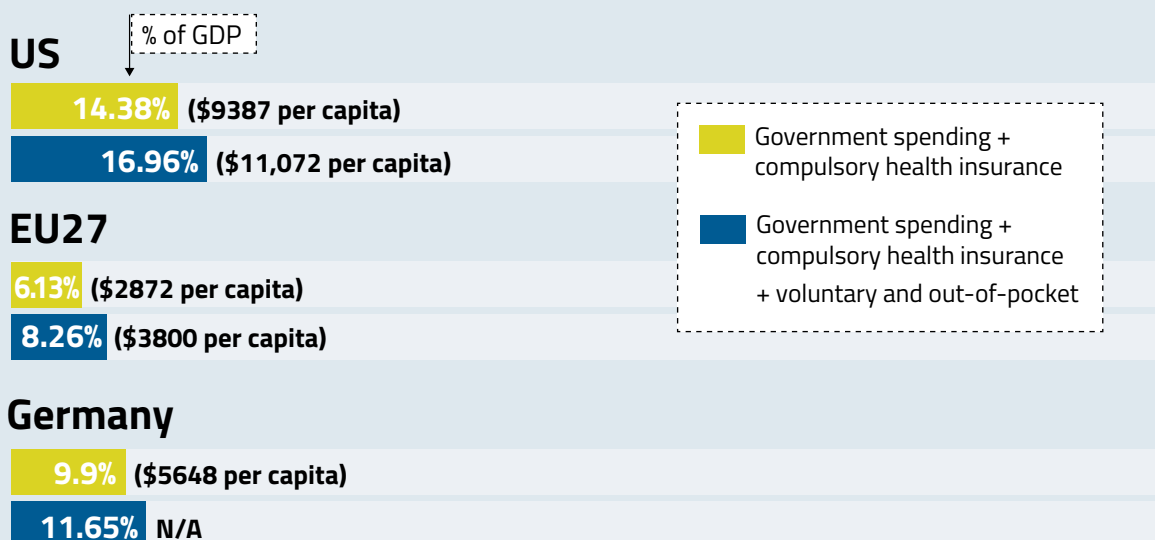
This indicates that a more privatised healthcare system is more expensive, not just for its end-users, but for the government too (see also Box 5). What’s more, and of paramount importance in the context of the pandemic, a [cross-country analysis](#) by the United Nations Development Programme (UNDP) looking at the effect of healthcare privatisation on COVID-19 found that a “10% increase in private health expenditure relates to a 4.3% increase in COVID-19 cases and a 4.9% increase in COVID-19 related mortality”. In other words, greater privatisation of healthcare “significantly raises the rates of COVID-19 prevalence and mortality across countries”. Privatisation policies are more costly and more deadly, thanks to the long-term damage they “can do to countries’ ability to cope with a rapidly-spreading infectious disease”.

Thus as well as eroding healthcare systems’ capacity to handle pandemics, private for-profit health services are not more efficient and not more cost-effective, which leaves the two major justifications for healthcare privatisation (including through the European Semester, an EU economic governance

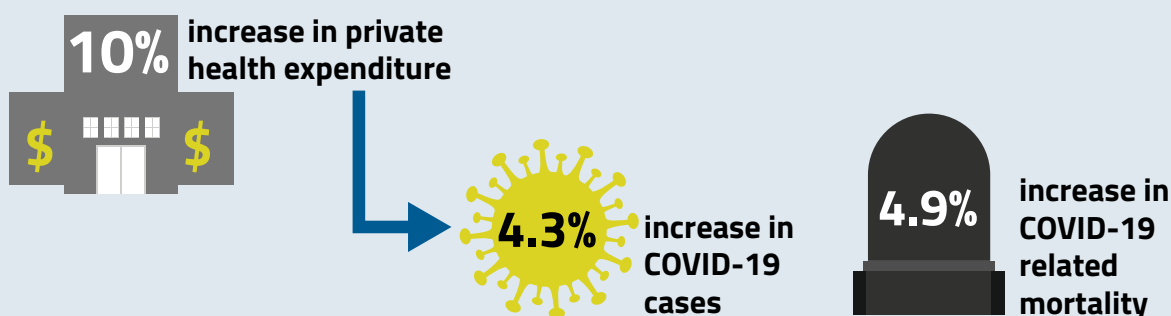
2 / Or latest available year.

3 / [According to the OECD](#), total healthcare spending includes a mix of financing arrangements including **government spending and compulsory health insurance** as well as **voluntary health insurance** and private funds such as households’ **out-of-pocket payments**, NGOs and private corporations.

The US spends vastly more on its highly privatised healthcare system than EU countries spend on their more public healthcare systems



Greater privatisation of healthcare significantly raises the rates of COVID-19 prevalence and mortality across countries



tool – see Part 4) in a very weak position. It is, therefore, an added irony that despite the ideological rhetoric for privatisation being to ease pressure on public budgets, UEHP in fact demands that private hospitals should get public money, if public hospitals do. An argument which is underpinned by the application to healthcare of the principles behind EU internal market rules, such as non-discrimination.

The COVID-19 crisis has, if anything, been used as fuel for this argument. UEHP's website hosts a [plethora](#) of emotive [articles](#) showcasing their members' response to the pandemic, and its 'integral' role in supporting the public sector, and

so on. One UEHP news item even describes its Italian member AIOP [putting an advertisement](#) in the "most known Italian newspapers (Lombardy Region editions)" with an infographic highlighting "the utmost contribution of the private healthcare sector during the COVID-19 emergency, with its 484 ICU beds made totally available to the Region". This picture stands in stark contrast to the catastrophic reality faced by the region (see Box 1). It also leaves out [the Italian decree](#) that permitted the requisitioning of private hospitals, which [would nonetheless be](#) "compensated for the full value of their services" with public money.

