

## A2 | FISCAL POLICIES IN EUROPE IN THE WAKE OF THE ECONOMIC CRISIS: IMPLICATIONS FOR HEALTH

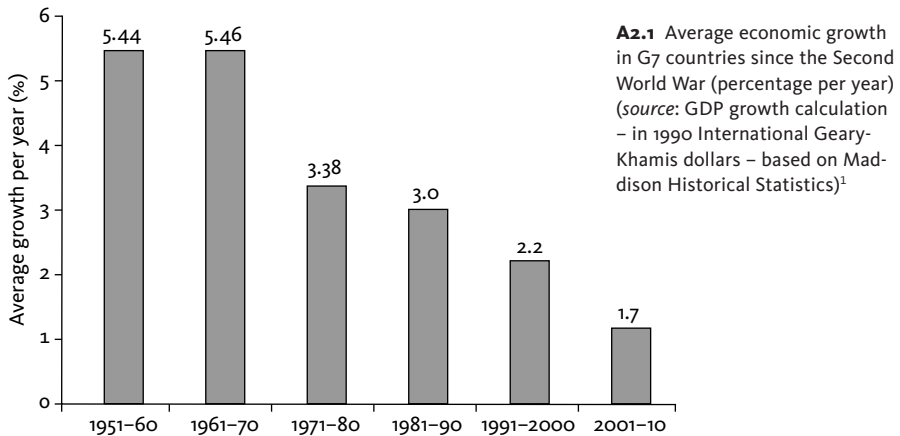
Those opposed to the welfare state never waste a good crisis. (McKee and Stuckler 2011)

### Genesis of the economic crisis in Europe

Until recently, Europe was exemplified by a combination of robust economies and strong social protection systems. After the Second World War, a combination of domestic and international compulsions promoted the development of social security systems and national health systems that had been at the centre of workers' struggles over most of the continent.

But from the early 1970s, things started to change. Markets became saturated and profit rates decreased. The first signs of a crisis of overproduction appeared. The OPEC's (Organization of Oil Exporting Countries) decision to increase oil prices exacerbated economic tensions, leading to a full-blown crisis (Cottenier and Houben 2008). This was no cyclical recession, as is 'normal' in a capitalist economy. The general economic trend became one of long-term decline (Shutt 1998). (See Figure A2.1.)

As the saturation of industrialized markets became a constraint on further growth, fierce competition forced transnational corporations to cut costs and to seek new markets. Over time this was done through different strategies. During the 1980s, there was a major thrust in exploitation of the markets of the global South, in order to dump excess capacity. This led to a huge rise in Third World debt and, for decades, the interest on this debt ensured an important source of income for the developed capitalist economies of the





**Image A2.1** Dismantling the 'welfare state' in Europe (Indranil Mukhopadhyay)

North (for a detailed analysis, see GHW 1, ch. A, [www.ghwatch.org/sites/www.ghwatch.org/files/A.pdf](http://www.ghwatch.org/sites/www.ghwatch.org/files/A.pdf)).

The second strategy employed was the restructuring of transnational companies. These companies were supported through tax reductions and privatization programmes. Concurrently, developing countries were forced to accept further liberalization, deregulation and privatization of their economies, thereby providing transnational corporations with an outlet for their excess capital. The health sector was not an exception; its profitable parts were increasingly privatized (Ginzberg and Ostow 1997; Armada et al. 2001; Iriart et al. 2001).

These strategies effectively masked the decline in the purchasing power of the developed capitalist economies, mainly the United States (consumption in the USA accounts for 25–30 per cent of the globe's GDP). Consumption needed to be maintained by increasing credits and debts in different ways, of which the most well known focused on real estate – the infamous 'sub-prime debts' (see GHW 3, ch. A1, [www.ghwatch.org/sites/www.ghwatch.org/files/A1.pdf](http://www.ghwatch.org/sites/www.ghwatch.org/files/A1.pdf)). This third strategy was based on 'fictive capital' – creation of money that exceeded the capacities of the real economy to produce the wealth needed to ensure its material basis.

