



# Because health is a right

Vision  
paper



geneeskunde   
voor het volk  
médecine  
pour le peuple



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# Introduction

Dear healthcare worker, Dear patient,  
Dear reader,

Let us share three stories from our patients – stories that are easy to relate to.

**Abdel** is a lorry driver. He works in a roadside assistance company and travels our roads every day repairing the lorries that transport our food, furniture and goods. Without Abdel and all of his colleagues, the shelves in our shops would be very empty. Abdel is 52 years old when his back gives way: broken, worn out. From now on, disability awaits him. As the sole breadwinner for a family of six, he's constantly counting and budgeting just to get to the end of the month. His employer's reaction? He fires Abdel and simply hires someone else. He has no responsibility, there is no due notice period to pay, nothing. After 28 years of service. How is that possible? Abdel is not the only one in his situation. At MPLP we are conducting an end-of-career study to show that working longer is not possible.

**Rosa** is 93 years old. She is a valiant woman who still lives in her own apartment. Last week, she burst into tears during a home visit. Things aren't good. Rosa finds it more and more difficult to move around and has to go into a nursing home. Tears are running down her cheeks. She has financial concerns: Will I be able to afford it with my 856 euro pension? Will my children have to pay for it? Her tears also express fear. Fear of losing her quality of life. Fear of having to go to bed at 5:00 p.m. due to a lack of staff. Fear of not having good meals any more. This is unacceptable. Rosa is not the only one in her situation. With MPLP, we are launching a petition for more investments in health care.

**Laura** is 23 years old and suffers from an autoimmune disorder. This causes painful inflammation in the groin and armpits. She can't sleep, she can't do her cleaning job properly without suffering terrible pain. The dermatologist prescribes a treatment. An expensive medication, but one that works. The inflammation decreases. Fortunately, it is covered by social security. Until it turns out that Laura needs a higher dose than most patients, which is not refunded by the health insurance company. Her doctors are doing everything they can to get free samples from the pharmaceutical company, but each new prescription leaves Laura anxiously waiting to see if there's enough without having to spend most of her salary on medication. Laura is not the only one in her situation. With MPLP, we are taking action for affordable medication.

A job that makes people ill, care that's too expensive due to commercialisation, unaffordable medication, etc. These are just some of the challenges that lie ahead. In response, Medics for the People presents a vision paper full of inspiring analysis and innovative ideas. In Chapter 1, we examine the social determinants of health. In other words: why do people get ill? How can employers be made more responsible for the health of their employees? How do housing, climate, economic policies, etc., affect our health? How can we make health a fundamental right?

In Chapter 2, we take a closer look at our healthcare system. How can we not only treat people who are ill, but also prevent people from getting ill? And how do we make this happen for everyone? Work pressure, high bills, inequalities, etc. What is causing all these problems? In Chapter 3, we are at the cradle of a true Salk Institute for medicine research and development. How to develop medicines according to the needs of the population? You will discover the answer to all these questions.

In 2009, we published our previous vision paper, *The Right to Health in a Healthy Society*. The presentation of this vision paper was one of the first activities I attended as a newly qualified young nurse. An inspiring moment, for me and for many others. The vision of Medics for the People is what unites us in our commitment to better health care and a better world. This vision is what protects us the most from the harsh weather of our time, from the stress of the many challenges that await us.

It is now thirteen years later, and the world has not stopped. Not only have we all inexorably aged, but it's getting worse: Inequalities are increasing, health care is becoming more and more expensive, the share of medicine costs in our social security system is rising, one government after another continues to neglect prevention. Fortunately, Medics for the People has not stopped either. More and more healthcare professionals, in more disciplines than ever, are finding their way into our medical centres. Both the multidisciplinary medical centre and the action centre have really developed. From the introduction of front-line psychologists to the follow-up of chronic patients by nurses, to rigorous triage by reception staff. From the fight against cost-cutting at local health centres to busloads of patients crossing the Dutch border to buy cheaper medication, to protesting against the track down of long-term patients. This vision paper is an exercise in looking at the larger picture. In 2020, we decided to embark on this work. What better occasion than our 50th anniversary?

And then, in March 2020, the world stopped for a moment. A virus took over our lives, our work, our society. As we work in the health sector, we saw all aspects of the situation. We were fighting the unknown. And yet, once again, it was our vision that kept us on our feet and showed us the way. Our vision of work and health sent us into enterprises to help with testing. We established a protocol to support trade unionists in their fight for workplace safety. Based on our vision of health care, we have set up local contact research, and assisted nursing homes in their need for materials, testing and staff. Based on our vision on medications, we have taken the initiative towards the European campaign No Profit on Pandemic, which aims to lift patents from the pharmaceutical industry on the vaccine. The coronavirus gave an extra shock to a model that was already shaky. It was THE moment to put forward our ambitious and innovative ideas.

This paper is not the product of just one single brilliant mind. As always at Medics for the People, this is the result of an exceptional collaboration. Dozens of colleagues and volunteers have contributed: after the first draft, we discussed our ideas with all the teams and various experts; the paper was then cast in its final, much improved version. I would like to thank everyone who has participated. From now on, it's a question of distributing this paper as widely as possible.

Medics for the People would not be Medics for the People if we just sat on ideas. No matter how good the ideas are, practice is the cornerstone of our daily work. Our 25,000 patients, 220 staff members and hundreds of volunteers speak out about health, living and working conditions and the right to accessible care and medication. Every day, stories keep pouring in into our medical centres. Stories like those of Abdel, Rosa and Laura.

It's with these stories that we set to work. We discuss them in team meetings, analyse the social causes of the disorders, conduct additional research and scientific studies, look for inspiring external examples, and then go back to the patients.

For example, Abdel gets up to speak at an information evening on work and health and Rosa signs our petition for investments in care for the elderly. Laura and her family come to an action for cheaper medication. Together, we speak to the press and tell our stories on social media. Our elected doctors and staff members bring them to Parliament and to the local councils. We are working with the PTB to put the issues on the political agenda, on the streets and in the councils. We enable patients to defend the right to health.

We call this process "empowerment". In the final chapter of this vision paper, we explain our approach to this process in the eleven Medics for the People medical centres. This chapter is new from our previous vision paper. But this is the very essence of Medics for the People. Understand the world in order to change it.

Medics for the People has been working for fifty years on the right to health; as a medical centre and as an action centre. Both are one and inseparable. The first generation of doctors and collaborators of Medics for the People decided not to make a career for themselves, but to build a different society with all their heart, head and hands. The current generation of doctors, nurses, reception staff, etc., plans to add many more years to this. Until everyone has the right to health.

There are significant challenges. Going to your GP without money, expanding the local health centre system, opposing the overly high salaries of specialists and the workload in health care, breaking patents that kill... It is normal to wonder if all this is possible. Can a system be changed so radically? Since the 1980s, we have witnessed the domination of the neoliberal idea that the free market always works best. This can be noticed not only among politicians, but also, for example, in hospital management, where financial managers are called in to run hospital institutions. Moreover, after the 2008 crisis, budget cuts accelerated everything.

The coronavirus has been a shock wave for the world, and shocks to the world. This can go in two directions: on the one side towards an even more commercial logic, or on the other side towards a more social, more public logic. They want us to believe that there is no alternative for the current neoliberal policy? The construction of the social security system after World War II shows us that reversal is possible. Under pressure from the grassroots, a more social logic has emerged. Again, we decide which direction we want to encourage. Two years ago we had to pay our last respects to Dirk Van Duppen, "Kiwi" doctor and president of Medics for the People. He left us hope for a better world.

I love hope,  
the opposite of fear.  
Fear calls for passivity, lethargy,  
it chases you off, trembling, under your bed.  
Hope teaches you to stand up and sing,  
perhaps timidly at first,  
like a swallow,  
but as time goes by, in a more determined way

(excerpt from:  
Ainsi s'est écoulé le temps qui m'était compté)

Are you a healthcare professional who wants to help nurture that hope? Then you are at home at Medics for the People. Indeed, changing society is a huge task. This can only be done if we unite to defend everyone's rights. In your consulting room, you cure diseases; together, in action, you cure the whole society.



Happy reading!

**Janneke Ronse**

1st April 2022

President of Medics for the People

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## Chapter 1

# Health, a question of fighting social injustice



- 1. Our health is determined by our living and working conditions**
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# 1. Our health is determined by our living and working conditions



*"Why treat people without changing what makes them sick?"*

Michael Marmot – Chair of the WHO Commission on Social Determinants of Health, 2008'

In this vision paper, we want to identify the circumstances that make people ill. A dockworker with a bad back or a cleaning lady with chronic wrist pain is of course given painkillers and, if necessary, they are granted a few days of sick leave. But what structural solution do we provide if these people have to continue to move heavy loads, operate drills, wring out mops and drag buckets all day? Often, as healthcare professionals, we cannot solve patient problems within the four walls of our consulting room





## "Show me your lungs and I'll tell you where you live"

The fight against the Lange Wapper viaduct in Antwerp started at our medical centre in Deurne. We found that six out of ten young children needed an inhaler, compared to only one in ten in a rural community about 40 kilometres away. We then found the explanation for this difference in the scientific journal 'The Lancet': a study showed that children who live near a motorway have less healthy lungs. That same week, we heard about the viaduct construction project "Lange Wapper". If completed, the Antwerp ring road would rumble over the densely populated residential areas of our neighbourhood. We knew that this would be a public health disaster. We built a case based on scientific evidence and started the resistance with patients, action groups and civil society.

The fight was long. It lasted more than 10 years. A fight that doctor Dirk Van Duppen recalls with emotion in his book entitled "Ainsi s'est écoulé le temps qui m'était compté". We have made as many people as possible aware of the effects of air and noise pollution on our health by organising actions and information evenings. It was the fight of David against Goliath. We were up against the powerful lobby of concrete construction contractors, enticed by a large and particularly lucrative assignment. But against the power of money and the lobby of contractors, we had the power of numbers. We raised awareness, mobilised and organised in every part of the city. Together with the citizen movements Ademloos and StRaten Generaal, we finally collected more than 50,000 signatures to force the city to organise a referendum. In this, the people voted against the Lange Wapper viaduct. The mayor, Patrick Janssens, had to back away. Years of bickering, legal and political games, information evenings and demonstrations have gone by. In the end, a much better alternative was proposed: covering the ring road. Browning this project to fruition remains a struggle, but everything has been set in motion to make it happen.

**Sofie Blancke**  
doctor, MPLP Deurne

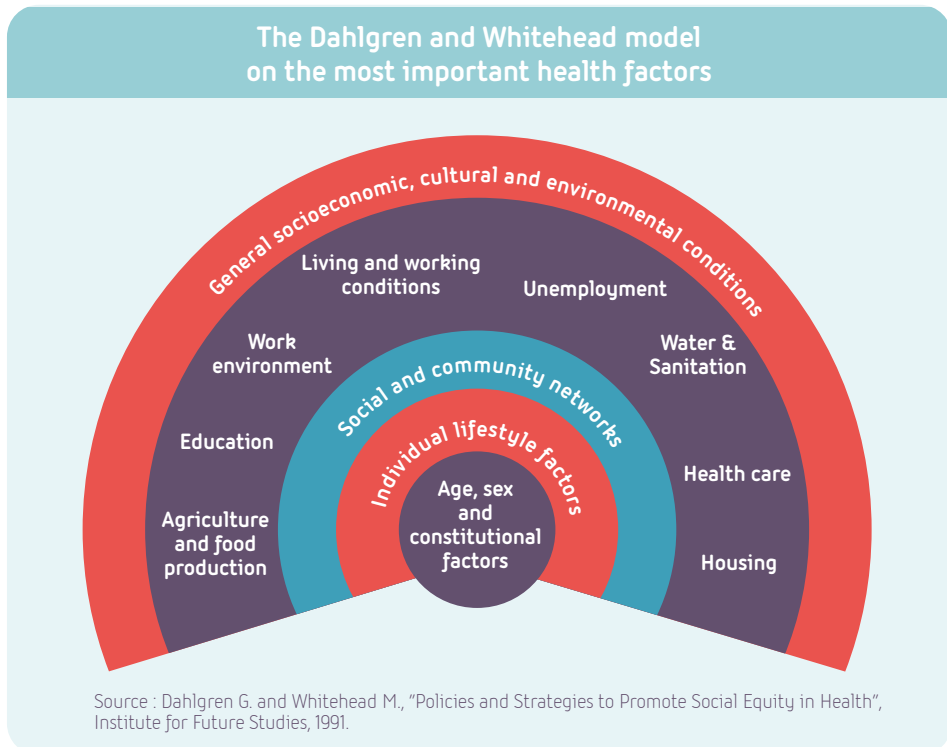


## Social determinants of health

Health is very much determined by the conditions in which people are born, grow, work and age. These are all factors that lie outside the health sector. They are known as the "social determinants of health".

Researchers Margaret Whitehead and Göran Dahlgren studied the different factors that determine our health and concluded that they could classify them into different "layers". These are depicted in the "rainbow" diagram they developed.<sup>2</sup> In the centre are the factors that we can hardly control: age, gender, genetic factors, etc. Then, in the second layer, there are a number

of factors related to our individual behaviour. These include smoking, diet and exercise. Then there are factors related to our immediate environment: where we live, for example. And finally, in the outer circle, we find the broader socio-economic conditions in which we live (where we work, the conditions in which we live, household income, etc.).



In fact, it's the factors in the outer layer that have the greatest influence. Biological and hereditary factors play only a minor role. Canadian researchers estimate that biological factors determine about 15%, the immediate environment about 10%, and the health system 25%. They say that half of our health is determined by social and economic factors.<sup>3</sup>

The same observation can be deduced from history. Interventions on social determinants have often been more important than some treatments. Think about how the prevalence of a devastating lung disease like tuberculosis has been dramatically reduced. The greatest decline in diseases occurred in the late 19th century, long before a cure was available. The labour movement was then able to impose better living conditions. Healthier food and better housing made it possible to reduce mortality from tuberculosis.<sup>4</sup>

# Not everyone is equal in the face of disease



*"Of all the forms of inequality, injustice in health care is the most shocking and inhumane".*

Martin Luther King – American civil rights activist

The fact that these social and economic factors are so important to overall health status is actually easy to understand when comparing health status around the world. A child born in Europe has a good chance of reaching 77 years of age. If born in Africa, their life expectancy drops to 60 years.<sup>5</sup> Health is not the same for everyone.

This phenomenon does not only concern poor countries. In Belgium, too, there are great inequalities. For example, a resident of Dour, a small town in Hainaut, will live to an average age of 76. That's eight years less than a person born eighty kilometres away, in Sint-Martens-Latem, a wealthy town not far from Ghent, where life expectancy is 84 years.<sup>6</sup> Even in a pocket-sized country like Belgium, the differences in life expectancy are enormous. Where does this come from? Our conditions of birth, life and growth are unequal.

For example, did you know that your life expectancy is influenced by your work? People in certain professions – such as healthcare workers, paramedics, railway workers, public transport drivers – die "sooner" than average. The graph below shows the excess mortality of this occupational group, i.e. a decrease in life expectancy compared to the average.

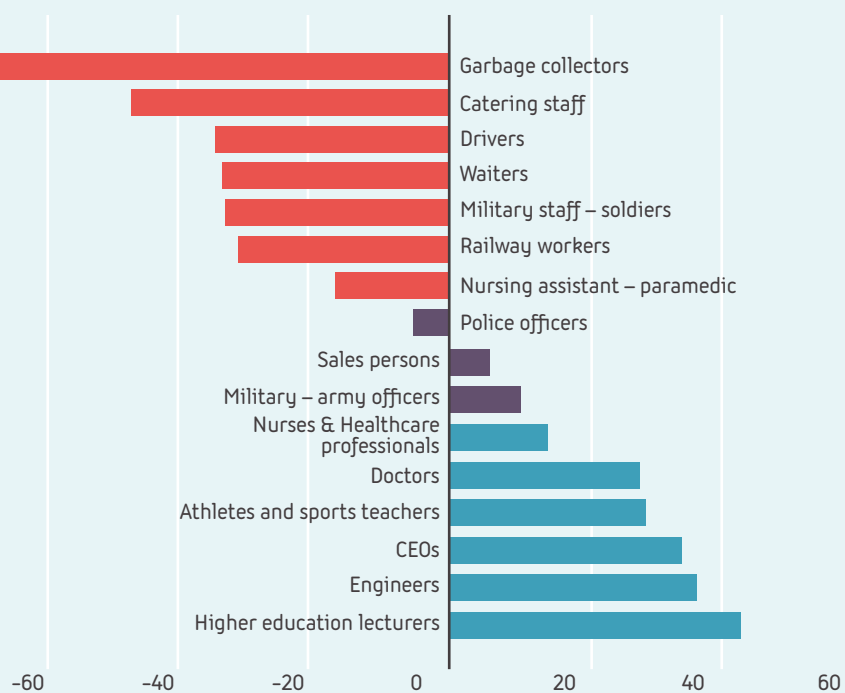
It is striking that the differences in the graph apply to all employed people. So when we talk about social determinants, it's not just about the poorest. When it comes to health inequalities, experts often refer to a "gap", but the real situation is more like a staircase. A staircase where, at each step, health is a little better than at the previous step. British researcher Michael Marmot calls it a "social gradient". So even those with jobs and income are not as well off as CEOs and wealthy rentiers.

Understanding the role of social determinants of health makes health inequalities between people and countries all the more unacceptable because they are largely preventable. You can't change your genes or your age. But the same cannot be said for the social determinants of health: these are the result of political and economic decisions.

Improving health is therefore more about social justice than it is about better health care. However, it is certainly not a question of individual responsibility.

"Social injustice is killing people on a grand scale", was the conclusion of the World Health Organization in 2008. The same is true today. To remedy this, we must attack the root of the problem and therefore the "causes of the causes" of social inequality.

## Certain professions lead to a higher or lower death risk



■ Significant excess mortality
 ■ Significant under mortality
 ■ Non-significant deviation from the mean

Source : Joël Girès, "Le travail c'est la santé ? (pas pour tout le monde)", L'Observatoire belge des inégalités, 14 December 2020. (<https://inegalites.be/Le-travail-c-est-la-sante-pas-pour>)

| Excess mortality/Under mortality = the increase or decrease in percentage of the death risk



## Health is a collective responsibility, not an individual one

I am assisting a young patient with a severe form of diabetes and morbid obesity at our medical centre. The young man has already radically changed his eating habits and his new medication is also having an effect. However, we are facing a major obstacle: his working conditions have disastrous consequences on his health. As a professional baker, he works the night shift of a large supermarket chain, every night from 3:00 a.m. until 10:00 a.m. Every day, he drags several tons of material, whether it's bags of flour or kneading machines. He sleeps on average two two-hour cycles, or four to five hours a day. His lack of sleep causes chronic fatigue and prevents him from exercising. It is also difficult to lose weight under these circumstances. He could switch to a daytime schedule, but that would mean the loss of a large portion of his salary. This is not financially feasible. His family needs the bonuses from night work to make ends meet.

When health problems occur, the authorities too often point the finger at the individual. Are people doing enough exercise? Are they eating healthily? It's guilt-inducing and ineffective. Eating, drinking, smoking and exercising are not simply individual choices. Behind the major health problems of obesity and smoking lies an industry which advertises unhealthy food and an influential tobacco lobby, as well as an economic system dragging people down. How can you tell families who work flexible hours, night shifts, and shift work for starvation wages that they need to take the time to prepare healthy meals together.

### **Mélissa Detilleux**

diabetes nurse specialist, MPLP Seraing



## 2. A system with a negative impact on health

Our health therefore depends largely on the context in which we grow up, work and live. And this is disastrous today. Never has our society been so tired and unwell. All indicators of well-being are coloring dark red. More and more people are suffering from pain and discomfort. They are living with anxiety and/or depression. And it's especially among the younger age group (16–24) that general well-being shows a downward trend in recent years.<sup>7</sup>

We also see this negative trend when considering differences in life expectancy. In 2001, a man with good education and high income lived six years longer than a man with a lower level of education. Ten years later, this gap had increased to ten years. For women, the difference has increased from nine to 13 years.<sup>8</sup> The economic crisis and the wave of austerity measures are hitting the population hard and are reinforcing social inequalities in health.

The question then is...why? On a global level, Oxfam notes that we live in a world "where, for more than forty years, those in the richest 1% have earned twice as much as the poorest half of the world's population."<sup>9</sup> There must be a mechanism in our society that creates and maintains this inequality. Psychologist Paul Verhaeghe puts it excellently: "The feeling of being "at the end" is becoming the great common denominator (...). When so many people develop the same symptoms in a single generation, we can no longer talk about individual problems. We are confronted with something else"<sup>10</sup> In the following paragraphs, we describe how the capitalist system undermines our health through various mechanisms.



### Medics for the People and Marx

What does an organisation of medical centres have to do with a philosopher born more than two hundred years ago? Marxism helps us to better understand how the conditions in which we live affect our health. For starters, by encouraging you to do systemic analysis whenever you are faced with social issues in your workplace. "Marxism is of great importance to medicine," wrote Richard Horton, editor-in-chief of 'The Lancet', medical journal.<sup>11</sup> It was Karl Marx who first analysed the very nature of capitalism as an economic system. And these same mechanisms are still observed today: from environmental pollution to privatisation of health care, to the disproportionate profits that multinationals are making via the consumption of medicines at exorbitant prices.

How does it work? In capitalism, companies must make the highest possible profits in order to survive in the competitive struggle. This can only be done in one way. By producing as much as possible for as little as possible. At the expense of people and the environment.

Human labour and nature are the sources of all wealth. The capitalist system pushes companies to further exploit workers and exhaust the planet, because it's the only way to make more profit. And this is bad for our health. Just think of longer working hours, flexible working hours, subcontracting, low wages, precarious contracts, etc. But also the continued extraction of fossil fuels, just because they enable profits – and this, despite all the warnings about global warming. Meanwhile, capital investors are constantly looking for new markets to grow even more, leading to public sector privatisations.

That is why, as a healthcare professional, it is important to also consider the social position of the patients. Marxism distinguishes class on the basis of your place in the economic process. And this class largely determines the impact of social changes on our health.<sup>12</sup> The working class includes all workers and employees who earn their wages by the work they do. It is the struggle of these workers for their interests which is the engine of progress for many social gains.

## 2.1 A system that exploits the worker

Housekeepers with backs broken by work, cashiers with wrists tired from scanning, automotive workers with neck pain, or elderly carers and childcare workers who are worn out and unable to work for a long time because of burnout: we don't need to explain to them that work affects their health.

People spend a lot of their time at work. It makes sense that work has a significant impact on health. Work can provide satisfaction and develop talents. It allows people to contribute to society. But work can also be detrimental to your health. More than half of the working people who are ill believe that their illness is partly due to their work situation.<sup>13</sup> Why is it that so many people in our society find their health threatened by their work?

What is certain is that our work environment is not getting any healthier. Every five years, the European research centre Eurofound compares the exposure of workers to occupational risks. These studies show that the intensity of work and mental and physical workload are increasing. Belgium is one of the countries where work intensity is increasing most rapidly. Other occupational health risks are also increasing, such as exposure to repetitive motions or working in uncomfortable positions. And in terms of environmental risks (exposure to toxic substances, noise, temperature, etc.), we are also seeing a rather unfavourable development in Belgium compared to neighbouring countries.<sup>14</sup> It is therefore high time to turn things around.

## 'They drive us crazy'



*"In the ten years that I've been working in this plant, things have changed dramatically. We've had to manufacture twice as many seats in the same amount of time, with fewer people. They were standing next to us with a stopwatch in their hands".*

Testimony of a 50-year-old assembly line worker<sup>15</sup>

Why do so many people get ill at work? It's pretty obvious. More and more is expected of workers. Every move is timed. Volvo workers have exactly 71 seconds before the next car goes on the assembly line. Nursing staff have 10 minutes to get the elderly up, washed and seated at the table. These restrictive deadlines do not allow for the correct procedure taught during the back safety training at school. This pressure is causing all sorts of new disorders, such as



Repetitive Strain Injuries (RSIs), a collective term given by doctors for all traumas related to the repeated execution of the same movements, sometimes small and in itself not painful, over a long period of time. It's not just physically demanding work that affects health. Many studies show how work affects health through frantic work rhythms, repetitive actions, inappropriate schedules and constant deadlines.

In 2021, Kim De Witte, the PTB's labour expert, carried out an in-depth analysis of the current labour market. They're driving us crazy: the title of his book couldn't be more appropriate. The testimonies and the numerous scientific studies presented in his book score a bull's eye: stress at work. It's a question of doing more with less staff everywhere, being more flexible, working longer. The number of burnouts is increasing dramatically.

"Work is not a health cure": this is the eloquent conclusion of the large-scale "Modern Times" survey conducted by the FGTB in 2017. In this survey, no less than 8 out of 10 workers declare that their physical and/or mental health is affected by the way work is organised today. In the study, the most common complaints were stress, sleep disturbance, burnout and irritability.<sup>16</sup>

Stress and burnout are becoming the black lung disease of the 21st century. Fifty years ago, when the first medical centres of Medics for the People opened their doors, the main issues were the lungs of workers who suffered from chemical exposure to asbestos, and patients who had to face the silent enemy of lead poisoning. Toxic substances and workplace accidents have always been a problem, but in addition to that, we are now facing an epidemic of mental problems and physical overload caused by work.



## The health of workers in the service voucher industry

Alexandra, a 32-year-old woman and mother of two young children came for a consultation. "Doctor, I can't take it any more", she told me straight away. "I have unbearable pain in my left shoulder and wrist. I can't work any more and when I get home I still have to do the housekeeping". She explains to me that she works for a large service voucher company, as a cleaner in private homes. Her daily work: scrubbing, cleaning floors on her knees, bending down dozens of times to lift a bucket of water, wringing out the mops, cleaning the windows from left to right, repeating the same movement, standing for hours at a time. Then I understand where this pain comes from and that it will only get worse if she continues to do such heavy work.

We discuss her case at the medical meeting. My colleagues are familiar with this kind of story. They also have one or two patients who work in the same industry and suffer from what we

call, in medical language, "musculoskeletal disorders". We often see a tendinitis of the shoulder or elbow, a pinched nerve in the wrist causing pain and tingling in the fingers, back pain, etc.

I then decided to devote my final year's work to musculoskeletal disorders in the sector of the service vouchers. We receive lots of testimonies from patients who work in this sector and who want to tell us how their work affects their health. We identify several factors: low wages, the fear of having to go on sick leave and by doing so losing clients, the anxiety of discovering that they can no longer work and will lose their family's only income (many of these people are single women with children), etc. During the study, the medical centre teams quickly realise that in order to put an end to the patients' pain, they must first support them in every way possible in their fight for better working conditions and wages.

**Elisa Munoz Gomez**

doctor, MPLP La Louvière



The pressure of constantly juggling work schedules and dozens of applications for a new job is also overwhelming. Job uncertainty or stress, related to the combination of two part-time jobs or temporary assignments is the order of the day for many people. In the temporary work sector, we still work with daily contracts. People only know just a few hours in advance if they will still have a job the next day.

Working under such a precarious contract is associated with poorer overall mental health, negative stress, psychological distress, anxiety, depression, use of antidepressants, and longer depression-related work disability. In the industrial and construction sectors, precarious and unstable jobs are associated with more and more severe work-related injuries and musculoskeletal disorders.<sup>17</sup>

Job loss and job insecurity resulting from the wave of restructuring and bankruptcy that followed the 2008 financial and economic crisis have had an extremely impact on mental health. According to one study, it has even made people from lower social classes more inclined to commit suicide.<sup>18</sup>

It has made us work harder, longer and in a more flexible way. Competition and the proclivity for more profit are constantly pushing in this direction, even at the expense of the well-being and health of workers. In various ways, our economic system is seeking even higher rates of profit. By making people work faster, by giving them temporary contracts and flexible jobs so that they only have to work when they are really needed, or by making them work longer. All three strategies have negative effects on health. Capitalism fundamentally undermines the balance between work and health.

## Alarming figures

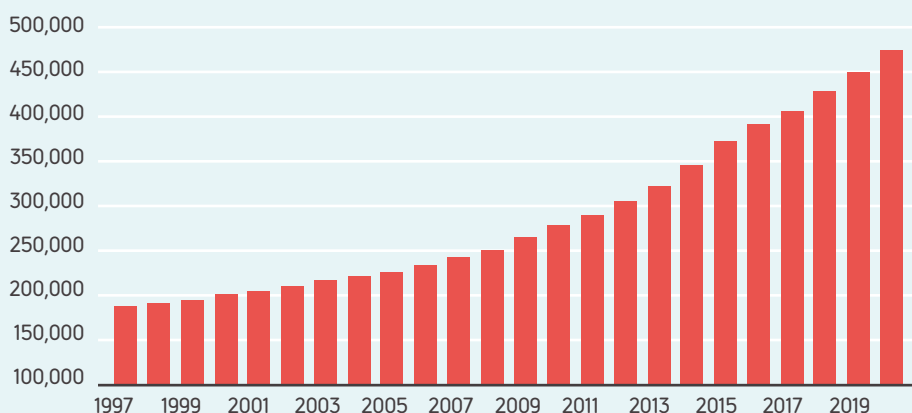
In the meantime, all the warning signs concerning work and health are red. For starters, the burnout epidemic. No less than one in three Belgian workers suffers from excessive stress at work.<sup>19</sup> In just over two years, the number of absent workers due to burnout has increased by 162%, from 3,713 at the end of 2017 to 9,708 in June 2020. There is also a worrying development: more and more young workers are also suffering from psychological problems.

In health care, we are all faced with an explosive growth of the problem. Psychology professor Paul Verhaeghe described it clearly when he retired after nearly forty years of practice: "The cause of serious mental problems has shifted dramatically since 1990, moving from family life to the workplace."<sup>20</sup>

But increasing work stress also has other health effects. We see, for example, that the number of serious accidents at work is increasing.<sup>21</sup> Although there are fewer accidents at work, the proportion of accidents with serious consequences is higher than ever. Claims relating to occupational disorders are also on the rise. These include muscle and joint disorders such as tennis elbow or carpal tunnel syndrome, which are clearly related to the work situation.