Box 2: Madrid: privatisation bad for private *and* public sector health workers

A **recent study** carried out in Madrid just before the COVID-19 crisis hit found that the workload of private healthcare nurses was higher than public healthcare nurses (attending an average of five more patients a day), while their salaries were 20-25 per cent lower. Furthermore, 82 per cent of nurses working in private hospitals and health centres considered that staff numbers were insufficient to carry out quality work.

On the other side of the coin, Amnesty International has described how a decade of austerity policies (enacted partly to comply with EU expenditure rules – see Part 4) saw public healthcare spending drop by 11.2 per cent from 2009 to 2018, even as Spain's GDP grew by 8.6 per cent. This left primary care services overstretched, understaffed, and underfunded when COVID-19 hit, with public health workers facing impossible workloads, personal risk, exhaustion and stress. Meanwhile, according to Spanish anti-health privatisation movement Coordinadora Antiprivatización de la Sanidad, the missing public healthcare investment has instead been transferred to private pockets, with two out of every ten euros spent on healthcare in Spain going to public-private partnerships with the for-profit sector.

Worryingly, Spain's Deputy Premier Nadia Calviño has firmly defended a policy of limiting public spending as much as possible in response to the crisis, to avoid big public deficits. Calviño was until June 2018, Director-General for Budget at the European Commission. However, recent protests in Spain suggest the neoliberal ideology of austerity-induced privatisation will not go unchallenged.

It is important to say at this point that enormous appreciation and respect is owed to all healthcare and other hospital workers throughout the pandemic, without prejudice to the ownership of the institutions in which they worked. But it is nonetheless worrying that the private hospitals lobby appears to be trying to use the pandemic to further entrench and expand the role of the private sector.

In April 2020, UEHP wrote to EU institutions emphasising that private hospitals' engagement in the public health crisis shows they are an "indispensable element", and "should be acknowledged as partners with equal rights". The pandemic is being used as another argument for why private for-profit hospitals should be on a level playing field with public hospitals in terms of receiving public funds.

UEHP has also been lobbying as part of EU Health Coalition (whose members include pharma lobby EFPIA and biotech lobby Europabio) to ensure that the EU's multi-billion covid recovery plan proves profitable for them. The EU Health Coalition "particularly welcome(s)" the Recovery Plan for Europe's second strand, which aims to support "more efficient and inclusive health systems". It also makes reference to the Commission's European Semester Country Specific Recommendations, which have historically been a tool pushing cuts to public healthcare expenditure (see Part 4).

...the private hospitals lobby appears to be trying to use the pandemic to further entrench and expand the role of the private sector.

2. The role of the market in COVID-19's devastating impact on long-term care

As the [OECD has noted](#), the COVID-19 crisis hit the long-term care sector very hard, highlighting “structural problems in terms of insufficient staffing, poor job quality and insufficient skills, all of which have a toll on quality of care and safety”. According to the European Centre for Disease Prevention and Control, “[deaths in care homes](#) represented 30-60% of all COVID-19-related deaths in the first month of the outbreak”. And it is not just elderly care homes that have been hit hard; [in Spain for example](#) centres for people with disabilities shared in the high numbers of COVID-19 deaths.

Commentators from Italy and Spain [have described](#) how badly privatisation affected healthcare systems and long-term care, contributing to the disastrous impact of COVID-19. Professor [Vittorio Agnoletto](#) [describes](#), for example, private care homes being paid (€150 according to [one report](#)) by the region

of Lombardy to take COVID-19 patients from its overwhelmed hospitals. The subsequent spread of the virus among vulnerable elderly residents had devastating impacts – [described by](#) the WHO deputy director as a massacre.

In Spain, where [three in every four care homes](#) are privately run (with many residents having their costs part publicly funded), the army was deployed to disinfect 1300 beleaguered care homes in Madrid, with distressing [reports](#) of residents found “dead in their beds”. The Patients’ Defenders ombudsman group described how “companies had to carry out savings somewhere to make a profit”, pointing to lack of equipment and minimum staff. In a [BBC investigation](#), family members of residents described symptomatic patients not being kept isolated, and ill staff not being replaced, leaving those remaining to do longer, exhausting shifts, with a lack of adequate protection.



► Image: Martin Bertrand

Crowded hospitals (see Box 3) were forced to turn away patients from care homes, and [guidance was even issued by the government](#) telling care homes *not* to refer residents with COVID-19 to hospital. By the end of April 2020, 6000 people had died in nursing homes in Madrid after showing Covid-19 symptoms. [Care home resident deaths](#) comprised over half all COVID-19 fatalities in Madrid and Aragón, and 86 per cent in Rioja (as of March 2020).

In a [December 2020 report](#) Amnesty International noted that the “denial of the right to health to older people is strongly linked to austerity measures and under-funding of health care in Spain. The decade of health and social cutbacks has undermined the public health system, deteriorating access, affordability and quality of health care” (see Part 4). Amnesty also points out that the fact that most elderly care home residents in Spain live in private care or subsidised residences “in no way diminishes the State’s obligation to guarantee the protection of their human rights” including against human rights abuses by companies. Privatisation of health and elderly care does not remove a government’s obligations to protect its people. Yet it seems the lessons from the first wave of the pandemic have not yet been learned, as too many mistakes are, unforgivably, being repeated in the second wave.

Business analysts have described the care home market in Spain as [a ‘resilient sector’](#), ie one which is ripe for investment and highly profitable (in part thanks to the casualisation and underpayment of care work, and other shortcuts that have been so deadly during the pandemic).

