

Privatisation in all its guises

by John Lister, of Keep Our NHS Public and Health Campaigns Together

Draft, April 2016

Privatisation in its various guises is spreading across Europe's health services like a rash.

Europe's health systems vary: some are "Bismarck" style systems, historically based on workplace insurance and a proliferation of insurance funds. These have historically always included a purchaser-provider split, in which the possibility of a private sector provider, especially of specialist non-emergency services has always been present.

Others, so-called "Beveridge" systems, like the NHS in England, have historically been financed through general taxation, and more centralised systems with strong government control and accountability. These have been "reformed" in various ways to open up public and social health care budgets to create opportunities for grasping private sector companies to cash in, carving out slices of services which were once provided by the public sector, and are still paid for from public funds and taxation.

Private companies are constantly also looking for the gaps in coverage and the limits to public sector provision and funding which might offer them an opening, a space in which to start up their business. Sadly this phenomenon is not restricted to Europe.

Care (and profits) outside hospital

In Canada for example an aggressive private sector has begun relentlessly exploiting the key weakness of the universal health coverage provided by Medicare. Reflecting the health care thinking of its time, the Canada Health Act which established Medicare in 1984 only covers *hospital* care, leaving scope in recent years in some provinces for a vast potential hinterland of private clinics delivering diagnostics and outpatient services, and – like many countries – leaving a huge gap where there should be continuity of care when patients are discharged from hospital.

Despite incessant rhetoric, similar to that in most countries, about the need to deliver more services out of hospital and support patients where possible to live at home, funding for home care has over recent years been frozen or cut in Ontario to below 2002 levels. A recent Expert Review highlighted the inequalities and gaps, noting the "struggle to manage rapidly growing volumes within the allocated funds".

As a result these services have effectively been privatised: those with money to pay have to pay themselves, those who don't have the funds have to do without. Often this means that they can't cope, and wind up in hospital anyway.

This privatisation, impacting on the frail and vulnerable who need support at home or in nursing homes, has no 'big bang' immediate visible impact on the wider population – and has been hard to fight.

Home care and “social care” offer possibilities for profits in many European countries: in the Netherlands, where the government has pushed through a €400m cut in spending, a nurse-led homecare group Buurtzorg has offered to take over the largest home nursing group TSN, which has run into financial problems – as long as the government agrees a €21-per hour tariff for services.

But a 34% cut in funding for home help (domiciliary care) services has led many municipalities to abolish provision altogether, despite a lack of any assessment of the impact on patients, who could wind up requiring nursing home or hospital care.

In England the separation of long term care from the tax-funded NHS, to hive it off to local government-run social services (which are subject to means-tested charges), began back in 1988, and was implemented into the 1990s.

It has been accompanied by the privatisation of home care services and residential homes previously run by local councils. The nursing home sector has always been run by the for-profit and on-profit private sector has expanded, but delivering poor quality service with a minimum of qualified nursing staff.

Pretext for private involvement

In European countries time and again a similar scenario is being created, of reduced real terms funding. This is forcing a rundown in publicly provided health and social care services. It has also meant a lack of public money for capital investment, creating a further pretext for the involvement of the private sector.

In some cases there is a debate over whether the growing inroads of the private sector arise from an organised strategy on behalf of the government, or simply from private companies exploiting the underfunding of public services. This underfunding, affecting services in addition to health care, is in many cases the result of neoliberal attempts to restrict levels of public spending and state provision.

But in some other cases – such as England, Finland and Sweden – it's clear that governments have wanted since the 1990s to create a competitive market, and deliberately changed laws or otherwise acted to bring it about.

In Finland the “purchaser-provider split” in the Beveridge-style system was launched in the 1990s but only implemented since the early 2000s. Initially the municipalities (many of them covering small populations) were made into purchasers. By 2012 estimates suggested up to a quarter of health & social services were provided by the private sector – although a large share of this would be social services and primary care. More recently for profit companies have begun to compete for contracts, and patients have been offered vouchers to allow them greater choice of health care provider since 2009¹. Now a new reform bill proposes to divide the country into much larger health and social welfare regions, reducing the 317 municipalities 18 autonomous regions and 15 healthcare regions, charged with further integrating health and social care services and holding down the rising costs of

¹ Tynkkynen L-K, Keskimäki I, Lehto J (2013) Purchaser-provider splits in health care – the case of Finland, Health Policy 111 (2013) 221-225

services². The hope is that the savings could stack up to €3 billion over the next few years, as part of a €10 billion cut in public spending.