Meanwhile, in Belgium, half a million people suffer from a long-term illness. Many of them are over the age of 55. Indeed, the high pressure of work makes it simply impossible for many workers to last any longer. Yet successive governments have forced us to work longer. The statutory pension age has been raised to 67 and many early or partial pension opportunities have been eliminated or reduced. Together with the trade unions, we warned that these measures would increase the

Evolution of the long-term sick in Belgium, 1997-2020



Source : data requested by MPLP at the NIHDI, National Institute for Health and Disability Insurance

number of people on long-term sick leave. Unfortunately, what happened next proved us right: For every one less early retiree since 2012, there is at least one more person suffering from long-term illness.<sup>22</sup> By the end of 2021, our country was on track to reach the record number of half a million people with long-term illness, i.e., people absent from their jobs for more than 6 months.

## Making health damaging working conditions healthy



*"Burnout could be seen as a normal reaction to a pathological environment."*

Belgian Superior Health Council,  
"burnout and work" opinion, 2017

Something needs to change fundamentally in the way we think about work and health. It is not normal for people to end their careers with disability or long-term illnesses. People have the right to leave the company, to which they have given the best years of their lives, as healthy at night as when they walk through the door in the morning. This can be done by assigning the responsibility for worker's health to the company.

The policy over recent years has gone in the opposite direction: whenever the increase in the number of people on long-term sick leave is mentioned, it is the sick workers who are singled out. Anyone who becomes ill must go through a reintegration track. This includes a series of questionnaires that sometimes make you feel worse than you already are.<sup>24</sup> In reality, reintegration is very rare. Employers have a responsibility to provide suitable work, but this is largely unmonitored. At the end of such a process, two out of three sick workers are simply laid off.<sup>25</sup>

We need to reverse this logic. Wherever work makes people ill, we must investigate the working conditions. So, every case of burnout or RSI (musculoskeletal disorders) should be seen as a signal that other workers are also at risk. Instead of focusing solely on a quick recovery for the ill person (and send him back to work), we need to focus more on the employer's responsibility. This way, we prevent the sick person's colleagues from getting ill on the long-term too. It's about getting to the root of the problem rather than just treating the symptoms.

Concrete measures would already be a big step forward:

- **Recognising that the real experts on healthy working conditions are the workers themselves.** We can give them more voice by democratising workplace prevention and protection committees. Worker representatives must be at the centre of this process and must have the time and resources to study and improve working conditions. Instead of just giving non-binding advice, they should have more decision-making power within the company.
- **Making employers financially responsible for workers who become ill.** They should pay guaranteed wages for at least two months. This idea has already been proposed twice in the federal coalition agreement, and each time the employer's organisation FEB has succeeded in changing the government's mind. Companies should be compelled to contribute to the income of long-term sick employees for a longer period of time. In some neighbouring countries, this is already the case<sup>26</sup>, providing an incentive to offer suitable working conditions and positions suitable for reintegration.
- **Helping people to work without forcing them.** Rehabilitation must no longer be coupled with dismissal. Employers should have to provide a certain percentage of adapted workstations. Long-term sick employees must be able to choose a suitable workstation in consultation with the company doctor and the representatives of the CPPT (Belgian Committee for Prevention and Protection at Work. This committee is composed of employer representatives and trade union delegates elected by the company's employees).
- **Motivating employers to engage in prevention.** Burnout must be recognised as an occupational disease, and the recognition of other illnesses and disorders should be improved so that companies become responsible for preventing them. Allowances for occupational illnesses should also be raised to at least the average level of other European countries, through contributions by the employer.

A structural problem requires structural solutions, both at the level of the company and of the society. We have the possibility to make work healthy again. So many young people are looking for work, so why make people work longer? Workload must be significantly reduced. A collective reduction in working hours by introducing the 30-hour week is a concrete response to the epidemic of overtime and overloaded schedules. With a full pension at the age of 65, early retirement at the age of 60 and end-of-career arrangements from the age of 55, we are making sure that it remains possible for older workers to continue working.

The example of burnout shows what we are facing. In its opinion on burnout and work, the Belgian Superior Health Council emphasises, like many others, that the causes and solutions to work-related illnesses can no longer be sought at an individual level.

On the contrary: "Burnout can be seen as a (normal) reaction to a pathological environment. (...) Preventing or treating burnout must indeed include a change in the model of society, rather than relying solely on adaptive solutions, or on medication or psychologisation." <sup>28</sup>



## Exactly how healthy are employees between the ages of 55 and 67 to still be able to work?

We asked ourselves this question at Medics for the People in the run up to the big pension demonstration in May 2018, when tens of thousands of people took to the streets to protest the coalition government's planned pension reform. The centre right government wanted to implement a points-based system, where we would all work longer in exchange for a lower pension. Every day, we see that many people's health simply does not allow them to work until the legal pension age, let alone until their 67th birthday. We are supporting the social struggle of the trade unions and wanted to back it up with concrete figures. We surveyed over 3,000 patients. The results show that at the age of 55, a quarter of the workers are already completely unable to work. Another quarter is partially unfit for health reasons and therefore needs adapted work. At the age of 65, one in two workers is completely unable to work. Our study proves that working longer, with or without adapted work, is not an option for a large proportion of workers. Thanks to the social struggle, two large demonstrations and numerous local actions, the people succeeded in getting the government to back down. The points-based pension, reduced to dust, has disappeared from the government table.<sup>23</sup>

**Karel Van Bever**  
doctor, MPLP Zelzate



## 2.2 A system that causes pollution

### Numerous pathogens in soil, water and air

You can't open a newspaper without reading an article about pathogens released into our soil, water or air that pose a threat to public health. Just think of the residents of Zwijndrecht or Linkeroever (Antwerp) who live nearby the chemical factory 3M.

In late October 2021, 800 of them were told that they had too much PFOS in their blood, a non-degradable, potentially carcinogenic and immune-disrupting chemical. In Moretusburg, a district in Hoboken (Antwerp), next to the Umicore metallurgical plant, excessively high levels of lead were found in the blood of workers and children living close to the factory.

Near Mons, pollution has been observed due to "metal crushers", which are the largest emitters of PCBs in Europe – toxic and difficult to degrade substances that accumulate in the fatty tissue. These are concrete examples of multinationals that are only interested in their short-term profits, to the detriment of the health of their workers, the area and the planet.

**First example. Air pollution is a global public health threat.**

The amount of pollutants in the air, such as fine particles, nitrogen dioxide or carbon dioxide, is so high that the World Health Organization calls it a "public health emergency". Air pollution from burning oil, coal and other fossil fuels caused 8.7 million deaths in 2018.<sup>29</sup>

Air pollution is also one of the factors that reinforce social inequality. In Brussels, the air quality in the different districts has recently been analysed. It has been found that the air in the poor districts is four to five times more polluted than in the wealthy districts. The map of air pollution can be overlaid almost identically with the map of the economic context of each district.<sup>30</sup>

**Second example. Climate change, code red for a healthy future.**

The devastating floods in the Vesdre Valley in the summer of 2021 highlighted the consequences of climate change. Dozens of people died, thousands of homes were destroyed, entire communities were dislocated.<sup>31</sup> The massive emission of CO<sub>2</sub> since the industrial revolution, mainly through the consumption of fossil fuels, is responsible for global warming. Around the world, people are increasingly feeling the effects on their health.<sup>32</sup> 'The Lancet', medical journal, has called climate change the most significant public health threat of the 21st century.<sup>33</sup>

But climate change doesn't affect everyone in the same way. On one hand, because just a small group is responsible for the problem. In Belgium, five multinationals emit almost as much as all households put together.<sup>34</sup> Globally, 100 multinationals are responsible for almost three quarters of emissions today.

On the other hand, it is the common people who suffer the consequences. From the workers who settled along the rivers in the wake of industry, and who are now the first victims of flooding, to the farmers and workers in the South who have to flee droughts or floods..

## Change the system, not the climate



*"Between the climate and the capitalist system, the war is raging"*

Naomi Klein – Canadian journalist and activist, author of 'This Changes Everything: Capitalism vs. the Climate'



"It is absolutely necessary to act faster and to put the health of people and the planet above everything else"<sup>35</sup>, is the imperative advice of scientists. This requires a systemic change. Because the climate crisis is a systemic crisis, a crisis of capitalism itself, as Naomi Klein demonstrates in detail in her book 'This Changes Everything'. It is certainly not technology that stands in the way of the radical ecological transition that's needed today. The technology to make our society climate-neutral exists or is under development.

Today, we can work in a perfectly clean way without harming the health of workers, the area or the planet. But this requires investment, and capitalism is governed by the iron law of maximal profit. Shareholders and CEOs of large multinationals are in control. They always choose what is most profitable for them in the short term, and they don't care about the long-term interests of the world's population and the climate. If the last drop of oil brought in enough money, the multinationals would not hesitate to pump it up. But, as Naomi Klein writes: we can change the laws of an economic system, not the laws of nature.

## 2.3. A system that leaves public services to the market

Housing, food, heating, finding a place at a reasonably priced nursery, being able to play sports, going on holiday, living in a nice area with lots of green space... These things are essential in our daily lives and so important for our physical and mental health. It is therefore also understandable that we, as a society, ensure that they are available to everyone. This is what our public services are all about.

But in reality, more and more savings are being made on these public services. The population is increasingly left to the whims of the free market, resulting in everything becoming more and more expensive with deteriorating quality.

By carrying out their harsh austerity policies, politicians have paved the way for the privatisation of public services. The American scientist and political thinker Noam Chomsky described this very clearly: "When politicians want to privatise a sector, they first ensure that it receives fewer resources. This results in lower quality and dissatisfied users, and then the same politicians claim that privatisation is the only solution".

We can see the evolution described by Chomsky in several sectors. Access to social rights is no longer guaranteed by strong public services, but is increasingly left to the laws of supply and demand in a private market. Health is becoming a commodity on the market, but so is our right to housing, transportation, energy, healthy food, etc.





## Austerity kills



*"The cost of austerity can be calculated in human lives"*

David Stuckler – British professor of public health and public policy

The austerity measures implemented after the 2008 financial crisis have taken their toll. After pouring billions of dollars into the bottomless pits dug by banks and financial institutions, governments have come to claim this money from the people. Public services have been cut everywhere, and social protection has been reduced. All this had a major impact on the health of the population. In Greece, a country that has been a somewhat dismal laboratory for austerity measures, the healthcare budget has been halved.

As a result, one in three cancer patients does not have the money to see a doctor regularly. In the rest of the world too, the consequences are disastrous. In Europe and North America, austerity measures have caused more than ten thousand suicides and up to one million additional depressions. Losing your job, even your house, and having huge debts... This drama seeps under the skin, literally and figuratively, and causes serious health problems. "If the European savings policy was part of a clinical trial, it would be stopped". This is the conclusion reached by researcher David Stuckler. "The evidence of fatal side effects is overwhelming. (...) A recession hurts, but these economies kill."<sup>36</sup>

### **First example. Home sweet home... The impossible right to housing.**

The right to housing may well be enshrined in the Constitution, but finding decent and affordable housing is increasingly becoming mission impossible. Why? The right to housing is in the hands of the market and depends on supply and demand. It is the private sector, usually the big real estate groups and housing barons, who decide which houses will be built and what will be the cost of living in them. With the sole purpose of making as much profit as possible. Families are therefore not housed according to their needs, but according to their purchasing power. The public authorities do almost nothing in this regard. Fewer and fewer public or social housing units are being built, and those that do exist are often in poor condition, especially in terms of insulation. As a result, more and more people are forced to choose: whether to settle for unsatisfactory accommodation<sup>37</sup> or to spend too much of their income on housing, which leads to debt or prevents them from making other, sometimes essential, expenditures.



## Housing in poor health

A patient consults us regularly for skin problems, that also affect her husband and their children. When we look for the causes of these problems, we quickly come to the conclusion that it's the housing conditions. She lives in an apartment in a large social housing block with more than fifty families. We go there with our team. We see damp problems on the walls, especially in the bedrooms. Water is dripping down one wall and there are traces of damp right next to their 14-year-old child's bed. In the other bedroom, their one-year-and-two-month-old child's bed lies just below a huge patch of mould. The family does everything they can to maintain the house and to make sure the damp disappears: cleaning, airing, repainting the walls, but nothing helps.

The local council is aware of these problems, but does not react. Worse, it tells the residents that it's their won fault. That they don't ventilate enough. The building is scheduled to be demolished, but no one seems to know when. Meanwhile, families continue to live in appalling conditions that potentially put their health at risk. Our team decides to have the mould analysed and to check if there is a link with the family's skin problems. Our social worker also contacts other patients who live in the same building and several families join forces. They ask all the neighbours to complete a survey to identify the problems. Thus, slowly but surely, a collective is formed which will demand that the council carries out the necessary work.

**Patricia Polanco**  
coordinator, MPLP Molenbeek



### **Second example: unhealthy food.**

Access to healthy food is one of the most important social determinants of health.

A healthy diet is essential for good health and helps prevent non-communicable diseases such as diabetes, cancer, heart disease and strokes. However, the reality in our country is not good. The Belgian diet is characterised by excessive consumption of red meat, processed meat and sugary drinks, and insufficient consumption of fruit, vegetables, nuts and seeds, milk, eggs and fish.

In 2018, only 12.7% of the population over the age of six consumed the recommended daily amount of fruit and vegetables (at least five portions). And 20.4% of the population daily drank sugary drinks.<sup>38</sup>

The way we eat today has changed a lot in recent decades, and this coincides with the commercialisation of agriculture and the food market. All food production – from farming to sale – has increasingly come under the control of multinational corporations.<sup>39</sup> Food production has become part of the international competitive struggle. In this fight, the laws

are simple: whoever provides the cheapest and best-selling product is the winner. But what sells best is not necessarily what's the healthiest.

In addition, healthy food is often expensive and not readily available. Hence the social differences in eating habits. Among men and women with higher levels of education, three times as many people eat enough fruit and vegetables as among those with the lowest level of education.

## Making a profit does not go hand in hand with ensuring good health

Food industry marketing is one of the reasons why a new field of research has emerged in the area of social determinants of health: the commercial determinants of health. The commercial interests of the large multinationals are clearly having an increasing impact on public health. They are the ones forcing unhealthy, processed food patterns on people. They are the ones speculating on the real estate market and driving up prices. There is growing recognition that we must absolutely name this impact on health

Yet, many politicians continue to advocate the privatisation of even more public services. Water distribution, trains and buses, etc. Even though foreign examples often show us that this is not a good idea. In our capitalist economy, investors will always look for new markets to increase their profit margins. In other words, protecting our public services is an important fight for the right to health.

## 2.4. A system that plays people off against each other

### Discrimination makes us ill

In our medical centres, we often see people who get ill, not because of increased workloads or the harmful effects of environmental pollution, but because they are facing discrimination. Discrimination is still very present in our society, on many levels. And this has a major impact on physical and mental health.

#### **First example. The health gap between men and women**

In the health sector, we see women in consultation almost every day who are victims of sexism, sexual violence, transgressive behaviour, domestic violence and countless other forms of inequality and discrimination. One in three women worldwide will experience sexual violence in her lifetime. In Belgium it is estimated that 100 women are raped every day. But only eight complaints are reported. Women's organisations have been sounding the alarm for years, as our government still does so little, despite the magnitude of the problem.<sup>40</sup> The consequence? The violence continues; in 2021, feminist organisations counted 21 *femicides* by the end of the year.

| Femicide: the murder of a woman, because she is a woman.



Violence and transgressive behaviour are not the only cause of health inequalities between men and women. Injustice is embedded in our society. We also note that the number of long-term patients is increasing twice as fast among women as among men. Indeed, women still have to take on the vast majority of household tasks and are therefore much more exposed to the "rat race". And to top it all off, proportionally, women still work much more in precarious employment situations than men. Flexible hours, temporary contracts, etc. The gender pay gap is 22.3%, and the average pension for women in Belgium is dismally low.<sup>41</sup> One in two female pensioners lives on an income below the poverty line.

And what about health care itself? Caregivers probably still pay too little attention to the health consequences of this structural gender discrimination in our society. In women, for example, stroke and heart failure are more often fatal.<sup>42</sup> The same symptoms are not treated in the same way: A woman suffering from tightness in the chest will more often be prescribed painkillers or anxiolytics, while a man is more likely to be referred to a cardiologist.

### **Second example. Racism and health**

Scientific studies show that discrimination based on nationality, origin or skin colour is a cause of depression, anxiety and psychological stress.

Discrimination also leads to greater risks of high blood pressure and obesity, cardiovascular disease and even breast cancer and premature mortality.<sup>43</sup> When a person experiences racism on a regular basis, they experience constant stress, anxiously awaiting the next time they will be a victim of racism. Victims of racism are also likely to internalise negative feelings of oppression and inferiority. The influence of social determinants on the health of people with an immigrant background also plays a role here: They are more likely to be directed to vocational or special education, and more likely to be excluded from the private rental market or the labour market. As a result, they find it more difficult to access quality and decent employment or housing that does not endanger their health.



## "Maybe I deserve these racist remarks?"

A young man comes to see me. It was only after much hesitation that he took the step of consulting a psychologist. He is often tense, easily angered, sleeps badly, withdraws into himself. He speaks hesitantly about his problems at work. He has a good job, his dream job even. However, he is not happy with the persistent racist remarks from his colleagues. He wonders if it's his fault. "Maybe I'm exaggerating", "maybe I deserve it?"

First we look together for ways to reduce his stress. But we also look at social factors during our discussions. We talk about the mechanisms of structural racism and the damage it causes. Its impact on stress circuits, self-image and confidence in others. About anti-discrimination legislation and how to file a complaint. I see this man gradually blossoming again. His story is part of a larger context. He realises that he is not alone, that it's not his fault. His uncertainty gives way to determination. Finally, we contact UNIA (successor to the Centre for Equal Opportunities and Opposition to Racism). I also promise to invite him to the next demonstration against racism.

Often, it's not the individual who is ill, it's society that needs treatment. The impact of the socio-economic environment is too often neglected in psychology. The focus is on people's ability to cope with stress or problems (think of concepts like coping strategies, resilience, etc.). In other words, the individual is to blame. However, it has been widely demonstrated that environment plays a determining role in the development of psychological problems.

### **Rody Verhage**

psychologist, MPLP Hoboken





## Divide and conquer

In our society, division and discrimination have two roots. On one hand, discrimination is rooted in the pursuit of corporate profit. It suits them to have second and third-class citizens among their workers. Without this division between workers, there would be no "Kleenex jobs". And these low-paying, hyper-flexible jobs are very important in pushing profits to the max.

THIS IS THE STORY OF A **BANKER**, A **WORKER** AND A **REFUGEE** WHO HAVE TOGETHER 20 COOKIES. **THE BANKER TAKES 19 OF THEM** AND SHOUTS TO THE WORKER

**"WATCH OUT! THE REFUGEE IS RUNNING OFF WITH YOUR COOKIE!"**

LET US NOT BE MISTAKEN ABOUT OUR **OPPONENT**

geneeskunde  
voor het volk  
médecine  
pour le peuple

On the other hand, the ruling class also benefits from the fact that the working class is divided. As long as we fight among ourselves and blame our neighbours for our social problems, we're not looking to those at the top of our society accumulating wealth. The ruling class wants to prevent the working class from coming together as one, to defend together its social rights. Individual fingers can easily be broken, but united they form a mighty fist. And that's why they try to pit us against each other.

### 3. Another society is possible



*"Another world is not only possible, it is on it's way.  
If I listen very carefully, I can hear it breathing".*

Arundhati Roy – Indian writer and activist

We began this chapter with the observation that we often treat people, only to return them to the conditions that made them ill in the first place. These conditions are rooted in the economic system that dominates our society, capitalism. In this system, people and nature are exploited for profit. Moreover, this system is increasingly dismantling our public services to suit the market, and pitting people against each other. Under such conditions, it is impossible to guarantee the right to health for everyone. This is only possible in a healthy society.

A healthy society means that health always comes first. That health always takes precedence over profit, whether it is good housing, healthy food, dignified work or other social determinants. Health and prevention experts refer to this as the "Health in All Policies" approach:<sup>44</sup> governments should prioritise our health in all policy areas. According to the analysis we made earlier in this chapter, this is impossible under the current capitalist system.

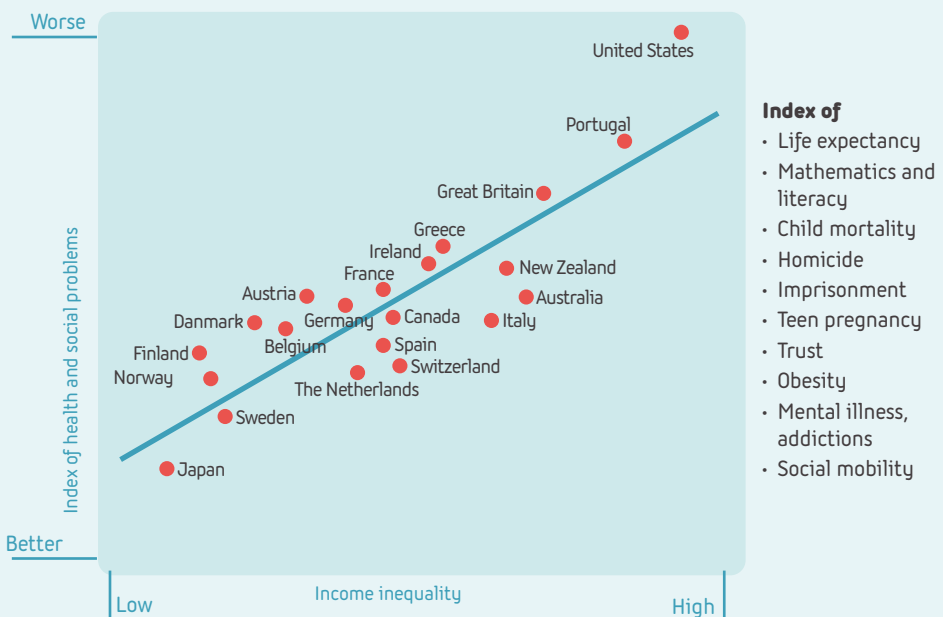
Another system is possible. In socialism, the workers themselves take control. Important sectors of the economy are taken over to the community. The economy is no longer determined by competition and the search for profit, but by the needs of the population and the capacity of the earth. People first, not profit. This is how we can guarantee the fundamental rights of everyone.



## Equality is good for your health

Drawing on a wealth of scientific evidence, British social epidemiologists Richard Wilkinson and Kate Pickett have shown in their best-selling book, *The Spirit Level*, how social inequality literally makes a society ill. The greater the income inequalities in a society, the greater the risk of being confronted with a whole series of health and social problems. In an unequal society, life expectancy is lower, infant mortality higher, mental health problems more prevalent, drug use higher and so is obesity. For example, in a country like Japan, less than one in ten people suffer from mental health problems; in a highly unequal society like the United States, it is one in four people. Unequal societies also face more violence, imprison proportionally more people, experience lower levels of mutual trust and have weaker community life. The poorest are not the only victims: all social strata of the population suffer under a high degree of inequality.<sup>45</sup>

### Social and health problems are worse in more unequal countries.



Source : Wilkinson R. and Pickett K., "The Spirit Level: Why More Equal Societies Almost Always Do Better.", 5 March 2009. (<https://equalitytrust.org.uk/resources/the-spirit-level>)

The choice of a different society, socialism, is the basis of the collaboration between Medics for the People and the PTB. The PTB brings together people from all different walks of life who want to work towards such a paradigm shift. The party's proposal for Socialism 2.0 describes concretely what such a socialist alternative could look like today in 21st century Europe and how such a major revolution can become possible.<sup>46</sup>

If we want to fundamentally change our economic system, it is essential that the struggle of the working class has a central role in the fight for a different society. But for this change to be possible, it is crucial to have a broad unity of all progressive movements in our society. Work and health is therefore a priority theme for Medics for the People. At the same time, our medical centres and staff are engaged in many other issues – from the environment to housing, to racism and sexism. Our goal is, with each small step, to get closer to this other world.



# Endnotes

- 1 Michael Marmot was the Chair of the World Health Organisation (WHO) Commission on Social Determinants of Health (CSDH). CDSS, "Closing the gap in a generation: health equity through action on the social determinants of health – Final report of the commission on social determinants of health", WHO August 2008.
- 2 Göran Dahlgren and Margaret Whitehead, "The Dahlgren-Whitehead Model of Health Determinants: 30 Years on and Still Chasing Rainbows", Public Health, October 2021.
- 3 These figures are from A. Sengupta et al., "The Dahlgren-Whitehead Model of Health Determinants: 30 Years on and Still Chasing Rainbows", Public Health, October 2021.
- 4 The doctorate of the Ghent historian Isabelle Devos dealt with the evolution of disease and mortality in Belgium in the 18th upto 20th century and the underlying mechanisms that played a role. I. Devos, "Allemaal beestjes. Mortaliteit en morbiditeit in Vlaanderen, 18de-20ste eeuw", UGent, 2006.
- 5 WHO, "Life expectancy has increased by five years since 2000, but health inequalities persist", World Health Statistics, May 2016; Inequalities Observatory, "Global life expectancy inequalities are decreasing", March 2018.
- 6 "Hier leven Belgen het langst", De Standaard, July 2015.
- 7 Findings of the Federal Planning Bureau, which, at the government's request, annually analyses a number of parameters that should determine the quality of life in our country. "Financiële crisis hakte in op gezondheid Belg" (the financial crisis has damaged the health of the Belgian people), De Standaard, 6 February 2020.
- 8 A study by demographer Patrick Deboosere (VUB) demonstrated the inequalities between men and women and between the educated and uneducated: F. Renard et al., "Evolution of educational inequalities in life and health expectancies at 25 years in Belgium between 2001 and 2011: a census-based study", Archives of Public Health, 2019.
- 9 World Inequality Report 2018 geciteerd in het Oxfam-rapport "The inequality virus".
- 10 According to a report by the London School of Economics in 2006, one in six Britons suffer from depression or a chronic anxiety disorder, W. Van Driessche, "Stress is de stoflong van de 21e eeuw", De Tijd, 2014.
- 11 R. Horton, "Offline: Medicine and Marx", The Lancet, November 2017.
- 12 Famous Marxist, biologist, and Harvard professor of public health Richard Levins spoke about the importance of this issue: "The scientific literature shows that the poor and oppressed are more vulnerable to almost all disease risks. Researchers point to differences in income, maternal education and even socio-economic status. But they don't talk about class. Yet social class is the best indicator when it comes to life expectancy, disability due to old age or the frequency of heart attacks". Source: [www.monthlyreview.org/2000/09/01/is-capitalism-a-disease/](http://www.monthlyreview.org/2000/09/01/is-capitalism-a-disease/)
- 13 The MC surveyed workers to find out what they thought was the cause of sick leave. More than half of the 4,350 people surveyed responded that their illness was partly due to working conditions: high work pressure, physically demanding work, poor relationships with superiors. For more information, see MC-information 284, "Incapacity for work. Incapacity for work patterns: People's experiences before, during, and after disability", June 2021.
- 14 Based on various Eurofound reports: [www.eurofound.europa.eu/publications/report/2012/working-conditions/](http://www.eurofound.europa.eu/publications/report/2012/working-conditions/) trends-in-job-quality-in-europe on [www.eurofound](http://www.eurofound)
- 15 Final project by general practice assistant Aicha Van Haeren and Liesbeth Veelaert. Published in Huisarts Nu [www.huisartsnu.be/2018/nr4/masterthesis/waarom-stijgt-het-aantal-langdurig-zieke-werknemers-focusgroepenonderzoek](http://www.huisartsnu.be/2018/nr4/masterthesis/waarom-stijgt-het-aantal-langdurig-zieke-werknemers-focusgroepenonderzoek)
- 16 The entire file can be found on the FGTV website, press folders, 2018
- 17 Final project by trainee general practitioner Heleen Aerts, "Gezondheidseffecten van werken met een niet-vast contract. Een bespreking van de literatuur en ervaringen van patiënten", KULeuven, 2015"
- 18 Final project by trainee general practitioners Susan van der Wielen and Filip Vanderroost, KULeuven, 2011
- 19 In April 2021, The CSC activist magazine, Vakbeweging, published a file 'Mental well-being at work: dancing on a loose rope!' Figures show that the number of people suffering from stress, burnout, harassment or violence has increased explosively in recent years. In 2019, one in three workers (36.8%) in Flanders had a problematic level of stress at work. In 2012, this figure was 30%.
- 20 K. Sokol, "Psycholoog Paul Verhaeghe aan vooravond van pensioen: "Oorzaak psychische problemen verschoven van gezin naar werkvloer," VRT NWS, September 2021.
- 21 FEDRIS, "2019 Statistical Report - Occupational diseases", 2020; FEDRIS, "2020 Statistical Report - Occupational accidents - Private sector", 2021.
- 22 From the figures that the PTB requested from the ONEM and the NIHDl, it appeared that between 2012 and 2019, the number of pre-pensioners decreased by 57,984, but over the same period the number of people on long-term sick leave increased by exactly 73,688 (over 55 years old) [https://www.ptb.be/une\\_tude\\_du\\_ptb\\_montre\\_le\\_lien\\_entre\\_l\\_augmentation\\_des\\_malades\\_de\\_longue\\_dur\\_e\\_et\\_la\\_casse\\_des\\_pr\\_pensions](https://www.ptb.be/une_tude_du_ptb_montre_le_lien_entre_l_augmentation_des_malades_de_longue_dur_e_et_la_casse_des_pr_pensions)
- 23 In 2020, when it became clear that the federal government (Vivaldi) was preparing new measures to make us work (even) longer, we conducted a new large-scale survey of all our patients aged 55 to 65. It showed that half of the workers cannot work until they reach retirement age, let alone until the age of 67.
- 24 R. Verhage, "Dit is Vivaldi: streng voor de langdurig zieken maar mild voor de bedrijven", De Wereld Morgen, October 2021