...the “denial of the right to health to older people is strongly linked to austerity measures and under-funding of health care in Spain.”

An investor outlook for the [‘Elderly Care Market’](#) by real estate firm Knight Frank⁴ published in early 2020 describes the “growing appetite for elderly care property assets”, with investment volumes “now over €6.5 billion per annum”. And you can see why: pre-tax profit margins for private operators, according to Knight Frank, “typically range from 25-35%”, supported, the company notes, by increasing fee rates and high occupancy, while staff costs “are the main challenge for operators”.

This is very telling, as time and again news stories about COVID-19 in care homes have focused on understaffed residencies, with staff not given sick leave/pay, lacking training or PPE, or undertaking casual work in multiple care homes, thereby contributing to the virus’ spread. Knight Frank also flags the “largely free market structure” of Spain as appealing, noting that “care operators and investors [are] now beginning to circle.” French-based DomusVi Group is the market leader in Spain, with 135 nursing homes; one of which, in Alcoy, hit headlines in March 2020 [after 21 people died](#). By the end of 2020 there had been [2,100 deaths](#) in DomusVi care homes in Spain.

Box 3: Downward pressure on quality in for-profit care homes

The European Public Service Union (EPSU), the European Disability Forum and Age Platform Europe [have called](#) on the European Parliament to investigate the tragic effects of COVID-19 on the long-term care sector, flagging the contribution of “failed policies and underfunding,” [as well as](#) human rights breaches, understaffing, and a lack of safety protocols before COVID-19. The lack of PPE for workers in care homes for the elderly or disabled has not just been deadly to the residents, but has also led to a [large number of staff casualties](#).

⁴ / Knight Frank is also a [member of](#) the European Association of Homes and Services for the Ageing (EAHSA).

An academic study on long-term care (LTC) homes in Canada found that “For-profit status is associated with the extent of an outbreak of COVID-19 in LTC homes and the number of resident deaths”. In the US, where alarming shortfalls of private care providers during the pandemic have been documented, one study has found a preliminary correlation “between private equity ownership of nursing homes and Covid deaths”. No such correlation has yet been found in Europe, and indeed the picture is complicated, as in the case of Belgium, which has suffered very high deaths in both public and private care homes, partly as a result of government decisions. However, in many cases there is still a lack of available data to judge, as for example in Spain, where only six regions were willing or able to provide data on how many people died in private residential care.

In Sweden the high proportion of temporary staff (on hourly contracts, and not protected by extended sick pay legislation) who often work in multiple care facilities are believed to have contributed to the virus’ fast spread. Many of the problems faced by care homes when the pandemic first hit – inability to access PPE, to replace ill staff, or relying on staff that worked in more than one home – were not limited to for-profit providers. However, the downward pressure on wages, working conditions and staff-per-resident ratios that comes from the need to make a 25 to 35 per cent profit for shareholders (see above) cannot be ignored when considering care homes’ capacity to deal with the pandemic.

This point is backed up by a 2017 study by EUROFOUND into elderly care home providers, which found that in some countries, private care homes provide fewer specialist medical services than public care homes; private care homes are more likely to be found in affluent urban areas; and, there were more staff per resident in public care homes. This has implications for (in)equality of access; indicates cherry picking by private providers (leaving those with more expensive care needs to the public sector); and confirms the downward pressure on staff numbers brought by the pursuit of profit.

EUROFOUND also noted that many “private providers are facing a dilemma between cutting costs by decreasing the quality of service or increasing prices and thus losing competitiveness”, further illustrating why a free market model is not appropriate for the provision of long-term and elderly care.

Finally, EUROFOUND noted that as private provision increases, costs to users will become a more significant issue *unless* there is an “increase in public benefits to subsidise funding”. In other words, it will increase inequality of access unless taxpayer’s money is used to subsidise those private companies – thereby further depriving public care homes of funds. This is true in Spain, where the private sector benefits “from subsidies meant to increase the affordability of services to recipients”.

In the context of COVID-19, and the supposed savings to the public purse that privatisation of elderly care brings, there is another elephant in the room: to what extent is public money having to be spent to sort out the mess in private care homes during the pandemic? This is a question that merits investigation. In the absence of specific data, however, there are warnings.

In the UK, where private equity backers of for-profit operators “have taken to skimping on operating budgets to maximise returns”, the Institute for Public Policy Research found that not only do private operators provide less training, lower pay for staff and have a higher staff turnover, contributing to lower quality of care, but that if the provider fails (often due to debts), local authorities must take on financial responsibility. This is the classic story of privatisation: profits into private pockets, but the costs of profiteering borne by the taxpayer.



► Image: Martin Bertrand

Unlike the private hospital sector, there does not currently appear to be a *specific*, active lobby presence at EU-level of private for-profit long-term care providers. The private sector group [European Confederation of Care Home Organisations](#) (ECHO), for example, does [not appear to have been active in recent years](#). The EU has limited competences regarding long-term care, but perhaps the main reason for this apparent lack of lobbying is that the application of EU internal market rules to health and care services already provides the conditions and tools to enable for-profit operators to flourish and expand.

Consider French elderly care multinational Orpea whose [2019 net profits](#) were €246 million, and whose [workers](#) have for years been [fighting for better pay and conditions](#). Orpea is not in the EU lobby register, but [it is a member](#) – alongside other long-term care giants DomusVi, Sanitas Mayores (part of Bupa) and Korian⁵ – of Spanish lobby group Asociación de Empresas de Servicios para la Dependencia (AESTE). AESTE is very vocal in Spain; in 2018 it [challenged public tenders](#) that it claimed violated the free competition of companies, boasting that it had, over seven years, filed over 50 such court appeals.

