

CONDITION CRITICAL



Health care, marketising reforms and the media

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Abstracts and extracts

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Failure of international policies to control diseases in LDC

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Objective

- To review the evidence base for the disease control policy promoted by international agencies in developing countries since 1993 and

Methods

A synthesis of recent own publications will be presented.

Results

International agencies do have a doctrine on aid and international aid policies: whenever possible, these policies allocate disease control to the public and curative health care to the private sector¹. Since a few years, WHO is also promoting private sector providers involvement in TB control, a component of the new Stop TB Strategy and the Global Plan to stop TB².

Such policies are neoliberal in their promotion of commoditization and privatization.

To assess their impact on access to decent quality health care, we refer to an analysis of health policies of three countries showing how health care privatization failed in Colombia and Chile, and what an alternative health policy can achieve (in Costa Rica and Chile). We conclude that together with other factors (such as Structural Adjustment Programs and WTO GATS negotiations³), orthodox policies are responsible for poor access to care v⁴.

On disease control, we present epidemiological trends of target diseases (AIDS, tuberculosis and malaria). To understand their control's failure, we performed simulations to estimate the success likelihood of malaria control in Africa under orthodox aid principles. We also refer to works suggesting an insufficient evidence base for the strong promotion of public private mix DOTS by WHO. We conclude that together with other factors, these policies are responsible for the lack of effectiveness of disease control in low and middle-income countries^{5 6 7}, and for many avoidable deaths in LIC/MIC^{8,9}.

Conclusion

Alternative aid and international health policies are justified. We propose a social and democratic strategy updating several Primary Health Care features¹⁰. We highlight its health care (quality criteria for medical care in publicly oriented services¹¹), integrated disease control¹², managerial and socio-political features. In particular, we plead for family and community health in publicly oriented services^{13 14 15}, publicly oriented hospitals with systemic responsibilities¹⁶, local health systems^{17 18}, reflexive methods to bridge the gap between the medical and public health identities of health

professionals¹⁹, a reorientation of international research²⁰ and in-service training²¹ efforts. To implement these methods, we consider different strategies fit for different health systems categories x²².

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Identifying the experiment in neo-liberal marketing approach to public health -1980-2008

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Resumé:

"Friedmanite" economics have been identified and documented since Sept 11..1973. Yet, 25 years of experiment embedding that same neo-liberal doctrine within public health has not been well understood: HIV/AIDS, 44 million people have died, an estimated 22 million Africans live with HIV today; tuberculosis out of control, could these be other facets of the 'chock doctrine' ?

We wish to review the scientific truth to the matter and the ideological neo-liberal 'deadly' doctrine at the root of the 'prevention' approach in HIV, TB, Malaria. We are helped by the Bias Free Approach (developed at the University of Toronto) to dissect what went wrong and why.

Our study, based on both in country experience, especially in sub Saharan Africa, and India, and on review of

scientific research literature, reports the experience of researchers, it examines:

- The decision to divorce public health from health systems, allowing the continued destruction of health systems by international financial institutions. Blood exposure to HIV in health care stopped in rich countries (after the contaminated blood scandals) but continued in developing countries.

- A world-first experiment in treating an epidemic with marketing/media, shifting the task of prevention on the individual, with the assumption of the individual as in the 'free market' being the ultimate 'consumer' making the right or wrong choice in 'sex'.

The assumption then resting on reinforcing the myth of the 'natives' having lots of sex and helping to stigmatize People living with HIV and Africans in particular. Development of a campaign helping related interest of media/marketing corporations for the development of new markets among adolescents in developing countries.

- A doctrine based on the new interest of international financial institutions in 'health', looking at both individual and population health 'value' from the standpoint of the "burden of disease" /Disability Adjusted DALY.

This research draws on contributions, commentaries and publications from Mary Anne Burke, (BIAS FREE FRAMEWORK), Canada; Jean-Marie Ndi, Public Services International and SOI Cameroun; Aimée Mwadi Kadi, President of SWAA, Dem. Rep. of Congo; and Steve Minkin, People's Health Movement, Bangladesh and USA.

Are international policies on health care evidence based? A light shed from Latin America

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Objectives

1. To outline the multilateral agencies' doctrine on health policy
2. To explore its empirical basis in Colombia, Costa Rica, and Chile. Colombia privatized large parts of health insurance and health care delivery. Costa Rica expanded its publicly oriented delivery system. In Chile, the dictatorship promoted the private sector and underfinanced the public sector. Transition governments did not change the scheme but financed public services decently.

Methods

To achieve the first objective, we analysed documents from WHO, EU and the World Bank. For the second objective, we traced the countries' health services results back to their health policy features. Data were collected

through a literature review and field visits in Costa Rica and Chile.

Results

There is a doctrine: multilateral agencies promote disease control programmes without possibility to integrate them with curative care, allocating the former to the public and the latter to the private sector.

Colombia applied this policy. Despite a large increase in health expenditure, more than 40% of the population is still not covered by health insurance. Real access to health care deteriorated. Key health indicators are preoccupying.

Costa Rica offered comprehensive care with a participative approach through public services. Efficiency and quality of care can still be improved, but health services sensitive indicators are outstanding. Costa Rica spends on health 1/9th of USA and scores better on life expectancy.

Chile has excellent health indicators at a cost of 50% above Costa Rica. Effectiveness is linked to public services operations (used by 85% of the Chileans) while inefficiency is due to Isapres costs (more than 40% of total health expenditure).

Conclusion

Colombia is one of the few countries where international doctrine has been fully implemented. As in other developing countries, inefficient contracting-out can be explained by government's weak capacity for control and regulation (not by the civil war). At odds with international aid policies, community participation and absence of purchaser-provider split are the cornerstones of the Costa Rican health policy. Results are remarkable. Chilean mixed results confirm the adaptation of public services to developing country conditions and the risks of privatizing both health insurance and health care delivery.

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Privatization of the health care system in Egypt

History, opposition and future prospects

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Abstract

During the past three years, a campaign to promote the privatization of health services and their marketization was launched by the government of Egypt (GOE). This campaign was supposed to finalize with passing a new "National Health Insurance Law" through the Egyptian parliament. However, confronting this move an anti-privatization campaign developed.

The campaign starting from a small group of health related civil society organizations was able to gain the support of a much wider range of allies and members including workers unions, professional organizations as well as that of the vast majority of the opposition political parties.