- 25 They are declared permanently unfit by the occupational doctor, so that the employer can invoke medical force majeure and get rid of the worker definitively, without redundancy payment and without maintaining collective social rights. The unions rightly speak of a 'dismissal machine'. Figures of the CSC (J. Matyn, "Christelijke vakbond ACV: "Twee op de drie werknemers worden na langdurige ziekte ontslagen", VRT NWS, November 2019), after confirmation by a study by KU Leuven and ULB: L. Godderis et al., "Evaluatie van de impact van de nieuwe reglementering op de re-integratie op het werk", KU Leuven & ULB, October 2020.
- 26 In the Netherlands, the employer must continue to pay 70% of the worker's salary for at least two years.
- 27 As in France, 5% for example.
- 28 Belgian Superior Health Council – 'Burnout and work opinion' (Avis burn-out et travail), 2017.
- 29 Source: <https://www.seas.harvard.edu/news/2021/02/deaths-fossil-fuel-emissions-higher-previously-thought>
- 30 During the CurieuzenAir Brussels research, the exposure of the Brussels population to air pollution was mapped. In October 2021, three thousand people, schools, companies and institutions measured the concentrations of nitrogen dioxide (NO2) in their street using a measuring device installed on their property. <https://curieuzenair.brussels/fr/curieuzenair-devoile-une-disparite-notable-des-niveaux-de-pollution-de-lair-a-bruxelles/>
- 31 MPLP President Janneke Ronse described the medical consequences of the floods in more detail for the PTB website ([www.ptb.be/inondations\\_les\\_besoins\\_m\\_dicaux\\_restant\\_le\\_v\\_s](http://www.ptb.be/inondations_les_besoins_m_dicaux_restant_le_v_s))
- 32 In the article "Code red for a healthy future", dozens of leading researchers explain in great detail how climate change affects health. Source: [www.thelancet.com/journals/lancet/article/PIIS01406736\(21\)01787-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS01406736(21)01787-6/fulltext)
- 33 Since 2015, 'The Lancet' has published an annual report on the impact of climate change on public health and they have published several articles on it. They can be found on their website [www.thelancet.com/countdown-health-climate](http://www.thelancet.com/countdown-health-climate)
- 34 PTB Research Department: 5 MULTINATIONALS ARE RESPONSIBLE FOR ONE FIFTH OF GREENHOUSE GAS EMISSIONS IN BELGIUM
- 35 T. Riley, "Just 100 companies responsible for 71% of global emissions, study says", The Guardian, July 2017.
- 36 In his book "The Body Economic, Why Austerity Kills", Stuckler has collected a wealth of figures on how austerity measures implemented by Western governments after the 2008 financial crisis have severely affected the health of the population: <https://www.theguardian.com/society/2013/may/15/recessions-hurt-but-austerity-kills>
- 37 In Belgium in 2019, 17% of families lived in inadequate housing (with water infiltration in the roof, along the walls, damp and mould problems, etc.). Many families are living in crowded, poorly located, damp and poorly insulated housing, with consequences for their physical and mental health and general well-being.
- 38 These figures are taken from [www.belgiqueenbonnesante.be/fr/etat-de-sante/determinants-de-sante/alimentation](http://www.belgiqueenbonnesante.be/fr/etat-de-sante/determinants-de-sante/alimentation)
- 39 One of MPLP's retired doctors, Staf Henderickx, went in search of the history of the food on our plate. His book is called "Van mammoet tot Big Mac". He explains in detail that the entire food chain is largely in the hands of multinationals like Nestlé and Unilever.
- 40 M. De Vries, "Een echt feministisch beleid leunt niet op vrouwen", Knack, March 2022.
- 41 K. De Witte, "Je kan niet applaudiseren voor de helden van deze crisis en ze vervolgens laten werken tot 67", Knack, October 2020.
- 42 This is, among others, the case for osteoarthritis, arthritis, lower back pain, neck pain, thyroid disease, incontinence, cataracts, allergies, migraine, asthma, depression, long-term fatigue and osteoporosis. J. Van der Heyden et al., Health Survey 2018: Health and Quality of Life. Summary of results, Sciensano, July 2019.
- 43 D. R. Williams et al., "Understanding how discrimination can affect health", Health Services Research, October 2019; J. Bouquet, "Racism, sexism...can discrimination cause illness?", RTBF, April 2021.
- 44 Developed as part of the Adelaide Statement, World Health Organization, 2010.
- 45 In their next book, The Inner Level, the authors explore the underlying reasons why inequality makes people ill. We learn how, in capitalism, competition between people makes them ill, because it goes against the essentially social nature of human beings. Read for example: <https://lavamedia.be/fr/quand-linegalite-faconne-notre-identite/>
- 46 The principles of socialism 2.0 and the strategy for change are contained in the texts of the PTB Solidarity Congress 2015: "Broadening, uniting, deepening". Available at [https://www.ptb.be/il\\_etait\\_une\\_fois\\_le\\_ptb](https://www.ptb.be/il_etait_une_fois_le_ptb)

## Chapter 2

# Health care



- 1. Health as a commodity**
- 2. Health as a fundamental right**

Health is precious. Everyone who gets ill wants good health care. Our society must aim not only to treat and care for the sick, but it must also keep everyone as healthy as possible. This is why prevention, accessibility and quality of care must be a priority, always and everywhere.

Health care is seriously ill today, in our country and around the world. Money-related issues are becoming more and more significant, to the neglect of human factors. Capitalist logic is infiltrating from all sides. Fighting for the right to health also means fighting for better quality health care and a more social approach.

In this chapter, we outline our vision on health care. First, we look back at the negative developments of the last few years. We are defending the solidarity of our social security against rampant commercialisation. We then go one step further and perste the fundamental systemic error that is affecting the organisation of our healthcare system in greater depth. We are advocating a fundamental change: care close to the people, starting at the local level. We show what such a system would look like in reality, from prevention work to hospital care. Finally, we explain why a public-social model is needed to achieve this result.



# 1. Health as a commodity

The right to health is a fundamental right, or at least it should be. This right is indeed more and more threatened, for various reasons. In this section, we briefly describe how health has gradually become a commodity. We begin by describing how patients themselves experience problems: high bills, long waiting times, overworked staff. We then explain how cuts in public spending lead to the commercialisation of health care. Finally, we focus on the very heart of all these problems: the systemic failure that's affecting our health care.

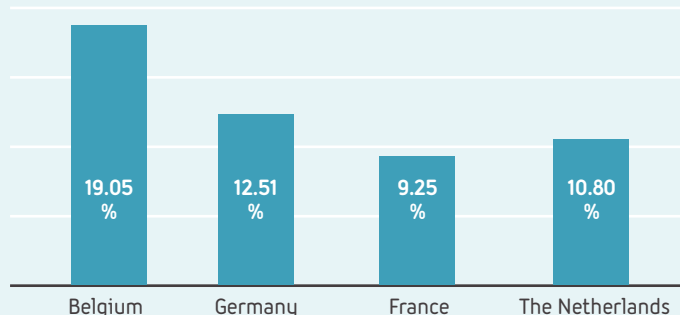
## 1.1 When the person is not at the centre of care

From time to time, the newspapers publish positive information about the Belgian healthcare system, which is "among the best in Europe".<sup>1</sup> Many Belgians are in fact very satisfied with the quality of the treatment they receive when they fall ill. The work ethic of our healthcare staff is outstanding. They are also well trained. But, if you ask the average Belgian if he thinks health care has improved in the last ten years, serious problems will surface. People complain about high bills, long waiting times and lack of staff time. The common thread? While healthcare staff choose this profession because they want to help people, the system is increasingly focused on money. Below we list some negative developments..

### Expensive, very expensive, always more expensive

Belgians pay about 20% of total healthcare costs out of their own pockets, either directly or through private insurance.<sup>2</sup> This means that social security doesn't pay for one out of every five euros. This proportion is much higher in Belgium than in neighbouring countries.

People's own expenses as a part in the total health care expenses for Belgium and neighbouring countries, 2018



Source: Federal Public Service – Social Security, "The evolution of the social situation and social protection in Belgium 2020", March 2021. (<https://socialsecurity.belgium.be/sites/default/files/content/docs/en/publications/silc/silc-analysis-social-situation-and-protection-belgium-2020-en.pdf>)

Hospital bills and medication represent the largest portion of costs incurred by patients in Belgium.<sup>3</sup> Belgians contribute a co-payment for medical consultations and medication. Certain treatments, such as psychotherapy and osteopathy, are poorly reimbursed, as are many medications for temporary use. In the event of hospitalisation, the patient also assumes a portion of the costs: co-payments, equipment, medication and surcharges.

These high hospital bills are the reason why almost all Belgians who can afford it now enter into private hospital insurance. But insurance companies aim to make a profit. If the bill goes up, so does the premium. These exploded from 5.5% to 9% in 2016 due to the increase in surcharge fees.<sup>4</sup>

Share of out-of-pocket spending in total health care for Belgium and neighbouring countries, 2018 Commercialisation is the process by which services are increasingly exploited for profit. The co-payment is the amount that you pay for medical expenses that are not reimbursed by the mutual insurance association. Public authorities believe that this will prevent people from abusing medical care. Incredible, isn't it? Consequence of these high bills: Many Belgians postpone certain treatments for financial reasons. We are well aware of this time-honoured problem, but it's getting worse. In 2008, 0.5% of the adults postponed medical care. In 2016 this number increased to 2.3%. For dental care, the figure increased from 1.6% to 3.7%. According to the Belgian Health Care Knowledge Centre (KCE),<sup>5</sup> these results are much worse than those of our neighbours. In 2017, 6.7% of people with the lowest incomes were unable to receive care in Belgium, the third highest figure in Europe (after Greece and Latvia).<sup>6</sup> By postponing their medical consultations, patients run the risk of worsening their cases and having even greater health problems and costs later. Poverty causes illness, illness causes poverty. Belgium has the largest gap in unmet medical needs between the rich and poor of any country in Western Europe.<sup>7</sup>

Anyone who has ever been hospitalised knows that the bill can be particularly high. In Belgium, it is often impossible for the patient to know in advance the cost of a consultation, treatment or hospitalisation. It is just not right that patients are afraid to receive their bill! There are huge differences between the most expensive and the least expensive hospitals. A patient in a double room pays between 136 and 370 euros just to give birth. Due to high surcharges, the bill for a single room ranges from 1,039 to 3,339 euros.<sup>8</sup>

## Two-tier medicine

Those who can afford it can afford quality care, the others just simply can't. This is also referred to as "two-speed medicine". The problem is twofold: Access is unequal, and care is incongruously organised, disconnected from the patient's needs. When two-speed medicine takes hold, we see the same evolution all over the world: the remunerative part of the care develops strongly, to the detriment of the care for fragile or destitute people. The same goes for Belgium. We are seeing the emergence of two-speed medicine. This is the case, for example, for specialists who carry out part of their procedures at the agreed standardised rate but add a non-standardised rate, deciding themselves how much extra the patient will have to pay. Our GPs often hear that patients can get

a consultation more quickly if they go to the specialist's private practice. If you can only pay the standardised rate, you will be put on the waiting list. A speedy pass in health care, who wants that?

## A serious lack of staff

Patients are not the only ones paying a high price for this development. The working conditions of our healthcare staff are becoming more difficult every year. Providing human care is now a superhuman challenge. Healthcare staff are too often seen as a cost that can be saved on. We are caring for more and more patients with less and less staff. Everyone knows that quality care requires more collaboration and more attention for each patient.

There is a serious shortage of general practitioners throughout Belgium. The number of areas with a shortage of GPs is increasing. These are the areas where there are less than 90 active GPs per 100,000 residents. Flanders has 300 municipalities, 227 of them lacked GPs in 2019. In Wallonia, this is the case for 146 of the 259 municipalities.<sup>9</sup>

What's more, nearly half of our GPs are aged 55 or older. The current influx of young GPs will never be able to compensate for the number of people retiring. In many regions, this will make it impossible for patients of a retiring GP to find a new doctor. The coronavirus pandemic was also a real-life test for GPs. They realised how urgent it was for primary care to be supported by additional doctors. In such a situation, it is untenable to limit the influx of new GPs through a medical school entrance exam and a quota system.

After years of austerity, there are fewer and fewer nurses at the patient's bedside. The human aspects of care have been reduced to the bare minimum. Caregivers often feel that they cannot do the job they have chosen, which is to care for patients – in principle the best job in the world. In Belgian hospitals, nurses take care of two to ten more patients than is considered safe internationally (about eight patients per nurse on average for a day shift). International studies have shown that if the number of patients per nurse is reduced, everyone's health improves and patient mortality decreases.<sup>10</sup> For doctors, nurses, logistics, maintenance, laboratory and kitchen staff, etc., the workload is too high and wages don't match. In 2020, 6.7% of the healthcare workforce had been unwell for more than a year, compared to 4.6% in the rest of society.<sup>11</sup> A 2020 study by MPLP found that 'presentism' is a huge problem among nursing staff.<sup>12</sup>

Standardised rate: Mutual insurance associations agree on prices with doctors to avoid a patient being unpleasantly surprised (financially) after a consultation. If a doctor accepts such agreements, he or she is 'contracted'. If not, he or she is 'not contracted' and is free to claim a higher fee from his patients. Doctors can also work partially as 'contracted' and partially as 'not contracted'.

Quota system: Since 1997, the federal government has decided to limit the number of doctors. It does so through the quota system. This means that only a certain number of doctors (the quota) has been given a NIHD number since 2005 and that only the services of these doctors are reimbursed by the mutual insurance associations. Access to the profession is thus limited.

'Presentism': being present at work when you are unwell.

This is why many professionals are leaving the healthcare industry. It is a global problem, the result of years of austerity. In Belgium, more than 19,000 qualified nurses work in another sector.<sup>13</sup> After the fifth wave of the coronavirus, one in three general practitioners thought of resigning.<sup>14</sup> The situation in nursing homes is equally dire.<sup>15</sup>



## “Impossible to provide quality care under these conditions”

“When you start to study nursing, you know that the job has its hard parts. But, today, in my job, I have a lot more to worry about than I had anticipated. The worst part for me is the anxiety of being summoned on a day off. Management regularly asks staff to work overtime to make up for staff shortages when hospital pressure is high. It is a permanent source of stress for all the hospital staff, the anxiety of not being able to recover.

We don't feel valued. I work shifts all year round, I do nights, weekends, I work on public holidays. Pay for healthcare staff is not on a par with the work they do. The fact that it is a heavy job is not recognised either. I'm young and I already know I won't last until I'm 67! The conditions that we work in today make it impossible for us to do our job properly. The government needs to invest in health care, and if it doesn't, the quality we usually pride



ourselves on will disappear. I love my job, I love being a nurse more than anything, but for how much longer? I'm only 28 and I'm already tired”.

Thankfully, people are resisting. Healthcare workers are fighting through actions, demonstrations and strikes for better wages and increased staffing levels so that they can provide care with a human face. The images of the staff of the CHU Saint-Pierre hospital in Brussels turning

their backs on Prime Minister Sophie Wilmès in the midst of the coronavirus crisis went viral. It was a huge victory for healthcare staff:

Under such pressure, the government had no choice but to release a 'White Coat Fund' with additional means. We saw that in other European countries (France, Spain, Germany, etc.), healthcare staff are also organising and fighting collectively for better working conditions.

### **Laura**

nurse at the CHU university hospital in Liege

## 1.2 Commercialisation is not a natural law, but the result of deliberate policy



*"The classic way to privatise: disinvest, make things not work, make people angry, and then turn everything over to private capital."*

Noam Chomsky – American professor of linguistics, philosopher, media critic and political activist<sup>16</sup>

### Austerity and big business in health care

In Belgium, social security has been in place since 1945. We collectively assume the costs so that people who are unwell can be treated. Social security is the anchor of this solidarity – between rich and poor, young and old, healthy and ill. But today, social security is under threat. Why are patients paying more and more out of their own pockets? Why is there a staff shortage? Because public expenditure for health care is too limited. Government after government is making cuts in health care. At the same time, private companies are playing an increasingly important role, whether they are insurance companies, service providers or stock market investors. Large companies and investors who put profit first.

In Belgium, the healthcare budget is determined by a growth target established by law. This is necessary because our healthcare needs are changing: increase in chronic diseases, ageing population, medical technological advances, etc.<sup>17</sup> In 2015, the Michel government reduced this growth target from 3% to 1.5%, without explanation. The Federal Planning Bureau recommended an average growth of 2.5% per year.

It's no coincidence that our hospitals have been suffering from a huge lack of money for years. One in three Belgian hospitals is unprofitable.<sup>18</sup> Fixed funding from social security is structurally too low.<sup>19</sup> It's not even enough to pay staff wages. Hospital managements are forced to look for alternative solutions, which leads to commercialisation. How exactly does it work?

On one hand, hospitals are trying to increase their revenue via specialist consultations. That's why surcharges have increased so much. The fact that doctors and hospitals get a performance-related pay means that many tests and treatments are prescribed without being really necessary. Do you need a scan? That makes money for the hospital. Do you need surgery? That makes money for the hospital. Do you need a period of recovery after a major operation or an attentive ear to find out why you're feeling unwell? Those things don't make money for the hospital: so, please give way to patients who need a scan or surgery.

The reduction in public funding of care in our performance-related system paradoxically leads to overconsumption. The OECD estimates that up to one fifth of all resources in Western countries are wasted. In Belgium, this would represent about 3.35 billion euros.<sup>20</sup> The main reason for this waste is overconsumption in our hospitals. Not only does it cost a lot of money, but it is also harmful to our health. The Belgian people are, for example, among the most irradiated people in Europe. A Belgian is exposed to radiation 1.5 times more than a French person in their lifetime, and three times more than a Dutch person.<sup>21</sup>

On the other hand, healthcare facilities are increasingly outsourcing services to commercial partners: suppliers and companies for catering, laundry, cleaning teams, public-private partnerships for infrastructure. This is a dangerous development. Take the example of the Forensic Psychiatric Centre (CPL) in Ghent, which has been managed by the private company Sodexo since 2014. Sodexo shareholders come first. The staff and patients foot the bill. Some days, there is not a single nurse on the high security wards.<sup>22</sup> We see the same scenario everywhere: in private nursing homes, commercial medical laboratories, etc.



## The NHS model, rise and fall



*"Illness is neither an indulgence for which people should pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community".*

Aneurin Bevan, British Minister of Health in 1948, founder of the NHS

The British NHS (National Health Service) is considered one of the best in the world. The NHS was created in 1948 during the post-war period, as a concrete realisation of society's desire for social progress in response to defeated fascism. The system provided quality care for all, free of charge, regardless of income or status. Every region, every area and every corner of the UK had equal access to care. It also offered complete, comprehensive care.

You could go to all local services for general or specialised care, as well as to the dentist, the physiotherapist, the psychologist, etc. A solid national-level organisation, under public control, also made it easy to centralise data and results for scientific purposes in order to adjust policies, if necessary. In short, it was a renowned system that was rightly copied in several countries, including Canada, Spain, Portugal and some Scandinavian countries.

But why is there so much backlash against the NHS today? The model has been under pressure for forty years due to successive budget cuts, dismantling and privatisation. As early as the

1980s, Margaret Thatcher dismantled entire sections of the NHS. She subjected it to market dictation. Increased competitiveness has generated a conflict between health and economic interests. The system was also hit hard in 2012 under David Cameron. The 2012 Health and Social Care Act further privatised the NHS by outsourcing its services to private companies, often under the control of international investment funds.



Health has become a commodity. The harmful consequences of this destructive policy are being felt today. Even before the coronavirus pandemic, one in six people had to wait for more than 18 weeks for routine treatment, while the NHS has been facing staff shortages for some time now.

Fortunately, the sector has mobilised in force to oppose further destruction of the NHS. Organisations like 'We Own It' are very clear: "The NHS is there for us all when we need it. Now it's the NHS that needs us."<sup>23</sup>

## The consequences of commercialisation

Looking at what has happened in other countries, we know the consequences of commercialising (parts of) the healthcare sector. The greater the commercialisation, the more unequal and costly health becomes. Efficiency decreases, as does quality. The people who need care the most are the ones who suffer.

Commercialisation of care costs more for patients and authorities. The figures showing the cost of the US system leave no room for doubt. There are several reasons for this.

**First of all**, there is no real solidarity unless the risks are shared among the greatest number of people. If patients with higher incomes withdraw and seek individual and more expensive solutions, they no longer contribute to solidarity. Care for other patients becomes more expensive. This increases the total cost of care for society.

**Secondly**, commercialisation of care results in additional costs. Profit is the most significant. In Europe, the Orpea Group, which has nursing homes in 16 European countries, made a profit of 160 million euros in 2020. The Helios-Fresenius Group, active in the hospital sector in Germany and Spain, made a profit of 666 million in 2020.<sup>24</sup> Money intended for health care is going straight into the pockets of shareholders. As well as profit, there are so-called transaction costs.

Commercialisation creates a lot of bureaucracy, as private insurers want to check everything before they reimburse. They try to avoid as many reimbursements as possible. Doctors and patients are overwhelmed by paperwork.<sup>25</sup> Advertising is also a transaction cost, increasing up to 15% of private insurer spending.<sup>26</sup>

Commercialisation leads to competition and fragmentation, whereas collaboration is crucial in health care. Patients suffering from one or more chronic diseases are particularly affected. Because it is precisely for them that collaboration and information exchange are so important.<sup>27</sup> This is also disastrous in the case of epidemics, as we have seen during the coronavirus pandemic.



## Why commercialising nursing homes is not a good idea

More and more Belgian nursing homes are managed by international commercial groups, much more so than neighbouring countries. In Flanders, their share has increased by almost 50% in six years.<sup>28</sup> They now control almost one third of the sector.<sup>29</sup> In Wallonia, almost half of the nursing homes are privately owned. In Brussels, this figure exceeds 60%.<sup>30</sup>

The objective of these large commercial groups is above all to make a profit. This compromises the quality of care. In Flanders, nursing homes run by large commercial groups employ 22% fewer staff than their public sector counterparts.<sup>31</sup> They are more often under close monitoring because of serious shortcomings. Incontinence materials and food are regularly subject to savings. And all this happens well knowing that residents pay on average more than 200 euros per month extra.<sup>32</sup>



While the elderly easily pay 2,000 euros per month and the staff are overworked, the shareholders are rubbing their hands. The "silver economy", the economy linked to the elderly, is booming and millions of euros have been paid out in dividends, including during the coronavirus pandemic. Both by commercial operators, such as Armonea, and by multinational healthcare real estate companies, such as Aedifica. "For the past fifteen years, the focus has not been on

Incontinence materials: materials used for people who can no longer retain urine or stool. This also happens when there's not enough staff to accompany them to the toilet in time.

welfare, but on growth and profitability. A huge amount of money", says Kris Cuyvers, a banker who was active in the commercial healthcare sector.<sup>33</sup>

However, the Flemish government has decided to further accelerate the commercialisation of health care. In a new decree, it wanted to allow private investors to buy out parts of public nursing homes. Staff and unions, the Vlaamse Ouderenraad (Flemish Council for the Elderly), civil society and the care sector reacted immediately. Through grassroots actions and pressure, we were fortunately able to prevent the decree from being passed, but the fight will certainly continue in the coming years.

**Lise Vandecasteele,**  
doctor, MPLP Hoboken and member of  
the Flemish Parliament for the PTB



## A European phenomenon

This process of cuts and privatisation is not just a Belgian phenomenon. We are seeing it all over Europe. And the European Union (EU) is jointly responsible for it. Although health care is the responsibility of the member states, the EU puts pressure on them, in various direct and indirect ways, to continue privatising health care.<sup>34</sup>

For example, the budgetary framework is very strict. Each member state is closely monitored by the European Commission. This ensures the monitoring of each country's budgetary, economic and fiscal measures on an annual basis. It makes recommendations based on reports submitted to it by the country. A recent example: the European Commission criticised the increase in salaries for healthcare staff in Belgium.<sup>35</sup>

There is no official European directive obliging Member States to privatise health care; (which is the case for the railways, for example). This is due to basic resistance. Since 2006, EU member states have been bound by the Bolkestein Directive, which obliges them to open their services to companies from other EU countries. Fortunately, thanks to union demonstrations, health care has been removed from the directive.<sup>36</sup>

Commercialisation lobby groups (including KPMG, McKinsey, etc.), think tanks and private healthcare players are doing everything they can to put an end to this exception. They whisper directly into the ears of European parliamentarians, participate in committees as "neutral" advisory bodies, and push European directives towards more privatisation.<sup>37</sup> It is clear that the European Union is not opting for a strong and universally accessible public health service.

## 1.3 The systemic error in health care

After the Second World War, a number of European countries chose to entrust the public authorities with the organisation of the supply of hospitals and healthcare providers (England, Spain, Scandinavian countries, etc.). In contrast, Belgium opted for "free medicine": healthcare providers set up wherever they want, collaboration is not encouraged and everything is paid for on a performance-related basis. Today, this model is reaching its limits.

No country in Europe has the same healthcare system as the others. They are all different. But with the political choices available, there are two fundamental opposing visions: a commercial vision of health care and a public vision. The commercial point of view assumes that health care is a commodity. Caregivers offer their product, treatment and care to ill people who seek their help. This vision divides health care into a market of providers and purchasers.<sup>38</sup> This leads to choosing a model in which these suppliers, healthcare providers, compete for purchasers, patients, and in which payment is determined by the number of procedures carried out.

The table below shows the different models of health care in different countries. These are often hybrids. The money for health care comes either from the government (public funding) or from the patient's own pocket or private insurance company (private funding). Healthcare facilities may be owned by the government (public), not-for-profit organisations or commercial players.

Possible combinations of public and private funding and provision

| Provision → | Public                                                 | Private non-profit                                                                    | Private commercial                                                                         |
|-------------|--------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Funding ↓   |                                                        |                                                                                       |                                                                                            |
| Public      | A. Public service paid by taxes – e.g., NHS            | B. Non-profit health system paid by social security – e. g. Belgium                   | A. Private providers who make profit, paid by social security                              |
| Private     | D. Public service paid by the users or their insurance | E. Non-profit care system paid by the users or their insurance – e.g. The Netherlands | F. Private care providers who make profit, paid by the users or their insurance – e.g. USA |

Source: WHO tasks force on health economics, 1995, in Elias Kondilis "Privatization of healthcare in Europe", 2016



## The United States, the counterexample

In the United States, the healthcare system is entirely commercial. Health care is entirely financed by insurance companies, the majority of which are private.<sup>39</sup> These companies have a lot of power and direct influence on health policy. Such a system has many problems. Firstly, it is not effective. The US spends more on health care than many other countries, but its results are no better for it. Compared to OECD countries, the United States spends 16.9% of its GDP on health care, compared to an average of 8.9%.<sup>40</sup> Yet the US population is no healthier. On the contrary: the United States has the highest infant mortality rate of all Western countries.<sup>41</sup>

Insurance companies follow only one logic – money. If you depend on an insurer for your health, the consequences can be terrible. The most painful stories are those told by the uninsured. In 2020, 13% of US citizens had no health cover at all.<sup>42</sup> Premiums are huge and often increase if you already have health problems.



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People who become ill and lose their income can literally sink into poverty overnight. High hospital bills, loss of all income, and finally an insurance company that no longer covers you.

There is an alternative to this failing system. With widespread support, Alexandria Ocasio-Cortez and Bernie Sanders have proposed "Medicare for All". Medicare is a nationally organised health insurance programme that covers people over the age of 65 and certain chronically ill people (over 59 million US citizens). Medicare for All would extend this coverage to all citizens, thereby reducing healthcare costs and making care more accessible.<sup>43</sup>



## The Netherlands: from mutual insurance associations to private insurance companies

The Dutch government decided to abolish mutual insurance associations in 2006. Private insurers have replaced them. They were supposed to make the system more efficient. Since then, every Dutch person has to join a health insurance company in order to be reimbursed for their medical expenses. This system can be compared to fire or family insurance in Belgium. The insured person pays a premium. This amounts to an average of 1,200 euros per year. Each policy also has a franchise. Before the insurance intervenes, the insured must pay the first costs out of their own pocket, on average 385 euros. The franchise was just 170 euros in 2011. Consequently it has doubled in ten years.



Fifteen years after the implementation of this reform, the results are negative in all respects. Health insurance companies want to attract as many customers as possible by purchasing as much care as possible at the lowest possible price. Healthcare providers are under constant pressure to do more with less money. This leaves them with less time for quality care. All of them also complain about the heavy administrative burden, starting with GPs. They have to fill out paperwork all the

time, negotiate contracts. "There are too many suit-and-ties in our healthcare system, and not enough white coats", summarised left-wing elected official Renske Leijten.<sup>44</sup>

Have costs decreased like the government promised? No. Between 2004 and 2012, healthcare costs increased from 65.4 to 92.8 billion euros. And this increase is not just the result of ageing and innovation.

## The Belgian system: a hybrid system

Belgium has a hybrid healthcare system: funding is mainly public, care is provided by private, not-for-profit and public stakeholders, and the organisation of care is largely free (liberal).

A growing number of people are aware of the problems in our healthcare system. Both the industry and patients have been frustrated for some time, but the pandemic has added to the problems. And the magnitude of these will only increase in the coming years, due to the changing needs of the population.

One of the most discussed problems is, without a doubt, the total neglect of prevention. Treating

those who are unwell, we do it well. But preventing people from becoming unwell, that's another story. Belgium has a poor record in terms of the number of deaths that could have been prevented. Much worse than its neighbouring countries.<sup>45</sup>

What's the reason for this? GPs, nurses and other healthcare providers are doing their best to develop prevention. But the problem lies elsewhere: Performance-related payment means that politicians see prevention as being unprofitable for the provider. This is why more money and attention is automatically given to curative than to preventive measures. Care that primarily requires time and effort automatically receives less attention than major technical interventions. Professionally designed prevention campaigns remain underused, as no one really has the time or space to do the work.

The lack of prevention is putting our health at risk. The number of stomach operations is increasing every year, but we are still lacking a comprehensive approach to obesity within society. Every day, Belgians take a million doses of antidepressants. If you are feeling depressed though, it is not easy to find someone for a comforting conversation or good advice. One in four children now uses an inhaler at least once a year for asthma, but air pollution remains a problem.<sup>46</sup>

The fragmentation of the healthcare landscape also has many negative consequences. There is almost no structured collaboration between hospitals and primary care. Even within primary care, collaboration leaves much to be desired. Especially in large cities, where scale plays an additional role. Despite the enormous involvement of nurses, pharmacists, physiotherapists, social workers, dentists, general practitioners, etc., consultation structures are very limited, whether to jointly treat specific patients or, even less, to deal with the more general health problems encountered in the area.