In 2019 [AESTE argued that](#) the Spanish law which transposed two EU Directives (on the award of concession contracts, and on public procurement and repealing, both from 2014), meant that regional regulations must “allow the participation of any type of private entity under the same conditions, regardless of its legal form or whether it is profit-making or not”. Thus the application of EU internal market rules to long-term care is being used by for-profit providers to expand their market share.

Orpea Germany GmbH and SeneCura Clinics ([owned by Orpea Group](#)) are also [members of the European Ageing Network](#) (EAN) – as is French firm Sodexo, involved in both [hospital services](#) and [senior living](#). EAN is active at EU level, but it represents *all* types of long-term [care providers](#); public, private non-profit, and private for-profit. Some of its recommendations, however, clearly do serve the interests of its for-profit members. In a [2019 report](#) on long-term care, for example, EAN states that “Public/private partnerships will become increasingly a source of solutions for the future”, and that private for-profit service companies “will certainly become a key player” due to increasing limitations of public funding.

It also describes moving from “Sole Public Finance to Co-payments and a Public/private Market” as a necessary paradigm shift. To be clear, however, EAN is not only promoting for-profits’ interests – other aspects of its work may promote public and non-profit provision, or the public good, for example advocating to “avoid the inequality gap between poor and rich”.

Aside from the application of free market rules to care services, and the EU’s pro-PPP stance (Part 3), its main policy tool to put pressure on member states regarding long-term care is the European Semester, [urging reforms](#) to increase ‘cost-effectiveness’ (see Part 4).

⁵ / Korian is listed as a member on [AESTE’s website](#) (as of 05/11/20), but was not listed as a member in AESTE’s [2014 lobby register entry](#).

3. Can COVID-19 shake the Commission's love of PPPs?

In our 2017 report we noted the Commission's reluctance to draw negative conclusions about PPPs, even in light of dire results (see Box 5), and despite its own advisory body [finding no evidence](#) that PPPs are more efficient or cost-effective compared to public healthcare provision, and may be more expensive. But that message is getting harder to ignore: in March 2018, the [European Court of Auditors published a Special Report](#), 'Public Private Partnerships in the EU: Widespread shortcomings and limited benefits'. It refers to Commission policy "encouraging the use of PPPs for some years (e.g. the Europe 2020 strategy)", its funding of them through Structural and Cohesion Fund grants and other financial instruments (together with the European Investment Bank, EIB), and its "aim to implement greater part of EU funds through blended projects including PPPs".

However, based on the PPPs it audited, the ECA found they were "not always effectively managed and did not provide adequate value for money," with potential benefits "often not achieved, as they suffered delays, cost increases and were under-used", resulting in €1.5 billion ineffective spending, €0.4 billion of which were EU funds. It also found that the "risk allocation between public and private partners was often inappropriate, incoherent, and ineffective".

The ECA therefore recommended the EU "not to promote a more intensive and widespread use of PPPs" until all these the issues were addressed.

The ECA report also referred to data from the European PPP Expertise Centre (EPEC) – the EIB's [pro-PPP advisory body](#) – showing that in 2016 64 PPPs (worth €10.3 billion) reached financial close, with PPPs in healthcare the second most common. It also identified the countries with most PPPs were the UK, France, Spain, Portugal, and Germany. [Academic research from 2013](#) showed the EU countries with most PPPs for healthcare projects included the UK (146 worth \$25.8 billion), Italy (71 worth \$5.7 billion), Germany (24 worth \$2.1 billion), Spain (19 worth \$2.3 billion), and France (16 worth \$1.6 billion).

Given concerns over quality of healthcare provision in PPPs – for example due to downward pressure on staff and bed numbers (see Box 5) – the relative preparedness of PPPs to deal with the pandemic merits scrutiny. Particularly in light of recent [UNDP research](#) which concluded that policies which privatise healthcare systems in order to "boost efficiency" in the short term, "reduce countries' long-term preparedness for dealing with pandemics".



► Image: Martin Bertrand

Box 4: Not PFI for purpose: private debts before pandemic preparedness

The UK may have left the EU, but the legacy of the Private Finance Initiative (PFI) model it exported to Europe is longer-lasting. PFIs, widely used in the UK since the early 1990s, involve private companies building National Health Service (NHS) hospitals and leasing them back to the NHS. Immensely profitable for the companies, the interest lands hospitals with billions in PFI debts – one UK hospital, for example, is tied to 40+ year PFIs that will see it pay back £7bn on contracts worth £1.1bn.

Academics have noted that the diversion of funds from other budgets to PFI payments make them “an engine for closure of public services and further privatisation”, while many UK PFI hospitals have faced “loss of bed capacity, loss of staff, and loss of other services” to pay the increasing contract costs. As UK hospitals struggled under the weight of COVID-19 cases in April 2020, Professor Richard Murphy flagged the £55 billion of PFI debts the NHS was facing (up to one sixth of all spending in some NHS trusts), and called for that debt to be cancelled.

The European Public Services Union has flagged the Commission’s efforts to roll out the UK’s PFI model across Europe, despite “no evidence of being a cheaper, more efficient or innovative method of providing public services.” Even the study DG SANTE commissioned found “strong evidence” that restrictive PFI contracts can “have an adverse effect on patient quality and financial performance”.

Yet in EU member states such as Spain, the PFI model was given new life by post-2008 financial crisis adjustment policies (see Part 4): hospitals could be built without public administrations incurring a deficit, as required by the EU’s Stability and Growth Pact, even as they increased government debt. In Madrid, the construction of seven new PFI hospitals has – thanks to annual fees paid back to the private companies, who continued to operate ‘non-health’ services – meant much higher costs for the public sector than if it had carried out the works itself.