In similar fashion the government in England has imposed a combination of cuts, legal reforms and “devolution” to city-regions and 44 new health and social care “footprints,” on top of the requirement on local health purchasers to put services out to competitive tender, open to “any qualified provider”. The “footprint” areas have an immediate central task of identifying “savings” to address heavy deficits among most acute hospital trusts – averaging £15m, with more than half the 155 trusts in deficit by more than £10m.

The result will be the acceleration for controversial planned cutbacks and closures, along with the rapid implementation of “innovative” policies for which there is no supporting evidence. More services will be privatised. The famous British tax-funded NHS is being piece by piece transformed into little more than a giant insurance fund to purchase services from a range of private providers.

However there is a limit to how far the private sector wants to go.

Around the world a common problem limiting the development of any genuine market in health care is the underlying contradiction: that most people in most need of health care are least able to pay the market price for that care – whether they be elderly, very young, people with mental illness or the chronic sick, many of whom are poor.

So the private sector, if it's to be profitable, therefore needs the support of public funding even to increase the scale of its market beyond the wealthy minority. Even more substantial subsidies are needed if private providers are brought in to take on the responsibility of delivering some form of “safety net” for the poorest and sickest, for whom almost any fee for service will be unaffordable.

This is clearly true even in the USA, where publicly-funded Medicaid and Medicare underpin some of the costs of supporting the poor and the elderly – and in doing so funnel billions of taxpayers’ dollars into private sector provision and insurance.

Privatising hospitals

Because of these limitations on the types of patients the private sector finds attractive as potential income streams, the outright privatisation of larger hospitals to turn them into fee-paying private hospitals has been rare in Europe.

Instead the privatisation tends to take place in such a way as to ensure a flow of public funds, and limit if not eliminate the extent to which patients are obliged to put their hands into their pockets and pay directly for access to services. This also avoids high profile and politically unpopular outright privatisation.

This privatisation of hospitals is possibly the most advanced in Germany, where local authorities lacking funds to upgrade buildings and develop services. By 2012 the squeeze had meant that half of all German hospitals could not afford to invest in new initiatives. The hospitals are then effectively handed over at knockdown prices to private companies, such as Fresenius-Helios.

² url

The company will invest where necessary in new buildings: but it also cuts back on numbers of staff, breaks away from negotiated pay agreements and imposes new, reduced pay and conditions in order to develop profitable services. Only in this way – making "savings" at the expense of the quality of care – can profits be extracted from otherwise bankrupt hospitals.

The payment for the treatment delivered in the privatised hospitals continues to flow via the insurance funds, and not through individual patient payments for treatment: so the privatisation appears to be a technical matter behind the scenes rather than a long-term threat to the quality of care and range of services available.

Up to now the model seems to work for the private sector: in Germany Fresenius Helios, now a giant multinational corporation whose main business is in renal treatment, is still expanding its hospital portfolio, and has just bought a debt-ridden 519 bed municipal hospital in Velbert in North Rhine Westphalia, hoping to do the trick again.

In Sweden too, large hospitals have been privatised and seen as a potential source of profit. But here too the private sector relies heavily on the flow of public funds to ensure that its services are largely free at point of use for patients, with no additional charges above those already in place, while of course the profits flow where possible into the pockets of shareholders. Private medicine and private health insurance remain relatively small-scale businesses in most of Scandinavia.

Risk of failure

Not all of these schemes can necessarily result in profit. But where they fail, even where the private sector is looking to pull out, there are political and financial obstacles to bringing services back into public ownership.

In Valencia the notorious Alzira-style privately owned and run hospitals that have been widely seen as a model for other projects, have been heavily losing money. Ribera Salud, the company with 50% ownership of the contracts, was expecting to buy the remaining shares at a knockdown price from the insurance company that owns them – although their longer-term plan was far from clear.

But for the public sector to end the contracts can be expensive and complicated. The PSPV, one of the three parties that won control of Valencia's regional government from the neoliberal right in May 2015, made an election promise to de-privatise the system: but this has now been ruled out as too expensive, because compensation payments to private companies running hospitals would be too high.

Only one of the contracts, the first one, for Hospital Ribera-Alzira (Valencia), which expires in April 2018 can affordably be terminated. The PSPV has now admitted Torrevieja hospital will remain in private hands until 2021, because returning it to the public sector would cost €28.5 million. The other three Alzira hospitals would be up to twice as expensive, and Valencia does not have the money to spare. But the UGT trade union points out that there were other ways of forcing an end to the contracts: "If they do not comply with every clause on their contracts with the Health Department, these could be rescinded."