The campaign succeeded in preventing the presentation of the law to parliament through three successive years from 2005-2008. However the GOE continues to declare its unyielding insistence on this course. Accordingly, the debate and confrontation around the current state and future of the the health care system in Egypt continues.

In its move the GOE has been and is currently supported by a wide and a strong international coalition, headed by the USAID, the World Bank and currently the European Union.

It is strongly linked to the neo-liberal global discourse, known as the "Structural Adjustment Policies", which promotes market run services as the only possible efficient alternative to the "failing" public run services. In this particular context it is claimed that it is the only possible alternative to the "decaying public health services and that it will bring about radical improvement in both the quality as well as the accessibility of services.

This paper intends to show that the proposed "National Health Insurance law" which is one of the representations of the "Health Reform Program" comes as a byproduct of this global discourse.

It also shows that in many ways it was the neo-liberal policies adopted by the GOE starting from President Sadat's era that played a major role in undermining and damaging the quality and functioning of the public run health services.

It questions the correctness of the proposition that these "restructuring" policies are and will improve the quality and access to health services. Moreover, it questions the degree to which these policies have and will infringe on the principles of equity and universal access to health services as a basic human right.

On the other hand, the paper adopts the view that the current crisis of the health care system is a reflection of the prevailing social crisis in all other aspects of life such as education, social services, transportation...etc. It is the crisis of the dominant market driven system.

The paper also highlights that the current crisis is a natural

development of the inherent crisis and failings of the Bio-medical model of health care which was introduced in Egypt during the early nineteenth century and developed, in the main, within the context of domination by the colonial powers. This model was introduced in a top down manner and was born alienated from the natural course of the social development of previously existing health care systems and institutions.

In addition, the paper looks at the milestones of the development of Primary Health Care in Egypt. In doing so it shows that attempts at developing this model i.e. an inter-sectoral social model of health, were introduced during the times when a wider independent social development project was promoted and was undermined when this project failed and was defeated.

This defeat was the outcome of the interaction between, the inherent characteristics of the curative Bio-medical model and the medical profession born within its context, on the one hand, and the external pressures of the old and new colonial Northern powers on the other. Moreover, the paper shows how the current proposal of "PHC" introduced by the "Health Reform Program" through the "Family Health Program" is a distorted picture of the model introduced by the Alma Ata conference in 1978.

Unlike the holistic approach of the PHC model, the current proposed one is mainly a rationalization for privatizing the major health care facilities in Egypt, while providing poor people with a "basic minimum package" of services while keeping most of secondary and tertiary available only for those who can pay through other types of private arrangements.

Finally, it highlights the major positions and developmental landmarks of the anti-privatization campaign and emphasizes the need for an international coalition to engage with the neo-liberal discourse in the area of health services reform and confront the powerful coalition which is promoting the privatization of health services as the only viable solution. There is a strong need for a new global alternative to the neo-liberal solution regarding the required health system reform.

Reporting Health and Health Policy in Northern Ireland post devolution.

Brian Laughlin. Employed as Media Officer with Belfast Health and Social Care Trust. Part-time PhD student at University of Ulster at Coleraine, studying the reporting of health by the media in post devolution Northern Ireland.

Abstract

Devolved government was first granted to Northern Ireland in the wake of the Good Friday Agreement in 1998, allowing for the transfer of certain powers from Westminster to the Northern Ireland Assembly at Stormont. However following a series of political crises, devolved government was suspended and not fully restored until 5 May 2007.

One of the major dispensations of devolved government has been the ability to manage budgets and administer

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policy in a number of social and economic areas. Probably the main beneficiary of this has been in the area of health and social services, which accounts for nearly half the budget in Northern Ireland with spending for this year amounting to £3.4billion.

This paper examines how the local media have reported issues of public health and health policy, post devolution. Have they been able to provide the citizens of Northern Ireland with the appropriate information to make informed decisions about these issues or to satisfy the public that health and health policy is in accountable and competent hands?

This paper arises from graduate research and presents the results of a pilot study of four weeks of routine local news in 2008, set up to monitor media reporting of health and health policy stories. While the results demonstrate the prominence of health news on the local news agenda, qualitative analysis raises uncomfortable questions about the accuracy and authority with which some important or more complex issues are reported. A major cause for concern is the BBC Northern Ireland's health reporting, which seems to have become dysfunctional and dumbed down.

Myths, misconceptions and the media - Irish health 'crises' through the lens of the media

Sara Burke

Sara is a journalist and a health policy analyst. She has worked in health policy in Ireland since 1997, working in the Department of Health and the Institute of Public Health. From 2004 to 2006, she was managing editor of an Irish left political magazine called Village. Since leaving Village in 2006, she works as a freelance journalist mainly covering political and health related issues. She also works part time as

a health policy analyst for organisations such as the Combat Poverty Agency, the Irish Congress of Trade Unions and the National Women's Council.

Abstract

This paper will take four high profile issues in recent Irish health policy and assess how they have been portrayed in the media. The issues examined are

1. The black hole myth; in Ireland between 1997 and 2007, spending on health quadrupled, this is regularly referred to in the media and public debates as a 'black hole'.

2. The crisis in emergency departments; despite repeated efforts, task forces and concerted action, attempts to reduce long wait times and chaos in Emergency Departments in Irish hospitals have mainly failed.

3. The reorganisation of health services into a new Health Service Executive; A much-heralded united Health Service Executive was set up in 2005. Despite a well-funded and concerted media machine, the public remain disheartened by the new, overly centralised, failing HSE.

4. The attempts to reconfigure (ie centralise) hospitals' emergency, acute and cancer care. Since the 1930s, government reports have recommended the rationalisation and reconfiguration of Irish hospitals, but the same hospitals have largely remained in place with 50 acute public hospitals serving a small island and 4 million people. This paper will examine how these issues are covered in the media and contrast that coverage to the actual situation on the ground.

Changing attitudes in the media to HIV and how public opinion is affected.

Author Danielle Cox, currently studying for an MA in Health Journalism at Coventry University.

Abstract

Has an 'active' understanding by the public audience forced the media into a more responsible attitude towards health, or vice versa? This paper will examine the changing attitudes of the media and the public to HIV and AIDs, and the extent to which these attitudes influence each other.

It will explore the myths surrounding the subject and how the media has been used to first perpetuate then destroy those myths as understanding of the condition has developed.