There is no plan that defines where we need what kind of care, based on the needs of the population. Each healthcare provider is free to set up wherever they choose. Supply therefore determines demand: if a region has many hospitals with orthopaedic services, more knee arthroscopies will be performed there, even though people in that region may not have more knee problems than elsewhere. The supply of healthcare providers, such as a GP's office, a psychiatric institution or a residential care centre, is randomly dispersed across the country, with sometimes high concentrations in one area and significant shortages or long distances in another.

The problems we have listed are not small ones. And they are well known. For years, books, reports, studies, etc. have been published regularly. They all underline the same sensitive points. And yet, (almost) nothing has changed. The reason is that the cause of the problem lies at the root. If we want real solutions, we must opt for a change of system. Lack of prevention, overconsumption, fragmentation, etc. A closer look shows that the problems are often the result of the commercial organisation of our healthcare system.



## Why a commercial healthcare system complicates things in the event of a pandemic

The coronavirus crisis has opened our eyes to how our healthcare system works. Within the first few weeks of the coronavirus crisis, it became clear that the government was unable to deal with the pandemic with the current model of care.

It started with the lack of protective equipment, burnt supplies. Contact tracing failed in every way. Patients who tested positive were not contacted or were contacted much too late by the commercial call centres used by the government. We've trained the volunteers in our medical centres to do contact tracing of our positive patients themselves.<sup>47</sup> The tracers need to be close to people to obtain the trust that this kind of work requires. This is crucial to limit the spread of the virus.



Later, patients contacted us in panic because they couldn't get an appointment to be tested. The Brussels government decided that only hospitals could perform tests, and these were overcrowded.

Our patients had to wait for up to 48 hours for an appointment and another 48 hours for the test result. We asked the council to establish a local testing centre, close

to the people. When we didn't get an answer, we decided to take the lead. In the evenings, the medical centre became a testing centre.

If there is a lesson to be learned from this crisis by political leaders and other politicians, it is that our healthcare system needs to be organised in a completely different way. "It is no coincidence that countries like Cuba, Vietnam and Thailand are doing better in this crisis", said Erika Vlieghe in De Standaard. "They have good preventive health care". During a health crisis, but also in a normal context, the focus should be on primary care, on multidisciplinary medical centres in which many people work as a team. By supporting each other and being close to the people in the local area, we can spot problems and deal with them quickly.

### **Nele Vandenbempt**

doctor, MPLP Schaerbeek



## 2. Health as a fundamental right

*Everyone has the right to a standard of living that is sufficient for their own health and well-being and for that of their family, including food, clothing, housing, medical care and necessary social services; the right to security in the event of unemployment, illness, disability, widowhood, old age or other loss of livelihood due to circumstances beyond their control.*

Article 25 of the Universal Declaration of Human Rights

The commercialisation of health care in Belgium is still relatively limited compared to its neighbouring countries. This is largely the result of the importance of the social sector, also known today as the non-profit sector. Apart from care for the elderly, most care institutions in Belgium come under the public and social sectors. Whether historically founded by the Catholic Church, by municipal authorities or university centres, our hospitals were not created to make a profit. Together with our solid social security system and our healthcare staff, they are the pillars that maintain the quality and accessibility of our health care.

But anyone who takes a critical look at our healthcare system realises that change is needed. Health care is seen as something that can be offered, not guaranteed. Hundreds of thousands of top-performing healthcare providers are facing the limitations of the current organisation. Care considered as a market, where the curative takes precedence over the preventive, where competition prevails over coordination and efficiency, where quantity outweighs quality, where financial balances are more important than the human dimension.

In order to fundamentally improve our health care, Medics for the People wants to fight a double battle. This chapter outlines both sides of this battle.

| Non-profit sector: sector composed of organisations that pursue a social objective without commercial intent. A non-profit organisation can generate income and make a profit as long as it's reinvested in the organisation.

On one hand, we want to protect and develop the strengths of our current system. Public funding through social security is threatened by commercialisation and attempts at division. On the other hand, we need an ambitious plan for the future. A plan that dares to think outside the box, outside what is generally considered feasible. This plan goes against the interests of private companies. It mobilises people for a public-social model 2.0.

## 2.1 Solid social security



*"Solidarity is tenderness between people"*

Tomas Borge, Nicaraguan politician

Medics for the People advocates the broadest possible solidarity. The working class built social security with its own hands. Together, by joining forces. At first, it was simply a matter of putting money aside to cover the salary of an ill comrade. In 1945, social security as we know it was created. Today, it is still a weapon against the 'every man for himself' attitude of the richest. Did you know that the risk of poverty in Belgium would not be 15%, but 43% if social security didn't exist?<sup>48</sup>

And yet, social security is under severe strain. On one hand, it is structurally underfunded. On the other hand, the nationalists are threatening to divide it.

### Paying together, not every man for himself

If we want to end commercialisation, our social security must be sufficiently funded. This is an essential prerequisite. But the government sees things differently, and has been cutting social security funding year after year for decades

| Nationalists: People and political parties who want to separate our country.

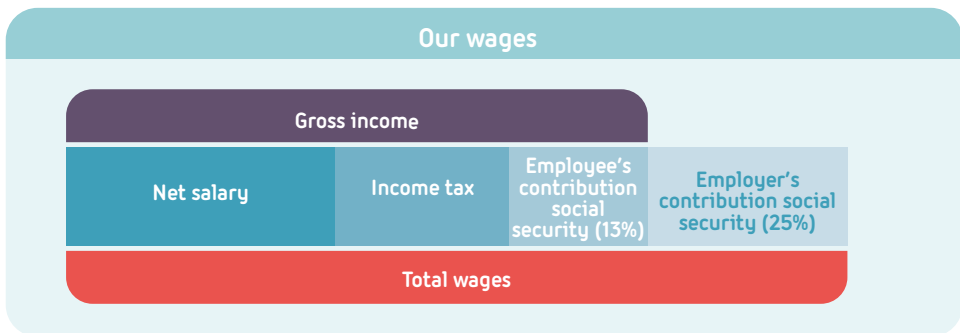


## Our social security money

We are told over and over again that funding of our social security system "costs too much". But what is it exactly?

The social security budget amounts to 100 billion euros. That's a lot of money. This is used to pay for our pensions, health care, benefits for the ill or unemployed, family allowances. It's all managed by the Belgian National Social Security Office (ONSS) and separated from the rest of the public funds. The money comes from contributions deducted from workers' wages. So we are actually giving up some of our income to provide for those in need at that time.

From the beginning, these social contributions have been threatened by those who pay our salaries, the employers. The less wages they have to pay, the more profit they make. That's why they attack the part of our salary that doesn't go directly into our bank account: the cost of labour decreases for the company, while our net salary remains the same or increases slightly. Employers are keeping more money in their pockets, while the solidarity funding for social security is crumbling.



## If you cut a house in half, it collapses

A Kiwi model is unthinkable if we have three or four separate health systems. Will three or four ministers negotiate the price of medicines with the multinational pharmaceutical companies, each on their own? Are we going to set up new consultation committees so that three ministers and just as much administrations can do what a single one could? Will the mutual insurance associations of each region or community have to negotiate doctor fees separately? What about ethical issues, if one public authority still reimburses dialysis after the age of 65 and the other doesn't?

Today in Belgium, social security is the main weapon against inequality. But the system is in danger to be split up. into two or more pieces. This is what the Flemish employer federation Voka wants. It wants to take total control of the healthcare sector, not to provide better care for patients, but to force the long-term sick back to work more quickly.

Proponents of free medicine and other progressive forces also advocate separating health care, while wanting to maintain government funding. This plan leads to insoluble problems. If health care is regionalised, but its financing remains a Federal government matter, Flemings and Walloons will be put against each other.<sup>49</sup> This will inevitably lead to the separation of the social security system as it is today.

The Flemish Health Insurance Scheme (Vlaamse zorgkas) is already an example of what social security will become if it falls into nationalist hands. Gone is solidarity in funding (everyone pays the same amount), gone is solidarity in spending (benefits no longer depend on need), gone is social consultation (unions are no longer involved) and gone is the public vision of social security (private insurers are allowed to enter the market). We cannot allow this to happen to the social security system as a whole.



## The chaos of the coronavirus

The management of the coronavirus crisis has painfully highlighted the complexity of the structure of the Belgian state. While a quick and centralised approach could have saved many lives, no less than nine health ministers have been jostling each other in our country. Everyone has jurisdiction, no one is responsible!

In-home nursing is a federal government responsibility, but if a home-care nurse helps out in a nursing home, which is a regional responsibility, the question arises as to who will foot the bill. Federal Minister De Backer has twice offered to supply surgical masks to nursing homes, but Flanders has declined the offer.

This contrasts with the solidarity of the nursing staff who came to the rescue of the nursing homes in the first wave. Patients from Limburg were also treated in hospitals in Brussels and Antwerp. In the second wave, patients from Liège were treated in Limburg. Working together has saved lives.

**Aurélie Decoene**

member of the research department



## We are one

Health care must be closer to the patients. We need local organisation of care and prevention in local health districts. The best way to develop these local health districts is to transform them into a powerful public health service, subject to directives that emanate from the government and are applicable to the entire country. An intermediate level of Flemish, Walloon or Brussels ministers will not bring health care one millimetre closer to patients. And having two levels of authority, both of which impose different directives, will not make life easier for local health districts.

A single health minister is not a guarantee of solidarity, but it is a prerequisite. Which allows us to join forces. It is also logical, healthier, more efficient and cheaper.



- **Logical.** The larger the group, the better the risks are distributed and the stronger the solidarity. We are not all young or old at the same time, nor are we all simultaneously healthy or ill. Those who are healthy and able to work contribute for those who need care.
- **Healthier.** Patients are better cared for if the front line, hospitals and nursing homes collaborate with each other. This collaboration must be encouraged by the political powers, not the other way around.
- **More efficient.** Unity of command allows for better patient care and better protection for caregivers.
- **Cheaper.** One health minister instead of nine also means less money wasted on ministers, departemental cabinets and administrations all doing the same job and having to work together.

## The best policy for all

"French and Dutch speakers have a different understanding of health care", we sometimes hear. MPLP is proud of the collaboration between its eleven medical action centres. This collaboration demonstrates that the major challenges of primary care are very similar, regardless of the region. A social and scientific view on health care carries more weight than any potential cultural difference. The habits are not always the same here and there, that's obvious. But what works best on one side of the language border should be extended to the rest of the country.

The differences are also sometimes greater between the east and west than between the north and south of the country, because doctors in Belgium have little guidance in the way they work.<sup>50</sup> Doctors and caregivers coordinate their practice with colleagues who have undergone the same training and with whom they are in close contact. But the training is different on both sides of the language border. It is clear that further separation will always lead to more differences. Nationalists turn these differences into antagonisms. And this is how differences become weapons against solidarity and unity. Each fragmentation leads to the next fragmentation. Continuing to separate health care is the fastest way to divide social security itself: Voka's intended goal.

MPLP advocates more unity and solidarity. We want the best policy for everyone. If something works well in some districts, all patients across the country should benefit from it.

## Supporting and developing civil society

We face significant challenges in defending the funding and unity of social security. We rely on civil society partners to overcome them. First of all, the unions and mutual insurance associations. But associations of patients, of fighters against poverty, of people helping refugees, etc., are also important in protecting social security and forcing change, together. When the government decided to financially penalise the long-term sick, critical reactions of civil society popped up immediately. In the first place the unions and the mutual insurance associations were able to stop the anti-social reforms. They are in closer contact with the workers, the youth and all of the oppressed.

Civil society is under pressure in the current neo-liberal climate. Organisations that perform emancipation work, as well as associations that enable people to assert their rights, are in the political frontline. The fact that the authorities are reducing their subsidies is not surprising. This would take us back to the time of medieval charity. MPLP wants to help people defend their rights. That is why we are working with civil society as much as possible.

## 2.2 The Future of health care

Protecting the funding and unity of social security is not the only challenge we are facing. As outlined above, strong social security is a crucial element in combatting the increasing commercialisation of our health care. Civil society, healthcare providers and patients are fighting with all available means against the constant pressure and attacks from the commercial community. If we want to consolidate the right to quality health care for everyone in the long term, we cannot limit ourselves to just fighting for a strong social security system. We must also address the organisation of our healthcare system. It is very good if you only want to cure people, but it fails if you want to keep them healthy. A radical change is needed to remedy this situation. We need to move to a social health system 2.0, where health is seen as a right, not a commodity. But what would such a different system look like? And what do we need to implement it?



### MPLP proves it works

The 50 years of experience of our medical action centres is positive. They contain all the elements of a social vision of health: accessibility, prevention, multidisciplinary cooperation, population-based funding, participation, accountability, etc. Why can't this be generalised?

I have been working for 1 year and 8 months at the Medics for the People's medical centre in Marcinelle. I started working here part-time as a cleaner to complement my other part-time job at the hospital where I had already worked for 5 years. For me, the hospital today is nothing more than a kind of "care factory". Care is based on finances and less on the well-being of patients. I clean the operating rooms and bedrooms, especially in the wards reserved for Covid patients, so I am in close contact with the nurses, healthcare staff, doctors, surgeons, etc. And I've seen how everyone in every department has to work so hard day and night to be able to see the masses of patients. I've seen how quickly we've had to work in the operating room, because we've had one operation after another, with other patients waiting and we couldn't afford to waste any time. I've seen in the eyes of my colleagues the stress caused by the continuous pressure imposed by management. This has only increased since the coronavirus pandemic broke out.

At Medics for the People in Marcinelle, I've discovered something completely different. Every day I see that MPLP puts the patient and worker first in terms of medical support and follow-up. All aspects of life are taken into account. With the complementaire system, the patients don't have to worry about how much they will have to pay or how many visits per month they can afford. I'm glad that I've discovered the values and vision of MPLP. I now know that different healthcare options are possible. Here, patients and their health come first, and everyone works together to achieve this goal.

**Fadwa Agday**

receptionist, MPLP Marcinelle



## 1. Health care close to the people

It is important to have a structure that connects all healthcare workers. We want to organise care so that each area has a primary care centre for its residents, where general practitioners, nurses, physiotherapists, psychologists, dentists and others can collaborate. With such organisation, hospitals are distributed across the territory so that every citizen can benefit from care as close to home as possible. The funding of hospitals is also dependent on the population of the area in which they are located, which eliminates any competition.

The best way to build a social health service that is accessible to everyone is to start from the bottom. WHO recommends that countries work with local health districts, areas of 100,000 to 200,000 residents that can form the intermediate level between national public structures and the local population.<sup>51</sup> Our healthcare system today is completely fragmented. This concept of a district would allow us to rethink everything. What do we think it would take in each area of about 100,000 people to ensure good health for everyone?

The frontline areas that already exist in Flanders are a first step in the right direction. Healthcare providers can consult each other within a local area. It is important that these frontline areas can become real decision-making bodies, rather than the simple consultation spaces they are today. To develop this potential, they need more staff and structural resources.

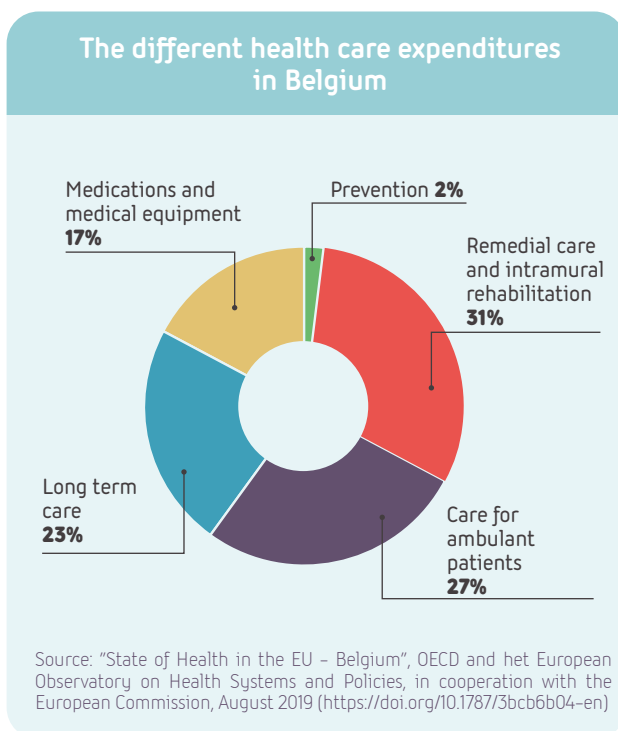


## A local prevention service

Our overall vision of health is for everyone to stay fit and healthy for as long as possible. In Belgium, we devote shamefully few resources to prevention and health promotion.<sup>52</sup> In recent years, only 2% of our health budget has been spent on prevention.<sup>53</sup> However, prevention experts say that at least 5% should be spent on prevention.<sup>54</sup> Every euro invested in prevention brings four euros back to society in the long term.<sup>55</sup> So, the resources available for prevention are extremely limited. Moreover, they have to be distributed among the different regions, which are each developing their own prevention campaigns.<sup>56</sup> Campaigns that are often useful on important topics – healthy eating, sexual health, mental well-being, etc. – but nobody is ensuring that as many people as possible are effectively informed at a local level.<sup>57</sup> A boat without oars. The social health system that we are planning is based on a local prevention service in each district, with prevention teams able to intervene on the ground.

Imagine what such teams could do. Information sessions at school. But also local projects, such as addressing an environmental issue in the area. These same teams could be deployed to combat epidemics and other infectious outbreaks.

In this respect, it is important that prevention officers are familiar with their local area. This makes them attentive to the problems of the individual person, his or her family, home, but also the area, e.g. dangerous crossings, environmental pollution, etc. They are specifically interested in vulnerable groups and their needs. We could adopt this approach, for example, in the context of vaccination against influenza or coronavirus. They can also work closely with the rest of primary care. For example, by working part of their time from existing medical centres. This is the best way to get to know many people and involve other healthcare providers.



A local prevention service can also serve as a bridge between the local area and other local prevention agencies. Think of the PMS centres, ONE services, occupational physicians, mutual insurance associations, etc. With the support of local epidemiologists, they could also monitor and analyse health data from the region to discover prevalent health problems.

Five prevention workers per local health district would provide considerable work. That's only 550 for the entire country. Considering that at the height of the coronavirus epidemic, the government employed 1,100 contact tracers in call centres, why couldn't we free up those resources for prevention on an ongoing basis?



## Japan

In Japan, there is a local public health department for every district with a population of around 300,000 people. These services, directed by the National Institute of Public Health, were created around 1937, because there were huge differences between health problems in the cities and the countryside. These "Hokenjo" can therefore have different functions depending on their population. There are doctors, nurses, lab technicians, pharmacists and other professionals trained by the national institute.

Tuberculosis was one of the leading causes of death in Japan in the 1950s and 1960s, but it has been nearly eradicated through detection, treatment and monitoring by the Hokenjo at a local level. Nursing staff went in search of tuberculosis patients and raised public awareness of the importance of hygiene. The Hokenjo conducts prevention campaigns, collects local data for epidemiological research, is responsible for food safety and environmental factors. It helps local doctors provide care for the elderly, chronically ill and children; it coordinates the organisation of dental and mental health care.<sup>58</sup>



© Kaname Yonegama/The Yomiuri Shimbun via AP Photo

When the coronavirus pandemic broke out, these local prevention services proved to be among the best in the world at responding quickly to an acute health crisis. Screening, isolation and support from local caregivers were implemented very quickly in Japan and saved many lives.

## A social medical centre in each local area

In a social health system 2.0, the front line serves as the foundation of our health care. This is where we can deal with health issues earliest and most effectively. We know that countries with strong primary care systems have better outcomes than others. Today, in Belgium, only 5% of the total NIHDI budget is dedicated to primary care. But increasing funding is not enough. It is the system that needs to change.

The healthcare landscape is currently determined by private practice and is completely fragmented. Healthcare providers are increasingly organising themselves into groups, but most of these practices consist of one or even two disciplines at most.<sup>59</sup> In addition, because of the fee-for-service system, income depends on the number of procedures, so there is often little time for consultation and care planning. Whereas for patients with chronic conditions, collaboration with many different disciplines is usually required. With a better overview of a patient's treatment in hospital, a GP or care coordinator would be able to streamline everything much better. That's why we need to build a strong front line, on the model of medical centres. Different disciplines come together under one roof.<sup>60</sup> This also improves accessibility and cooperation.<sup>61</sup>

If the government wanted to, it would be perfectly possible to establish a local medical centre, a social medical centre, within each district. With general practitioners, nurses, psychologists and physiotherapists. But also, why not a dentist, a social worker, etc.? Social care in our country is extremely fragmented, which is why we stress the importance of integrating it into a medical centre. We thus achieve an accessible and generalist approach.

We can work towards a goal of five to eight medical centres, with a patient population of ten to twenty thousand, per health district of 100,000 people. This medical centre becomes the nerve centre of the local area, the point of contact where everyone can go for questions and problems.

Proximity to the local area allows you to quickly make the connection between individual patient problems and a collective health problem. If it turns out that several children have cavities, it makes more sense to address this problem preventively at school than to send each child to the dentist separately.

In any case, investing more in community health centres does not involve additional costs for the public authorities. Costs are increasing on the front line (general medicine, physiotherapy and nursing), but decreasing on the second line (hospitals, specialists, medication, etc.). In other words, investing in medical centres means, first and foremost, changing the allocation of resources, with more attention given to good basic health care and prevention.<sup>62</sup>



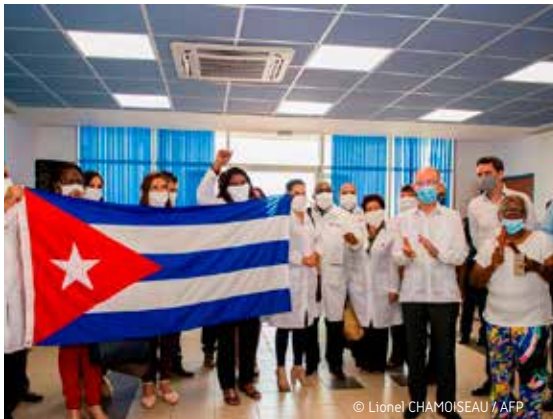
## In Cuba, people stay healthy for a long time

The socialist island of Cuba is in dire need of money due to the US economic blockade. Hospitals have to content themselves with obsolete equipment. For example, they rarely have access to a scanner. Nevertheless, many of the country's health indicators are excellent: The average life expectancy is 79 years, almost the same as in the United States, while the infant mortality rate (4/1,000) is even lower than in the United States.

How do Cubans achieve such good results? Cuba is working to build a socialist society in which the human being is at the centre. Health is a human right, included in the Constitution. Health is not seen as the absence of disease, but as a state of physical, mental and social well-being. This integral and inclusive vision is based on sports and culture, free education from childhood to retirement, community and solidarity. In Cuba, health care is completely public, free and accessible to all. The focus is on the front line and on prevention.

The Cuban Ministry of Health is convinced that preventive actions can lead to a reduction of diseases by 90%. This preventive approach can be observed at all levels. There is a general practitioner and a nurse for every 150 to 200 families. They live in the area and know the people and their health issues very well. Depending on their risk category, each patient receives a visit from the GP at least once a year. During these home visits, the doctor also gives

advice, for example, on eliminating stagnant water, healthy eating and hand hygiene.



Each district has a polyclinic, covering roughly 25,000 people, where specialists hold consultations. Also an epidemiologist is at work there. This is where information on the health of the population provided by general practitioners is centralised. And this is also where area-wide health campaigns are launched. If necessary, an infectious

disease specialist can be called in. There are also specialised hospitals.

The authorities are conducting prevention campaigns throughout the country. Health education is thus part of the subjects taught in school. Contraception is free and Cuba has one of the highest vaccination rates in the world for many diseases. In addition, the food industry is centrally controlled to limit the salt content of food products. Here, food industry lobbies do not have the same influence as in the West. Health first, not profit.<sup>63</sup>

## Mental health: talking rather than prescribing

Mental suffering is widespread in our society. In 2018, a third of Belgians suffered from mental health problems.<sup>64</sup> The coronavirus crisis has further aggravated the situation. Belgium has also had the highest suicide rate in Western Europe for years. Yet, as many as 60% of people with mental health problems have no access to the help they need. They face serious obstacles: the difficulty of knowing where to turn, the high cost of private therapists or long waiting times in subsidised centres (sometimes up to a year and a half!).

It is clear that we need an effective approach to addressing and preventing mental health problems. People need to be able to quickly find their way to appropriate psychological care and support. We advocate a system where people can access quality treatment without unnecessary medication.

There is a need for easily accessible services that can be accessed both physically and verbally by family and caregivers of people with mental health problems, in order to allow them to obtain the relevant information and to be directed quickly to the appropriate care. We need to invest in frontline psychological care, accessible to everyone, without prescription and without diagnostic or seriousness criteria. The primary psychologist conducts an assessment of the problems in a limited number of sessions. They treat mild to moderate psychological problems and, if necessary, refer people to appropriate, more specialised care.



A frontline psychologist needs to be close, accessible and affordable. It's best if this is in places people are already familiar with. In this way, mental health care has its place in the local care services: in schools and socio-educational activities, in ONE centres, in service centres for the elderly, in accessible structures such as medical centres, in associations, etc. As close as possible to the people, so that those who need it can receive the appropriate care quickly.

By investing in preventive measures first and being highly accessible, mental health issues can be addressed early and more people can be reached. Including those who previously slipped through the net. For those who require more specialised help, the focus should be on mental health centres<sup>65</sup>, which are currently facing ever longer waiting lists. For people with serious psychiatric problems, our priority is to expand mobile teams. These can be deployed quickly to help people in their own familiar environment, both for crisis situations and for follow-up and chronic care.

## A patient-centred hospital

When the hospital really cares about patients, and less about money, it also becomes less central in the organisation of care. It cooperates with medical centres and the local prevention service within each local health district. For example, collaboration between different health professionals could be financially supported. A bonus can be given to the general practitioner, physiotherapist and specialist if they work together on a chronic patient's case, rather than the patient having a separate consultation with each of them. In some parts of the world, primary care and hospitals even benefit from a common budget, which strongly encourages them to focus on prevention.

The proper functioning of a hospital requires participation from everyone: from cleaning and kitchen staff to caregivers and logistic assistants. All professions working in the hospital should have their say in hospital policy, not just doctors. To achieve this, it is therefore important that hospitals are no longer financially dependent on doctors. Anyone who works in the hospital must also work for the hospital. Outsourcing and the use of agency work diverge quality standards, staffing standards and wages.

When the public authorities provide a sufficient budget, hospital companies can become hospitals again, and hospital networks can start cooperating instead of competing.



### Let's fund health, not disease

In the Black Forest region of Germany, a group of doctors convinced two health insurance funds to finance the health care of a population of around 30,000 residents on a *complementaire* system basis. This is how the health organisation *Gesundes Kinzigtal* was born. Doctors receive additional income if they participate in the programme. Many prevention initiatives have emerged, including encouraging patients to exercise more. The number of emergency hospitalisations has decreased for four years. This has reduced spending by 17% compared to the rest of the population.

In Spain, Sweden, and New Zealand, some local health districts operate in a similar way. The question they are trying to answer in the first instance is: "How do we keep people healthy?" Hospitals, general practitioners, mental health care, prevention and home care are funded by a common budget. In their health care district, all of these healthcare providers are jointly responsible for improving the health status of the population. This is the opposite of maximising the quantity of care observed in our country. An inspiration to radically change the way hospitals are financed in Belgium?

## Special care for our elderly

"The elderly are the future, not the past. "We will all be old one day, that's life. We are entitled to rest and care at the end of an active life in which we have contributed to the community. The neo-liberal view portrays the elderly, as well as the disabled or the long-term sick, as "inactive" and unproductive, costing us money. The pressure to privatise elderly care for profit is enormous, as we saw earlier in this chapter.

Numerous studies show that exercise, music, social interaction and learning keep people and their brains in shape. Social isolation and loneliness, on the other hand, seriously affect the elderly's health. Lonely elderly people have a higher risk of dementia and fatal cardiovascular diseases.<sup>66</sup>

Instead of cold private nursing homes and fragmented, poorly coordinated home care, we need elderly care that is highly integrated in the local health district. A council for the elderly guarantees a say in how best to organise the care and health promotion of the elderly at a local level. Their views must be taken into account when planning public spaces and social housing.



With sufficient resources for customised home care, with the integration of social services, medical follow-up by frontline caregivers from the medical centre and a public nursing home in each locality, we ensure the well-being of every elderly person.

Elderly care is not a cost, but an added value. We can learn so much from people with rich life experience. A public nursing home is an open nursing home, not a place to "dump" the elderly. The residents remain local residents. Their garden belongs to the community, school children do activities there, and staff have the time and resources to provide a thriving social life.

## An inclusive policy

A society proves its strength when it cares for each person in solidarity. We want an inclusive society where people with disabilities actively participate. They must have a right to support and assistance. This right must be legally enforceable, binding upon the public authorities. It is important that people with disabilities have as much independence as possible and are involved in decisions that affect them. The current policy does not guarantee these rights. The meagre budget provided to them makes inclusion and independence a farce, not a right.

Every child, every young person, every human being must be able to develop, take control of their life, be involved and recognised for their talents and potentials. This is why proper care for young people is a fundamental right.

Whether it's about caring for young people or people with disabilities, sufficient resources must be invested in supervision, care and care workers, research and the exchange of expertise and experience.

## 2. Funding by the population

We regularly read about the lack of money in hospitals and the exuberant salaries of specialists. We want to change the paradigm from "how to make the most money from ill people" to "how to keep people healthy". Therefore we are considering an alternative funding system. This would be based on the quality and the cooperation between institutions. This is only possible with common funding at the local health district level. An financial budget for the running of healthcare services based on the needs of the population being cared for, Motivation thus shifts from more production to more health.

This goes hand in hand with a fixed salary for healthcare providers. Doctors receive a good salary, like university professors. This salary takes into account qualifications, on-call time and overtime, but values all specialisations equally.