As Xavier Sol from Counter Balance has noted, “a profound change of mindset” is needed to avoid repeating past mistakes; COVID-19 has shed light on such failures, with “support for Public Private Partnerships – that the EIB has heavily promoted over the last decades – having played an important part in dismantling public health structures and undermining the universal right to health.” But what’s worrying, as Sol points out, is that “there may be further pushes for PPPs in the post COVID-19 economic recovery plans.”

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Certainly, private hospitals are keen to get a slice of the recovery funds, as UEHP’s lobbying through the EU Health Coalition shows (see Part 1). Meanwhile, one advisor to the European Commission, consulted by the High-Level Task Force on Investing in Social Infrastructure in Europe, published a paper in September 2020 anticipating that the share of private investment in health “could rise to nearly 60% from the current share of 35% by 2040”. It advises policy-makers that there should be “No retrospective changes of rules and regulations; especially [as] PPPs require time and a high degree of trust to succeed,” and calls for a “public-private EU fund for social infrastructure”.

Box 5: Pushing private interests? McKinsey's confidential COVID-19 work for the Commission

In 2017 we noted the key role that global accounting and consultancy firms have played in “promoting health sector reform by supporting governments to introduce internal markets to public health care systems”, as described by the Public Services International Research Unit. McKinsey, for example, is known for its integral role in the creeping privatisation of the UK NHS, from advising on structural reforms to brokering meetings between health officials and private hospital firms.

Documents released under freedom of information law – albeit after a four month wait – reveal that McKinsey & Company wrote to Health Commissioner Kyriakides at the beginning of March offering to help shape the EU's response to the COVID-19 pandemic:

“On our side,” wrote McKinsey & Company Belgium and Luxembourg, “we have been centrally involved in helping governments and multi-lateral institutions shape their response to several global health crises, including SARS, MERS, and Ebola, in recent years. We have also helped WHO rethink approaches to health emergencies and are actively engaged in aiding governments – often in partnership with the private sector – organise effectively in the face of COVID19”.

The global management consultancy wanted to discuss how it “can best assist in the EU's crisis response to COVID-19” and offered “to field a pro bono team on crisis response in the relevant structure of the EU Institutions” which “could leverage our many capabilities and resources”. In response, DG SANTE suggested a video conference to discuss their “kind offer”, and then... ACCESS DENIED.

Further correspondence between DG SANTE and McKinsey was refused on the grounds that the four later documents⁶ contained – according to McKinsey – details which would allow readers to “draw conclusions about the company's methodologies and unique approach to problem solving for its client work which is commercially sensitive, proprietary and confidential.”

Thus in the midst of a pandemic – a health crisis of a scale the EU has not previously known – the public is denied information about whether a firm renowned for guiding governments towards greater healthcare privatisation has been allowed to shape the EU's COVID-19 response, because of that firm's ‘commercial confidentiality’.

As for the “client work” McKinsey does, its clients are undisclosed, but certainly include private healthcare. McKinsey & Company is not in the Transparency Register⁷ (as of 3 November 2020), but McKinsey Global Institute, “the business and economics research arm of McKinsey & Company” is, and has held several top-level Covid-related meetings with the Commission.⁸

The Commission's decision to put commercial confidentiality before the public interest during a pandemic is a huge lapse of transparency, which – as the European Ombudsman says – must be upheld “not despite the crisis, but precisely because of the crisis”.

6 / According to the document list released by DG SANTE these four documents included one more on the same subject, namely ‘COVID-19 outbreaks - potential pro bono support’ on 03/04/20 [Doc no. 33], two with the subject ‘Follow-up phone call with McKinsey’ on 14/04/20 and 29/04/20 [Docs no. 36 and 41], and one with the subject ‘McKinsey - RE: Testing’ on 22/05/20 [Doc no. 42].

7 / Though it has been in the past, as various entries for McKinsey & Company in Lobbyfacts.eu show.

8 / On 16 September 2020 with Anne Bucher, Director-General Health and Food Safety (SANTE), as part of an “External strategic and performance analysis of ECDC [European Centre for Disease Prevention and Control] response to COVID19”. And on 26 June 2020, with Frans Timmermans, Commissioner for the European Green Deal, to discuss “Post-COVID stimulus: How to bring EU economic and environmental priorities together”.

4. EU economic governance: a deadly legacy on health?

No examination of the pressures towards privatisation would be complete without looking at the history of the EU's economic governance, a major driver of public spending cuts in healthcare. Shortly after the eurocrisis broke out in the aftermath of the 2008 financial crash the EU started adopting a series of new procedures to reform member states' economic policies. Budgets were to be policed more strictly, and member states were to be encouraged to adopt more 'structural reforms' that were believed to be conducive to growth.

The EU's rules on economic and fiscal policies have an impact on member states' health budgets in several ways. The root of that competence lies in the so-called Stability and Growth Pact (SGP) which impels member states to keep their budget deficits below 3 per cent and their debts below 60 per cent of GDP. But there are many roads from Brussels to EU capitals: the enforcement of rules on economic and fiscal policy takes place through a plethora of procedures, and the health sector is potentially affected by all of them.

Loan programmes and the ECB: Most starkly, this can happen through a loan agreement, such as the ones concluded between the EU and Greece and Portugal in the aftermath of the financial crisis and the eurocrisis. In [Portugal's loan agreement](#) (Memorandum of Understanding) from 2011, reduction of costs in the health sector ranked high among the demands of the creditors in the EU. As a consequence, the expenses for staff in the Portuguese health sector were [reduced by a full 27 per cent](#) between 2010 and 2012. In the same vein, in Greece three consecutive adjustment programmes tied to loans led to a sharp fall – approximately 40 per cent – in health expenditure per capita between 2010 and 2016, according to [data from the World Bank](#).