Since 1985, important measures for integration were taken at the European level. A common market was set up in 1990 and the Maastricht Treaty (which created the European Union and led to the creation of the single European currency) was signed in 1992. In 2002, the euro was introduced as a common currency across Europe. The Lisbon Strategy (an economic plan for the European Union between 2000 and 2010) was developed in the first decade of the twenty-first century, although it faced fierce popular resistance.

### **Influence of policies in Germany**

Policies pursued in Europe today are deeply influenced by those in Germany – the largest economy in Europe. Germany is the exporting nation par excel-

lence, and the strongest driver of the monetary unification of Europe. Through its exports to the rest of Europe, Germany became the biggest beneficiary of the euro. Its profits were made mainly at the expense of the peoples in the south of Europe. The crisis in countries such as Greece, Italy and Portugal and the trade surplus enjoyed by Germany are clearly linked. In Portugal, Greece and Italy, national industries were wiped out, German products were imported, and these countries amassed substantial debts (Mertens et al. 2012). Germany's export-led economy is predicated on domestic wage reductions and retrogressive policies towards the unemployed and other socio-economically disadvantaged groups. Now this policy is presented as an example to be emulated by the rest of Europe. European integration shuns the possibility of countries in Europe developing sovereign financial policies, especially those in a crisis. Loans are being offered to bail out the economies in crisis in Europe on the condition that they are used to pay the interest on accumulated debts, but not to protect the populations of the affected countries (e.g. in Greece) (Bricmont 2012). Today's crisis is used as an opportunity to impose an even more radical process calling for the same neoliberal 'solutions' as employed in Germany.

It needs to be understood that the recession in Europe is linked to the functioning of the capitalist system itself, based on the need of continued growth while the consumption possibilities of the population are increasingly limited (Houben 2011). When overproduction occurs, a capital surplus follows. This excess capital cannot be used to increase production because it collides with the limits of the market. This capital constantly searches for high returns. Conditions enabling the emergence of this situation were created by financial deregulation and the invention of new financial instruments. The entire bubble was inflated even further through excessive credit stimulus, as granting credit is a way of creating money out of nothing (see GHW 3, ch. A1, [www.ghwatch.org/sites/www.ghwatch.org/files/A1.pdf](http://www.ghwatch.org/sites/www.ghwatch.org/files/A1.pdf)).

### **Crisis in the US and its aftermath**

In 2006, the United States was hit by an economic recession (which still continues) and in February 2007 the first banks providing mortgage loans went bankrupt. In spite of attempts by the US government to continue bailing out the failing banks, in September 2008 the bubble finally burst and over two million house owners lost their homes in the USA. The crisis in the largest global economy had a cascading effect throughout the world. Across the world, over US\$1,000 billion worth of junk bonds had been sold (i.e. bonds which the banks were unable to buy back), and – one after the other – banks declared losses. Almost every country came to the swift rescue of their banks – governments from London to Berlin took over or bailed out faltering banks (Landler 2008). Consequently, the (private) bank debt became a problem of the state (that is, of all of us), combined with a worsening economic crisis. As we discussed earlier, the rapid creation of 'fictive capital'

(money that exceeds the capacities of the real economy) has now come to haunt the developed capitalist economies of the world.

Fears of a serious debt crisis grew from late 2009. In several countries private debts arose from a property bubble, but were transferred to sovereign debt as a result of banking-system bailouts. The overall slowdown in the economy also implied a decrease in tax incomes, further adding to national debts (Lewis 2011). In addition, the downgrading of government debt on international markets led to a dramatic increase of interest on debt. To tide them over the crisis, several countries in Europe have effected cuts in public and social expenditures, which in turn have led to a further decrease in the purchasing power of a large majority (Plumer 2012).