These aspects are being examined through a review of British media coverage and comparative medical knowledge and released information since 1981. The results will demonstrate how health scares and health education can both be delivered by the media to affect the public's understanding. 1) Motivation/problem statement:

This paper will examine to what extent the changing attitudes in the media are reflected, or not, in the changing attitudes of the public with particular emphasis upon the media's portrayal of HIV and AIDs; and conversely, the effects that public opinion and understanding of the virus and ensuing disease have had upon the media's portrayal of it.

Also looking at how the media has helped to explode many of the myths surrounding HIV and at how many of those myths were originally perpetuated by the media.

Methods/procedure/approach:

I am currently researching the topic, primarily using British newspaper and television coverage from the last 28 years and reports and 'propaganda' released by various action groups.

Results/findings/product:

I believe my findings will show the changing attitudes of the media reflecting the changing attitudes of the public and the perception of the virus, from being a 'homosexual disease' to being a widespread condition capable of affecting anyone.

Conclusion/implications:

Though my research and analysis are not yet complete, I believe that they will demonstrate that an 'active audience' has over the years begun forcing the media to take a more responsible stance towards such issues. 'Health scare tactics' are still reasonably common in today's newspapers but further information is demanded on the subject and pressure is placed upon the media as a whole to be as factual and accurate as possible.

Health Journalism: Advertising masked as news; courtesy of charities

Marisa de Andrade is a freelance broadcast and print journalist. She is currently completing a PhD with the Department of Geography and Sociology at the University of Strathclyde in Glasgow on the communication strategies of pharmaceutical companies.

Abstract

Health journalists have a responsibility to deliver news to patients on behalf of regulators; pharmaceutical companies; and health boards. This article details the findings from an analysis of articles on the cervical cancer vaccine, Cervarix, published in seven of the UK's top national broadsheet and tabloid newspapers: Mail; Mirror; Telegraph; The Independent; The Guardian; The Sun; and The Times, from 2005 to 2009.

The 283 articles retrieved during this period were compared and contrasted. Health officials and experts who were quoted in the pieces were identified, along with patient groups and charities.

An investigation was carried out to establish links between these organisations and individuals and their association with the pharmaceutical industry. Findings indicated that a core group of experts and institutions who advocate the use of the vaccine were repeatedly referenced in every newspaper.

Furthermore, it was established that they had some affiliation with drug companies, despite claiming to be independent. Some of these patient groups have connections with public relations firms representing a number of big pharmaceutical clients.

These findings illustrate how health journalists need to be trained to distinguish between 'charities' and industry-funded front groups, or they will continue to unconsciously serve the interests of private companies to the detriment of patients.

BRAZIL: NATIONAL NEWSPAPERS AND THE PUBLIC HEALTH SYSTEM

Patrícia Resende, currently studying for an MA in Health Journalism at Coventry University

This paper will present an overview of the public health system in Brazil (SUS – Sistema Único de Saúde) and illustrate how it is covered by national newspapers.

The space given by the Brazilian media for news related to health is apparently increasing in the country. In fact, more articles related to scientific findings, treatments, life style and beauty are published day by day, with the target being the middle and high classes. However, an extended coverage of the SUS, attended primarily by the lower classes (70% of the population), is not so evident.

With support from a qualitative and quantitative analysis of articles published during one month by three of the most important newspapers in the country (Folha de S.Paulo, O Globo e Correio Braziliense), this paper will assess the Health coverage in Brazil and specifically how the SUS is covered by the press.

The aim is to show that coverage of health issues related to the public sector is, in general, weak and limited. The paper will demonstrate that news about the SUS is published relating only to specific claims or problems, without presenting a clear overview of the system.

Global Neoliberalism and the consequences for healthcare policy in the English NHS

Dr Clive Peedell BM MRCP FRCR Consultant Clinical Oncologist James Cook University Hospital, Middlesbrough, England Council Member of the BMA and HCSA The views expressed in this paper are my own and may not necessarily reflect the views of the BMA and HCSA

Abstract

The political, economic and philosophical doctrine of neoliberalism has had significant influence on UK social policy over the past 3 decades, leading to market-based reforms of many public services including the NHS in England.

This was started by Margaret Thatcher in the 1980's with the introduction of the internal market and new public management (NPM). New Labour, under the guidance of Tony Blair and Gordon Brown, have continued to embrace the neoliberal doctrine with major consequences for NHS policy in England.

This has occurred via a piecemeal process over the last 10 years probably in no small part to the sacred "cow status" of the NHS. This should be contrasted to the situation on the United States where there has been no such obstruction to neoliberal free market ideology on healthcare provision.

More recently, however, the pace of reform of the English

NHS has increased significantly with greater emphasis on marketisation and commercialisation through the mechanisms of patient choice, payment by results, and a plurality of providers including the private and third sectors. Darzi's Next Stage Review shows no sign of slowing this process and actually adds fuel to the fire of marketisation by introducing patients held budgets.

Choice, Voice and Marketisation in the NHS

Dr Paul Dorfman NHS Centre for Involvement University of Warwick

Abstract

England has a long history of health policy explicitly framed in terms of both markets and patient and public involvement (PPI). In terms of healthcare policy the two streams, of involvement and marketisation, have been interwoven and their trajectories intersect.

We propose that this intersection could be conceptualised as three waves of reforms that have deployed both of these divergent drivers.

Critically, we argue that the deployed mechanisms have been significantly different, presented and justified in very different, often oppositional terms. The first wave of reforms brought the introduction of the internal market, focused on mechanisms to contain healthcare costs and coincided with neo-liberal inspired reforms that swept OECD countries.

The second wave can be tied to the New Labour government and highlighted PPI as well as consumerism and competition to leverage quality improvement across the NHS. The third wave of reforms, emerging in early 2000, attempted to twin patient and public involvement and patient choice to further a localism agenda - whether expressed through individual choice or collective voice.

The paper describes the rhetorical policy moves that underpin these waves of reform in order to unpack their practical implication.

The effect of health reforms in Turkey: Out-of-pocket payments are increasing

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Abstract

Health Reforms have been brought to the agenda of Turkey in the late 1980's. First attempt is the "Basic Law for Health Care Services" which was accepted in 1987. Basic approach of the law was to provide appropriate conditions for free-market economy in health sector.