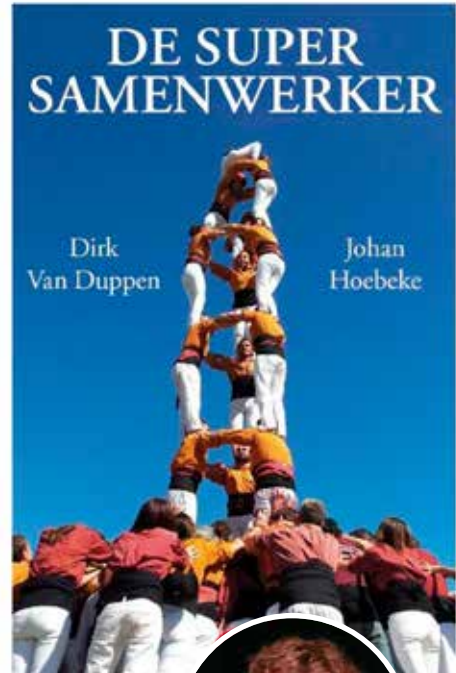
A comprehensive approach is more difficult if healthcare providers are paid on a performance-related basis. A health district with a fixed budget enjoys many healthy patients. This is what stimulates them to focus on prevention, health promotion and collaboration between lines of care. This is clearly demonstrated by the fixed-rate system in community health centres. This greater autonomy for care providers is only possible if the resources they receive are linked to the population for which they are responsible, not to the number of consultations or technical services they provide.



## Money is not the intrinsic motivation for caregivers

In his book "L'Homme, un loup pour l'Homme" – Les fondements scientifiques de la solidarité", Dirk Van Duppen described how the human being is, by nature, a social being who takes care of others. Healthcare workers are motivated if they can provide the best patient care as part of a good team. The same is true for all professions in the care sector. A system that relies solely on financial incentives for each additional act is not stimulating. It leads to alienation, dehumanisation of care and professional exhaustion, or burnout.

-If we know that the intrinsic motivation of caregivers is not financial, the solutions are even more obvious: End the performance-related remuneration and guarantee good fixed wages and working conditions for all healthcare workers. The quality of care will be improved, thanks to a strong human motivation to take care of the others. Everyone's health has a lot to gain: the patient's as well as the caregiver's.





## Common funding encourages cooperation

Thirty-five years ago, the Doctor's surgery was a private business. I only had time for curative medicine. Since then, health care has become more complex. As the population ages, the number of patients with chronic diseases is increasing. Technological development has also led to greater superspecialisation within hospitals. This increases the need for coordination. Don't these different specialists contradict each other? And what does the patient think of all this? Add to this the increase in psychological problems: people suffering from stress, burnout and depression.

Quality medicine requires more prevention, health promotion, accountability, consultation and an effective electronic medical record. This is only possible because the support in our medical centre has improved considerably. Here in Lommel we have four doctors, three nurses, an accountant, a care assistant, a dietician, two receptionists, a coordinator and a cleaner. The nurses have taken over a lot of our work: blood tests, treatment of warts, dressings, prevention, follow-up of people with chronic diseases, etc. Previously, it was the doctors who took care of all this. We often consult each other. This makes us much more competent. When we look at a case together, we understand it better.

### **Luc Ectors**

doctor, MPLP Lommel



## 3. Everything under democratic management

The creation of a health centre in each area, the management of a local prevention service, the organisation of full funding for each local health district... If we are to ensure all of this, the government must play a much more active role in our healthcare system than it does today. This will only work if everything is as democratic and participatory as possible.

The main representative of each local health district must be democratically elected. In addition, we organise a care council in each district composed of representatives of all stakeholders, which meets monthly to participate in decision making on all important issues. On the one hand, the caregiver representatives, with a good distribution between the different care institutions and the different disciplines within the district. On the other hand, the patients – basically, all the people in the local area. They can also be involved through patient associations, mutual insurance associations and other civil society organisations.

It is high time that all of these stakeholders had a greater say in the ins and outs of our healthcare system. NIHDI, which manages Belgian health insurance, is now jointly managed by

the mutual insurance associations and the professional associations. However, these national structures are mostly disconnected from reality. The establishment of 110 health councils (one in each local health district) would go a long way towards ensuring that everyone is involved in thinking about and speaking out about the future of our social health system 2.0.

## 4. Quality standards

The various scientific institutes in our country are doing good work. We saw this during the pandemic, but also before it. Yet they often have few staff and little resources.

During the pandemic, many doctors and healthcare providers complained about the multitude of information being disseminated by a multitude of different bodies. Information containing medical guidelines from various institutions and organisations was sent out every week: Sciensano, Domus medica, the Belgian Health Care Knowledge Centre, the local care group, the Superior Health Council of Belgium, the Flemish frontline areas, the Belgian Centre for Pharmacotherapeutic Information, etc. It was almost impossible not to lose one's marbles. It is essential to unify command, especially in terms of quality standards and guidelines.

We therefore advocate that practical and clear national guidelines are to be developed and communicated to all healthcare providers. A health policy works best when it is based on scientific evidence. More resources and staff are needed to implement it. We need independent expertise to make the best use of our public funds.



### The Swedish example

Health care in Sweden is of good quality. The life expectancy of Swedes is one of the highest in the world. The public healthcare system is funded by taxes. Basic services are free. The price of other services is restricted. Healthcare providers and patients have great confidence in this policy. Health care is organised at a regional level, with strong support from various national public scientific institutions. The policy is unified. The national health website [www.1177.se](http://www.1177.se) is a good example. This health service is available day and night. Nursing staff answer your questions. They find or arrange care for you. The same advice is provided throughout the country based on national scientific guidelines for diagnosis and treatment.

## 2.3 A public-social model 2.0



*"What is needed now is not a reform but a transformation, a revolution. A quiet, collective and thoughtful revolution, like the one that gave rise to the constitution of the NHS in 1945".*

Allyson Pollock, Professor of Public Health, Newcastle, UK.

Solid social security. Community-based community care, population-based funding, democratic management, attention to mental and social well-being, etc. Steps forward can be taken in each of these areas separately. Think of the development of care pools in Wallonia based on the positive experience of the frontline zones in Flanders, think of the medical centres that are multiplying, think of the preventive approach of the Office of Birth and Childhood (ONE), think of the struggle of healthcare staff to get a better salary.

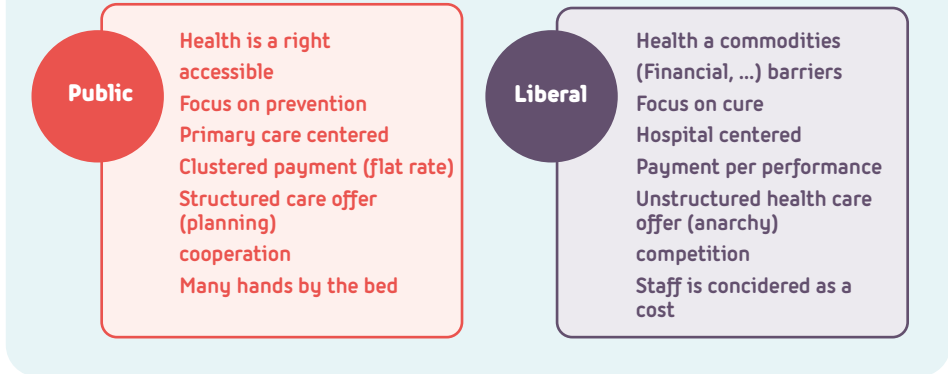
But the infiltration of the market into health care cannot be contained by simple projects. In the current commercial healthcare system, all gains are sooner or later challenged. And we often hear the old line: "there's no money", "it's a crisis for everyone" and "we do what we can". Just think of the social security savings from the Michel government's tax shift in 2016. Or the commercialisation of nursing homes and the cuts in medical centres that Minister Maggie De Block was planning.

It is important to protest against such measures, but in this vision paper from Medics for the People, we go further. It's not enough to just play around a bit. We must dare to radically change direction. It is impossible to deal with the "systemic error" mentioned in the first part of this chapter without making fundamental changes to the system. We need to get to the root of the problem.

We want to anchor our health achievements in the long term and develop them ambitiously. This requires a completely different healthcare system. This alternative health system is a public-social model 2.0. The entire healthcare system is organised with a public vision. This is different from the current commercial vision. It is time to put this debate on the agenda.

This public-social model 2.0 allows us to sustainably consolidate the strengths of our current non-profit system and to effectively achieve new ambitions. Because the needs are significant.

## Differences between public and liberal vision



Funding is provided by the public authorities. The budget is sufficient to ensure that the healthcare sector is no longer under constant pressure to cut costs, privatise and commercialise. Health care thus becomes a right and ceases to be a commodity. Common funding for various lines of care, in the form of a fixed amount for the local population, based on health needs. Prevention is no longer seen as a cost, but as an investment in keeping people healthy.

Health care providers work for the public service. This ensures that we have a sufficient number of staff working in good conditions. It also guarantees fixed and satisfactory salaries, a good pension and solid social security. This way, specialists are paid alike, whether they perform human or technical work. This allows healthcare providers to focus on quality over quantity. Cooperation can fully flourish.

To ensure that everyone is covered, care is coordinated centrally and organised locally. The federal government ensures that no one is excluded, that there are sufficient staff and resources, and that guidelines are clear. Districts apply the policy locally, close to the people.

Only a public-social service 2.0 will ensure that health becomes a right for everyone, everywhere and forever.



# Endnotes

- 1 Here, as an example, is the title of a long article that appeared in De Standaard at the end of February 2019. Detail: the study was conducted by the Health Consumer Powerhouse, a private, commercial think tank that views health care only from the perspective of the individual consumer. Significant reservation expressed by Ri De Ridder when the news was announced. [https://www.standaard.be/cnt/dmf20190225\\_04205485](https://www.standaard.be/cnt/dmf20190225_04205485)
- 2 <https://data.oecd.org/healthres/health-spending.htm>
- 3 [https://atlas.ima-aim.be/jive/workspace\\_guid=e09625c3-b5d8-4d40-947d-b16c12640778](https://atlas.ima-aim.be/jive/workspace_guid=e09625c3-b5d8-4d40-947d-b16c12640778)
- 4 <https://kce.fgov.be/fr/performance-du-système-de-santé-belge-évaluation-de-l'équité>
- 5 The trend in Belgium is the opposite of that observed in Europe, where unmet medical needs in the lowest income group have decreased from 4.7% (2011) to 2.3% (2017). [http://www.ose.be/files/publication/hehttp://www.ose.be/fichiers/publication/santé/2020\\_Ces\\_Baeten\\_NIHDL\\_Inequalities\\_access\\_care\\_Report\\_FR.pdf](http://www.ose.be/files/publication/hehttp://www.ose.be/fichiers/publication/santé/2020_Ces_Baeten_NIHDL_Inequalities_access_care_Report_FR.pdf)
- 6 OECD - Country Health Profiles 2019, Belgium [https://read.oecd-ilibrary.org/social-issues-migration-santé/belgium-country-profile-health-2019\\_e5559793-nl#page9](https://read.oecd-ilibrary.org/social-issues-migration-santé/belgium-country-profile-health-2019_e5559793-nl#page9) 10 the standard rate recommended by the mutual insurance association and on which reimbursement is based.
- 7 OECD Country Health Profiles 2019, Belgium
- 8 [https://read.oecd-ilibrary.org/social-issues-migration-health/belgique-profil-de-sante-par-pays-2019\\_1860d1c0-fr#page9](https://read.oecd-ilibrary.org/social-issues-migration-health/belgique-profil-de-sante-par-pays-2019_1860d1c0-fr#page9)  
<https://www.dkv.be/fr/a-propos/presse/la-forte-augmentation-des-couts-des-soins-hospitaliers-entraîne-ineluctablement-unv>
- 9 References: <https://www.medi-sphere.be/fr/actualites/socio-professionnel/la-liste-des-146-communes-wallonnes-en-penurie-ou-en-penurie-grave-de-medecins-generalistes.html> <https://www.zorg-en-gezondheid.be/aantal-huisartsarme-gemeentes-blijft-toenemen#:~:text=227%20huisartsarme%20gemeentes,juni%202019%20tot%20eind%202020>
- 10 [https://kce.fgov.be/sites/default/files/atoms/files/KCE\\_325B\\_Dotation\\_infirmiere\\_synthese\\_2nd\\_edition.pdf](https://kce.fgov.be/sites/default/files/atoms/files/KCE_325B_Dotation_infirmiere_synthese_2nd_edition.pdf)
- 11 <https://www.idewe.be/fr/-/le-secteur-des-soins-face-%C3%A0-36-d-absent%C3%A9isme-en-plus-que-les-autres-secteurs>
- 12 Presenteeism among nurses: A qualitative and quantitative study, Dr. L. Lagrandcourt, MPLP
- 13 [https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/infirmiers\\_sur\\_le\\_marche\\_du\\_travail\\_2017.pdf](https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/infirmiers_sur_le_marche_du_travail_2017.pdf)
- 14 Reference: <https://www.vrt.be/vrtnws/nl/2022/02/10/1-op-3-huisartsen-wil-stoppen/#:~:text=Uit%20een%20bevraging%20van%20de,n%20a%20met%20een%20huisartsentekort>
- 15 The staff shortage in our nursing homes is untenable. We would need about twice as many staff to provide safe, quality care. 80% of healthcare staff in Flemish nursing homes (private and public) have too little time to give residents the care and attention they need, according to CSC surveys.
- 16 [https://www.hetacv.be/docs/default-source/acv-csc-docsitemap/6000-centrales/6440-acv-openbare-diensten-csc-services-publics/6540-sectoren-\(overzicht-met-links\)-secteurs-\(aper%C3%A7u-avec-liens\)/openbare-zorg/brochure-zorgenqu%C3%AAtelv.pdf?sfvrsn=afb40c5b\\_4](https://www.hetacv.be/docs/default-source/acv-csc-docsitemap/6000-centrales/6440-acv-openbare-diensten-csc-services-publics/6540-sectoren-(overzicht-met-links)-secteurs-(aper%C3%A7u-avec-liens)/openbare-zorg/brochure-zorgenqu%C3%AAtelv.pdf?sfvrsn=afb40c5b_4)
- 17 Famous American linguist and philosopher, born in 1928.
- 18 MC, September 2020: "The healthcare budget in historical perspective. Towards an erosion of our social model?" [https://www.mc.be/media/0-CM-info%20281-11705-FR\\_tcm49-67219.pdf](https://www.mc.be/media/0-CM-info%20281-11705-FR_tcm49-67219.pdf)
- 19 MAHA-Analyse Belfius 2020  
<https://www.belfius.be/about-us/fr/actualites/maha-analyse-2020>
- 20 The Financial Budget Resources.
- 21 Calculations in the vision paper "Helping people live the healthiest lives possible". Based on KCE and OECD figures. <https://proxy-ftp-upload-statics.kubernetes.prod.cloud.mediafn.digital/static/tijd.be/pdf/Helping%20people%20live%20the%20healthiest%20lives%20possible.pdf>
- 22 From the book by Ri De Ridder, "Goed Ziek," p. 91.
- 23 <https://www.demorgen.be/nieuws/soms-geen-enkele-verpleger-per-afdeling-in-hoogbeveiligd-centrum-baca0510/>
- 24 Reference: <https://www.independent.co.uk/voices/how-nhs-being-dismantled-10-easy-steps-10474075.html> <https://www.bmj.com/content/361/bmj.k2791/rr>  
<https://www.health.org.uk/publications/long-reads/returning-nhs-waiting-times-to-18-weeks>
- 25 Sebastian Franco, "Mapping the privatisation of healthcare in Europe", European Network of Corporate Observatories, 14 October 2021.
- 26 Health, health care and capitalism. In L. Panitch and C. Leys (eds.), *Morbid symptoms: Health under capitalism*, Wales: Merlin Press, 2009, p. 18.
- 27 Why Single-Payer Health Care Saves Money, Robert H. Frank, 7 July 2017, The New York Times, <https://www.nytimes.com/2017/07/07/upshot/why-single-payer-health-care-saves-money.html>
- 28 Financing of integrated care in primary care, Impact of commercialisation in the Netherlands and Sweden, Tim Joye, Master's thesis in general practice, Ghent University, p. 40.
- 29 [https://www.nieuwsblad.be/cnt/dmf20180308\\_03398914](https://www.nieuwsblad.be/cnt/dmf20180308_03398914)
- 30 Agentschap Zorg & Gezondheid, "Hoeveel bedraagt de gemiddelde dagprijs in uw woonzorgcentrum. Meting 2020", <https://www.zorg-en-gezondheid.be/dagprijzen>.
- 31 Sebastian Franco, "Mapping the privatisation of healthcare in Europe", European Network of Corporate Observatories, 14 October 2021.
- 32 This is what emerged from a parliamentary question of the PTB in the Flemish Parliament, see [http://www.pvda.be/gemiddeld\\_22\\_minder\\_personeel\\_in\\_commerciele\\_woonzorgcentra](http://www.pvda.be/gemiddeld_22_minder_personeel_in_commerciele_woonzorgcentra)

- 34 Agentschap Zorg & Gezondheid, "Hoeveel bedraagt de gemiddelde dagprijs in uw woonzorgcentrum. Meting 2020", <https://www.zorg-en-gezondheid.be/dagprijzen>.
  - 35 "Privatisering van openbare ouderenzorg : de kraak van de eeuw", Lise Vandecasteele, Knack, 12 July 2021.
  - 36 Corporate Europe Observatory, January 2021, "When the market becomes deadly
  - 37 European Commission, November 2020, Commission opinion on the 2021 Draft Budgetary Plan of Belgium. [https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/stability-and-growth-pact/annual-draft-budgetary-plans-dbps-euro-area-countries/draft-budgetary-plans-2021\\_en#belgium](https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/stability-and-growth-pact/annual-draft-budgetary-plans-dbps-euro-area-countries/draft-budgetary-plans-2021_en#belgium)
  - 38 However, care homes continue to be considered as private services in the European free market, leaving multinational business groups free to buy more and more of them.
  - 39 In addition, the European Commission in principle considers health care to be an "economic activity" covered by single market legislation, which provides for the free exchange of goods, people, capital and services. Based on this framework, there is intense lobbying to outsource health services to private companies. The European market favours public-private partnerships, competition between healthcare institutions and the sale of hospitals to private investors.
  - 40 In English, we speak of providers & purchasers. The purchase of care can be made by the patient out of his own pocket, through health insurance plans (public or private) or directly with government money.
  - 41 Private insurance companies are the main providers of healthcare cover (for 68% of the population in 2019). 2019 figures. <https://www.census.gov/library/publications/2020/demo/p60-271.html>  
The insurance offer is also not very diversified. In 2014, four companies shared 83% of insurance policies. This does not promote competition or lower prices as promised by the law of the free market.
  - 42 Health at a Glance 2021, OECD, <https://www.oecd-ilibrary.org/sites/ae3016b9-en/index.html?itemId=/content/publication/ae3016b9-en>
  - 43 The United States spends 16.8% of its GDP on health care, compared to an OECD average of 8.8%. Health at a Glance 2021, OECD, <https://www.oecd-ilibrary.org/sites/ae3016b9-en/index.html?itemId=/content/publication/ae3016b9-en>
  - 44 "Women's Health Insurance Coverage", Kaiser Family Foundation, 8 November 2021, <https://www.kff.org/other/fact-sheet/womens-health-insurance-coverage/>  
The commercialisation of health care also increases gender inequality. Nearly one in four women only has access to health care through their husband's insurance. This strongly discourages her from leaving him if she is a victim of domestic violence.
- State of Health in the EU, Country Health Profile 2019, Belgium
- 45 Interview for Solidaire in 2015  
<https://www.solidaire.org/articles/pays-bas-trop-de-costumes-cravates-et-pas-assez-de-blouses-blanches>
  - 46 State of Health in the EU: Belgium. Country Health Profiles 2019. [https://ec.europa.eu/health/system/files/2019-11/2019\\_chp\\_be\\_french\\_0.pdf](https://ec.europa.eu/health/system/files/2019-11/2019_chp_be_french_0.pdf)
  - 47 REFERENCES STILL TO BE COLLECTED IN THE TEXT FOR THE PROMETHEUS PLAN
  - 48 We published our experience with local contact tracing in a study: "Haalbaarheid van actieve contact tracing van COVID-19-infecties in de eerstelijnszorg: een pilootproject," Tijdschr. voor Geneeskunde, 76, no. 12, 2020
  - 49 SOURCE: [www.socialsecurity.be](http://www.socialsecurity.be) 2014 figures
  - 50 Tom Zwanepoel and Tony Van de Calseyde, "Splitsing gezondheidszorg legt bom onder interpersoonlijke solidariteit", De Gids, 26 April 2021
  - 51 Healthcare Knowledge Centre, Study of Disparities in Elective Surgery in Belgium, Report 42A, 2006. Guy Tegenbos, "Kans op operatie verschilt zeer sterk per regio", De Standaard, 11 October 2006. "Kijkoperatie degeneratieve knieartrose vaak overbodig", De specialist, despecialist.eu, 24 September 2019.
  - 52 Bart Criel and Janneke Ronse in De Morgen <https://www.demorgen.be/meningen/onze-les-uit-de-coronacrisis-organiseer-gezondheidszorg-meer-lokaal-b32a7e95/>  
Even more elaborate in TVG: <https://tvvg.be/nl/artikelen/van-basisarts-tot-public-health-verschillende-wegen-om-naar-rome-te-reizen>
  - 53 What is the difference between the two? In short, prevention is more about avoiding disease, for example through vaccination or early detection of cancer. Health promotion encourages people to make healthier choices, for example, by raising awareness of the need for more exercise and healthier eating.
  - 54 Calculated by MC. [https://www.mc.be/media/PREVENTION%20ET%20PROMOTION%20DE%20LA%20SANTE\\_tcm49-69773.pdf](https://www.mc.be/media/PREVENTION%20ET%20PROMOTION%20DE%20LA%20SANTE_tcm49-69773.pdf)
  - 55 Prevention Platform opinion [https://logoantwerpen.be/sites/default/files/domain%20editor/Melissa/Opiniestuk%20Preventieplatform\\_de%20nood%20om%20te%20investeren%20in%20preventie%20is%20nog%20noot%20zo%20groot%20gewest.pdf](https://logoantwerpen.be/sites/default/files/domain%20editor/Melissa/Opiniestuk%20Preventieplatform_de%20nood%20om%20te%20investeren%20in%20preventie%20is%20nog%20noot%20zo%20groot%20gewest.pdf) See also the appeal of dozens of academics in the medical sector at the end of 2019, even prior to the coronavirus crisis. [https://www.standaard.be/cnt/dmf20191006\\_04648748](https://www.standaard.be/cnt/dmf20191006_04648748)
  - 56 Figures from health economics professor Lieven Annemans, based on a British study. (REFERENCE?)
  - 57 In Flanders, this is the Agentschap Zorg & Gezondheid (Care and Health Agency). In Wallonia, the Agency for a Quality Life (AViQ). In Brussels, no less than three different institutions(!) are competent. More details in the MC report [https://www.mc.be/media/PREVENTION%20ET%20PROMOTION%20DE%20LA%20SANTE\\_tcm49-69773.pdf](https://www.mc.be/media/PREVENTION%20ET%20PROMOTION%20DE%20LA%20SANTE_tcm49-69773.pdf)
  - 58 In Flanders, there are the Logo (Lokaal GezondheidsOverleg). But more than anything it is a network organisation. Their primary task is to connect local organisations and healthcare workers with existing prevention projects. Their objective is not to go to the target audience themselves. The available staff is also limited: 90 full-time equivalents, spread over 15 Logo entities in Flanders and Brussels.  
Information on the website <https://www.vlaamse-logos.be/node/75>  
Francophones have Local Health Promotion Centres (CLPS). With nine centres for the whole of Wallonia and one for Brussels, the same limitations are observed. <https://sante.wallonie.be/?q=transfert-competences-sante/organismes-agrees-organes-avis>
  - 59 1) [https://www.researchgate.net/publication/51167509\\_Structure\\_and\\_roles\\_of\\_public\\_health\\_centers\\_hokenjo\\_in\\_Japan](https://www.researchgate.net/publication/51167509_Structure_and_roles_of_public_health_centers_hokenjo_in_Japan)  
2) <https://www.niph.go.jp/journal/data/69-1/202069010002.pdf>

60 This makes Belgium the bottom of the class in Europe.

See Qualicopc-studie <https://www.demorgen.be/nieuws/artsen-spelen-soloslim~b16bb612/>

61 For each registered patient, the mutual insurance association pays a fixed amount per month to the medical centre. The patient and the mutual insurance association no longer pay on a fee-for-service basis.

62 Again in May 2020, this forum of professors from Antwerp and Ghent in the context of the coronavirus crisis. <https://www.demorgen.be/nieuws/de-coronacrisis-kan-de-huisartsenzorg-voorgoed-veranderen~b70fc191/>

63 This figure was calculated by the mutual insurance associations in their comparative study of the two systems. See <https://ima-aim.be/Communique-de-presse-Les-Maisons?lang=fr>

64 References:

1. <https://www.mediscontact.nl/news/latest-news/article/learning-about-cuban-health.htm>

2 Gardiner J. Is Cuba the answer? *BMJ* 2011; 343:d7460 doi:10.1136/bmj.d7460

3 Campion EW, Morrissey S. A different model--medical care in Cuba. *N Engl J Med*. 24 January 2013; 368(4):297-9. doi:10.1056/NEJMp1215226. PMID: 23343058.

65 Why Single-Payer Health Care Saves Money, Robert H. Frank, 7 July 2017, *The New York Times*, <https://www.nytimes.com/2017/07/07/upshot/why-single-payer-health-care-saves-money.html>

66 The Centra Geestelijke Gezondheidszorg (mental healthcare centres) in Flanders and the Service de santé mentale (mental health service) in Wallonia are subsidised centres where people with (serious) mental or psychiatric problems can go for help and support. The team at each centre is composed of psychiatrists, psychologists, psychotherapists and social workers. The standard fee for a psychological interview is 11 euros. Emergency care and an initial consultation remain free. People who receive an increased intervention, under the illness and disability regulations, or budget guidance pay a reduced rate of 4 euros per interview.

67 Social Isolation and Loneliness in Older Adults: Review. *American journal of geriatric psychiatry*. December 2020 28(12): 1233-1244.

## Chapter 3

# Medication



- 1. Twenty years of struggle for the right to medication**
- 2. Patients and social security pay a high price**
- 3. The pharmaceutical business model hinders social progress**
- 4. The solution: make essential medication and vaccines a public good**

# 1. Twenty years of struggle for the right to medication

Medication is an essential part of our healthcare system. After describing a health problem that people face, the next question inevitably follows: "Is there a medication?". For many patients, the discovery of new medicines has made a world of difference. While this is unfortunately not the case for all medical conditions, medications do help people recover. Whilst we, the community, have absolutely no say in what pills and powders are developed, let alone how much they cost. The government has given the keys to the medicine policy to the private sector, making us totally dependent on a handful of multinational pharmaceutical companies.

The former president of MPLP, Dirk Van Duppen, who died far too early, sounded the alarm in 2004 with his book "The medicine war". The book was a bombshell and launched a social and political debate on medicine policy. Throughout the book, he carefully exposes how we pay far too much for medication. How multinationals are plundering billions from our social security. But also how pharmaceutical companies manipulate scientific research. How they are primarily interested in how to make a profit and not what is necessary for public health. And how they try to influence the prescribing behaviour of doctors. "That's all in the past", we sometimes hear the pharmaceutical lobby say. But is this really so? We find that many of the abusive practices denounced by Dirk Van Duppen still exist today, even if they sometimes take a different form.



## The Kiwi model

The story of the medicine war began with one of general practitioner Dirk Van Duppen's heart patients, a patient whose medication was not reimbursed. At the MPLP Medical Centre De Bres in Deurne, they decided to conduct a small scientific study. Doctors then discovered a pattern: patients who did not need medication were reimbursed and the patients who needed it were not! Dirk Van Duppen raised the issue in the De Morgen newspaper and the medicine war broke out. A year later, in 2004, he published a book with the same title. "The medicine war – Why are medicines so expensive?" was an indictment of the pharmaceutical industry and its greed for money, its marketing machine and its plundering of social security. The book also showed that it was possible to pursue a different medicine policy. Dirk was then inspired by New Zealand. There, it's not the pharmaceutical lobby, but the government that's in charge. It organises a public tender for medicines and reimburses only the products with the best value for money. In New Zealand, medication is up to 90% cheaper than in Belgium. This system is known in Belgium as the "Kiwi model". The idea worked like a magnet and

| Multinational: a company with establishments in several countries.

| Lobby: an organisation whose main objective is to influence decision makers so that their undemocratic interests can be incorporated into law.

encouraged many people. In no time, one hundred thousand people signed a petition from the Christian employees' union and the KWB. MPLP has also carried out its own actions. We took our patients to the Dutch border town of Hulst, where they could buy cheaper medication.

In 2005, the medicine war reached the federal Parliament. The MPs were asked to vote a law that could have introduced the Kiwi model in our country. Supporters emerged from almost every political family. This caused great panic among the pharmaceutical companies, who organised a joint press conference for the first time in history. The only message was the



following: a Kiwi model is absolutely unacceptable. Their lobbying operation was not without consequences. The Kiwi model has mutated into "kiwi light".<sup>1</sup> But even this very light version has lowered the costs. Awareness of the excessive amounts of money that fall into the hands of pharmaceutical companies has also increased. The Kiwi model has been applied for community purchasing of vaccines, such as the HPV vaccine for cervical cancer. The price has fallen from 375 euros to 51 euros for three injections. This has enabled the vaccine to be administered free of charge to all girls in the first year of secondary school.<sup>2</sup>

For the past few years, MPLP medical centres kept touching the sore spot. Every year we present our calculations to the press on how much money the Kiwi model can bring in.<sup>3</sup> When the then health minister, Maggie De Block,

announced that she wanted to make antibiotics and stomach acid inhibitors more expensive, we travelled to the Netherlands in 10 buses to demonstrate the huge price difference.

It was a success because Maggie had to back down. And once again, we highlighted the alternative of the Kiwi model. A new bill proposal on the Kiwi model was one of Dirk Van Duppen's last achievements before he was struck down by a fatal illness. Our PTB MPs have tabled a bill detailing how such a Kiwi model would look like in Belgium.<sup>4</sup> We are continuing Dirk's fight!

### **Tim Joye**

head of the MPLP research department



# From Lipitor to Humira

The pharmaceutical sector has certainly not been idle in recent years. The road to the biggest profits is not the same as it was twenty years ago. This evolution was inevitable, especially as the spectacular progress of science has changed the type of medicines marketed.