Levels of spending

Where existing hospitals have been privatised, the ownership and control of the hospitals has been at local level – and levels of health care spending are relatively high.

By contrast the only recent experiment in privatising the management of an NHS hospital in England, at Hinchingbrooke hospital in Cambridgeshire, was imposed on the hospital trust in the midst of a sustained and continuing squeeze on spending and real terms cuts in NHS budgets.

Circle, the company which took over the hospital, had wrongly presumed it would be effectively exempt from these pressures, but soon found it impossible to deliver its expected high level of "savings" – indeed impossible to secure any profits at all. After just two years the company paid £2 million to walk away from this failure, and plans for similar so-called franchising of hospital management to the private sector in other parts of England were promptly dropped.

There are no signs so far of any fresh private sector attempt to take over NHS general hospitals, with their costs, risks, complexity and relatively large numbers of staff.

However there are concerns that now the British government – through the so-called "devolution" of health and social care services and smashing up the national pay agreements that protect doctors, nurses and other grades of staff – is seeking new ways of splitting up the NHS.

This could potentially facilitate renewed attempts at privatising hospitals and health services.

Uncertain profits

Across Europe levels of profits for private sector operators are often surprisingly uncertain. The Europe-wide laboratory group Unilabs for example has been growing in every country apart from Spain, and cut its costs last year – but still made a net loss of €8 million, following a €100 million loss in 2014.

BUPA, the international insurer, saw its pre-tax profits fall 39% last year, and made just £374 million on sales of £9.8 billion. In Russia the collapse of oil prices is causing major crisis in private health care in which is estimated a third of private health companies could disappear: the country's largest imaging group has seen its profits slashed by two thirds.

In the Netherlands the boss of the largest Dutch private clinic group, Bergman clinics, has told the national press that the financial pressures have been so great he has more than once toyed with the idea of shutting the door and not coming back.

In Italy the not-for-profit private sector is struggling to stay afloat and selling off assets as a result of the budget squeeze – and for-profit companies are moving in to buy up services cheaply, hoping for profitable opportunities in the future.

In Norway private hospitals are refusing to participate in a government scheme to reduce waiting times and increase "patient choice" by offering patients the choice of treatment in the private bed: the private sector complains that the fees on offer for treating publicly funded patients are too low.

In Greece, where the economic crisis triggered by the banking crash has taken a heavy toll of public spending on health care, the loss of jobs has meant huge numbers of Greek workers have lost their private health insurance, and their requirements for healthcare have landed on a cash strapped

public sector. But the crisis has also destabilised both the private insurers and the private healthcare providers, and triggered an increase in all kinds of ill-health.

Any notion that simply destabilising public sector providers through cuts in spending can automatically trigger a private sector takeover are immediately refuted by the Greek experience. The private sector needs the public sector in order to stand any chance of profitable operation.

The reason for citing these examples is in no way to seek sympathy for the struggling private sector. It's to point out that in many cases the profits they are seeking are small and uncertain, and their role in delivering necessary health care is at most marginal, while the damage that they do by undermining publicly provided services, recruiting staff trained at public expense, and the cost of resources they waste, is disproportionately high.

Private sector: not so big as they seem

We can also easily get a false impression of how big and powerful the private sector has become in Europe. In fact across Europe healthcare systems are still predominantly state funded.

According to the *Economist* in 2013 "Sweden has gone further than any other European country in embracing the purchaser-provider split—that is, in using government money to buy public services from whichever providers, public or private, offer the best combination of price and quality".

20% of public hospital care in Sweden and 30% of public primary care is provided by private firms. So it's a specific type of privatisation: in Sweden, as in most other countries, most of the private sector's business comes from public sector budgets. Less than 3% of Swedes have private health insurance, which gives little additional cover.

Capio, one of Europe's largest health-care companies, with 11,000 employees is a Swedish-owned multinational company: but Sweden's own home market accounts for almost half its business, and Sweden and France together make up over 85% of its turnover. So Capio may be a big problem in Sweden, but it's a relatively small scale irritant in most of Europe.

Most beds and services in public sector

The majority of Europe's hospital beds and services are in the public sector, and many more are in non-profit private organisations.

In Germany, with a large non-profit sector, it might look as if the for-profit private sector is bigger: there are 601 public sector hospitals compared to 697 in the for-profit private sector: but the public hospitals average 400 beds, compared with just 13 for private sector, resulting in 48% of hospital beds being in public sector hospitals, compared with just 18% in for profits.