However the law couldn't be executed because the main articles of it were abrogated by the Turkish Constitutional Court. In 1990's private health sector has begun to be developed as a "free-market" and the number of private health institutions has increased rapidly.

In November 2002, with the 58th government, a period

of one party which has held the majority in the parliament, started. In this period, the name of the health reforms has been put into effect with the name of "Health Transformation Project". The main approach forming the basis of "Health Transformation Project" is providing the health finance by a social insurance system and the remove of the state from the provision of health care. This period which is still continuing has been the most supported one by the private health sector and private health insurance companies.

The financing of the health services in Turkey is provided by four main sources that are state budget, social security trust funds, private health insurances and out-of-pocket payments. "Health Transformation Project" claims to reduce out-of-pocket payments.

This study was carried out in a district of Turkey in 2006, in order to compare the out-of-pocket payments for health care with the outcomes in the year 2001.

The study was executed in Gemlik which is a district of Bursa Province located northwest of Turkey. The population of the district is 88,690 in the year 2000. In 2001, out-of-pocket payments were determined by a study in the district. This study, which the method of it was, adopted exactly the same as the cross-sectional research carried out in Gemlik in 2001, is the repeat of that in 2006. In both studies the data was collected in the months of April-June.

Cluster sampling method was used in order to determine the households who participated in the research. 43 streets in the district center and 3 villages in the rural area were participated in the research. Across the determined streets and villages, every household was visited and each individual participated in the study. 10.290 individuals in the year 2001 and 7.016 in the year 2006 were participated in the study.

In the study, questionnaire forms containing 8 questions were filled in with face to face method. In the questionnaire socio-demographic characteristics and information about getting sick and out-of-pocket payments for health care were available.

Only the last month taken into evaluation for health care expenses. At the end of the study in order to calculate the annual expenses, amount of monthly expenses multiplied by 12 and divided into the total number of the people belonging to the group of social security for health. Thus, yearly expenses (payments) were determined. Expenses for health were calculated in terms of US Dollars.

Out-of-pocket payment was accepted as the amount of money the individuals have to pay when they apply any health institutions for diagnosis and treatment or pay for medicines (without checking if applied to any health institution or not) from their own funds. It is defined as out-of-pocket payment in case that the money is not paid back in any way (from the related institution or insurance). Out-of-pocket payments were evaluated according to the sources of security for health.

While the ratio of people having no health insurance was 37.2% in 2001, that ratio was decreased to 16.4% in 2006 ($p < 0.05$). In the last five years in Turkey the part of the community benefiting from health insurance has increased.

While the ratio of people paying out-of-pocket for diagnosis and treatment in the last month in 2001 was 7.3% (749/10290), this ratio increased to 9.1% (635/7016) in 2006. There was an increase in the ratio of individuals paying for medicines as well. While the ratio of people paying out-of-pocket for medicines in the last month in 2001 was 15.4% (1585/10290), this ratio increased to 25.3% (1772/7016) in 2006.

In the study, annual total out-of-pocket payment was calculated 83.1 dollars in 2001 whereas 248.4 dollars in 2006. Out-of-pocket payments increased 198.9%. Increase is especially significant in the ones having no health insurance. Total out-of-pocket health expenditure of those increased from 93.9 dollars to 522.2 dollars. The ratio of increase is 456.1%.

The government claims that out-of-pocket payments are reducing with the "Health Transformation Project" implementations. However, it is necessary to be suspicious of this claim. The results of this study that we carried out in a district located northwest of Turkey, has shown that health reforms in Turkey increased out-of-pocket payments.

After now on, in terms of the process it will be useful to carry out more detailed studies in order to evaluate the effect of health reforms.

FOR WHOM IS THE HEALTH SYSTEM IN TURKEY BEING RESTRUCTURED? AKP Government, TUSIAD and World Bank

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Abstract

Since the last two decades, there is about no difference from the point of the health policies and practices of the capitalist countries' government.

There is a "health crisis" which is defined as a result of increasing costs in health sector, and health reforms are offered as a prescription for the solution of the crisis in these countries.

The study aimed to determine the planned and experienced implementation which are conducted by AKP government and supported by World Bank and The Turkish Industrialists' and Businessmen's Association are same with former government implementations and also same with implementation in rest of the world and in spite of rising economy and excessive increase in public health expenditures, the social health indicators show that there is no improvement.

When examined data by considering the AKP government and former government period, the total health expenditures increased by 299% and public health costs increased by %319 and current public health expenditures increased by 318% at the period AKP government. While the non-attendance rate of DBT1-Rubeola immunization was zero in 2002, but it increased to 11% in 2006.

Under-5 mortality rate is 26 per thousand. This rate takes the 96th rank within 194 countries. However, GDP per capita was 2500\$ in 2002, it increased to 5400\$ in 2006. In conclusion, in spite of Turkey's higher national wealth, it has worse social health indicators comparatively.

COMPARATIVE QUALITY EVALUATION OF PUBLIC VS PRIVATE HEALTH SECTOR: EVIDENCE FROM GREECE

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Introduction:

Comparative quality evaluation of public vs. private health sector is a common research practice, especially in countries where private enterprises are dominant both in the provision and financing of health care services.

In Greece this research practice does not follow the international trend, a fact strongly related to the lack of quality evaluation mechanisms and relative data within the health care system.

Objective:

In this paper a review of empirical evidence and original research results concerning quality evaluation of private vs. public health sector in Greece are presented. Method: for the purposes of our study

(1) a systematic literature review of published papers (1987-2007) through PubMed, Iatrotek, Google Scholar was carried out. Papers published in collective volumes and books as well as Health Inspectors' Annual Reports through the years 2004-6 were also included

(2) National Statistical Service's unpublished data concerning number of patients discharged, number of hospitalization days and nursing staffing rate by hospitals' ownership type were processed

(3) Public Health Insurance Funds' unpublished data concerning number of patients discharged and number of hospitalization days by hospitals' ownership type were also processed

(4) data concerning number of patients, hospitalization days by diagnosis and by place of birth (private or public maternity hospital) during the years 2001-6, stemmed from a public Neonatal Intensive Care Unit operating in the Thessaloniki area.