Italy, though hard hit by the financial and economic crisis, was never subject to an adjustment programme; instead, the European Central Bank put pressure on the Italian government to reform health spending, most famously in [a letter](#) from the European Central Bank that demanded swift reforms, including cuts in healthcare. In the following years the Italian government did just that. One legacy from this era is the lower number of hospital beds, discussed in Part 1: and indeed, the number of acute beds per 100,000 inhabitants [dropped by 13 per cent](#) from 2010 to 2015, a trend that had not been reversed when COVID-19 hit. This is very significant for the pandemic as higher hospital bed capacity has been [found to lower](#) COVID-19 mortality rates.

Also telling is that while Italy and Germany had a similar number of hospital beds per 1000 in 1990 (Italy 7, Germany slightly higher), after ten years of post-2008 crisis austerity, in which Italy's health budget was slashed partly to comply with EU expenditure rules, [Italy had dropped to 2.6 beds per 1000, while Germany remained above 6](#). In that same period, 2008 to 2018, Germany nearly doubled its total public health care expenditure (in nominal terms ie including inflation), while Italy's increased by only 5.3 per cent.

The European Semester: The economic governance procedure that affects the most countries, however, is the European Semester. Set up in the early stages of the eurocrisis, the European Semester was designed as a tool to keep member states' economic and fiscal policies under closer surveillance. Each year the Commission drafts recommendations to every member state (except those covered by an adjustment programme tied to a loan agreement, as explained above). A discussion in the Council follows, which then adopts the final recommendations in June or July – almost always recommendations identical or similar to the Commission's.⁹

⁹ / According to CEO's count of all recommendations to date on health, the Council passed in all substance identical recommendations in 100 of a total of 107 recommendations between 2011 and 2020.



► Image: Martin Bertrand

For most governments, the recommendations are of little consequence, for others – those with economic woes – they send a very serious message. The European Semester forms part of the EU's 'economic governance' and is, first and foremost, set up to prevent member states from violating budgetary rules on deficits, debt and so-called 'macro-economic imbalances', for which the Commission can propose a fine.

The member states whose economies are in a poor state for whatever reason will receive recommendations that address those matters in particular. They are typically about bringing expenses under control through cuts, though they can – as in the case of [France in 2016](#) – be about the implementation of labour market reforms that make collective bargaining less favourable to workers.

Health has been an important and recurring theme since the first European Semester in 2011. In total, the Commission has issued 107 recommendations related to the health sector (including 'long term care'). Bearing in mind that each country typically received 4-5 recommendations annually, this shows health to be a major issue.

Health on the business agenda: including healthcare in the EU's 'economic governance' recommendations has been supported and pushed for by big business. The employers' association BusinessEurope – one of the most powerful lobby

groups in Brussels – produces a report called Reform Barometer every year in an attempt to influence the recommendations. In all reports, health is a standard theme and when ranking its proposals, reforms of the health sector and the pensions system (treated as one cluster) made third or fourth place every year since its inception in 2011 (with 'tax reform' and 'business environment/regulation' topping the lists).

In BusinessEurope's latest edition of the Reform Barometer, from March 2020, 'health' slipped to fifth place, which might appear strange given the COVID-19 context. But BusinessEurope's main interest in the European Semester is not to seek healthcare improvements, but to ensure taxes on business are not raised to accrue resources to sustain the public health sector.

In six of the nine Reform Barometer reports released between 2012 and 2020, BusinessEurope makes the following comment (or a slight variation thereof) on taxation levels and policy choices linked to the provision of public healthcare: "many Member States are at, or approaching, the point where tax levels are harmful for growth by weakening incentives for both investment and workers to enter the labour market." (Reform Barometer from the years 2013 to 2018). Clearly, BusinessEurope is seeking an austerity approach to health, often in conjunction with pension reforms, to avoid higher taxes.

Documents released by the European Commission also show that it consults with private healthcare providers when drafting its European Semester Country Reports. As part of a Commission fact finding mission to Paris in November 2018 (in [the “context of the drafting”](#) of the 2019 reports on macroeconomic imbalances and 2019 country report on France), DG ECFIN and DG SANTE [invited the French private hospitals lobby FHP](#), alongside the French [public hospital association FHF](#), to share its views.

The Commission in sync: The Commission is in full sync with BusinessEurope’s approach, and follows member states’ expenditure on healthcare with great zeal. Of the 107 recommendations adopted from 2011 to 2019, a full 76 suggest either reforms to improve the ‘cost effectiveness’ of healthcare, or outright cuts. Here, as in other areas, the most frequent advice is about the cost-effectiveness of the healthcare system, a recommendation proposed by the Commission and adopted 39 times since 2011. On the list of proposed areas for investment, health appears in less than a handful of cases. This suggests that the term ‘cost effectiveness’ is little more than a call for cuts – an assessment often confirmed by events.

The argument is squarely about public finances, as with Slovakia in 2018: “Healthcare expenditure continues to pose a risk to the long-term sustainability of public finances as increasing the cost effectiveness of healthcare in Slovakia remains a challenge.” Or [Germany in 2014](#): “Only limited progress has been made by Germany in enhancing the cost effectiveness of public spending on healthcare and long-term care, although new initiatives have been announced. While their aim is to improve the cost-effectiveness of health care, these plans might not be sufficient to contain expected future cost increases.”