### **Greece and Spain: acute manifestations of the crisis**

Greece, which has attracted attention since 2010 for the country's growing economic instability, is a typical example of the unfolding crisis in Europe. Leaders of the EU and sections of the media have tried to place the blame for the crisis on Greece itself. They claim that Greece's misfortune has been brought about by a 'way of living beyond its means', as the country allegedly created a 'ballooned welfare state' and offered (over-) 'generous payments' to its civil servants and 'low retirement age pensioners' (Armitstead 2012; BBC News 2012). Uncontrolled government spending combined with inefficient state-owned enterprises and cumbersome business regulations are claimed to be the key factors for Greece's public debt crisis (OECD 2011).

Greece's predicament, however, is much more clearly linked to the structure



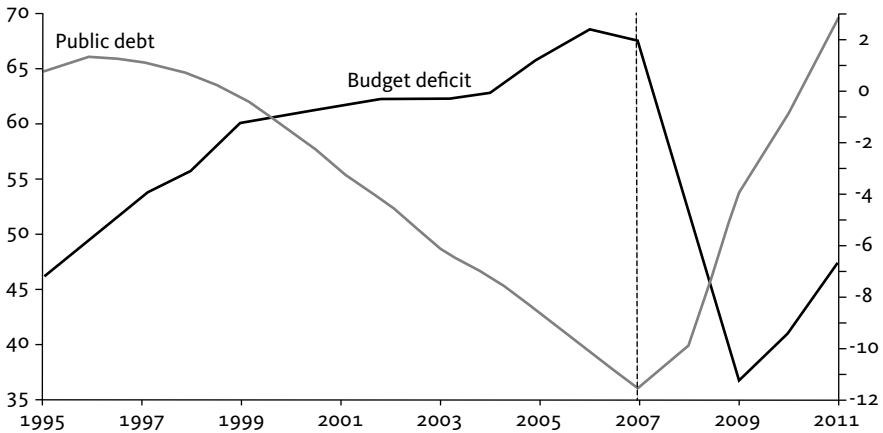
**Image A2.2** A deserted street in Barcelona as the city is closed down by protesters (Eddie Dep)

and policies of the European Union. The economic contraction in Greece is an outcome of Greece's unequal development within the EU and the pressure exerted on the national economy by the global structural crisis (Mavroudeas 2012b). The participation of Greece in the EU and in the Eurozone weakened the country's economic competitiveness. EU regulations forced Greece to open its doors to cheap imports (from Germany, for example), thus destroying domestic manufacturing capacity and leading to a deteriorating trade balance since the late 1980s in favour of the more industrialized countries of Europe (Mavroudeas 2012a; Lapavitsas 2010). With the onset of the global crisis in 2007, Greece was one of the worst affected, given its already unstable economic foundation.

While Greece is being blamed for its 'overdeveloped and overspending public sector', actually the Greek welfare state – when compared to those of many other European countries – was always poorly funded and had a relatively limited outreach (Navarro 2012). While there have been issues about efficiency in the public sector in Greece, the much bigger issue is that the public deficit in the country was a result of declining state revenues rather than expanding public expenditures (ibid.). On the other hand, huge amounts of public revenue were forgone owing to tax-relief measures for the flourishing Greek shipping industry and billions of euros of untaxed money have flowed into Swiss banks.

In Spain, the crisis immediately translated into massive job losses. The unemployment rate reached an unprecedented 25.1 per cent in August 2012, with more than 50 per cent of the youth being denied employment. Just like that of Greece, the Spanish economy had already been destabilized as a consequence of cheap imports from within the EU and the recession further aggravated the situation. A surplus budget of 20.2 billion euros in 2007 quickly turned into a deficit of 98.2 billion euros as consequence of declining tax revenues (accounting for 43 per cent of the total decrease in the government budget). Similar trends were seen in many other European states, but the weakness of the industrial structure in Spain and the collapse of its housing market aggravated the situation.