Results:

(1) cesarean sections rate is 15-27% relatively higher in private maternity clinics

(2) nurses per dialysis machine ratio is 30% relatively lower in private dialysis centers

(3) in one case, where data were available, mortality rate was higher in a private cardiosurgery clinic compared to a public cardiosurgery hospital

(4) patients' satisfaction for medical and nursing services provided by public hospitals in all cases is significantly high, in contrary with patients satisfaction for public hospitals' accommodation and auxiliary services which is lower compared to private clinics

(5) Health Inspectors' annual reports indicate multiple cases of fraud in private clinics such as overcharging of hospitalization fees and incompliance to operational requirements

(6) average length of stay - ALoS is 50% higher in private clinics compared to public hospitals. In the case of patients insured in public insurance funds the divergence of ALoS between private and public hospitals amounts to 250-280%

(7) nurses per hospital bed ratio is 100% relatively lower in private clinics. Public hospitals use more and better qualified nurses

(8) evidence shows a continuous flow of patients with complicated and severe cases from private clinics to public hospitals (up to 50% of patients, treated in a public neonatal intensive care unit, came from private maternity clinics).

Conclusion:

Empirical evidence of comparative quality evaluation between private and public health sector in Greece is limited. Nevertheless, the results of our analysis confirm the international research evidence according to which private for profit ownership seems to have a negative impact on the quality of services and health outcomes.

"1990-2008: The continuous and complementary spectrum of neoliberal policies in the Greek NHS"

Aristomenis I. Syngelakis & Chrisanthos D. Tassis E-MAILS

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Syngelakis holds a Degree in Dentistry, a Degree in Political

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Dr. Chrisanthos D. Tassis holds a PhD in Political Science,

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by the Greek Ministry of Labour and Social Protection on

Social Security

Abstract

The purpose of this presentation is to examine the privatisation process of the Greek National Health System (ESY) during the last 18 years. In 1983, the newly elected Socialist government set as a top political priority the establishment of a public health system in Greece based on the principles of equality of solidarity and of social justice.

In the Greek case, this was the first attempt a unified health system to be created. Although this process seemed to satisfy the peoples' needs, it was in contrast with the international neoliberal tendencies which "put pressure" for adopting restrictive policies in the welfare state.

Therefore, the "revolution of ESY" remained incomplete as the Greek economy faced huge budgetary deficits and high inflationist pressures which "forced" the socialist government to change its political orientation trying to adopt with the international restrictive trends.

During the period 1990 - 1993, Nea Demokratia, the Greek conservative party, came to power with a neoliberal agenda and imposed significant changes to ESY, favouring

policies of privatisation and liberalisation. Under the dogma of “shrinking of the state”, the responsibility on health issues was considered no longer as the exclusive remit of the Greek state.

Therefore, the establishment of private hospitals was facilitated and substantial changes took place in the terms of employment of ESY’s personnel.

As a result, the private health expenditure reached the levels of public expenditure and the health inequities were increased. PASOK at its second governmental tenure (1993-2004), and especially under the leadership of C. Simitis (1996-2004), adopted the policies of the “Third Way” and focussed on the entrance of Greece in the Economic & Monetary Union trying to be in concordance with the prevalent political tendencies: the correlation of health policy with the prevailing economic priorities of budgetary discipline, the rationalisation of health expenses, the gradual replacement of the principle of universality by the principle of selectivity and the further introduction of private functions in the public health system.

The implementation of the law 2889/2001, despite the publicly expressed intentions or rhetoric, contributed to a further NHS privatisation process.

The subsequent governmental policies during this period highlighted the “adjustment” of the Greek Socialists from the radicalism of the 1970’s to conservative wing of the European Social Democracy in the 1990’s.

During 2004 to 2008, the Conservative government continued the privatization process as it introduced several legislative measures to strengthen the private enterprises’ share in the health services market.

By and large, most of them were effectively a tacit subsidizing of the private health sector through governmental or social security funds. Thus after 19 years of privatization the Greek NHS seems to be more deregulated and privatized in comparison to the other European public health systems.

It presents inefficiency in promoting health care, it apparently fails to tackle with health inequalities, it faces severe lack of personnel and resources, it functions to increase the patients’ co-payments and, in effect, strengthens the private health services sector.

PRIVATIZATION OF HEALTH CARE SERVICES IN GREECE: RECENT TRENDS

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Introduction:

Health care system in Greece is characterized by a high level of privatization. This ongoing process of privatization in Greece is mainly reflected in:

- (1) the proportionally high level of private health expenditure (mainly out-of pocket payments)
- (2) the high penetration rate of private for profit enterprises mainly in the provision of health care services
- (3) the deregulation of public services through financing restrains, understaffing of public hospitals, abolishment

of health personnel’s life tenure, outsourcing and private medical practice within public hospitals, unsolved queuing problems and unmet health needs.

Objective:

The objective of our analysis is to describe recent trends in the privatization process of health care services in Greece. Results: two are the main recent policies towards marketization of health care in Greece:

(a) Public Private Partnerships - PPPs. Since 2005 the conservative government following the guidelines set by the European Union enforced a new legislative framework (Law 3389/2005) under which PPPs became the main mean of capital investment for new hospital infrastructure.

The Greek government adopted the British model of PPPs, known as Private Finance Initiatives - PFI, according to which private consortia design, built, finance and operate new “public” hospitals. Already, 4 new PPPs/PFIs hospitals in the Thessaloniki – Preveza and Katerini area are in the stage of design

(b) Privatization of Primary Health Care - PHC. The government recently presented a new Bill for the unification of the fragmented primary health care services in Greece.

Under this new legislative framework Alma Ata’s PHC principles are abandoned, private enterprises play a key role in the provision of PHC services (mainly diagnostic and curative), general practitioners are compensated through capitation (following the principles of Britain’s fund holding GPs) and limits are set for user’s health care consumption.

Conclusion:

Based on the already high level of privatisation of the greek health care system achieved by both conservative and social democrat governments the last 20 years, the nowadays trends of health policies in Greece are characterised by the implementation of both Private Finance Initiatives for hospital care and the privatisation of Primary Care.

Utilising the private sector to reduce waiting times for public patients in elective care in Ireland and England. Comparing the experiences: is it working, providing value for money and good quality care?

Sara Burke

Sara is a journalist and a health policy analyst. She has worked in health policy in Ireland since 1997, working in the Department of Health and the Institute of Public Health. From 2004 to 2006, she was managing editor of an Irish left political magazine called Village. Since leaving Village in 2006, she works as a freelance journalist mainly covering political and health related issues. She also works part time as a health policy analyst for organisations such as the Combat Poverty Agency, the Irish Congress of Trade Unions and the National Women’s Council.