With respect to Italy, whose hospital system was so overwhelmed in the pandemic’s first wave (see Box 1), the Commission’s 2019 Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability concluded that “reforms implemented in recent years... to improve

efficiency... [and] to control overall expenditure... were to a very large extent successful and, therefore, Italy should continue to pursue them.” It identified the main challenges for Italy being to “continue increasing the efficiency of health care spending” and ensuring that “regions showing deficit in the health sector budget restore the balance and ensure efficiency”.

Soft push for hard austerity: This is hardly surprising. As three academics remarked in [a paper](#) in 2015: “The hierarchy and subordination of policies within the European institutions is not something new and has been reported elsewhere confirming the observed tendency of linking health goals more closely to the EU’s economic growth narrative rather than valuing the health policy objectives in their own right. Despite the existence of official documents supporting the need to invest in health, investments in health infrastructure and human resources as a prerequisite for economic growth do not feature as a priority.”

This has significant implications in the context of COVID-19’s economic impact: if Europe’s health systems had been better equipped to handle the pandemic, it may not have led to such major economic impacts. Well-resourced systems, with enough trained care home workers, nurses, hospital beds, PPE, and so on, would have been in less danger of being overwhelmed, potentially ameliorating the need for such strict lockdowns, with their resultant economic impacts.

Yet well-resourced public health systems have been actively discouraged by the myopic approach to healthcare under the European Semester – one that pushes for solutions that prevent costs from going up, and preferably brings them down. Often this is spelled out explicitly: six countries were asked to reduce access to early retirement,¹⁰ while a recommendation to look closely at hospital spending by cutting costs (for example, by reducing hospital treatment (outpatient care), or introducing ‘activity based funding’) was approved for four countries (Lithuania, Bulgaria,

10 / Malta 2018 and 2019, Croatia 2014, Luxembourg 2014, Austria 2014 and 2018, the Czech Republic 2013, and Belgium in 2012, 2013, 2014, and 2019.

...when Europe emerges from the pandemic in poor economic shape, EU economic governance rules will be switched back on, likely requiring more public spending cuts, including to healthcare.

Romania, and Ireland). Hence when COVID-19 first hit, many member states had brought down the number of hospital beds available: according to [Eurostat](#), between “2012 and 2017, the number of hospital beds in the EU-28 decreased by 3.3%”, in some cases at a rapid pace.

Leveraging Spain’s healthcare cuts: It is difficult or impossible to identify the exact effect of this pressure on member state governments, as the European Semester is only one piece of a bigger puzzle. The significance of the European Semester depends on how a country is faring with regards to the rules on debt, deficits, and other macroeconomic indicators that led to the European Semester in the first place. But Spain is a telling example of just how important the European Semester can be: [in a loan agreement in 2012](#), concluded to support the country’s financial sector, the Spanish Government was required to comply fully with “the recommendations to address macroeconomic imbalances within the framework of the European Semester”.

This opened the door to very direct intervention by the Commission into decision-making on the budget for health. Recommendations in [2013](#) and [2014](#), for example, asking for ‘cost effectiveness’ in the Spanish health sector were to have dire consequences. In 2012 the Spanish Government presented a law to cut costs (Royal Decree Law 16/2012) in the health sector. Its preamble, as [noted](#) by Amnesty International Spain, stated that the immediate application of the law was “necessary, in the current socio-economic context”, and its measures were needed to respond to factors including the “viability required by the European Union”.

According to Amnesty International, this led to a reduction of 28,500 staff in the Spanish public health system between 2012 and 2014 (when the total number was approximately 477,000). This is hugely significant for the COVID-19 crisis, throughout which lack of staff has been a major issue for overwhelmed Spanish hospitals, and the subsequent high fatality rates.

Post-pandemic Semester could force more cuts: The days of the European Semester’s role in member states’ health strategies are far from over. The recommendations issued by the Council in the midst of the pandemic, in June 2020, stress that at the moment the most imposing rules on budgets, debt, and deficits are suspended. But when the crisis has passed, this waiver will be lifted again and member states will have to return to normal, once more starting to work towards the objectives on debt and deficit.

At that point, there is little doubt that most member states’ economies will be in dire straits, while the importance of the European Semester will have been boosted significantly. As it stands the largest chunk of the EU’s COVID-19 economic recovery funds will be distributed through the European Semester. In other words, there will be conditionalities attached: if they want the EU funding, they’ll have to live up to the country specific recommendations.

There will, no doubt, be recommendations of great variety, as for some years now the European Semester has included ideas to support education, youth employment, and other ‘social’ recommendations. But the recommendations that have ‘teeth’ are those that are tabled to make sure that the policies and expenditure of a member state are in line the rules on debt, deficits, and macroeconomic imbalances.

What this means is that when Europe emerges from the pandemic in poor economic shape, EU economic governance rules will be switched back on, likely requiring more public spending cuts, including to healthcare. Yet the pandemic demonstrates that exactly the opposite is needed, particularly as [scientists warn](#) there are likely to be more pandemics to come thanks to the rate of biodiversity destruction.

Conclusion

The marketisation of health and long-term care, the push for PPPs, and the public spending cuts encouraged by EU economic governance, have all contributed to the increased privatisation of health and long-term care services, putting Europe on poor footing when it came to facing a pandemic. The effects of this pandemic will continue to be felt for a long time; it is for all our sakes that we need to confront and challenge the interests, and ideology, that have been all-too-successful at incrementally transferring public healthcare into private, for-profit, hands.