In the era of the medicine wars, pharmaceutical companies made their profits mainly from medication used for very common illnesses: too much cholesterol, high blood pressure, stomach acid, etc. These were the products that made a lot of money, medication that could be prescribed to very large groups of patients and that often had to be taken for a long period of time. Guaranteed revenue. Like blockbusters in the movie world, blockbuster producers with multi-million dollar budgets make a lot of money. For many of these blockbusters, the patent expired and cheaper generic versions appeared on the market. In 2009, we read in the newspaper: "Most of the big pharmaceutical companies are now struggling to maintain their position, sales and profits".<sup>6</sup>

The pharmaceutical industry therefore began to look for other ways to sell medication at a high profit. They have a problem with the new medicines of the last decade: Most of them are for things that affect a much smaller number of patients. Many treatments currently under development are in the fields of immunotherapy and gene therapy. These are areas of medical science that were still in their infancy twenty years ago, but that have evolved enormously since then. This paves the way for better treatment of many diseases. These include chronic immune diseases such as Crohn's disease or rheumatoid arthritis, but also cancer and certain genetic disorders. These are therefore high-impact medicines, but with a smaller target audience than their predecessors 20 years ago.

To make this group of medicines the new cash cow, pharmaceutical companies have changed their prices. If the target audience is smaller and you want to make the same amount of money, you have to increase the price. In seven years, the cost of a cancer treatment has increased twentyfold, for example.<sup>7</sup> The business model has been adapted to the technological evolution. We've gone from blockbusters to nichebusters.<sup>8</sup>

The comparison in the attached table makes the evolution more concrete. We show number 1 in the NIHDI Top 25 of 2002 and 2020. This is the list of the 25 medicines that cost the NIHDI the

Generic: a medication containing the same active ingredient as the brand name medication originally marketed. The generic can only be marketed after the patent of the original brand name medication has expired.

Immunotherapy: medical therapy aimed at the immune system. We treat diseases by stimulating or inhibiting our defences. Many new cancer treatments

Gene therapy: introduction of genetic material (DNA, RNA) to the patient to prevent or cure a disease.

### Most expensive pharmaceuticals for the NIHDI – 2002 and 2020

|      |              | Price per dosis | Number of refunded doses | Total refunded amount |
|------|--------------|-----------------|--------------------------|-----------------------|
| 2002 | atorvastatin | 0.68 euro       | 111 million              | 76 million euro       |
| 2020 | adalimumab   | 20.39 euro      | 5 million                | 102 million euro      |

most. The current number one, adalimumab (brand name Humira), is used by far fewer people than the cholesterol-lowering medication atorvastatin (brand name Lipitor) was 20 years ago.

The price history of adalimumab, Humira, is a good illustration of how prices are artificially increased even more than before. Humira is an anti-inflammatory medicine for the treatment of rheumatoid arthritis. It was first marketed in 2003 by Abbott (now AbbVie). After the patent expired in 2018, many hospitals re-tendered to take advantage of lower prices. The price of Humira immediately fell by about 80%.<sup>9</sup>

## Transparency at risk

| For very small niches, such as so-called **orphan medicinal products**, a specific reimbursement scheme has even been created within the NIHDI – the famous article 81; This way, the exact cost price of this category of medication remains a well-kept secret.

The history of this new procedure – section 81 – demonstrates how the government has completely followed the new business model of the pharmaceutical industry. In 2015, liberal minister Maggie De Block entered into a "Pact for the Future" with pharma.be, the Belgian lobby for big pharmaceutical companies. The pharmaceutical industry has accepted that the price of many conventional medicines can be lowered in exchange for the promise that new niche medicines can gain quick and easy access to reimbursement.

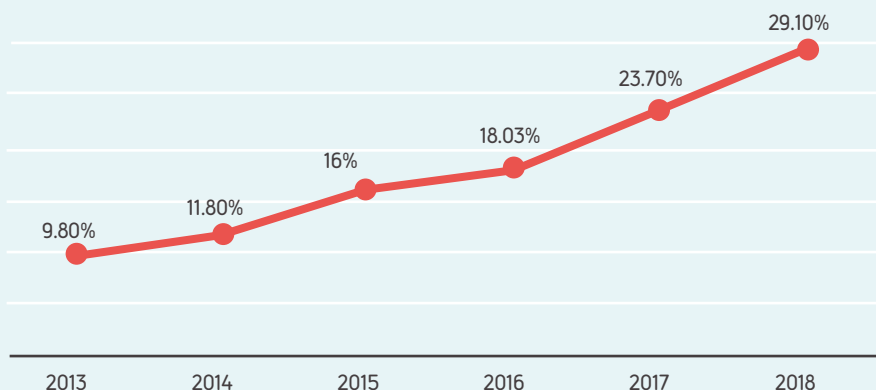
Since then, the number of medicinal products covered by Article 81 has increased exponentially, from six in 2010 to 135 in 2019.<sup>10</sup> We therefore negotiate with the big multinationals on the price of their medicines, but we don't tell neighbouring countries the amount. This is to ensure that the company's competitive position is not harmed. This system undermines our democracy. Even elected members of Parliament do not have access to the secret contracts. It is a mechanism that simply encourages higher and higher prices.

| Orphan medicinal product: medicine for the treatment of rare and serious diseases



Section 81 isn't the only red carpet that politicians have rolled out for Big Pharma. In the European Union, there was the Orphan Drug Regulation, and the United States did the same with the Orphan Drug Act. Among other things, these directives include tax benefits and market exclusivity. The number of orphan medicinal products with annual sales of more than €1 billion in the EU has increased from four in 2013 to 20 in 2019.<sup>11</sup>

Percentage of the expenses for pharmaceuticals in Belgium under secret contract (article 81), 2013 – 2018



Source: Simon Andries, "How the liberal minister eliminates the free market", De Standaard, 2 June 2018. ([https://www.standaard.be/cnt/dmf20180601\\_03541830](https://www.standaard.be/cnt/dmf20180601_03541830))



## Baby Pia

In September 2019, a wave of solidarity swept through our country. A baby named Pia was diagnosed with spinal muscular atrophy (SMA), a genetic and incurable muscular disease that can lead to paralysis and, in the worst case, death. Over a million SMS messages worth 2 euros were sent to help pay for the extremely expensive medicine Zolgensma. The pharmaceutical company Novartis claims 1.9 million euros per dose. Novartis cites the high research costs for Zolgensma, but ignores the fact that Novartis didn't achieve the scientific breakthrough. It was realized by the public research laboratory Genethon, which was itself financed by public funds and – ironically – by the general public through crowdfunding. Secondly, the American start-up AveXis invested the necessary resources to carry out the clinical studies. It was only when these studies proved conclusive that the pharmaceutical giant Novartis jumped on the bandwagon.



Is this medicine so expensive because the production costs are high? No, Novartis is exploiting the fact that the medication works so well and is so coveted. The €1.9 million sale price generated a three-month profit of €143 million in 2019.<sup>11</sup> David Lennon, Chairman of AveXis, unashamedly stated:

"So should we treat all Pia's for free? The value of the product is very high and the price is right".<sup>12</sup> Unscrupulous. The protest has further escalated. Finally, the company found a solution: a lottery.<sup>13</sup> In countries where Zolgensma is not reimbursed, lots will now decide which babies under the age of two will receive the medication free of charge. Heads or tails on life or death. Together with the PTB, we demanded that the minister intervenes. This is possible with a regulatory licence.<sup>14</sup> This means that the minister obliges the patent holder

to licence another manufacturer to produce the medicine. This could have lowered the price of Zolgensma. The story of baby Pia prompted our group in Parliament to introduce a bill to facilitate the use of regulatory licencing in our country.

### **Sofie Merckx,**

doctor, MPLP Marcinelle  
and group leader of the PTB in the Chamber



<sup>11</sup> Start-up: this is usually a fast-growing company that wants to bring an innovative product or service, business process or platform to market.

## 2. Patients and social security pay a high price



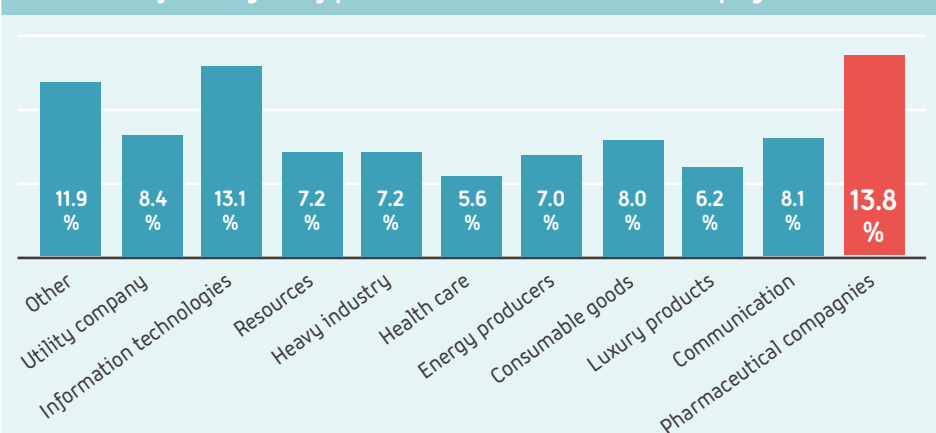
*"Is illness the most profitable investment after oil and real estate?"*

Médecins du Monde – "The Price of Life" campaign <sup>15</sup>

Families still pay hundreds of euros out of their own pockets for medicines every year.<sup>16</sup> Equally important: with its exorbitant prices, the pharmaceutical industry is also committing a real hold-up on our social security system, which is responsible for reimbursing these extremely expensive products. It presents the government with an agonising choice: Either we pay the price it charges or patients are denied access to new medication. As a result, no other healthcare expenditure item is increasing as dramatically as medication. This puts pressure on the entire social security system, so that all other sectors have had to tighten their belts for years. Between 2020 and 2024, some 1.4 billion euros will be needed for the reimbursement of medicines in Belgium. This is 30% more than the budget of the previous period. This is despite the fact that healthcare expenditure will only increase by 241 million euros (14%).<sup>17</sup>

Meanwhile, the profits of multinational pharmaceutical companies are soaring. Thus, in 2021, the Roche Group became number one with a fabulous profit of 13.7 billion dollars.<sup>18</sup> Pharmaceutical companies are much more profitable than other large companies.<sup>19</sup> The graph below shows the difference in net profit margin by economic sector. The pharmaceutical

Profit margins of pharmaceutical and other companies



Source: Ledley F. et al., "Profitability of Large Pharmaceutical Companies Compared With Other Large Public Companies", JAMA, 2020. (<https://jamanetwork.com/journals/jama/article-abstract/2762308>)

The profit margin indicates the net revenue generated as a percentage of total revenue.

Median profit margins for 500 companies (included in the S&P 500 dataset) between 2000 and 2018, grouped by industry, are displayed here.

industry wins hands down. For every 100 dollars in sales, it made 13.8 dollars in profit. This is better than the banking sector, better than the energy sector, etc. The average profit margin of the other sectors was only 7.7%.<sup>20</sup>

## The price of medicines "is what the fool is willing to pay"



*“Pharmaceutical companies assume that people are willing to sell their homes to be cured of cancer”.*

Dirk Van Duppen – former president of MPLP

How can pharmaceutical companies justify charging so much money for a single product? Take the example of sofosbuvir, a medicine for hepatitis C. Médecins du Monde discovered that it costs about 100 euros to produce, while Gilead Laboratories charges up to 43,000 euros for it.<sup>21</sup> The pharmaceutical industry often cites the high costs of research and development of innovative medicines and the high risks it takes to set to work. But it is inconceivable that it can justify a sales price 400 times higher than the cost of production, as is the case for sofosbuvir. We also know that the coronavirus vaccine is much more expensive than the cost price. Pharmacologists and economists estimate that Pfizer's vaccine can be produced for between 0.8 and 1.4 dollars. Add to that the costs of research, development, and distribution, and you're looking at a maximum of 3 dollars per dose, even with generous estimates. Our government is currently paying Pfizer 19.5 dollars.<sup>22</sup>

Pharmaceutical companies say that the search for new medicines is becoming increasingly expensive. But the examples above show that this cost is nowhere near the sky-high prices. Another example: For ten widely used new cancer treatments, the researchers calculated that the average development cost was about 648 million euros, while the median gain was 1,658 million euros.<sup>23</sup>

The problem is that governments often do not know the exact cost for the development of a new medicine. Researchers from Leuven also found that the pharmaceutical industry greatly overestimated the average development costs in its communication. The average cost of developing a new medicine has been proven to be nearly 1.5 billion dollars less than the pharmaceutical industry claims.<sup>24</sup>

If the price is not determined by the cost of production, and if it is not determined by the cost of research and development either, then what is it determined by? The example of sofosbuvir and hepatitis is very illuminating. The company calculated this price based on the cost to the patient and the community of a liver transplant, an operation that can be avoided with sofosbuvir treatment. Big Pharma lobbyists call this "value-based pricing". The price therefore depends on the value that the medicine has for our health. This is absurd. It's like the cost of installing an

airbag in your car depends on the value of the life saved in a serious accident. How is the value of a human life determined? Health is priceless, the sky is the limit. How far would you go if your child had leukaemia and needed medication? If you needed to, you would sell your house and all your furniture. Poor people are willing to do a lot to be cured. This is precisely what the pharmaceutical industry exploits by charging the highest possible price for medicines that patients and healthcare insurance are willing to pay. "It becomes possible to profit from the needs of others, and there is a risk that the price will not be in line with production costs. It is sometimes said that it's "what the fool is willing to pay", explains Marc Reynebeau.<sup>25</sup>

## Patents and monopolies: the privatisation of public research

How come pharmaceutical companies have so much power that they can manipulate prices in this way? The famous "patents" make it possible. A patent gives a company the exclusive right to market a medicine or vaccine. Patents aren't as heavily regulated and protected in any other industry as in the pharmaceutical sector. A patent gives companies a **monopoly** position for at least twenty years. No one else is allowed to produce and market the product, and the pharmaceutical company is free to set the price entirely unilaterally. There are no cheaper competitors at all.

However, new medicines or vaccines are not generally discovered by the pharmaceutical companies themselves. Of the new medicinal products that pharmaceutical giants such as Pfizer and Johnson & Johnson bring to market, they have discovered 11 to 23% themselves.<sup>26</sup> The strategy of multinational pharmaceutical companies is very simple: they scour the market for the most promising medicines and technologies and invest considerable sums to buy them. How exactly does it work?

- Breakthroughs in the research and development of innovative medicines are almost always the result of years of publicly funded research by passionate scientists at various universities. This basic research is the most expensive and carries the greatest risks.
- New discoveries are then usually developed through private for-profit **spin-offs**. The new knowledge is protected by a patent so that no one else can use it.
- Large biotech or pharmaceutical companies don't jump on the bandwagon until the first **clinical studies** have gone well. They select the most promising medicine candidates for development and commercialisation. They acquire the patents or – even more often – throw money at them to add start-ups, spin-offs and biotech companies with the most promising products in their portfolio..

| Monopoly: A situation in which a product or service is offered by just one organisation. The price is not determined by the functioning of the market, but set by the sole supplier.

| Spin-off: a spin-off is a company that is created from another larger company or research institute. These are often innovative companies that are the direct result of research.

| Clinical study: in a clinical study, medicines or other medical treatments are tested on human guinea pigs. A medicinal product is only allowed on the market if a clinical study proves that the substance is effective and does not cause serious side effects.



In other words: public investment in high-risk research ends up being privatised by Big Pharma. Most of the research behind new medicines is publicly funded. In America alone, more than 70% of the basic research leading to new medicines is done by public institutions, universities and other non-profit organisations.<sup>27</sup> This collective research does not produce a public good, but knowledge that is monopolised by corporations. And the taxpayer pays twice: once for the research and a second time for the reimbursement of very expensive medicines. Public expenses, private profits, a well-known mechanism of capitalism.

The profit model of the pharmaceutical industry has therefore changed considerably in recent years. Pharmaceutical multinationals are no longer just companies that manufacture and sell medicines. A large part of their profits no longer comes from sales, but from financial transactions. Large investment funds have been buying up the shares of the pharmaceutical giants; these companies are themselves buying back their own shares to drive up the price. Dividends paid to shareholders are steadily increasing and exceed the budgets devoted to the research and development of new medicines.<sup>29</sup>

Monopolisation in the pharmaceutical sector is enormous. Small companies with promising products in development are constantly being bought up by the big players. The big ones no longer only swallow the small ones, but also other big ones. The number of annual mergers and acquisitions grew from about 100 deals in the late 1980s to 800 deals in 2015. Power in the pharmaceutical world is therefore concentrated in the hands of a small club of multinationals.<sup>29</sup> In 2017, the four largest pharmaceutical companies accounted for more than 40% of total pharmaceutical sector turnover.<sup>30</sup> Companies must contend with this competition to maintain their position: it's a case of eating or being eaten.



## TRIPS and AIDS

Until the 1990s, patent protection stopped at national borders. A US patent had no legal value in India or Brazil, for example. By starting to develop their own industries, these countries would be able to produce their own medicines – legally – and would therefore no longer be dependent on American exports. The American pharmaceutical giants saw this as a major threat to their turnover. After a massive lobbying campaign, patent protection was implemented worldwide. Under great pressure, in 1994, 123 countries signed the famous TRIPS Agreement (WTO Agreement on Trade-Related Aspects of Intellectual Property Rights).<sup>31</sup> In it, they committed to enforce patent protection in their territories for at least 20 years. Without a patent, it is therefore illegal to produce and sell a given medicine. This has increased the dependence of countries on a handful of wealthy multinationals for their medicines.

They committed to enforce patent protection in their territories for at least 20 years. Without a patent, it is therefore illegal to produce and sell a given medicine. This has increased the dependence of countries on a handful of wealthy multinationals for their medicines.

But then came AIDS. The HIV pandemic highlighted the conflict between corporate interests and public health. In South Africa, thousands of people were dying of AIDS every day. AIDS inhibitors existed, but were far too expensive and the companies that held the patents refused to lower their prices. The South African government had just emerged from apartheid and wanted to take advantage of the opportunity provided by the TRIPS agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights) to import cheaper generic AIDS inhibitors from India. Of course, the pharmaceutical industry could not sit back and watch. In 1998, 39 multinational pharmaceutical companies – backed by Bill Clinton's US government and the European Commission – brought legal action against the Mandela government.



Big Pharma versus Nelson Mandela. Massive public pressure, supported by a number of NGOs and grassroots movements all over the world, forced the American government to back down. The pharmaceutical giants also finally gave up their action. In South Africa, Big Pharma has bitten the dust for the first time.

Finally, a declaration in Doha in 2001 reaffirmed that the TRIPS Agreement allows countries like South Africa to use certain measures of the agreement, such as regulatory licencing and "parallel" imports from another country.

Thankfully, this system is increasingly being criticised. In 2020, at the beginning of the coronavirus pandemic, the American Nobel Prize-winning economist Joseph Stiglitz wrote "Monopolies are lethal". In his view, they are cutting off access to life-saving medicines that would have been available in an alternative system.<sup>32</sup>

The Italian economist Mariana Mazzucato is also very critical. For several years, she has been conducting research on the topic of innovation. She described the pharmaceutical industry's attitude in the coronavirus times as "criminal". In 2019, she published the international report "The People's Prescription", making a stark diagnosis of the health innovation model which, according to her, is "broken."<sup>33</sup> Her message is clear: "Today, patents are generally too strict. We have let corporations abuse it". Mazzucato describes how the pharmaceutical industry, through its monopoly, simply sets the price of a medicine at the maximum limit of what a country can afford. She is very clear on the issue of innovation: "Current patents do not encourage innovation, they are even detrimental to it. They destroy value instead of creating it."<sup>34</sup>

### 3. The pharmaceutical business model hinders social progress



*"For Big Pharma, it is more profitable to make a new body lotion than a vaccine".<sup>35</sup>*

Noam Chomsky – American professor of linguistics, philosopher, media critic and political activist

"No patents, no innovation": Anyone who has ever sat through a patent discussion knows this peremptory statement. When, during the coronavirus crisis, the call to lift vaccine patents grew louder and louder, the N-VA (Flemish Nationalist Party) quickly jumped on the bandwagon with its familiar argument.<sup>36</sup> "Abolishing patents is a communist idea", they added. However, the reality is that the business model of the pharmaceutical industry and its patents are a barrier between scientific progress and the health of our population.

# From now on, it is not health, but private profit that drives innovation

The pharmaceutical industry is currently neglecting many important health needs. Alzheimer's disease is a good example. Pfizer, Merck, Roche... one after the other, the largest multinationals have stopped their research on Alzheimer's disease in recent years. For our ageing population, this research has tremendous value, but the initial results were too weak, so they gave up.

Bart De Strooper, a specialist in Alzheimer's disease, experienced this during his research and accurately described what it is like today: "Early research on medicines did not give the expected result. Clinical studies could be improved and a larger budget is needed for basic research. The pharmaceutical industry has been too quick to develop medicines and too quick to give up when it didn't lead to immediate success. Due to disappointing results, Big Pharma has abandoned dementia research. It's very cynical. Pfizer then announced that it would pick up the thread "when it sees new opportunities". So they don't want to use their enormous resources until others put their hand to it first".<sup>37</sup>

Even when the pharmaceutical industry receives government funding for innovation, it chooses to use it primarily for the health topics of most commercial interest.<sup>38</sup> This is why we were completely unprepared when the coronavirus outbreak occurred. But we haven't learned from our mistakes. Antibiotic resistance is perhaps the biggest problem we will face. Experts fear that after the coronavirus, this is the next "silent" pandemic to come. It's about bacteria that no longer respond to existing antibiotics. The problem is that no new class of antibiotics has been developed since the 1980s. Only three pharmaceutical companies have small-scale research programmes. The reason is simple: antibiotics often only need to be taken for about seven days and are simply not profitable enough for the pharmaceutical industry. Therefore, protecting our bodies from bacteria is not sufficiently cost-effective for them.<sup>39</sup>

Investing in a vaccine that prevents a disease or in a medicine that cures is anyway less commercially attractive since it is usually only needed once. This prompted investment bank Goldman Sachs to ask the following honest, but shocking question: "Is curing patients a sustainable business model?" From a profit point of view, it is much more interesting to develop medicines to be taken over long periods of time by wealthy consumers. "Heart medications, addictive tranquillisers and male impotence treatments are the most profitable. Not medication for hospital-acquired infections, emerging infections and traditional deadly tropical diseases. A universal flu medication – a vaccine that targets the immutable parts of the virus surface proteins – has been achievable for decades, but it's not cost-effective enough to be a priority", summarises writer and political activist Mike Davis.<sup>40</sup> American scientist and political analyst Noam Chomsky is therefore right: a body lotion does pay off more than a vaccine. On the other hand, many new medicines are brought to market without proven effectiveness. For example, via Maggie De Block's famous article 81. Of the 12 cancers for which new treatments have been

approved in recent years, the Belgian Health Care Knowledge Centre found a (slight) increase in life expectancy in only six cases. In the other six, nothing at all.<sup>41</sup>

In reality, a very large part of the pharmaceutical industry's pharaonic turnover is not used at all for innovation purposes. The pharmaceutical industry spends approximately 15% of its turnover on research and development.<sup>42, 43</sup> It often spends as much or more on marketing.<sup>44</sup> From annual reviews of the largest multinationals, we know that they spend one and a half times more on dividend payments than on research departments.<sup>45</sup>

It is also striking that this policy is aimed at curing disease rather than preventing it.<sup>46</sup> Preventing disease is much more effective and less costly than treating it. Economic reasons lead researchers to focus on curative medicines. The sooner pharmaceutical companies complete clinical studies for a new medicine, the longer they can take advantage of the beneficial period guaranteed by the patent. Preventive treatments require much more research time. For example, 17,000 studies were under way on medicines to cure advanced cancers with very little chance of patient survival, while only 500 studies dealt with cancer prevention.<sup>47</sup>



# Influence on researchers and prescribers

The big pharmaceutical companies have enormous power over medical science today. But the problem goes beyond the priorities they set for themselves. They also influence scientific research in several ways. This results in the distortion and manipulation of our understanding of reality.<sup>48</sup>

For example, the results of clinical trials are often kept secret if they are disappointing. Research has shown that 15 to 50% of all clinical studies are never published. Therefore, scientists do not have an overview of the research already carried out. They only see the positive results. In this way, we cannot learn from the failures already experienced by others.<sup>49</sup> This leads us unnecessarily down the wrong paths, and to waste. Cochrane, an organisation that evaluates medical research, has calculated that 150 billion euros are wasted each year on studies that a competitor is also conducting or that were conducted ten years ago and whose results have never been made public.

Then there is the influence on the doctors themselves, those who prescribe the medication. The number of pharmaceutical visits to general practitioners may be down, but the influence remains. In 2019 Pharmaceutical companies have invested nearly 250 million euros in "collaboration" with healthcare providers, healthcare facilities and patient organisations.<sup>50</sup> The industry increasingly prefers to visit the specialists, as they often prescribe the latest medication.

It is preferable that doctors who prescribe medication to patients are informed by an independent organisation to ensure evidence-based quality medicine. In Belgium for example, until recently there was the not-for-profit (ASBL) organisation Farmaka, an independent centre that promoted the responsible use of medicines.<sup>51</sup> Farmaka was a thorn in the flesh of the pharmaceutical industry. The centre had to lay off its 28 employees as a result of the budget cuts made by minister De Block (Open Vld).

## Frequent medicine shortages

Patients rely on being able to get necessary medications when they need them. But they are increasingly facing shortages. Patients go to the pharmacist with their prescription, only to be told that their medication is not available. Sometimes they have to wait for months. This situation naturally creates a lot of uncertainty for both doctors and patients. Often, these stock shortages are not a coincidence: they are completely linked to the price that producers can get elsewhere.

Producers and wholesalers play with their inventory, as it were, depending on where the biggest profits can be made. The way in which pharmaceutical companies and wholesalers cause shortages and use them to increase their profits has become a business model in itself.



## Pfizer bows down to a group of patients

At the end of October 2016, Pfizer stopped supplying Ledertrexate. The injectable medicine was used, among other things, to combat joint pain and autoimmune diseases. As a result of Pfizer's decision, an estimated 10,000 patients were without their medication as from November, resulting in unnecessary pain and progression of the disease. I was one of them and I contacted Pfizer. The company stated that the supply disruption was due to a production issue at their factory. A case of force majeure, so to speak. But after investigation, it turned out that Pfizer had factories for the production of this medication in at least four countries! A production issue in a factory could not simply stop deliveries to Belgium. Unless Pfizer preferred to sell the product where they could get a higher Price for it. With Medics for the People, we decided to take legal action. We wanted Pfizer to appear in court. On 25 January, two lawyers sent a formal notice to Pfizer on our behalf, demanding the resumption of deliveries within 24 hours. Otherwise, the pharmaceutical giant would be prosecuted in summary proceedings. The next day, Pfizer sent a notification to the lawyers, "Supply has been resumed".

**Peter Franssen**  
patient of MPLP Genk



## 4. The solution: make essential medication and vaccines a public good

We need a radical change of course. The medicines we use, the treatments we develop, the diseases our researchers work on: the functioning of medical science and the pharmaceutical industry must be based on the health needs of the population, not on the private interests of a few pharmaceutical giants. For this, we need a government that takes ownership of medicine policy and plays a proactive role, from initial research and subsequent development to final production and distribution.

### Inspiration from the New Zealand Kiwi model

The New Zealand government underwent a radical transformation during the 1990s. It was at this time that Pharmac was created, a government agency responsible for regaining control of the development, production and sale of medicines from multinational pharmaceutical companies. For years, this has been the inspiration for Medics for the People's Kiwi campaign. The goal of the Kiwi model is for our country to take control of the medicine policy.



This model was first described in Dirk Van Duppen's book, and was later developed for the Belgian context in a PTB bill.

The idea consists of three stages. First, we look at what treatments the population needs. A needs analysis will determine which medications are eligible for reimbursement. A team of independent experts then selects the most appropriate medicines based on objective scientific criteria and studies. Only the medicines that really work, the ones that are better than what already exists, are retained. Finally, a public tender is organised, in which the government asks pharmaceutical companies to submit a price offer for the production of the selected medicines. Only the company that offers the best medicine at the best price will be reimbursable by social security.<sup>52</sup>

It is a simple idea, with a logic diametrically opposed to the current situation in Belgium. With the Kiwi model, we take back control of our medicines as a society. Today, the whole policy is determined by the financial interests of the pharmaceutical industry. With the Kiwi model, we move from a supply-driven approach to a needs-based approach. Secondly, the government uses the collective purchasing power of social security as a counterweight to the pharmaceutical monopolies to impose the lowest possible price.

In 2021, the Belgian Court of Auditors confirmed that the Kiwi model guarantees cheaper and better quality medicines.<sup>53</sup> Their opinion on the proposed legislation is positive and reaffirms the main advantages. The Kiwi model brings in money for social security. It also ensures better medicines, as only medicines with proven added value are reimbursed. It avoids conflicts of interest by selecting medicines on the basis of scientific criteria, rather than on the basis of lobbying and marketing by private companies. It also offers guarantees in terms of security of supply.

The sooner we can introduce this system in Belgium, the better. Even today, our social security system could save a lot of money with a Kiwi model. Within the group of new medicines, there is also a category that deserves special attention. Biosimilar medicines, generic alternatives to expensive biologic medicines (biologics) such as Humira, discussed at the beginning of this chapter, have been emerging for several years.<sup>54</sup> This may represent a considerable cost saving. In 2019, biosimilar medicines saved 271 million euros, despite their limited use.<sup>55</sup>

Nevertheless, the Kiwi model is not sufficient to fully realise the right to medicines. The new business model of the pharmaceutical industry poses new challenges to which the Kiwi model alone cannot provide an answer. How can we make sure that in the future we don't have to hear heartbreaking stories like those of baby Pia and baby Lucien? How can we ensure that more research is devoted to less lucrative areas such as antibiotic resistance? So many years after "The medicine war", we need to update the Kiwi model to meet new challenges.

"Biomedicines" are biological medicines. This means that they are manufactured using a living organism. When a generic company creates a similar product after the patent has expired, it is called a biosimilar. Because in biological medicines the structure is never quite the same.