Abstract

There has been a recent surge in contracting for-profit health care providers to supply aspects of hospital care across European health systems.

In both England and Ireland, similar measures have been

introduced which engage the private sector to reduce waiting times for elective care. In England, the Independent Sector Treatment Centre (ISTC) Programme was set up in 2003 with the aim of reducing waiting times for diagnostics, day or short-stay medical or surgical procedures in areas that had the longest waiting times.

It also aims to increase patient choice. In Ireland, the National Treatment Purchase Fund (NTPF) was established in 2002 with similar aims to meet government targets on waiting times for elective procedures.

Under the NTPF, any patient waiting longer than three months is entitled to have treatment privately. There is not yet much evidence on the impact of ISTC and NTPF on waiting times and patient choice but there are concerns about whether they are providing good quality care and value for money.

This paper will assess their impact on waiting times for elective care. It will use any available evidence to evaluate their impact on public hospital provision and whether these initiatives provide value for money. sarabur@gmail.com 00353876504092

World champions in privatization: The case of Germany's hospitals

Nils Boehlke, Institute for economical and social research, Düsseldorf
Ian Greer, Leeds University
Thorsten Schulten, Institute for economical and social research, Düsseldorf

Abstract

Since the 1990s there has been an ongoing restructuring process in the German hospital sector; in fact, no other country has privatized hospitals as rapidly.

As the number of hospitals and beds has decreased, the share of hospitals owned by private for-profit companies has doubled, from 14.8 per cent in 1991 to 29.7 per cent in 2007. This development has had a tremendous impact on employees and patients.

After privatization, new employers usually attempt to speed up work, derecognize bargaining and establish a two-tier workforce.

ressures are especially intense in easy-to-outsource areas such as cleaning, laundry and cooking, but are also present in nursing. Based on approximately 40 interviews with managers, employees, worker representatives and

policymakers at four different hospitals we examine the changes in working conditions and industrial relations in privatised hospitals and compare them with developments in the public sector.

We then outline the detrimental effects of economization on quality.

Finally, we describe the rising wave of (often successful) protest by unions, local activists, political parties and employees against privatization and economization.

The impact of European free market rules on Belgian health care organisation. Which way forward?

Pol De Vos Public Health Department Institute of Tropical Medicine, Antwerp, Belgium
Freek Louckx Social Law Group Law faculty Free University of Brussels - VUB, Brussels, Belgium

Abstract

European market competition rules push Belgian health care and social security towards further marketisation. In this, the European Court of Justice (ECJ) is playing an important role, as it considers free competition rules applicable to parts of health care and health insurance defining them as 'economic activities'.

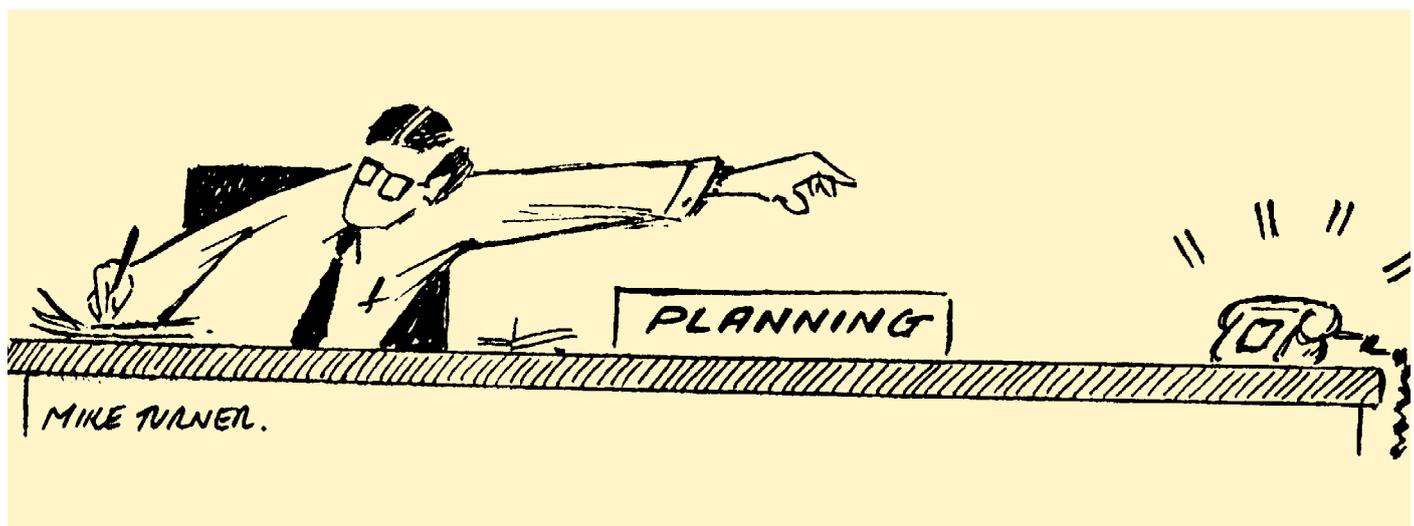
Moreover, we demonstrate how the EU's and ECJ's individual approach of 'consumer rights for health care', i.e. the free movement of patients in the framework of the 'free movement of services', undermines national collective rights and solidarity mechanisms.

We further analyze the rationale of strategies proposed by Belgian action groups to protect the Belgian health system from European deregulation policies.

First, the reorganization – at national level – of aspects of medical care and social security to make them 'immune' to European free trade rules by creating or reinforcing solidarity mechanisms (and limiting market mechanisms).

Second, the challenge of the interpretation by the ECJ of certain health care activities as an economic activity, based on their undermining consequences for health care accessibility and equity.

The evaluation of possible consequences of the implementations of these proposals helps answering the question 'which way forward'.



Friday June 19

Ellen Terry Building ETG34

Patients, profit and primary care England and international lessons

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Abstract

The UK government wants to be a world leader in outsourcing government services, including health care. Its vehicle is "competitive tendering".

This presentation describes current developments in England from a view of public policy and from the work floor, and reviews effects on health inequalities and public and patient trust based on literature from the US and other countries.

The importance of "skimming, dumping and skimping" as strategies for maximising profits is discussed within and without state funded health care systems.

Current and potential societal and professional responses are discussed.