The relative size tells a story: most private hospitals are focused on elective and specialist care. This means that an entirely privately provided health service for the whole population, which is far from the case even in the US, is even less likely in Europe.

The share of for-profit hospital beds in Germany has been rising through the acquisition of bankrupt public sector hospitals as overall numbers go down. More than half of the private beds are owned by chains such as Fresenius Helios, which is the leading hospital operator – with 6% of the market.

In France, with a relatively even larger private hospital sector, there are 1047 for-profit private hospitals compared with 947 public hospitals. But the for-profit hospitals average just 94 beds, and again deliver almost exclusively elective and specialist treatment, whereas the average public sector hospital has 273 beds and offers a wide range of services accounting for most acute medical care, follow up and long term care, mental health and specialist services.

In much of eastern Europe, too, change has been slow from the health care systems established under the old Soviet Union or its influence. The private hospital sector in these countries is tiny, and the potential market for insurance limited by low incomes and by the continued provision of public or social health insurance. Ukraine's biggest private operator, backed by private equity, aims to open two clinics and two hospitals and go national ... in five years.

Targeting small segment of care

In England the average size of a private sector hospital is just 50 beds. They deliver only elective services, with no full-time medical staff or multi-disciplinary teams. They all rely on NHS hospitals to deal with any serious emergencies or complications that might arise. Private sector income has risen in recent years largely through increased numbers of NHS-funded patients.

Time and again the figures show the same pattern: even where it grows, the private sector deliberately restricts itself to a relatively small segment of health care services, taking on only elective services and diagnostics wherever possible, especially if patients are funded through public or social health insurance.

Another big area of private sector interest in much of Europe is voluntary health insurance to cover out-of-pocket payments and hospital fees where these are charged. Many European countries charge per diem fees for hospital beds and services, and many charge for rehabilitation services, while most have fees for prescriptions.

Across the continent the level of these payments, the calculation of exemptions, maximum payments, means-testing, and the extent of charges for services such as physiotherapy also vary widely. But wherever these charges are substantial enough to create anxiety among those with the means to pay insurance premiums, the insurance sector has been ready to exploit these anxieties.

The private sector is also able to exploit the pressure on patients to make "top-up payments" to access or enhance their treatment in Finland, Bulgaria and Turkey, where the basic state "universal" system consists of a National Health Insurance Fund which offers a capped payment for treatment, but where public services are widely seen as inadequate.

The private sector has high hopes for expanding work in imaging, diagnostics, laboratory services – and also for profits to be made from technology, whether this be video consultations or apps designed to ensure patients monitor and respond to their own health needs. But so far these appear to be much more advanced in the US than in Europe, and even in the US video consultations have been slow to take off: only 1 million online consultations took place in 2015.

European countries in many cases have yet to put appropriate regulations in place, or convince doctors that they would not simply get paid less for delivering their consultations online without any physical contact with the examination of their patients.

Exporting privatisation

To make matters even worse, the EU is actively seeking to export the idea of privatisation – notably in the Philippines. The European Commission allocated €33 million to support the health sector reform proposals of the Philippine government, despite the fact that it was already embarked upon policies designed to commercialise health services, arguing that further privatisation was "critical and urgent".

In 2012 the Philippines health minister announced the plan to outsource all 72 public hospitals to the commercial sector, arguing despite the costly schemes that have caused significant problems in England and elsewhere that public-private partnerships (PPP) were the only way to meet health needs of the growing Philippines population.

The European Commissioner for Development has also pressed for "A stronger role for the private sector in achieving inclusive and sustainable growth in developing countries" – regardless of the evidence of increased costs and contract failures.

How to fight privatisation

As the impact of privatisation makes itself felt in various forms across the continent, health workers' trade unions, along with campaigners and political parties must urgently work together to develop a more proactive response, and develop series of tactics as part of a longer term strategy to fight back and defend the concept of publicly financed, publicly provided and publicly accountable healthcare delivering a comprehensive service accessible to all, irrespective of income and wealth.

In Germany where for-profit ownership of hospitals has been most advanced, the trade unions began with two, fairly minimal key campaigns:

- to fight to ensure that staff in the for-profit hospitals are organised in trade unions and covered by collective bargaining agreement giving similar pay and conditions to those in the public sector
- and to call for more public financial support for hospital services

The German unions have gone on to seek to improve working conditions for staff working for contract companies, with a goal of achieving at least equal conditions to those employed directly by the hospital. Where possible they have gone on to press for ending the use of temporary staff in hospitals, while also pressing for higher staffing levels through the introduction of legal minimum requirements for hospital staff.