## A European Salk Institute: making essential medicines and vaccines a public good

When Novartis decides to charge 1.9 million euros for a medicine that can save a baby's life, the Kiwi model offers no solution. And faced with such a situation, the New Zealand Pharmac Institute is also powerless. What any government can do, of course, is grant a regulatory licence to break the monopoly on a certain medicine or treatment and allow other companies to produce it, as in the fight against AIDS. However, this is not a sustainable solution. The problem with regulatory licences is that they have to be applied for country by country and patent by patent. That condemns us to to pick up the pieces. It is crucial that we regain public control much earlier in the process of scientific research and medicine development, starting with the medicines and vaccines that are truly essential to our public health.

This is a future scenario that the Belgian Health Care Knowledge Centre recommended in its 2016 report<sup>56</sup> which, in collaboration with an international think tank, sought solutions for the high medicine prices. It is a plea to consider medicines as a "public good" from A to Z: "In such a scenario, patents and monopolies would no longer have a reason to exist, as medicines and other health technologies would be considered public goods. (...) The public pays for all research and therefore has a legitimate right to the results". It couldn't be more clear.



### "Would you patent the sun?" (Jonas Salk)

Jonas Salk has proven that you can also do things differently. In the middle of the last century, polio ravaged the world. It is one of the most devastating diseases ever known to mankind. Virologist Salk, along with his team of passionate scientists, fought against the virus. Some 20,000 doctors and health workers joined forces, and did so successfully: On 26 March 1953, Jonas Salk announced a safe and effective vaccine against polio. When a journalist asked, "And who



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owns the patent now?" Dr. Salk replied soberly, "The people, I would say. There is no patent. Would you patent the sun?" "The polio vaccine was made available without a patent, and the disease has been eradicated in large parts of the world.

Knowledge about medicines and vaccines that we develop largely with public funds can be kept in public hands. It is the powerful monopoly position of the patent holder that now puts governments offside. A Europe-wide initiative could create the power to change strategy. A European institute for research and development, which we could call the "Salk Institute" in honour of the selfless discoverer of the polio vaccine..

## How does the European Salk Institute work?

The European Salk Institute has three focusses.

1. First of all, research. We have an ambitious research fund bringing together all European research grants. We fund the biomedical research of our scientists with public funds, from A to Z. This can be done either by taking over the clinical studies or by giving the research centres the necessary resources. But from the start, conditions are attached to the funding. Transparency, all data and research results must be accessible to the public. And the participating research groups or companies are not allowed to patent the results themselves.
2. The second focus is the creation and management of a public knowledge database. A collective knowledge pool, where all results and technological knowledge are gathered and shared. Any final product developed within the Institute will be subject to an [open licence](#). We ensure that all necessary data and information remain public and that know-how about the production of a medicine can be passed on to those who need it.
3. Finally, a production focus, which organises production and distribution. Pharmaceutical companies can bid for the production and supply of a medicine for all participating countries. For each product, we then conclude a contract with a company, selected on the basis of various criteria. Price and quality, of course, but the institute may also decide to look at the working conditions of the staff, for example.

The principles of the Kiwi model continue to apply at the Salk Institute. Only necessary and value-added medicines are eligible for reimbursement. Pharmaceutical companies can continue to produce medicines, but what changes is that they can no longer acquire a monopoly right over public knowledge. If different companies have the capacity to produce a certain medicine, it should be perfectly possible.

| An open licence means that the ownership of the invention is protected, but that any new user is automatically allowed to retrieve and use all information relating to it.

The European Salk Institute can also exploit its own research and production capacities. Public research laboratories can be directed to prioritise the search for solutions to the greatest threats to public health. For example, antibiotic resistance. And public production companies can help break the Big Pharma monopoly and drive prices down further.

There are different examples in which medicines are or have been developed or produced. The best-known example is Cuba, where the public research institute has already developed two complete vaccines against the coronavirus. But there are also examples of capitalist countries. In the 20th century and for 70 years, Connaught Labs of Canada was a public company with its own research capacity. Scientists have contributed to some significant medical breakthroughs, such as the development of penicillin and the polio vaccine.

## What are the advantages?

The European Salk Institute relies on the power of "open science". Collaboration and sharing because knowledge flourishes when it's shared. Knowledge sharing allows researchers to build on the work of others. Just as in software development. If scientific teams work together to find

### What does 'delinkage' of drug research and drug production mean?



Neutralise  
monopolies



Lower drastically  
the price of drugs



Stimulate  
research



Economy for  
consumers, taxpayers  
and working people

Source: Knowledge Ecology International, "Delinkage is a term to describe changes in the way we finance R&D", website visited on 12 January 2022. (<https://delinkage.org/>)

answers, we can make many more breakthroughs. Collectively, we can go beyond the sum of individual for-profit companies that today often do the same work in parallel. We would ensure that the intrinsic motivation of passionate scientists is fully exploited: people perform better when they can clearly see that they are working for the progress of the community, rather than for the maximum return of private shareholders.



## No Profit On Pandemic

Since the beginning of 2020, Covid-19 has caused a lot of human suffering around the world. The advent of vaccines brought hope for improvement. Vaccines have been developed with large amounts of public money, but pharmaceutical companies control production and set prices through their patents. As a result, there are not enough vaccines for the entire world population. Vaccines are also expensive because companies want to make a profit. South Africa and India proposed a solution: they asked the World Trade Organization to temporarily suspend patents on medicines, vaccines, testing equipment and other key technologies in the fight against Covid-19. This has happened before with the polio vaccine and HIV medication. However, the European Union, among others, opposed this proposal. Many citizens and social organisations launched a European citizen initiative called "No profit on pandemic", with the goal of getting one million signatures from one million Europeans. The European Commission will then have to discuss the lifting of patents again. Everyone has the right to a vaccine and medication to fight Covid-19. Information on the quality, safety and production costs of vaccines and medicines must be made public. Publicly funded vaccine research should not be privatised. A pandemic cannot be profitable. Basically, everyone has the right to health, because no one is safe until everyone is safe!

### Mathilde El Bakri

head of the MPLP Schaerbeek medical centre  
and national campaign manager



World Trade Organization: The World Trade Organization is an intergovernmental organisation responsible for enforcing trade agreements between countries.

Citizen initiative: an opportunity for citizens to draw political and administrative attention to their ideas. A European Citizen initiative must be supported by at least one million citizens with the right to vote from at least seven EU countries.

With a European Salk Institute, we can reduce the price of medicines enormously. Today, multinational pharmaceutical companies cite the high cost of development to justify their sky-high prices. But by keeping the development of new medicines under public control and sharing all the knowledge gained, the institute dissociates production from research and development.

| English literature speaks of "delinkage". This is the way to achieve much more transparency, as the price of a medicine can be determined by the actual cost of production.

Potential price reductions are potentially huge. British researchers estimate that the prices of patented cancer medicines could fall by 75%.<sup>58</sup> In New Zealand, the Kiwi model is saving the government 1.56 billion dollars a year on the medicine budget. And this, with a population of 5 million residents. If we apply these figures to the 447 million European citizens, we save 140 billion euros.

By bringing prices down to a normal level, we are empowering our social security system and the entire healthcare system. To invest in more staff and more prevention. And part of the funds saved by each country could be invested in the European Salk Institute. Indeed, a Europe-wide research fund will need billions of euros. In 2021, Italian economists were already working on a proposal for the European Parliament. They spoke of a starting budget of 6.5 billion euros.<sup>59</sup> But if we really want to give ambition to the project, we will have to go further. According to the KCE (Belgian Health Care Knowledge Centre), it is possible. "Grants for independent studies do not require more financial resources than those previously invested in health care", their report states. "With the price of medicines having fallen significantly, part of the health budgets previously spent on medication is now being used to invest in research".

So it is perfectly possible. Jonas Salk had already said: "Hope lies in dreams, in the imagination and courage of those who turn dreams into reality".



| Delinkage = literally means "to unlink". In the current model, a pharmaceutical company ties the cost of development and the cost of production to the price of its medicine, which is the reason for lack of transparency and abuse.

# Endnotes

- 1 In 2011, for his master's thesis in sociology at KU Leuven, Jasper De Witte investigated why the Kiwi model did not emerge in Belgium. In 2007, Herman Van Eckhout (Pharma.be) admitted that his industry organisation had launched the biggest lobbying campaign in its history. Source: Tom Cochez, "Hoe het kiwimodel tot kiwimoes werd gereduceerd," Apache, 4 November 2011
- 2 De Morgen reported this significant price difference in "Vaccins tegen baarmoederhalskanker vijf keer duurder in Wallonië" on 9 September 2010. At the time, Flemish schools were able to negotiate a significant discount between the two manufacturers Sanofi-Pasteur-MSD and GSK.
- 3 Each year, Medics for the People analyses the 25 drugs that receive the most funding from NIHDl. It looks at the type of medicines, how effective they are compared to other medicines, and how much lower their price could be by holding a public tender. In 2019, 325 million euros could be saved in public spending, but also 227 million euros cumulatively for patients. Sources: Simon Grymonprez, "Kiwimodel voor medicijnen brengt half miljard euro op", De Standaard, 23 April 2019.
- 4 The text and the report of the Court of Auditors can be consulted on the website of the Chamber. Raoul Hedeboom, "Proposed legislation establishing an efficient, effective and accessible medicine policy through the application of the Kiwi model", Belgian Chamber of Representatives, 4 December 2019. (<https://www.dekamer.be/doc/flwb/pdf/55/0848/55k0848001.pdf>).
- 5 De Morgen's analysis following Pfizer's monster takeover of its rival Wyeth. In particular, the paper was referring to the expiration of the patent for Lipitor in 2011, a medicine that played a significant role in The medicine war. (<https://www.demorgen.be/nieuws/farmareus-pfizer-biedt-record-voor-overname-van-wyeth-bd03f2b0/>)
- 6 Immune disease: a congenital and chronic disorder of the immune system, in which parts of the defence mechanism are absent or function less well.
- 7 A term introduced by Nature in 2010. When it was found that all major pharmaceutical companies have turned to the orphan medicine sector, <https://www.nature.com/articles/nm0810-837a>
- 8 In 2021, the Dutch Pharmaceutical Accountability Foundation (Nederlandse Stichting Farma ter Verantwoording) called AbbVie to account for the exorbitant prices it charged for Humira for years. According to the foundation, they abused their dominant market position. (<https://www.farmatervantwoording.nl/nl/humira-adalimumab/>)
- 9 Official figures for this category of medicines are available in the "Monitoring Of Reimbursement Significant Expenses (MORSE)" reports prepared by NIHDl. By adding up those for 2019, we come to 135. (<https://www.inami.fgov.be/fr/publications/Pages/rapport-morse.aspx>)
- 10 Source: Marselis D. en Hordijk L. "Van blockbuster naar nichebuster". Nederlands Tijdschrift voor Geneeskunde. 29/07/2020.
- 11 "...dat leverde de farmareus in de maanden juli, augustus en september geen windeieren op: het medicijn bracht omgerekend 143 miljoen euro op, ruim de helft meer dan de 88 miljoen euro waarop de analisten hadden gerekend." Kristof Simoens wrote in "Medicijn voor baby Pia levert bedrijf Novartis grote winst op: 'Dit is dus rijk worden op de kap van de zieken'", Gazet van Antwerpen, 23 October 2019 ([https://www.gva.be/cnt/dmf20191022\\_04678771](https://www.gva.be/cnt/dmf20191022_04678771))
- 12 From an interview with David Lennon in "Moeten we dan alle Pia's gratis behandelen?", De Standaard, 23 October 23 2019 ([https://www.standaard.be/cnt/dmf20191022\\_04678681](https://www.standaard.be/cnt/dmf20191022_04678681))
- 13 "Gratis 'Pia-medicijn' wordt verloot", De Standaard, 21 December 2019
- 14 "Medicine budget: two steps De Block should take (rather than making secret deals with Big Pharma)", 21 October 2019 ([https://www.ptb.be/budget\\_des\\_medicaments\\_deux\\_mesures\\_que\\_de\\_block\\_devrait\\_prendre\\_plutot\\_que\\_de\\_passer\\_des\\_accords\\_secrets\\_avec\\_big\\_pharma](https://www.ptb.be/budget_des_medicaments_deux_mesures_que_de_block_devrait_prendre_plutot_que_de_passer_des_accords_secrets_avec_big_pharma))
- 15 "The Cost of Life" campaign. (<https://thecostoflife.org/fr-BE/>)
- 16 The average annual expenditure on medicines and pharmaceuticals per Belgian household increased from 653 euros in 2016 to 668 euros in 2018 and 861 euros in 2020. Source: Belgian household budget survey (<https://statbel.fgov.be/en/themes/menages/budget-des-menages>)
- 17 Figures are from the Monitoring Committee. Described by Jeroen Bossaert in "Gezocht: 1.4 miljard euro extra voor geneesmiddelen", De Morgen, 21 October 2019.
- 18 The Fortune Global 500 is a ranking of companies, from the largest to the smallest, based on their annual turnover. ([https://fortune.com/global500/2021/search/?q=500\\_profits-desc](https://fortune.com/global500/2021/search/?q=500_profits-desc))
- 19 Source: Ledley et al., "Profitability of Large Pharmaceutical Companies Compared With Other Large Public Companies", JAMA, 3 March 2020 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7054843/>) cited by philosopher, biologist, and investigative journalist Ruben Mersch in "De prijzen van geneesmiddelen kunnen echt wel lager", De Correspondent, 30 April 2020. (<https://decorrespondent.nl/11195/de-prijzen-van-geneesmiddelen-kunnen-echt-wel-lager/696890362080-81f500e9>)
- 20 Source: Ledley et al., "Profitability of Large Pharmaceutical Companies Compared With Other Large Public Companies", JAMA, 3 March 2020 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7054843/>) Quoted by investigative journalist Ruben Mersch in "De prijzen van geneesmiddelen kunnen echt wel lager" (Medicine prices can really go down), De Correspondent, 30 April 2020.
- 21 Médecins du Monde 2016 campaign. (<https://www.rbf.be/article/hepatite-c-medecins-du-monde-conteste-le-brevet-et-le-cout-exorbitant-d-un-medicament-8903736>)
- 22 And we know from the published notes of the negotiations that Pfizer originally wanted to charge 100 dollars. De Standaard journalist Ruud Goossens talks about the "Pfizer hold-up".
- 23 Reference by patent expert Amaka Vanni in Lava to an American study published in the medical journal JAMA Internal Medicine. Lava: <https://lavamedia.be/en/propriete-intellectuelle-et-imperialisme-vaccinal/> JAMA: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653012>
- 24 Using publicly available data, it has been calculated that it costs 1,200 million euros to bring a new medicine to market. This is a big difference from previous calculations, which came to 2,500 million euros. Remarkably, these figures are based on figures provided by the companies themselves. Source: Wouters et al., "Estimated research and development investment needed to bring a new medicine to market, 2009-2018", Journal of American Medical Association (JAMA), 2020. (<https://nieuws.kuleuven.be/en/content/2020/average-cost-of-developing-a-new-drug-could-be-up-to-1-5-billion-than-pharmaceutical-industry-claims>)
- 25 Historian and journalist Marc Reynebeau expressed his criticism in "Wat de zot ervoor moet geven", De Standaard, 21 April 2021.
- 26 Figures that investigative journalist Ruben Mersch collected for the Dutch news website De Correspondent. For Big Pharma, medicine development has become a secondary issue. 9 July 2020. (<https://decorrespondent.nl/11398/voor-farmabedrijven-is-het-ontwikkelen-van-medicijnen-bijzaak-geworden/70952714312-41f162a>)
- 27 Analysed by Ruben Mersch in "De uitvinder van het coronavaccin is... niet Big Pharma (maar die krijgt wel de eer én de poen)", De Correspondent, 5 February 2021.
- 28 The Dutch organisation SOMO has researched the financialisation of the sector and their report can be found on their website: [www.somo.nl/nl/somo-toont-financialisering-farmaceutische-industrie-aan/](http://www.somo.nl/nl/somo-toont-financialisering-farmaceutische-industrie-aan/)
- 29 Myoung Cha, Theresa Lorrman, "Why pharma megamergers work", McKinsey & Company, 1 February 2014. ([www.mckinsey.com/industries/pharmaceuticals-and-medical-products/our-insights/why-pharma-megamergers-work](http://www.mckinsey.com/industries/pharmaceuticals-and-medical-products/our-insights/why-pharma-megamergers-work))

- 30 An analysis by pharmacist, Master of Business Administration (MBA) and blogger The Minimalist/Pharmacist in "A detailed business analysis of the Pharmaceutical Industry". 1 February 2018. (<https://medium.com/minimalist-pharmacist/pharmaceutical-industry-analysis-f4834efbe947>)
- 31 Investigative journalist Ruben Mersch has nicely described how current intellectual property protection rules are written at the behest and measure of the Western pharmaceutical industry in "Coronavaccins zijn te belangrijk om aan een handvol farmaceuten over te laten", De Correspondent, 26 February 2021.
- 32 Among other things, he points to the 100,000 preventable child deaths from pneumonia in India because Pfizer has a monopoly on the PCV13 vaccine, which therefore costs hundreds of dollars. Source: Joseph E. Stiglitz et al., "Zeker nu zijn monopoliesodelijk", De Standaard, 29 April 2020.
- 33 It makes a fourfold diagnosis of the current innovation model, where research and development are driven by short-term profit rather than public health priorities; where there is a lack of transparency and collaboration; where medicine prices are soaring; and where short-term shareholder returns and financialisation rule. [https://www.ucl.ac.uk/bartlett/public-purpose/sites5/public-purpose/5files/peoples\\_prescription\\_report\\_final\\_online.pdf](https://www.ucl.ac.uk/bartlett/public-purpose/sites5/public-purpose/5files/peoples_prescription_report_final_online.pdf)
- 34 "Politici hebben een gebrek aan visie": econoom Mariana Mazzucato over de kansen die de overheid laat liggen" (politicians lack vision: economist Mariana Mazzucato on the opportunities that the government leaves dormant), De Morgen, 31 December 2021.
- 35 "Noam Chomsky: 'Coronavirus Pandemic Could Have Been Prevented'", RSN, 4 April 2020. (<https://readersupportednews.org/opinion2/27775/62229-noam-chomsky-coronavirus-pandemic-could-have-been-prevented>)
- 36 Annelien Van Bossuyt & Kathleen Depoorter, "Het opheffen van patenten is alleszins niet de oplossing", De Morgen, 29 January 2021. (<https://www.demorgen.be/meningen/het-opheffen-van-patenten-is-alleszins-niet-de-oplossing-b48a0bab/>)
- 37 "Alzheimer-autoriteit Bart De Strooper: 'Strijd tegen dementie moet even dwingend worden als die tegen kanker'" (Alzheimer's expert Bart De Strooper: "The fight against dementia must become as imperative as the fight against cancer"), De Morgen, 26 February 2022.
- 38 Thanks to the European Innovative Medicines Initiative, the pharmaceutical industry had a research budget of no less than 2.6 billion between 2008 and 2020 to invest in health innovation. NGOs Global Health Advocates and Corporate Europe Observatory have revealed how the pharmaceutical industry has failed to invest these funds in areas of research where public funding is urgently needed, such as long-term preparedness for epidemics (such as coronavirus), HIV/AIDS, and poverty-related neglected tropical diseases. ([corporateeurope.org/sites/default/files/2020-05/R%C3%A9sum%C3%A9-Ex%C3%A9cutif-PPP-Rapports.pdf](https://corporateeurope.org/sites/default/files/2020-05/R%C3%A9sum%C3%A9-Ex%C3%A9cutif-PPP-Rapports.pdf))
- 39 A finding that led a former chief economist at Goldman Sachs to conclude that only a public company could provide a solution to this global public health challenge. (<https://www.theguardian.com/business/2019/mar/27/nationalised-drug-companies-may-be-needed-to-fix-antibiotics-market>)
- 40 Mike Davis, "The monster at our door", Lava, 5 June 2020. (<https://lavamedia.be/fr/le-monstre-entre/>)
- 41 Belgian Health Care Knowledge Centre study, 2021. (<https://kce.fgov.be/fr/les-nouveaux-m%C3%A9dicaments-contre-le-cancer-offrent-ils-toujours-un-%C3%A9el-b%C3%A9n%C3%A9fice-aux-patients>)
- 42 The pharmaceutical lobbying organisation, the European Federation of Pharmaceutical Industries and Associations, shared these figures in "The Pharmaceutical Industry in Figures - Key Data 2021" (<https://www.efpia.eu/media/602709/the-pharmaceutical-industry-in-figures-2021.pdf>)
- 43 The "Campaign for Sustainable Rx Pricing (CSRxP)" analysed this expenditure in "Breaking down the Big Pharma dollar - Part I", 15 May 2019. (<https://www.csrxp.org/dose-of-reality-breaking-down-the-big-pharma-dollar/>)
- 44 The world's largest organisation of health regulators, the Regulatory Affairs Professionals Society (RAPS), has analysed expenditure in "Do Biopharma Companies Really Spend More on Marketing Than R&D?" 24 July 2019. (<https://www.raps.org/news-and-articles/news-articles/2019/7/do-biopharma-companies-really-spend-more-on-market>)
- 45 We have already mentioned the study on these annual reviews. "The financialisation of Big Pharma". (<https://www.somo.nl/nl/wp-content/uploads/sites/2/2020/04/Report-The-financialization-of-Big-Pharma-def.pdf>)
- 46 Doctors and pharmacists in Ibadan, Nigeria, wrote a letter to a scientific journal to explain that preventive medicine is more important than curative medicine. Babatunde et al., "Enhancing preventive medicine over curative medicine: Role of telemedicine", Public Health in Practice, November 2021. (<https://www.sciencedirect.com/science/article/pii/S2666535221000550>)
- 47 Austin Frakt is a Harvard health economist who wrote in this article about priorities in cancer medicine research. Austin Frakt, "Why Preventing Cancer Is Not the Priority in Drug Development", The New York Times, 28 December 2015 ([www.nytimes.com/2015/12/29/upshot/why-preventing-cancer-is-not-the-priority-in-drug-development.html](https://www.nytimes.com/2015/12/29/upshot/why-preventing-cancer-is-not-the-priority-in-drug-development.html))
- 48 A study from the University of Bath analysed eight industries to understand how they use science to maximise profits. Legg et al., "The Science for Profit Model-How and why corporations influence science and the use of science in policy and practice," PLOS ONE, 2021. (<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0253272>)
- 49 Nature Human Behaviour emphasised how important it is to also publicise lack of results or setbacks. "The importance of no evidence", Nature Human Behaviour, 2019. (<https://www.nature.com/articles/s41562-019-0569-7>)
- 50 Thierry Christiaens, professor of clinical pharmacology (UGent) and affiliated with the Belgian Centre for Pharmacotherapeutic Information (CBIP), among others, criticises the growing influence of pharmaceutical companies in Debackere E., "Farmabezoekjes aan de huisarts dalen, maar 'beïnvloeding blijft'", De Standaard, 2021 ([https://www.standaard.be/cnt/dmf20210103\\_98300563](https://www.standaard.be/cnt/dmf20210103_98300563))
- 51 Farmaka offered a wide range of medical literature that could be downloaded for free, until it closed in 2018. BCFi/CBiP, "Farmaka Archives", 16 May 2019. (<https://farmaka.cbip.be/fr/documentation/publications>)
- 52 In our proposal for the Kiwi law, we advocate the creation of a government agency ("Agency for Pharmaceutical Management") with a scientific and an economic branch, to organise needs analysis and public procurement respectively.
- 53 Jeroen Bossaert, "Rekenhof steunt PVDA-voorstel: 'kiwimodel' kan factuur geneesmiddelen onder controle brengen", (The Court of Auditors supports the PTB proposal: the 'Kiwi model' can give control over the bill for medicines), De Morgen, 26 May 2021.
- 54 When generic companies make an equivalent product after the patent expires, it is called a "biosimilar" because the structure of a biological medicine is never exactly the same.
- 55 Mutualité chrétienne (MC) has published an analysis of biosimilar medicine use in 2019 that shows that Belgium lags strikingly behind neighbouring countries. ([https://www.mc.be/media/21\\_0654\\_studiedienst\\_magazine\\_A4\\_FR\\_CM-info285\\_M%C3%A9dicaments\\_tcm49-71604.pdf](https://www.mc.be/media/21_0654_studiedienst_magazine_A4_FR_CM-info285_M%C3%A9dicaments_tcm49-71604.pdf))
- 56 Calculations by Medaxes, the Belgian lobbying organisation for generic medicine companies, ([www.medaxes.be/sites/default/files/inline-files/20190322\\_medaxes\\_memorandum\\_fr\\_final.pdf](https://www.medaxes.be/sites/default/files/inline-files/20190322_medaxes_memorandum_fr_final.pdf))
- 57 KCE and ZIN, "Future scenarios for accessible medicines: Belgium and the Netherlands convene an international think tank", 22 June 2016. (<https://kce.fgov.be/fr/press-release/des-sc%C3%A9narios-du-futur-pour-des-m%C3%A9dicaments-accessibles-la-belgique-et-les-pays-bas-%C3%A9>)
- 58 Doctors and pharmacists in the UK have described how new and affordable cancer treatments can be achieved and made available to doctors and patients worldwide through the use of generic medicines.
- Hill et al., "Estimated generic prices of cancer medicines deemed cost-ineffective in England: a cost estimation analysis", BMJ Open, 2017. (<https://pubmed.ncbi.nlm.nih.gov/28110283/>)
- 59 The Italian economist developed several policy options after surveying stakeholders in a report for a European Parliament committee on science and technology research (STOA).
- Florio et al., "European pharmaceutical research and development: Could public infrastructure overcome market failures?", STOA Panel, 2021.

## Chapter 4

# Empowerment



- 1. The strategy for change**
- 2. Individual empowerment to collective empowerment**
- 3. Caregivers and empowerment: from healthcare provider to health activist**

# 1. Strategy to bring about change



*"Ensuring a strong body is not so much done by the skilled work of a doctor's hand on a weak body, but rather by the work of the whole community on a social level."*

Ernesto 'Che' Guevara – doctor and revolutionary

The system we live in fails to guarantee everyone's right to good health. The health gap is growing. Far too many people live and work in conditions that are unhealthy. In health care, health is increasingly regarded as a commodity and budgets are cut back. Meanwhile, Big Pharma is plundering patients' wallets and our social security. If we want good health for our patients, something has to change fundamentally in our society.

Every day in our doctors' offices, we are confronted with the consequences of this unjust system. A construction worker with a knackered back who has to work another 15 years before he can retire. A single mother who gets into financial trouble because of the bills for her cancer treatment. As health workers, we want to tackle the causes of illness and inequality. We set our face against the idea that we cannot do anything about it; that we, as healthcare workers, should just accept the situation and limit ourselves to dealing with the complaints. Our medical centres do not want to offer a quick fix; they want to be levers for structural solutions.



We cannot fight for the right to health care without our patients. Change does not come about by itself. A small powerful group in this society benefits from the status quo. Multinationals that pollute the air, soil and waterways, Big Pharma that makes usurious profits, the European institutions that swear by austerity and privatisation... To win from them you have to be many. Research into mortality rates over the last 200 years has shown that more prosperity does not automatically lead to better health.<sup>1</sup> Only when people organised themselves and stood up for their rights did their health improve. In our country, too, Belgian historians argue that all major reforms in Belgium came about not on the initiative of parliament, but under pressure from 'the street'.<sup>2</sup>

So for us, the main goal is to bring together as many patients as possible to stand up for our rights together. We want to help people but also make them stronger, that is the idea behind the term 'empowerment'. We want to be a healthcare provider and an activist at the same time. In our 2010 vision text, it sounds like this: "Empowerment strategies should help people connect their personal struggle for better health with the collective struggle to improve the health of all."



## Safe working conditions in COVID times

During the pandemic, the workplace was a major source of infections. "Free play for the virus," a newspaper headlined in the autumn of 2020 about the spread of the coronavirus in companies. One in five people were infected at work, we found out. We discovered this by calling all our patients who tested positive. How to explain such a high circulation at work? Our doctor Sofie Merckx found out in Parliament that more than 6 out of 10 employers did not implement the coronas measures.

During that period, a railway worker, a patient in our medical center, called me to say that in his workplace in La Louvière, several colleagues had tested positive for corona. The sick colleagues had to go into isolation, but the other colleagues who had been in contact with them were asked to go back to work. The SNCB (the national railway company) refused to organise a test for the colleagues who had been in close contact, despite the fact that the trade unions had repeatedly insisted on it. The railway worker explained to me that his colleagues were worried. Some were high-risk patients and others had vulnerable family members at home. I presented this problem to my team and, after discussion, we decided to test 44 workers from the La Louvière workshop ourselves.

We met with the workers on a Saturday morning. The whole team of the medical center was involved, together with the volunteers who came early to organise the reception. Some of them registered the railway workers, others did the administration and the doctors took the tests... After this beautiful and smooth cooperation, we parted with a smile on our faces. After 48 hours, the results came in. 12 tests turned out to be positive. 12 railway workers on 44 were carriers of the virus without knowing it themselves. They could have infected colleagues and passengers on the train every day.

Several practices of Medics for the People came to the aid of patients at their workplace. In Herstal, our colleagues carried out tests in an AB Inbev department with a high infection rate. The workers went on strike, which led to better safety rules regarding the spread of corona in the company premises. All this were important steps in the fight for work safely in COVID times.