There have been attempts to link the crisis in Spain to its public debt. However, facts indicate an entirely different picture (Figure A2.2). At the onset of the global economic crisis, Spain's public debt was 36.2 per cent of GDP (down from 65 per cent in 1995) and the budget deficit was 1.9 per cent of GDP. By 2011 the public debt had increased to almost 70 per cent of GDP. On the other hand the budget deficit was converted into a surplus by new austerity measures that imposed savage cuts on public expenditure. Thus the 1.9 per cent budget deficit in 2007 was quickly transformed into a surplus of more than 11 per cent by 2009. We see two important trends here – a sharp increase in public debt *after* the crisis hit Spain, and a sharp contraction in public spending leading to a high budget *surplus*. The austerity measures have, thus, led to decreased economic activity. In contrast, what is required is an



Note: left scale = figures for public debt; right scale = figures for budget deficit

**A2.2** Public debt and the budget deficit in Spain (as a percentage of GDP) (source: AMECO database)<sup>2</sup>

economic recovery programme to increase economic activity which is driven by higher government spending. However, the neoliberal agenda, which is being driven by German capital and by some European business leaders, is very different. They see an opportunity in the crisis to impose austerity measures across Europe and thereby decrease costs in manufacturing (essentially by reduction in salaries), so as to make European exports more ‘competitive’ in the global market. The crisis is also an opportunity for them to dismantle social protection measures across Europe.

### Social consequences

The responses to the global economic crisis, in Europe, are based on strengthening of market mechanisms, combined with the encouragement of competition between countries through reduced production costs (by lowering labour costs), fiscal policies and social dumping. The inevitable consequences of these measures are decreasing purchasing power of the population, declining public investment, and a steady breakdown of social protection mechanisms.

In October 2012, the unemployment rate for the EU was 10.7 per cent, an increase of 3.6 per cent over the rate in 2008. Young people have been badly affected – in September 2012, of the economically active population in the EU in the age group fifteen to twenty-four years, at least 22.8 per cent were unemployed (Alatalo et al. 2013). In 2011, more than 24.2 per cent of the EU’s population (nearly 120 million people) were at risk of poverty, with women having a 2 per cent higher risk than men. Having a job was no longer an insurance against poverty; 8.7 per cent of workers in 2011 were below the poverty line and one third of the poor were the ‘working poor’ (ABVV 2012).

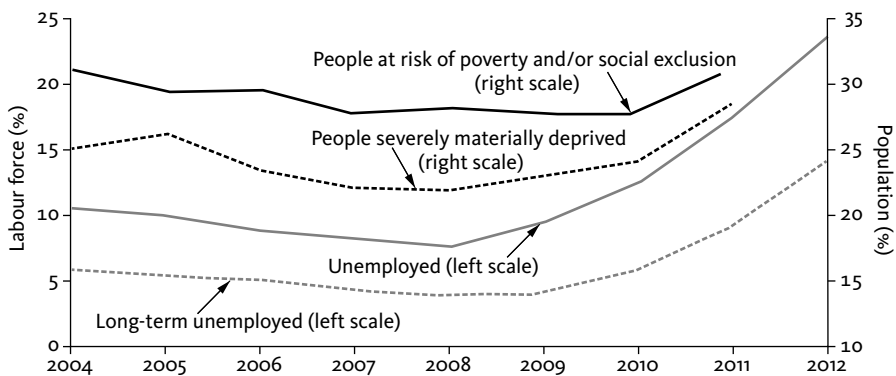
The dramatic increase in public debt and thus the alleged ‘unsustainability’ of health and social security systems is used as an argument to push for

further privatization. While the social consequences of the crisis (joblessness, housing problems, poverty, etc.) are the determinants of dramatically increasing health needs, healthcare is being progressively transformed into a marketable commodity.

### Greece: the face of the health crisis in Europe

While the Greek government still argues that the economic crisis in Greece does not constitute a threat to the population's health (Liaropoulos 2012; Polyzos 2012) a World Health Organization report stated in January 2009 that 'some countries are at particular risk ... and these include developed countries that have required emergency assistance from the IMF, where spending restrictions may be imposed during loan repayment' (WHO 2009). Today, in Greece, the toxic combination of protracted economic recession and neoclassical adjustment policies constitutes a double threat to the population's health and well-being.