These policies offer some ways to undermine profiteering and exploitation where hospitals have already been privatised: but they are limited. They don't challenge the concept of privatisation, or offer an immediate way to resist plans for privatisation.

No single blueprint

It's clear that the context in which the privatisation of services is proposed varies substantially from one country to another, and sometimes from one region to another within a country. No single

blueprint can be devised for all cases, and in many cases ideas need to be modified to make them best suited for local situations.

But there certainly seems to be a need to work case by case to expose the potential consequences of privatisation, both for the workforce of the service involved, but more especially for the wider local public, patients and local politicians who might also be made aware of issues which affect them and motivate them to join a fightback.

Where the company involved has a track record of similar privatisation elsewhere involving extortionate profits, or profits at the expense of cutting pay and conditions or slashing numbers of jobs, this should be exposed both for the existing workforce and the wider public.

Campaigns need to point out that slashing pay and increasing workloads and stress on front-line staff inevitably have an impact on the quality and safety of services. Reducing staffing levels and diluting the skill mix of staff on wards not only puts the quality and safety of patients at risk but also undermines possibilities of recruitment and retention of key front-line staff.

Support services

Privatisation of in hospital services such as cleaning, catering, portering or even clinical support such as diagnostics has a track record of poor quality, poor value for money, and contract failures going back to the 1980s.

In England there has been a major challenge by celebrity chefs to the notion of private contractors providing hospital catering, and practical examples developed of ways in which professional in-house catering can both enhance the quality of patient nutrition but also the diet of hospital staff while at the same time making financial surpluses. But this has not been enough to stop employers seeking to make short term savings by bringing in cheapskate contractors, who use cook-chill food and have no need for qualified chefs.

Privatised hospital cleaning has also become a byword for catastrophically poor quality of services and poor value for money for more than three decades.

Campaigns challenging any such privatisation highlighting some of the many examples of failure at hospital staff, need to target publicity at the wider local public and concerned patient groups, to maximise pressure on hospital management and on any would be private companies.

Centralisation of services

Where a privatisation plan or major cutback in government spending centres on the centralisation of specialist services, with the closure of units elsewhere, campaigners must draw out the implications in terms of reduced capacity, reduced levels of access for older and more vulnerable sections of the population will have further to travel – and for their friends and relatives who may need to visit them in hospital.

The closure of local hospitals to centralise services also inevitably has a substantial impact on employment and the local economy in the losing area: health care professions are relatively well-paid and inherently relatively stable jobs, and hospitals generate a variety of other areas of employment in the localities around.

Towns and districts seeking to attract new population and expand will be less attractive if they cannot offer local and prompt access to hospital services.

Emergency care

The private sector as we have seen is reluctant to get involved in the provision of emergency or other unplanned services, so preparing hospitals for privatisation may result in undermining existing emergency services.

The arguments on swift access to appropriate levels of care for those with the most serious emergency health needs can be vital in winning wider public support and mobilising political pressure in defence of public health services.

This means that plans that would centralise surgery and highly specialised treatment also need to be coupled with provision for sufficient numbers of beds to accommodate the severely ill patients who need in-patient care. To bring together medical teams is relatively simple, but the cost of developing hospital buildings large enough to deal with very large catchment areas is likely to be prohibitive.

The wider the catchment, the bigger the problems of delays in accessing services from localities which lose their local services, and the chances of delays which can potentially put lives at risk.

These arguments can play very strongly with local communities, especially with those who are already relatively deprived, and among older patients and their families who feel most likely to be affected. Campaigners must press for, and analyse the fullest possible data on how the hospital and its supporting services are to be planned, costed and delivered, so that all of the factors that might legitimately anger and scare local people are spelled out clearly and sharply, ensuring that the facts reach the local news media in terms journalists are able to understand and use.

The costs of PPP/PFI

Where the private sector profit stream centres on the development of public private partnership or PFI funded new buildings, there is extensive evidence from England, and from various countries around Europe and elsewhere on the inflated costs of such projects compared with public funding, and the impact this can have in forcing reductions in other services.

The fight against forms of funding is always a difficult one when a new hospital is proposed, and can fail to win support if it all appears to be abstract or even ideological.