**Saskia Deceuninck**  
GP MPLP La Louvière.





The origin of the term empowerment lies in the social movements of the 60s and 70s. Their aim was to increase the power and influence of oppressed groups. The Brazilian liberation pedagogue Paulo Freire, among others, developed the concept. The three pillars of empowerment were: increasing critical awareness, increasing control and actual action. Freire wanted people to gain knowledge and understanding of the nature and causes of injustice through their own direct experience, with the intention of changing it.<sup>3</sup>

The concept of empowerment provides a foothold for organisations such as Medics for the People that want to link individual assistance with collective struggle. In healthcare, we foster a vision of the relationship with the patient that radically breaks with the classic paternalism of 'estimable physician'. In our vision, the patient is not in a dependent position in relation to the care provider, but both are equal. Empowerment presupposes that patients emancipate themselves and take their fate into their own hands. It starts from the power of people to empower themselves, to claim their rights and to transcend their possible dependence on help or charity. Empowerment contains the word power. Power change is central, in contrast to the classic approach to aid, which focuses on the alleviation of needs.<sup>4</sup>



## Empowerment, a 'malleable' concept

These days, everyone is talking about empowerment. But what if even the World Bank also uses this term randomly? Does everyone refer to the same thing? Over the past 30–40 years, empowerment has become a malleable concept with different meanings.<sup>5</sup>

Neoliberalism abused the term from the 1980s onwards to push its own agenda. 'Empowerment' became a good-sounding term to defend measures whereby people had to learn to solve their problems themselves as much as possible. In this way, they could also relieve the authorities of their primary duties. Empowerment was no longer about redistributing power but about citizens who had to cope with their 'own strength'.<sup>6</sup>

In recent years, we repeatedly hear more social organisations using the term empowerment. There is an increased interest for inequality in health and the many barriers that socially vulnerable people experience. Nowadays, one hears care providers and social workers talking about 'equity' or 'proportional universalism', which means thinking about how to offer people the help and opportunities they need. In the first place, this means lowering thresholds and putting extra effort into reaching the socially vulnerable. But empowering people, giving them more control, is also often mentioned.<sup>7</sup>

At the same time, we see that there is more and more debate about the social responsibility of the GP and other first-line workers. 50 years ago the idea of a district health centre was considered radical, but today it's on the rise. These centres put the model of 'community-oriented primary care' on the map.<sup>8</sup> They enable general practitioners and other primary care providers to detect and identify local health problems and pathogenic factors ('health advocacy'). The idea of healthcare providers making the connection with the social context is making a comeback, which is positive. But in reality, policy is not always on our side and signalling is often not enough to change things. So it is important to reinstate the concept of empowerment: organising people to increase their power and enforce change.

Practices of Medics for the People are both a medical centre and a centre of action. Empowerment is our protection against becoming systemic. A worker struggling with depression because he lost his job, or a toddler who has asthma because the bedroom walls are full of mould: they need our care, but what is the effect of care if we limit ourselves to it? Then the consequences of injustice in society are mitigated and the system is further perpetuated. Through empowerment, we try to end such injustices. That is the difference between system-confirmation and system-deliverance.

The American healthcare worker Irving Zola once described this with a beautiful metaphor: "As doctors, we stand at the edge of a swirling river. We hear the cry of a man drowning. We jump into the river, put our arms around him, bring him to the bank where we give him artificial respiration. Just when he starts breathing again, we hear another cry for help and the whole scene repeats itself. We are so busy rescuing and resuscitating that we forget to go upstream and see who is pushing all those people into the river.' Systemic rescuing means just that: moving upstream together with the victims and tackling the causes of their suffering.





## Change does not occur automatically

Over the last thirty years, the NGO Viva Salud has worked intensively on the right to health care and empowerment. Empowerment, we believe, is the best guarantee for sustainable change. Change does not occur automatically. People who profit from exploitation and oppression will not spontaneously give up their power. The socially oppressed can only gain power by organising themselves and standing up together for their collective interests. In this way, they create a counter-power that can exert pressure on companies or the government. By mobilising, great victories can be achieved. An example of this by our partners in the Philippines is the fight for the Fabella hospital. Fabella is considered the most active maternity ward in the world (with an average of 70 to 80 deliveries per day). In the country, where healthcare is largely privatised and unaffordable for the majority of the population, the hospital has been a haven for women from the capital and surrounding provinces since time immemorial, as services are free. Due to a lack of government investment, the building had not been renovated for a long time. The government used the dilapidated state as an argument to close the hospital and replace it with a private one. The closure would leave ordinary workers and an average of 1,000 patients per day out in the cold. One of them was Aniceta. She said, "When you enter a hospital, the first thing you think about is not whether you will get better soon but whether you will be able to pay the bills. I remember having to share a bed with another patient because there were not enough beds. When I heard the government's privatisation plans, my first reaction was: what will happen to people like me if we get sick?"

Our partners launched an appeal to protest against the privatisation plans. This call caused a real popular uprising. Pregnant women, nurses and many concerned Filipinos took action day after day. After several confrontations, the hospital director decided to enter into dialogue with the demonstrators. The women had won.

Over the months, many of the women active in the protest movement learned about their rights. Aniceta wrote to us: "In the training sessions and forums that I participated in, I learned that the privatisation of hospitals is part of the government's neoliberal programme. If I had not been organised, I would never have felt the urge to understand what is happening in our society. But by taking part in demonstrations and actions, my desire to fight for people's rights became deeper and stronger." The change Aniceta describes goes beyond the moment itself. One of our partners, the women's movement Gabriela, works specifically on the violation of women's rights in the Philippines, in the family and in society. In combat experiences like Fabella's, women's self-confidence grows and they dare to demand their rights. They no longer see themselves as victims, not only in relation to the government, but also, step by step, in relation to their husbands.

But beyond the individual consequences, it is only when all these people organise themselves and take the streets together that a real difference is made. In the end, the collective effort of the national Filipino antiprivatisation movement led to a major victory in March 2018: the parliament passed the 'antiprivatisation law for public hospitals, health institutions and health services'. That law prohibits the Secretary of Health or any other person from initiating, causing or approving the privatisation of a public hospital, public health institution or public health service.

**Geraldine Malaise**  
employee Viva Salud



## 2. Empowerment from individual to collective

In a medical action centre you can work in many different ways to empower patients.

### A. Involving the patient

**To start with, you can involve the patient in the examinations or treatments you are planning.** Empowerment in the consultation starts with this 'shared-decision making'. The goal is that patients can participate in thinking about the best treatment for them, so that they can gain more control over their health. This goes against the paternalism of the 'Amighty Physisian' that you unfortunately still frequently come across in healthcare. From doctors to nurses to receptionists: people still regularly talk about and to patients from the position that only the healthcare provider knows what needs to be done. Whereas, in fact, a lot can be learned from each other – one as the expert of medical knowledge and the other as the expert of his or hers own body and health. Shared-decision making puts the patient at the centre and tries to depart from the goals that people themselves set, instead of focusing on everything that makes the person ill and weak. It gives people more control over their own health and thus makes them stronger.

### B. Increasing critical awareness

**In addition to increasing control, increasing critical awareness is also crucial in empowerment.** Patients who come to us are primarily looking for a medical solution to their health problems. At that moment it can help to think, together with those people, about the social context of their complaints. At Medics for the People, we call this the social stethoscope. Drawing that broader picture can give people back their energy, because you show them that their problem lies beyond themselves. It goes against the individualistic and culpabilising discourse of media, politics and employers. "You have a burnout because you don't set your limits." "You have corona because you didn't get vaccinated." "You have diabetes because you don't eat healthily." "You had an accident at work because you're not careful."

It is important to keep that social view as broad as possible. A house in poor condition, difficult working conditions, pollution in the air: people often experience their problems as a condition that cannot be changed. Those who remain alone with this "awareness of exploitation" may just get sicker. It can lead to frustration, anger, resignation. In those circumstances, as a doctor, you see patients who give up, take too much medication, do not follow the therapy faithfully and have no motivation for treatment.

It is not fate, however, it is an injustice done to you by the decisions of governments or companies that are in charge. Raising critical awareness also means telling people that it doesn't have to be this way. Why does the government make everyone work longer? What is behind their fine words on TV? It is the first step towards taking action. Should we resign ourselves to our fate or can we do something about it?



## "It's not just me."

Rita, a single woman of 54, calls me for an appointment. She was reluctant to contact me, she says, but her union advised her to take the step anyway. Rita has been home for a year now, since the Ford factory where she worked for 20 years closed its doors. Lately, she has been feeling very tense. She is tired of always being asked if she has finally found another job. Employers are often reluctant to hire her, as they prefer younger workers. Her supervisors tell her not to be picky, not to look for work only nearby. It feels as if she has to prove herself constantly. Every time she has an appointment with her employment officer, she feels tense. Meanwhile, her income has also decreased. Even more stress. She also feels insecure, because for 20 years she had a steady job in which she felt good, and now suddenly she has to do something else. In a different place, with different colleagues. She misses her old routine, her old clique, her job where she had security and self-confidence. It is an emotional visit. I can feel her stress.

We often saw a story like Rita's emerge in the years following the closure of the Ford plant. In our country, there is little guidance for people after a collective dismissal. Neither mentally nor socially. They are put under pressure to find a job quickly, but it was not their choice to become unemployed from one day to the next. Once they go to the psychologist, problems are often treated individually, which is quite appropriate for certain problems. But job loss and its consequences are also social problems. The more I discuss this with Rita, the better she understands the situation and she increasingly realises that this is a collective problem. When patients gain the insight that (part of) their problems can be explained by social inequality or other social problems, it can be very liberating and empowering. I clearly notice that our conversations are good for her. At the next meeting, I motivate her to participate in a discussion café for people who lost their jobs at Ford. Now it is no longer her individual problem: together in a group, it becomes again possible to achieve things. The group discussions about life after Ford provide support, understanding and information to dozens of former employees.

**Aysun Yildiz**

psychologist, MPLP Genk



## C. Collective

**A third level of empowerment is the collective.** To show patients that they are not alone with their story, we try to bring patients and 'fellow sufferers' together around certain themes through practical health promotion projects. For overstressed patients we organise a group course on the causes and effects of stress; to local migrant women we give Dutch lessons, and so on. By getting to know each other and exchanging experiences, people discover that many of them are all in the same boat.

This collectivity was also essential in Freire's vision of empowerment. "Because real changes in living conditions are never possible on an individual level alone. It is always a collective and personal process."<sup>9</sup>



### Talking together about chronic pain

Every week I have several visiting patients with persistent pain complaints. The shoulder, the neck, the knee, the back... They work in construction, at the port, in the supermarket, you name it. I often see them walking from one specialist to another, looking for an explanation and solution for their pain. Each time, they get a different advice, a different treatment. But the pain does not go away. After a while, no one seems to know how they can really get rid of their pain. Patients lose courage. They do not get better, but have a huge bill for medical expenses.

In our doctor's surgeries, we organise group classes for people with complaints of persistent pain. An important part of the content goes to pain education, explaining how the perception of pain works in our body. Medical knowledge about the origins and persistence of pain in our brain has evolved enormously in recent years. Getting this information to patients is very important.

Pain is an alarm signal from the body that does not always correspond to a problem at the location of the pain. Therefore, if the pain persists for a long time, there is no point in using technical examinations to look for possible injuries. It seems that many psychosocial factors, such as worrying and emotions, stress, but also experiences from the past, also influence the occurrence and the strength of the pain. This offers opportunities to learn how to positively influence these factors yourself in order to regain control over your pain.

Our group courses help you do this. Fellow sufferers find recognition, understanding and advice from each other. They are not alone in their pain; it is something that others also experience on a daily basis. Pain becomes a shared problem. Chronic pain is also exposed: what appears to be a personal issue is more of a social alarm signal. The rat race of our performance society keeps people chronically ill and excludes them from active life. After an often years-long futile search for a miracle cure with specialists, patients find courage and trust in each other again.

**Leen Vermeulen**

general practitioner and national staff member  
of the group projects.



## D. Concrete action

**Finally, there is the step to concrete action.** From lead pollution in Hoboken to a wave of coronas at work in Herstal, when it appears that many people are affected by the same injustice, it is time to take up the gauntlet with the aim of really changing things.

Participating in a movement makes people stronger. Studies show that empowerment is good for your health. Researchers in Baltimore, for example, noticed a spectacular improvement in various health parameters when the people in certain neighbourhoods began to organise themselves to fight against racism and discrimination.<sup>10</sup> In our own country, the CM health insurance fund found that there is a link between social commitment and health. "Those who are socially engaged feel themselves more a part of society, experience stronger social bonds, feel less lonely, have a stronger sense of self-development and are less individualistic than those who do not participate."

Moreover, the more active the engagement was, the greater the differences became.<sup>11</sup> Viva Salud writes in their handbook on empowerment: "When we ask people to tell us what was the most important change for them since they organised themselves in a collective struggle for social justice, it appears that collective action strengthens their self-confidence and that they gradually realise that their situation is not their destiny, but that they can do something about it, together with like-minded people."<sup>12</sup>



## Political campaigns at MPLP, how do they work?

Collective action is in our DNA. We are not satisfied with taking care of illnesses in our cabinets. Every campaign we run in our group practices is a moment of exchange with our patients and with the working class in general. Whether the campaigns are national, local or European, people recognise and are interested in them. They always generate a lot of discussion and reflexion. And many concrete actions too! The corona crisis has shown this more than ever. Medics for the People is a signatory to the European citizens' initiative "No Profit on Pandemic". In this context, we collected thousands of signatures in Belgium to demand the lifting of patents on vaccines. We asked our patients to sign this citizens' initiative and they themselves got people around them, in their families and at work to sign. Together with other organisations, we staged actions in Brussels in front of the European Commission and Pfizer headquarters. We moved the lines of march and put the following social debate on the agenda: are we really going to allow Big Pharma to maximize their profits out of the pandemic by selling its vaccines at exorbitant prices?

We want people to realise that their health problems, working conditions, housing situation and financial worries are the result of a capitalist system that does not put people and their needs at the centre. And above all that things can change and that we are not obliged to accept the situation as it is. There are many opportunities to get involved and take action. That is the engine of change. We want to work together on a broad emancipatory movement via our campaigns by involving as many people as possible around us.



We also try to encourage people to actively organise themselves: in their trade union and in their workplace to defend their right to work in good conditions; in neighbourhood committees for the preservation of green spaces or for decent and affordable housing; in a youth movement such as RedFox to offer free tutoring to pupils with learning difficulties. Or even in the Workers Party of Belgium (PTB), the party that fights for a different, more solidary society.

**Amandine Linotte**  
national campaign manager



### 3. Health workers and empowerment: from care worker to health activist



*"You cannot be committed to health without being committed to the social struggle for health."*

Bernard Lown – American professor of cardiology and inventor, received the Nobel Peace Prize in 1985.

For the right to health care we need good and social health professionals but also and above all committed health activists. At Medics for the People we combine the two.

Social engagement is recognised by more and more people as an important part of the job of a health professional. In training, 'social action' is one of the seven crucial competences you have to acquire – for doctors, nurses and paramedics alike.<sup>13</sup> An American dean of a medical faculty wrote a plea for 'Doctors as activists' in a top medical journal: "Only by denouncing social problems can we improve the health of the population. Social engagement should be part of the job description."<sup>14</sup>

This is even more true in primary health care than in the rest of medical care. The GP practice is in a privileged position because of its long-term and intensive contact with all sections of the population. This social perspective puts us in a strong position to contribute to the prevention of diseases and the identification of pathogenic factors.

Empowerment can protect healthcare workers from feelings of powerlessness and burn-out. "The longer you work as a GP, the more you see the influence of political decisions on people's health," Professor of General Medicine Stephanie De Maesschalck said in Humo. This observation can be a source of indignation and commitment, but it can also have a demotivating effect on many care providers. In a survey by the Artsenkrant (Medicine's Newspaper) 4 out of 10 doctors scored high for burnout. A quarter of them sometimes have completely had it with the job and a third of them express themselves in a more and more detached way.<sup>15</sup> EA hospital specialist who quit after 13 years put it this way in Knack: "I feel an overwhelming powerlessness when I see patients lying in bed in front of me. (...) People get sick and die of preventable causes. As long as the real causes are not addressed, I will continue to feel this powerlessness."<sup>16</sup>

Yet in your training for GP you receive very little education on how to get started with this important task. On the contrary, both training and professional experience often teach you

a number of attitudes preventing patient empowerment. Commitment and activism not only empower patients, they also have an impact on care workers themselves and on their way of working.

## A. Approach people in their strength

Empowerment allows you to pay more attention to the strengths and talents of patients. In a general practice you usually see people when things are going badly. A worn-out back, burn-out, high fever... Based on those impressions, it is sometimes difficult to believe that those same people can stand up for their rights and enforce a healthier society. Aid workers often lapse into fatalism. "So much misery in the world, people are constantly busy solving their problems, it is impossible to mobilise or organise them." But by taking actions together with patients, you often discover to your own surprise an awful lot of hidden strengths and talents.

## B. Sharing is often the sustainable solution

As a care provider, you regularly encounter complex problems. Patients often come to you with their individual problem and you feel the pressure to think up a quick solution. Take for instance the young person in his twenties who has no chance on the job market, or the family that is desperate because of moisture problems in their rented house for which they cannot find a solution. Doctors, psychologists and social workers sometimes spend hours writing certificates or calling agencies. At such frustrating moments, it can be good to stop and think: maybe other people in the neighbourhood are victims of the same problem? It is a click that you have to be able to make: put the individual request for help of a patient on hold for a while and take the time to share your experience with others. Sometimes it seems as if you, as an individual care provider, are failing the patient at that moment, but often this collective approach delivers much more and sustainable results in the medium term.



## Teamwork during corona: from pessimism and clamming up to a collective approach and relying on each other's strengths

At Medics for the People, you are never alone, which is quite unusual in the healthcare sector. Although they come into contact with dozens of patients every day, many GPs felt completely abandoned. The outbreak of the corona crisis was such a moment. Suddenly there seemed to be nothing but phones, emails, rules, administration and extra tasks, along with an illness we knew little or nothing about. Many colleagues shut themselves more in. After all, there was a lot of paperwork to be done and, of course, there was the danger of getting infected. The frustration grew gradually. Every day we had many patients on the phone with problems due to quarantine, loss of income, loneliness or sick family members for whom we could do little. It looked as if everyone had to save his own neck.

But MPLP would not be MPLP if we did not work together to find solutions. At the team meeting, we made an inventory of the main problems our patients were facing. And then: we mobilised people and took action. Together with patients and local residents, we set up several volunteer teams: to run errands and carry prescriptions, but also to inform patients, to offer a listening ear in times of lock-down, to help with testing and contact and source research, and to make mouth masks. As it turned out, more than 300 volunteers joined MPLP during corona.



Even a parish priest opened his church to us as a testing centre. All of them were super collaborators who helped us to continue to guarantee patient-oriented, preventive and social primary care during that entire period. .

**Anne Delespaul**  
general practitioner MPLP Deurne



## C. Doctor and patient of equal value

Empowerment also helps to make the relationship between healthcare provider and patient less top-down. In society, care providers – and certainly doctors – are still put on a pedestal. The patient comes with a request for care and is therefore dependent on the care provider in one way or another. But that does not make him or her inferior. Taking action together is one of the best ways to reduce this feeling of asymmetry as much as possible. By talking to patients about the ins and outs of the world, you show that their opinions are valued.



## D. Taking sides

We consciously choose to take sides. If we see that people are in trouble, we want to do something about it. Many relief workers are not used to this approach. They feel that it is not their responsibility to take a stand on the abuses that occur in their practice. "Don't get involved in political antagonisms, because that only polarises and puts your medical work at risk", they say. The question is, where does that attitude get us in the long run? "Politics is medicine on a grand scale", wrote Rudolf Virchow, one of the founders of social medicine in the 19th century. We have learned from the corona pandemic that this lesson is still valid. Being involved in politics is often seen as a restriction or a distraction, but it actually makes you stronger. It is an extension of our daily work. Therefore it is also the task of health professionals to engage in politics. Doesn't taking sides go against the principles of medical neutrality? Of course you have to be neutral in your treatment of patients. Everyone is entitled to the same good care, whether you are left-wing, right-wing, religious or atheist. But that does not mean that, as a health professional, you cannot take action when you are confronted with abuses.

"If you are neutral in situations of injustice, you are taking the side of the oppressor. If you see an elephant crushing a mouse's tail, your neutrality does not help the mouse", said South

African human rights activist Desmond Tutu, who died in 2021. Not taking sides is also taking the side of the status quo, the side of the elephant in Desmond Tutu's quote. That is why Medics for the People is associated with the PTB, the political party that is fighting for a different system. "Scientists have done nothing more than interpreting the world differently; when the chips are down, the world should be changed," said Karl Marx. When his 200th birthday was celebrated in 2018, editor-in-chief Richard Horton addressed readers in the leading medical journal The Lancet: "Marxism is a call to engage, an invitation to strengthen the struggle to protect the values we share. We can conclude that medicine has a lot to learn from Marx."<sup>17</sup>



## With the PTB on our side

When I started as a GP at Medics For The People more than 10 years ago, my experience of inequality and its social determinants was very limited. I knew that some of my colleagues were very active in the PTB. That seemed to me at the time to be a difficult position to maintain. How can you act objectively in a consultation room if your commitment is openly coloured? Are you still credible as a doctor?

However, it were the patients' stories that made me realise that, as a doctor, you have to take sides actively if you want to improve people's health. There is the example of Moretusburg in Hoboken, a working-class residential area along the factory walls of the metalworking multinational Umicore. In the proximity of the factory heavy metal emissions have been causing major health problems for decades. The children who grow up there and visit us do not benefit from an 'impartial' counsellor who accepts the status quo. The confrontational stories of worried parents automatically push you in the direction of social activism.

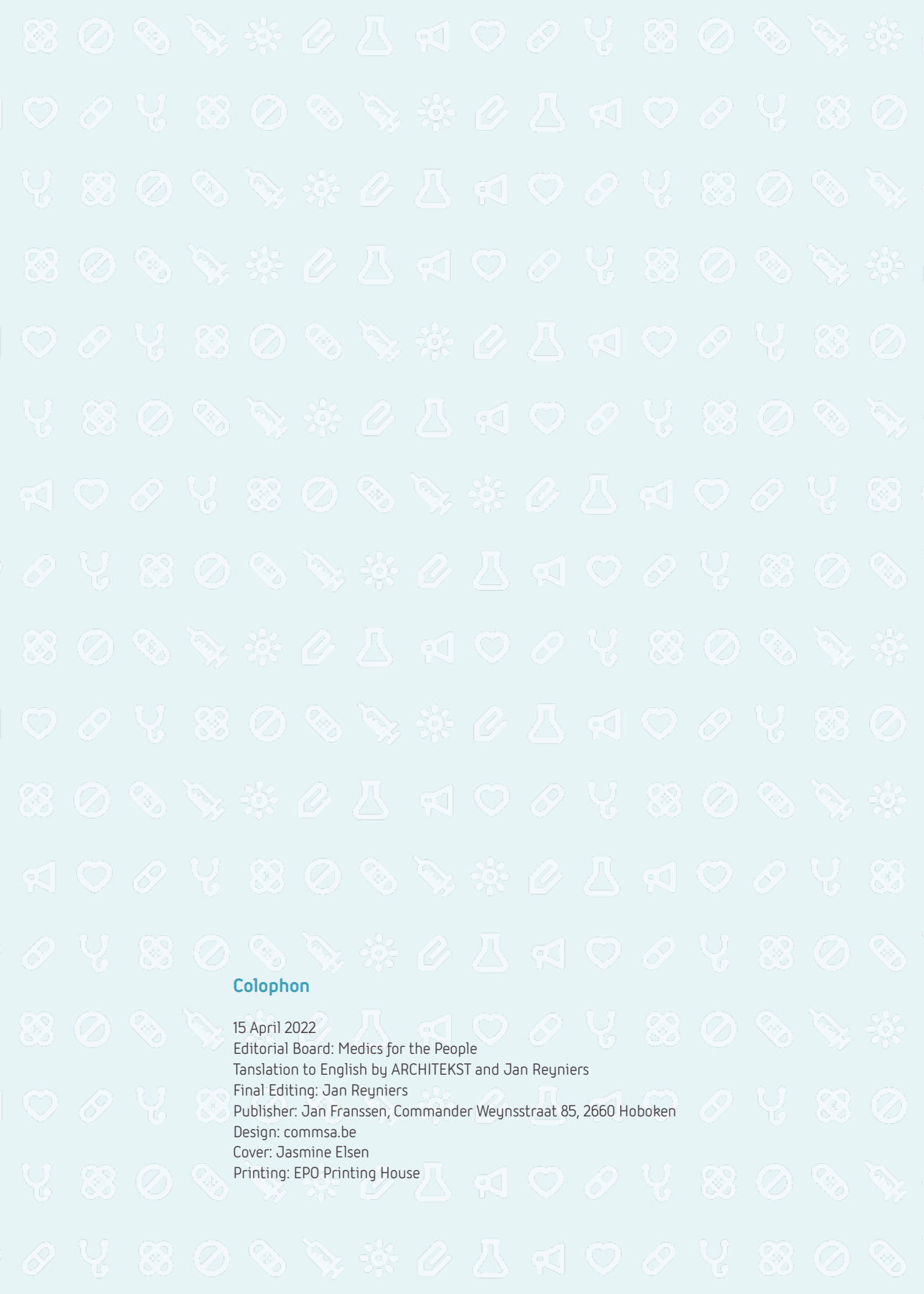
PTB helped to bring these stories to people's attention and translate them to a political level, so that subsequently they could work together with the people to reduce the lead levels in their blood. The power of symbiosis between MPLP and PTB proved to be a real lever to get things moving on the ground. As a result, living conditions have improved spectacularly for many people over the years, an impact that is hard to match as an individual doctor. MPLP really does make a structural improvement to people's health.

**Filip Vanderoost**  
GP, MPLP Hoboken



## Endnotes

- 1 British historian Simon Szreter studied the history of public health over the last 200 years in Cambridge. His findings go against the idea that capitalism and industrialisation in the 19th century led to an improvement in public health. On the contrary, the effect was rather negative. Life expectancy only began to rise when politicians invested in social reform, under pressure of social struggles from below. Jason Hickel, author of the book *The Divide*, often refers to Szreter's work in the debate with progress optimists like Steven Pinker. See his opinion in *The Guardian* in 2019: <https://www.theguardian.com/commentisfree/2019/nov/22/progressive-politics-capitalism-unions-healthcare-education>.
- 2 Marc Reynebeau is the author of *Een Geschiedenis van België* (A History of Belgium). He bases his thesis on the work of history professor Jan Dhondt: 'In 1954, professor of history Jan Dhondt of the UGhent put forward the thesis that all major changes in Belgium's political system were not brought about by parliament or politics, but rather under the pressure of street protest.' [https://www.standaard.be/cnt/dmf20160531\\_02317229](https://www.standaard.be/cnt/dmf20160531_02317229)
- 3 Former MPLP president Dirk Van Duppen wrote a chapter on empowerment in 2014 for the 'Leerboek Huisartsgeneeskunde' (Manual GP Medicine), which focuses on the work of Paolo Freire. (Chapter 18, p. 246)
- 4 We refer to the theme brochure of Viva Salud, 'Empowerment. Samen sterk voor Gezondheid' (Empowerment. Together strong for Health). (p. 85) <https://www.vivasalud.be/wp-content/uploads/2020/10/Brochure-Empowerment-NL.pdf>.
- 5 Tribute to an article in *Santé Conjuguée* for the concept. *Santé Conjuguée* is the magazine of the French-speaking *Fédération des Maisons Médicales*. <https://www.maisonmedicale.org/L-empowerment-une-notion-malleable.html>.
- 6 Health scientist Jenny Boumans has been working for years on the denotation of the term empowerment. She wrote the book *Naar het Hart van Empowerment* (To the Heart of Empowerment). She writes: 'Empowerment should be given a broader perspective. Especially now that government policy is rather one-sidedly aimed at boosting the 'own strength'. It is equally important that vulnerable citizens are also given more voice and that they are able to influence their living conditions.' <https://www.movisie.nl/artikel/focus-empowerment-not-only-effort>.
- 7 Proportional universalism is a method of addressing health inequalities. The concept is that the policy or action is aimed at all citizens (universal), but that its application is all the more intensive the more vulnerable the target groups are and the more obstacles they have to overcome (proportional). The term was first launched by Michael Marmot, author of the WHO report on social determinants. More information can be found in the *Healthy Living* brochure on proportional universalism. In their 10 practices, they also emphasise the importance of working in a politicised and empowering way <https://www.gezondleven.be/files/ongelijkheid/10-werkwijzen-volgens-het-principe-van-proportioneel-universalisme.pdf>.
- 8 In the textbook on general medicine of the Flemish and Dutch faculties, Professor Jan De Maeseneer writes "The social perspective of the general practitioner also stems from his position and working method in the front line of healthcare. GPs are co-responsible for optimising the use of healthcare facilities. GPs ensure that people who need most care also receive most care (the equity principle). Four important contributions that the GP can make are described:
  - Offering accessible care
  - Actively responding to social factors, and if necessary referring to social work to address those social factors
  - Identifying pathogenic social factors
  - Strengthening social cohesion and patient empowerment by working together with local health and welfare servicesCommunity-oriented primary care (COPC) is the term used when primary care services initiate interventions to improve the health status of their neighbourhood (p. 240-242).
- 9 Quote from Jenny Boumans from the same work on empowerment. <https://www.movisie.nl/artikel/focus-empowerment-niet-alleen-eigen-kracht>.
- 10 This study is described by the Spanish sociologist Vicenç Navarro in an article from 2007 where, among other things, he elaborates his vision on empowerment strategies. <https://pubmed.ncbi.nlm.nih.gov/17436983/>.
- 11 'Sociaal Engagement en Gezondheid' (Social Commitment and Health). From *CM Informatie* (CM Information) March 2020 [https://www.cm.be/media/CM-Info-Sociaal-engagement-en-gezondheid\\_tcm86-65707.pdf](https://www.cm.be/media/CM-Info-Sociaal-engagement-en-gezondheid_tcm86-65707.pdf)
- 12 Empowerment brochure by Viva Salud (p. 67).
- 13 This is called the CanMEDS model, developed in Canada and used today internationally as a reference framework for the training and recognition of doctors, nurses, etc. <https://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>.
- 14 Tribute in the top journal *New England Journal of Medicine* on the occasion of the 200th anniversary of Rudolf Virchow and the 100th anniversary of Bernard Lown, two doctors who made a career commitment: 'Physicians as Activists'. <https://www.nejm.org/doi/full/10.1056/NEJMp2103050>.
- 15 Description of the results by De Standaard: [https://www.standaard.be/cnt/dmf20210519\\_98356659](https://www.standaard.be/cnt/dmf20210519_98356659)
- 16 "After 13 years I am planning to say goodbye to medicine. I don't want to be a doctor anymore." Farewell letter on Knack.be from internist in training, Sam Proesmans, <https://www.knack.be/nieuws/belgie/na-13-jaar-ben-ik-van-plan-om-de-geneeskunde-vaarwel-te-zeggen-ik-wil-geen-dokter-meer-zijn/article-opinion-1451199.html>.
- 17 Offline: *Medicine and Marx* – [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32805-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32805-2/fulltext).



## Colophon

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pour le peuple