As six UN special rapporteurs [recently testified](#), COVID-19 has exposed the catastrophic impact of privatising vital services. They observed that states “are not absolved of their human rights obligations by delegating core goods and services to private companies and the market”, yet contracting out public goods and services transforms rights holders “into the clients of private companies dedicated to profit maximisation and accountable not to the public but to shareholders”. Even more damningly, [UNDP analysis found](#) that healthcare privatisation contributes to greater spread of, and more deaths from, COVID-19. People are dying during this pandemic because of privatisation. Fighting the privatisation of health and care services is a fight to save lives.

In November 2020 the European Commission presented its initial proposal for a European Health Union, which would give the EU more power over health policy. The proposal included a range of initiatives that can be achieved without changing the EU treaties, ranging from an EU-wide pandemic preparedness plan to the proposed new health emergency agency.

At the moment, health policy is primarily a member state responsibility, and the EU institutions have limited formal powers. There is clearly a strong case for better coordination between EU governments in tackling pandemics, but seeing how combined EU policy pressures – as documented in this report – have contributed to the weakening of public healthcare systems, a key question is what the EU would do with more power over health policy.

The goals of the European Health Union, [says Health Commissioner Stella Kyriakides](#), are about “facing up to common health threats together as a union ... and building strong EU health systems overall that can deliver better outcomes for EU citizens and their daily lives.” Strong health systems are indeed what’s needed, but it is crucially important to define more clearly how this is to be achieved. The Commission’s communication includes an [EU health crisis/pandemic preparedness and response plan](#), with measures including:

- Enhanced member state reporting of preparedness and response plans;
- Regular public health and cross sector stress tests carried out at national and EU levels;
- Support to member states to strengthen the resilience, accessibility, and effectiveness of health systems through co-operation, training, technical support, and financing from EU programmes.

As part of its crisis response policies the EU has also launched a multi-billion [EU4Health](#) funding programme for 2021-2027, “to build resilient health systems in the EU to better equip us for the future”. Alongside proposed measures to tackle cross-border health threats and make medicines available and affordable, EU4Health includes a third pillar of ‘strengthening health systems’. Under this point, the Commission wants to “improve accessibility, efficiency

and resilience of health systems” and “reduce inequalities in accessing health care”. Concrete proposals for strengthening health systems are still to be presented.

What is noticeably missing, however, is any recognition of the importance of the public and not-for-profit nature of healthcare systems. The Commission has historically (and erroneously) equated greater ‘efficiency’ with more private provision; proposals to improve efficiency will, therefore, merit particular scrutiny. Furthermore, this report has shown that it is equally essential for the EU to decide what not to do. To strengthen health systems in Europe, the EU should terminate neoliberal policies that have resulted in damaging budget cuts and created pressures to privatise and commercialise healthcare and elderly care systems, thereby weakening Europe’s pandemic preparedness.



► Image: Martin Bertrand

Concretely, the EU should:

- **End austerity**, starting with a commitment not to return to pre-COVID-19 austerity rules, including the Fiscal Compact, and keep the escape clause working (ie a continued freeze of the EU's Stability and Growth Pact). Clearly including healthcare in a procedure intended to enforce austerity policies has had some dire consequences, and the European Semester in the future could undermine good initiatives taken elsewhere. Thus we also need an overhaul of the economic governance system and measures to enable public investment in healthcare (including strong action to end tax avoidance and tax evasion).
- **Remove the pressures towards liberalisation**, commercialisation, and privatisation that undermine public healthcare systems and the welfare state more generally. This should start with an overhaul of European Commission policies, culminating in a moratorium on any policies that contribute to such pressures, to be followed by changes to EU directives (Cross-Border Care, procurement, concessions, etc) and the EU treaties.
- **Ensure that COVID-19 recovery funds are used to strengthen public hospitals and healthcare provision**, rather than for-profit, private hospitals. This includes the €9.4 billion EU4Health funding programme. Furthermore, any European Health Union must safeguard the future, and resilience, of public not-for-profit healthcare systems that can meet the needs of all, including during health emergencies.
- **Protect public services** from being further [prised open by the EU's trade and investment agenda](#), and ensure that other areas of the European health agenda – from digitalisation to integrated care – are not co-opted by private for-profit companies attempting to increase their market share, and profits.

The COVID-19 pandemic has been a wake-up call for many people, both in terms of the value of health and care workers (as well as all other key workers), and in terms of how ill-prepared for the pandemic many health systems and long-term care services were. Privatisation, commercialisation, and marketisation of health and care services are a major reason why this was the case, as this analysis has shown.

Now people across Europe are mobilising for a better future for these vital public services. Trade unions and campaigning groups, together with thousands of health and social care workers, have [been demonstrating](#) for increased health funding, better pay and conditions for workers, increased staffing, and a block on closures and privatisation. And on 7 April 2021 ([World Health Day](#)), you can join the Day of Action for #Health4All, coordinated by the [European Network Against the Commercialisation and Privatisation of Health and Social Protection](#).

The 7 April day of action will focus on the European Citizens Initiative and the demand to invest more in healthcare and health workers. [<https://noprofitonpandemic.eu>] There will be decentralised actions throughout Europe. Keep an eye on the website of the network or email <europeanhealthnetwork@gmail.com> to receive information about how to get involved.

Published by Corporate Europe Observatory (CEO), Brussels, January 2021.

Written by Rachel Tansey and edited by James O’Nions. Authorial contributions from Olivier Hoedeman, Katharine Ainger and Kenneth Haar. With thanks to Sarah Melsens (European Network against the Commercialization and Privatization of Health and Social Protection), Jan Willem Goudriaan, Luca Scarpiello and Jakob Embacher (European Public Service Union), Borja Arue (AGE Platform Europe) and Leigh Haynes (Peoples Health Movement). Designed by Emily Sadler.

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