But the scale of the financial problems that have been created by PPP/PFI projects already offers a tangible and practical line of argument to challenge those that claim that the new hospital is necessarily a gain in itself. Indeed many British PFI examples show the extent to which a new PFI hospital is paid for not only through higher financial payments but also through the loss of bed capacity, loss of staff, and loss of other services to pay the increased, and steadily increasing contract costs over the long-term. British campaigners can help colleagues in Europe resisting PPP schemes by publicising more and more systematic data of how PFI rips off taxpayers, inflates the costs of care and undermines local health services.

Community health services

In England the experience of attempting to privatise provision of community health services has been a mixed one for the private sector.

In a few cases companies have managed to develop a portfolio of relatively small-scale and under-funded contracts, but they have also seen little prospect of significant profits to be made.

One important example has been the embarrassing failure of the market leader Serco, which was forced into withdrawing from one of the more substantial early contracts, to deliver community health services in Suffolk, having lost millions of pounds and faced growing problems in recruiting and retaining staff. The company has since withdrawn from all tendering for clinical contracts with the NHS.

There is no evidence so far that Virgin, the current market leader, is making significant if any profit from its growing range of community-based services, most of which appear to hinge on employing fewer and less well-qualified staff to deliver services.

The fight against privatisation of these services involves a combined fight for adequate funding of the existing public sector providers, and a focus on contracts failures so far, and the ways in which the private sector would inevitably scale back the quality of care to make profits for shareholders at the public expense.

Private sector trains no staff

In fighting all forms of privatisation of clinical services, it's also important, certainly in England, to focus on the longer term needs for training and recruitment and retention of sufficient qualified staff to deliver a range of health services.

The private sector trains no staff, but instead recruits from the limited pool of already trained public sector staff. So the more services are privatised, the more limited will be the scope to increase numbers of new trainees – or indeed the plan the future healthcare workforce.

Exclusions and charges key to private insurance

Expanding private health insurance and fee-for-service medicine in much of Europe centres on increasing levels of exclusions, whether this be services excluded from public funding, or patients excluded on various grounds from access to services – obliging those requiring healthcare to find ways of paying for it themselves.

The notions of top-up fees and co-payments for services of the previously been publicly or collectively funded also feeds potentially more customers to private health insurers.

Campaigners need to keep clearly in mind that, over and above the obvious problems of inequality and affordability of health care for those on lower or no incomes (who in many cases are those with the most severe health needs) the limits of private health insurance are twofold:

- they are resistant to insuring for pre-existing conditions, and therefore to insuring much of the older population whose level of health needs, and therefore potential claims on insurance, tend to be greater
- and private health insurance in almost every European country will stop short at the point where the patient requires emergency treatment, since virtually no emergency services are available from private providers.

So in virtually every country the whole population, whether they know it or not, depends upon the continuation and availability of accessible publicly provided health care, and its ability to recruit and retain staff. Public challenges to any expansion of private insurance need to make this issue prominent: we are fighting for the WHOLE population, not a particular section of it.

Limits to viable health care market

To those who argue that people with the money to spend should be able to choose what healthcare provider they like, and that it does not matter who provides health care, or that public funds should be spent wherever best value can be obtained, public or private there is a simple answer.

There is no organic, sustainable free market in private health care: it all depends on state subsidy.

Those who really believe that a free market in health care is the answer need to show how they would stop subsidising profit-seeking companies but keep private medicine alive.

Political parties arguing abstractly for the alleged virtues of free markets in health care need to be called on to demonstrate to the electorate exactly how their model of health system – which does not exist anywhere in the world – could ensure that health care is available to the very old, very young, chronically ill.

What they would do with the millions who would no longer be able to afford to access healthcare? How would they explain this to their families? These families are the voters we need to mobilise.

Simple language

We need to get these issues set in simple, accessible language, and related to the *specifics* of each particular threatened privatisation as well as seeking to raise the general level of understanding of the threat to our health care posed by privatisation across Europe.

We are many, although it doesn't always feel like that.

They are few: that doesn't change. More people will always stand to lose than win from private provision of health care and privatisation of publicly-funded services.

We need to develop the alliances and the skills in winning public support that can actually make our potential base of support and political movement stronger than that of the privatisers.

It's a big task, but it's a winnable task, because the evidence, the hard facts are on our side, and only ideology and the commitment to the market and private profit stand on the other side.

Let's make that count: let's build the big movement across Europe that stops privatisation in health – and gives a lead to those fighting privatisation in education and other public services.

Let's do it: across Europe we still have a lot to defend. Let's do our best to defend it!