The economic recession and the austerity measures imposed in the country by the troika – European Commission, International Monetary Fund (IMF) and European Central Bank – have triggered a sharp deterioration in the socio-economic conditions of the working class and even sections of the middle class. It is estimated that 3.9 million Greeks (out of a total population of 11 million) were living below the official poverty line by the end of 2013 (Stevens 2013) and the unemployment rate stood at 27.3 per cent in 2013 (Dabilis 2013). The inability to pay mortgages is increasing evictions and steadily increasing the number of homeless people; 28 per cent of the Greek population (compared to 22 per cent of the population in 2008) stated that they were living in conditions of severe material deprivation, not being able to meet basic needs such as paying rent, eating a meal with meat, chicken



**A2.3** Basic social indicators, Greece, 2004–September 2012 (sources: Calculations based on data derived from (a) Hellenic Statistical Authority (ELSTAT), *Quarterly Labour Force Survey*, [www.statistics.gr](http://www.statistics.gr); (b) ELSTAT, *Survey on Income and Living Conditions 2011: Indicators of change 2003–2011*, [www.statistics.gr](http://www.statistics.gr))

or fish every second day, and keeping their home adequately warm (Kondilis, Bodini et al. 2013). (See Figure A2.3.)

Greece's mortality and morbidity data reflect the deep impact of the crisis on people's lives. For example, the Infant Mortality Rate (IMR) in Greece increased by 51 per cent between 2008 and 2011. Further, suicide and homicide mortality increased by 11.5 and 40 per cent respectively between 2007 and 2010 (ibid. 2013). Concurrently, private health expenditure started decreasing sharply from 2009, and total private health expenditure in Greece (calculated on 2009 constant prices) decreased by 16.2 per cent between 2008 and 2010 (Table A2.1) This reflects the inability of households, in times of crisis, to purchase health services even in a situation where the public system is crumbling.

TABLE A2.1 Private health expenditure in Greece, 1998–2010

| Type of service/survey year | 1998/99  | 2004/05  | 2008     | 2009     | 2010     |
|-----------------------------|----------|----------|----------|----------|----------|
| Pharmaceuticals             | 1,031.72 | 1,369.77 | 1,633.09 | 1,542.80 | 1,525.89 |
| Medicines                   | n/a      | 1,128.96 | 1,353.16 | 1,275.22 | 1,299.11 |
| Therapeutic devices         | n/a      | 240.8    | 279.93   | 267.09   | 226.30   |
| Outpatient care             | 3,811.95 | 4,515.30 | 4,329.52 | 3,923.91 | 3,186.24 |
| Medical care                | 1,311.93 | 1,600.92 | 1,487.19 | 1,331.01 | 1,062.87 |
| Dental care                 | 1,878.19 | 2,140.46 | 2,092.06 | 1,947.64 | 1,574.18 |
| Other outpatient            | 621.82   | 1,547.83 | 1,501.04 | 1,290.53 | 1,097.43 |
| Inpatient care              | 683.23   | 988.98   | 1,065.32 | 1,162.65 | 1,178.86 |
| Public hospitals            | 167.88   | 278.351  | 293.28   | 299.18   | 336.61   |
| Private hospitals           | 515.35   | 710.63   | 772.53   | 862.98   | 841.77   |
| TOTAL                       | 5,527.07 | 6,874.04 | 7,027.93 | 6,628.88 | 5,890.99 |

Notes: 1. Private health expenditure expressed in million euros (€), 2009 constant market prices;  
2. n/a = data not available

Sources: Calculations based on data derived from (1) ELSTAT, *Households' Budget Surveys for the Years 1998/99, 2004/5, 2008, 2009, 2010*, [www.statistics.gr](http://www.statistics.gr); (2) ELSTAT, *Consumer Price Index 1959–2012*, [www.statistics.gr](http://www.statistics.gr)

