

Opening

Our research at Aristotle University together with networks of People's Health Movement around the world investigated how privatization of healthcare done before and during the pandemic impacted services.

For the past decades international financial institutions along with a network of investment and central banks have influenced or even pushed countries to implement monetarist policies that are more ideological than evidence-based, to facilitate global capitalists' agenda.

The ideology I'm speaking of here is what's known as Neoliberalism. In public health we define neoliberalism as the vigorous promotion of markets combined with a reduction in governance. Governments have been forced to make large cuts in public spending to meet arbitrary and strict budget deficit target. Sectors that are deemed wasteful, like health, social, and education sectors are usually the first to get attacked. Decades of austerity have slowly eroded Europe's welfarism while privatization hailed as the ultimate solution to meet public needs.

We describe all these in much more detail in at least 3 chapters of the new Global Health Watch 6.

So, how have these decades-old policies impact public health services and financing and created various problems during the Covid19 pandemic?

Financing and data

Low govt prioritization and underfunding over the last 25 years have eroded basic public health functions. Even in countries with social security organizations, testing and contact tracing had to be contracted out to for-profit providers. This has prevented authorities to have comprehensive and timely knowledge of the virus' spread and led to significant resurgences which then forced authorities to enforce lockdowns.

Private health insurance also created some hurdles. Co-payments and deductibles have discouraged sick patients, especially with the rise of unemployment and insecure job contracts. Costs of treatment were charged even when Covid-19 hospitalization fees were waived. There are also issues when making covid-19 hospitalization claims; pre-existing conditions often cited as reason for non-coverage.

PHC

When cuts are made, primary care and public health programs had been the first to go while at the same time the commercial actors didn't find them lucrative. So for decades, this part of the health system which is key in detecting and controlling outbreaks has been severely neglected. Decades of adjustment programs and austerity have weakened PHC networks, severely limiting its capacity to serve the public and to raise public health awareness in communities. This of course then made managing Covid-19 disinformation very difficult as there was no existing infrastructure and mechanism to penetrate the communities and build trust.

We also saw acceleration of push for digitalization and telemedicine in PHC, introduced to replace GPs and to counterbalance the disruption in provision, but all relied on unregulated or limited regulation of private technology and increases inequalities in marginalized groups.

Hospital

Expansion of private-for-profit hospitals in the name of improving efficiency is also common. Fiscal decentralization policy also has facilitated regional outsourcing of hospital provision.

For-profit hospitals were reluctant to take possible COVID-19 cases and unwilling to compromise in their more profitable services. In Ireland, the UK, Italy and Greece, private hospitals admitted COVID-19 patients in a very limited manner and only after having secured lucrative contracts with governments or after having been forced to do so through compensated requisitions. Nevertheless, there are many reports of Covid-19 cases kept getting redirected to unsubsidized private beds, for which patients were charged higher, because of unregulated fees.

Care Homes

The worst of the pandemic in the developed economies, including the EU, had been in long-term care. There has been a lack of public investment and political will to address longterm care policy and provision. Public care homes were known to be chronically under-funded and under-staffed.

Austerity has resulted in commercialized elderly care facilities to flourish to meet the need of aging populations. But these were under-resourced despite government subsidies and have been known to cut corners in staffing and equipment to maximize profits which often result in lower quality of care. There is mounting evidence that PFP care homes significantly contributed to the COVID-19 mortality crisis in European countries.

Public ownership matters. The evidence suggests that public or government-run care homes performed better during the pandemic.

Closing

I'm sure the rest of the panels here will testify from their experience at the frontlines to further illustrate what I've described.

To close, we need to increase public financing, predominantly through progressive taxation, and by this, I mean taxing corporates and sections of the society who profitted most from health-related privatization. There needs to be direct public investments for new public infrastructure and modernization of existing public facilities, empowerment and support of public healthcare workers, and re-socialization of essential health services (including long-term care) to safeguard European societies.