Struggle for right to health in Turkey: 2003-2009

Öztürk Osman, MD.*, Çerkezoglu Ali, MD.**, Ağkoç Süheyla, MD.* * General Practitioner, Istanbul. Medical Association, Turkish Medical Association, Former Executive Committee Member ** Forensic Medicine Specialist, Turkish Medical Association, Turkish Medical Association Executive Committee Member

Abstract

The "reform" program called "Transformation of Health Program" is being conducted since 2003 in Turkey. The aim of the program is destroy public health services and privatize it.

The so-called "reform" program has faced powerful opposition mainly from health professionals and various social groups and organizations.

The major opposition to the Program is led by Turkish Medical Association (TTB) and Union of Public Employees in Health and Social Services (SES).

The struggle of the health professionals is not confined to defend their own partial rights. In their struggles, TTB and SES unify the rights of their members and the right to health of the community.

TTB and SES have continuously been conducting activities and actions for their demands. Some of these actions have been organized jointly with worker and public employee unions.

On March 14, in 2008 a two-hour general strike was conducted together with labor organizations. The

government has not been able to fully implement the neo-liberal health "reform" imposed by WB and IMF in 6 years due to the social resistance.

Also, the implementation of the Program is under greater challenge because of the global economic crisis.

'HEALTH TRANSFORMATION PROGRAMME' IN TURKEY: A CRITICAL COMPARATIVE REVIEW

Dr. Gulbiye Yenimahalleli Yasar* Senior Lecturer Department of Health Service Management Faculty of Health Sciences University of Ankara, Turkey Fatih Cad. 197/A e-mail: gulbiyey@yahoo.com Tel: +90 312 380 81 72 Fax: +90 312 357 53 23 Dr. Pinar Guven-Uslu Norwich Business School University of East Anglia Norwich, NR4 7 TJ e-mail: p.guven:uea.ac.uk tel: 01603 591179 * Corresponding author

Abstract

The aim of this study is to investigate and critically review newly implemented performance management policies of Turkish Health System following publication of 'Health Transformation Programme-HTP' in 2003.

Critical review includes some comparisons with performance management of English National Health Service (NHS). HTP(Ministry of Health-MoH, 2003)policy document expected to bring fundamental changes to how the system is managed and how services are delivered.

Important policy changes included introduction of organisational performance metrics and associated financial incentives, hospitals gaining autonomous business organisation status so that MoH does no longer appear as provider of health services, introduction of family-medicine-scheme managed by the MoH and finally introduction of general-health-insurance-system which does not provide universal coverage.

The paper compares organisational aspects of performance management in HTP to that of NHS England and concludes that there are some fundamental differences in terms of management of performance at provider organisations, process of target setting, calculation of performance metrics and influences on Government funding.

Excessive private sector provision and inequalities in health service delivery are seen as the main reasons of these fundamental differences.

These reasons are considered important because they provide an insight to understand some of the issues about introduction of competition to health service market in England and contribute to international dimension of this debate.

The reporting of the special hospitals in the UK press

Geoff Dickens, Research Nurse, St Andrew's Hospital, Northampton

Abstract:

The portrayal of mental illness in the media can be negative and stigmatising. Mental health nurses therefore need to be aware of the ways in which the media frame mental illness issues, and should be prepared to challenge inaccuracy.

This paper examines the changing nature of the UK press' reporting of mental health issues by focusing on two areas.

First, the changing terminology the press uses in their attempt to appear more sensitive, exemplified by recent growth in use of the term 'suicide watch'.

Secondly, the paper examines press reporting of the three English high security special hospitals as an example of how the framing and personalisation of stories is used to set the public agenda on mentally disordered offenders.

Reducing senility to 'bare life': are we heading for a new Holocaust at mid c21?

Dr Andrea Capstick, Bradford Dementia Group, Division of Dementia Studies, School of Health Studies, University of Bradford, West Yorkshire.

Abstract

This paper addresses the conference theme 'Elderly care and mental health: markets v. equity' and also touches on related media coverage.

Drawing on the work of Agamben (1990) and others I take the bold standpoint that people with late-onset dementia (or Alzheimer's disease) are increasingly reduced to the condition of 'bare life'; politically excluded, physically contained, and presented as a drain on the economy.

Like the refugees and European Jews of the mid-20th century they are considered to have no rights, only needs which compete with those of the 'more deserving'.

demographic panic related to the projected doubling of the population with dementia within a generation (Dementia UK Report 2007) is opening up debates about active and passive euthanasia which run to hundreds of thousands of web pages. Ethicist Baroness Warnock has recently advocated that people diagnosed with dementia opt for voluntary euthanasia in order to prevent inconvenience to their relatives.

Coupled with earlier diagnosis and imprecision about the relationship between mild cognitive impairment and 'full blown' dementia, this raises serious concerns about how society will deal with its ageing population at mid-21st century.

With Jacoby (1996) I will argue that 'social amnesia' prevents us from recognising the historical precedents.

"The case of mental health reform in Greece: masking privatization behind de-asylumization, corporate interests behind NGOs and dominant ideology behind humanitarianism" Oral Presentation submitted for the XVth Conference of IAHPE, Coventry, UK, June, 2009

George Nikolaidis Psychiatrist MD, PhD, Director of Department of Mental Health and Social Welfare, Centre for the Study and Prevention of Child Abuse and Neglect, Institute of Child Health Contact Details Address: 7 Fokidos Str Postal Code: 11526 City: Athens Country: Greece Email: gnikolaidis@ich-mhsw.gr geornikolaidis@hotmail.com Telephone: 0030 210 7774776 Fax: 0030 210 7792648 Mobile phone: 0030 6932623814

Abstract

In the case of mental health services, the traditional critical account of the "medico-industrial complex" bears certain peculiarities, viz. that, for a big portion of severe mental health illnesses, the function of repair (thus, reproduction) of the impaired working class' ability for labor is doubtful.

Consequently, due to the inability of many chronic psychiatric patients to pay for commercialized health services, invested capital in mental health services tend to manifest an overt "dualism" as being addressing needs of either very reach or very poor parts of the population.

As a result, last decades' neoliberal reforms either have focused on "clients" with less chronic and severe types of mental illness or have utilized public funds in some or other form to tackle with the issues of severe chronic mental illnesses" treatment and rehabilitation. In addition to these, mental illness and its management represents a crucial point reflecting dominant ideology, especially on aspects like social control and deviation management.