At the same time, the demand for public healthcare services has increased since the advent of the crisis. The growing demand on healthcare facilities is reflected in an increase of 36 per cent, between 2008 and 2012, in the number of hospitalized patients (Greek Ministry of Health 2012). Paradoxically, austerity measures imposed by the Greek government on the directive of the troika are restricting free access to healthcare services. In a situation of increased healthcare needs, the Greek government has responded by adopting restrictive policies: a decrease in funding and a downsizing of public health services, higher user fees, and cost-sharing. Between 2009 and 2011, the total expenditure of the Greek Ministry of Health decreased by €1.8 billion. On the other hand, in 2011, patients spent €25.7 million on out-of-pocket-payments for outpatient services in public hospitals – services that had been free at the point of use before the crisis (Kondilis, Giannakopoulos et al. 2013). Further, from 2009





**Image A2.3** Poster for the plebiscite against water privatization in Greece (Alexis Benos)

to 2011, the number of people reporting inability to visit a doctor owing to economic hardship or high waiting lists increased by almost 50 per cent.<sup>3</sup>

Health insurance coverage is available only to those who work for more than fifty days per year. This leaves out major sections of the population, including the unemployed, casual workers and irregular immigrants; 2.5 million people in Greece are without any form of health insurance coverage (according to 2014 data from the Greek Ministry of Labour). The current situation points to a fundamental flaw in the way public healthcare services have traditionally been funded. Historically, the social insurance funds were linked to employment, and this worked fairly well when unemployment rates were low. Faced with the present crisis and the huge rise in unemployment, the system is on the verge of collapse and the assets of social insurance schemes have decreased dramatically. Clearly, there is a need to organize public health services and their financing in a manner that doesn't entirely link access to healthcare with conditions of employment.

The crisis in financing of the public healthcare system has had a cascading effect. To tide over this crisis the government has introduced co-payments, which further increase the burden of out-of-pockets costs. Cost containment policies and expenditure cuts are being imposed, leading to the virtual

dismantling of the public services infrastructure. Staff shortages abound and health professionals are facing a huge increase in workload.

The restructuring of public health services is being driven by conditionalities imposed on Greece, as part of the austerity programme. From 2010 to 2013, 170 conditionalities related to healthcare were included in the memorandums of understanding signed by the Greek government and the troika. These include budget caps, introduction of multiple user fees, freezing recruitment of staff, and substantial reductions in health workers' wages and in the social security funds' healthcare benefit packages (Kondilis, Giannakopoulos et al. 2013). Also included are various measures on healthcare reforms that promote the establishment of an internal market in public health services, and ultimately lead to the privatization of these services. By virtue of a vicious cycle of increasing demand and decreasing capacity, the collapse of Greece's public health system has triggered a humanitarian crisis of unprecedented proportions. In sharp contrast to the current reforms in Greece's health system, what is urgently necessary is the construction of a tax-funded national and public healthcare system that provides high-quality care that is free and accessible to all.

### **Manifestations of the crisis on healthcare in different parts of Europe**

In the UK, the government has allowed corporations to enter the arena of healthcare by implementing a series of incremental and far-reaching legal changes designed to allow the entry of capital (see Chapter B2 for a detailed analysis of the NHS reforms in the UK).

In Portugal, public spending declined by 8 per cent in 2011, after having remained stable between 2009 and 2010.<sup>4</sup> Measures imposed by the troika have led to decreasing salaries, pensions and unemployment benefits, with overall tax increases. The national health service is under siege; important parts of the public sector have been privatized and many health workers are losing their jobs (Augusto 2012). Co-payments for healthcare have gone up drastically, causing a decrease of 900,000 first-line consultations and half a million emergency consultations between January and October 2012 compared to the year before, while 'rationalization' of medicine use has led to significant increases in cost to patients (Campos 2013). A study conducted in May 2012 of 980 Portuguese families showed that 22.2 per cent had reduced their health expenditures. In families where one or more members were unemployed (20 per cent of those interviewed), the figure was 39.9 per cent. The crisis is having its most dramatic impact on mental health. Between 2011 and 2012, diagnosis of depression increased by 30 per cent in the north of the country. In the same period, suicide attempts grew by 47 per cent among women, and by 35 per cent among men. The monthly average admissions to mental health hospitals have increased by 76 per cent. In a recent study of family health centres, basic equipment for routine activities had been out of stock more than ten times during 2012 in 34.3 per cent of the centres (OPSS 2013).

In Italy, the growth in health expenditure between 2000 and 2010 was the lowest among the thirty-four OECD countries; yet savage health budget cuts have been imposed (projected to be 25–30 billion euros during 2012–15). This is resulting in increased user fees, removal of healthcare benefits, reduction in specialist care and decreased access to care – particularly for vulnerable socio-economic groups (Costa et al. 2012).<sup>5</sup> In 2011/12, the overall expenditure for drugs decreased by 5.6 per cent. While public healthcare expenditure decreased by 8 per cent, private expenditure increased by 12.3 per cent. A sharp increase in user fees for drugs (117.3 per cent between 2008 and 2012) has contributed to this (ISTAT 2013). In a recent survey, 10 per cent had postponed surgical treatment for financial reasons and 26 per cent reported increased expenditure for medical emergencies due to higher co-payments (Freni Ricerche Sociali e di Marketing 2011). Given that government officials claim that the National Health System (NHS) is no longer sustainable, reforms to achieve more ‘efficiency’ may well lead to even greater privatization of the healthcare system (Maciocco 2012). A national survey showed that for the first time 40.9 per cent of Italians are dissatisfied with the NHS (ranging from 21 per cent in the north-east to 57.6 per cent in the south of the country). People are shifting increasingly to the private sector, which is not surprising considering that 27 per cent of those interviewed said that they have paid higher fees in the public sector compared to the fees charged by the private sector for the same service. Even more worryingly, 41.2 per cent of Italians now consider the NHS as a safety net for essential services, and believe that all the rest should be purchased privately, and 11 million are covered by private insurance schemes (ISTAT 2013).

In Spain, the healthcare budget has declined by 18.21 per cent since 2009 (Economist 2013). Healthcare services have been cut, 53,000 health professionals have been removed from the public health system in the last three years, and user fees have been increased (including co-payments for medicines). The earlier universal entitlement to access to the public health system has been replaced by employment-based entitlement, thus excluding large population groups (e.g. approximately 900,000 undocumented migrants, who are now entitled only to emergency care and maternal and childcare). As a consequence quality of services has declined and out-of-pocket expenditure on healthcare has increased. There is a rise in waiting lists for patients who require major procedures – in 2010, 50,705 patients were on the waiting list for surgical interventions, while in 2013 their number had increased to 89,000. National and regional governments are using budget cuts targets to force the privatization of the Spanish healthcare system – 236 out of 550 acute care hospitals are now private (European Network 2014). While public–private partnerships (PPPs) are promoted (Quercioli et al. 2012; Peiró and Meneu 2012; Benach et al. 2012), there are widespread reports about conflicts of interest, nepotism, monopolistic practices and ‘revolving doors’ between government officials and

private sector healthcare managers (Abril et al. 2012; Jara 2010; Güell and Castedo 2012).

While the German economic model is presented as a success story, 16 per cent of the German population live in poverty and almost five million workers have ‘mini-jobs’ with a monthly salary of 400 euros. The 8 per cent increase in employment between 1996 and 2011 is due to an increase in working hours and also related to an increase in part-time employment without social security rights (ABVV 2012); 26 per cent of jobs in Germany are precarious (temporary contracts, part-time jobs, etc.); 8 million workers (23 per cent of the country’s workforce) lived in poverty in 2010, and this included 50 per cent of workers with full-time jobs (Bosch 2012). In 1998, the poorest 50 per cent of the population possessed only 4 per cent of Germany’s wealth and this plummeted to 1 per cent in 2008. Germany has also seen one of the largest waves of hospital privatization in Europe. Between 1995 and 2010, the proportion of private hospitals doubled while at the same time the total number of hospitals fell by 11 per cent (Destatis 2013). The share of cases treated in private hospitals grew from 5.2 per cent in 1995 to 9.1 per cent in 2003, and further to 16.1 per cent in 2010.

In Belgium, the social security system still functions better than in Germany, in spite of attacks against it by proponents of neoliberal policies (terming the system ‘wasteful’). Though 15 per cent of the population are poor and their numbers are growing, compared to Germany, Belgium had a higher rate of increase in employment between 2006 and 2011 (ABVV 2012). The number of working poor did not increase, while the figure almost doubled in Germany and increased even more sharply in Spain and Greece. However, since the 1990s, Belgium too has cut back on investments in public healthcare infrastructure and social security. Healthcare provision is evolving to favour for-profit, private care provision. While, currently, 140,000 elderly people reside in retirement homes, the proportion of commercial retirement homes rose from 45 per cent to 57 per cent between 2009 and 2010 (European Network 2014). From 1997 to 2005, out-of-pocket payments for healthcare rose from 23 per cent to 28 per cent and this has had catastrophic effects. In 2007, about 14 per cent of the Belgian population reported having postponed necessary care because of financial problems (compared to 8 per cent in 1997 and 10 per cent in 2004) (OECD 2007). Data from 2009 suggest that almost 30 per cent of the population regularly has trouble paying medical bills. In 2010, 8 per cent of Belgian families stopped an ongoing treatment and 26 per cent postponed it for financial reasons (Test-Aankoop 2012).

### **Solidarity in the midst of a crisis**

The evidence from post-crisis Europe, especially as regards the major changes that have taken place in healthcare services, is a clear reminder of the need to defend public services. It is precisely at this juncture – when the

economic crisis in Europe is eroding the livelihoods of millions of people – that public investment in education, healthcare and infrastructure needs to be ramped up.

The question may be asked, who would pay for enhanced investment in social protection measures? In large parts of Europe the public debt is extremely high and mounting. Yet there remain islands of extreme affluence within Europe – 3.2 million families have a combined wealth of 7,800 billion euros (Waitzkin 2011). A tax on the financial wealth of the richest 2 per cent could yield 100 billion euros every year. There is a need for European solidarity, and it is only through solidarity that problems can be solved, differences narrowed, and conditions ameliorated.

There are moments in history when social logic must take precedence over other considerations. In the late nineteenth century, the British parliament was opposed to the prohibition of child labour on the grounds that children were the perfect size to work in the mines. The labour movement imposed a social logic, and child labour was abolished. It is high time that we followed the elementary logic that collective solidarity and actions lead to collective prosperity and improved living conditions for all. We need an economy that is not driven by maximizing profits for the few, but by the fulfilment of the needs of the many.

To argue for a health ‘commons’ is to guide health workers and activists towards new ways of engagement and resistance, of participation in the struggle to protect and animate the public sphere. As noted by Stuckler and McKee: ‘There is an alternative: public health professionals must not remain silent at a time of financial crisis’ (Stuckler and McKee 2012). Mass mobilization by civil society that encourages public debate and raises political consciousness will demystify the given orthodoxy and counteract the received wisdom. The challenge is to develop strategies for activism that can lead to broader social change (Waitzkin 2011).

## Notes

- 1 See Maddison Historical Statistics, Groningen Growth and Development Centre, [www.rug.nl/research/ggdc/data/maddison-historical-statistics](http://www.rug.nl/research/ggdc/data/maddison-historical-statistics).
- 2 See Annual Macro-Economic database (AMECO), European Commission’s Directorate General for Economic and Financial Affairs, [ec.europa.eu/economy\\_finance/ameco/user/serie/SelectSerie.cfm](http://ec.europa.eu/economy_finance/ameco/user/serie/SelectSerie.cfm).
- 3 See Hellenic Statistical Authority (ELSTAT), [www.statistics.gr](http://www.statistics.gr).
- 4 See OECD Health Statistics, OECD iLibrary, [www.oecd-ilibrary.org/statistics](http://www.oecd-ilibrary.org/statistics).
- 5 See *ibid.*

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