Given the above, Greece in the late '90ties has been one of EU countries that showed little progress on the issue of mental health reform. Several publishing by international press and media has exposed Hellenic governments for the tragic and inhumane conditions of publicly owned big psychiatric institutions.

On these grounds, EU approved and subsequently released a series of EU-funded programs targeting at mental health reform. Within a decade or so, many public mental health hospitals have been downsized and some have been evacuated. WHO officials along with Greek governmental agents celebrated the outstanding success of the "Hellenic case of mental health reform" advertizing it as an example to other new coming EU member states.

In this presentation I will try to advocate for the fact that appearances can be quite misleading in that particular occasion.

First of all, an overview of the development of the whole "mental health reform" issue reveals that as opposed to other countries in which mental health reform was instantiated, in Greece there was not any mature movement or even public debate on both the generals public and the professionals' communities apart from separate individual contributions.

Secondly, it is beyond doubt that a major change in

mental health reform policy has taken place by the late '90ties, viz. that from directing funds to the public sector in order to improve conditions, release rehabilitation programs, implement new structures etc, there was a major redirection of funding towards various "non-profit" NGOs.

In a few years, Greece has found itself having more NGOs operating than many other European countries. Most of them, of course, were nothing but the legal dressing of a small number of individuals, who gradually dominated the field, not necessarily having the slightest involvement with mental health services before that time.

In addition to this, these NGOs were well protected by the state itself: they were funded with extremely high sums of money per beneficiary; their personnel's wages were kept at minimum figures by Ministerial Act and excluded by law from employers-employees negotiations; there was no public control over their activities with chronic patients; there was no evaluation of outcome of their services; there was minimal financial control over management of funding; there was heavy promotion and demonstration of their supposed "task" covering every objection on the grounds of their "humanitarian efforts".

Finally, there was no similar project for the many private mental health asylums operating in Greece, which not only were kept intact but in some geographical areas gained substantial portion of the market as the only alternative solution for hospitalization, since public psychiatric hospitals have been shut down.

The rationale behind this enterprise was a strange mixture of managed-care competition theory and anti-psychiatric movement. So, involvement of "philanthropists" (practically, private investors seeking for opportunities of secured profit) never having to do with mental illness was vindicated in virtue of the anti-psychiatric movements renouncement of the "specialists' power".

Legal framework concerning the personnel of hostels and day centers operated by NGOs did not include specialized professionals (mental health nurses, social workers, psychologists and psychiatrists) but minimally; this was similarly justified, thus, allowing for the cheapest solution ("laymen") to be considered as the ideal.

Extremely high costs (reaching marginally for the period of EU-funding almost 4.500 Euros per month per beneficiary) were explained for "rehabilitation"; needless to say that for the most, these funds were utilized otherwise by the NGOs' owners.

Personnel's inability to cope with hardships of chronic mental health illness management was addressed with recruitment of volunteers (that had the additional benefit of no salaries at all).

Absence of a central system of need assessment and management of patients has been justified in virtue of the necessity of "individual specialization" of each and every of these NGOs' structures. By now, that the EU-funding period is over and that funding of all these structures have passed to the regular public budget, many of these units have been sold, margined or downsized substantially.

Shortcomings of public rhetoric of this model of reform are overt: at the end of the day the declared target of minimizing public spending on mental health has been refuted, since public money increased throughout the last decade but it was redirected not to the public sector but to various NGOs.

Moreover, NGO operated new structures have not been

exhibiting less functional costs than traditional public sector; they were just redistributing budget giving less to the professionals employed and more to dubious owners' activities. Furthermore, the overall functioning of mental health services for the general population did not improve substantially; it was more an assisted re-creation of an emerging public sector dressed up as a "non-profit" one.

Finally, the quality of "small asylums" that were created for the poor chronic psychiatric patients was rather equivalent to that of big psychiatric institutions.

Although these small asylums were obviously better in cleaning and tidiness, this was nothing but "window-dressing" totally incommensurable with chronic patients needs: Foucault's criticism is still valid on all these new "reform" structures where patients are still been treated as not subjects bearing human rights, as in a permanent state of childhood, as quasi-agents.

Consequently, behind locked doors of these "small asylums" all traditional practices of the asylum have reappeared: binding, locking up, violence, threatening, insulting manipulating and taking advantage of their financial elements.

Medical Workforce Planning in the National Health Service: 1948 – 2008

Vanessa Jessop University of Edinburgh College of Medicine and Veterinary Medicine Year 4 Student Selected Component - Research Project Supervised by Professor Allyson Pollock c/o Centre for International Public Health Policy School of Health in Social Science University of Edinburgh Teviot Place Edinburgh EH8 9AG

Aim

The aim of this report is to provide a review of the reports on medical workforce planning in the National Health Service (NHS) in England, highlighting key recommendations and commenting on policy influences.

Methods

A literature review was conducted to identify articles, reviews and government reports containing the term 'workforce planning' in the text.

Only those concerning medical workforce planning in the National Health Service in England were included in the study. Results I found 38 government reports related to medical workforce planning.

Of these, 11 were concerned specifically with changes to annual medical school intake. However, information as to the evidence and methods underpinning decisions to increase the number of medical students was lacking.

Conclusions

Workforce planning is increasingly subject to market forces, with traditional planning norms abandoned.

The introduction of a healthcare market in 2000 has paved the way for the commercialisation of both the NHS and higher education, together with deregulation of standards and training.

Working Conditions of Physicians Employed in Public Institutions in Turkey

Nilay Etiler, MD, Assoc. Prof. 1-Kocaeli University Faculty of Medicine, Public Health Department, Kocaeli Turkey 2-Turkish Medical Association, Public Health Office, Ankara, Turkey Betül Urhan, PhD, Assist Prof. Kocaeli University, Faculty of Economic and Administrative Sciences, Department of Labour Economics and Industrial Relations, Kocaeli Turkey

Abstract

The 1980s witnessed a private sector-led integration process of Turkish financial/economic system into the liberal international system.

Public services have been affected tremendously in this market-oriented reconstruction process. Commodification of public services including health care has been the primary goal of this agenda, since these services have historically been under the responsibility of the state, thus excluded from the profit maximization approach of the capitalist system.

During this period, efforts to extend flexibility practices that have already been in use within the private sector, to public services and employees have gained momentum. Introduced in 2003, the Health Transformation Program (HTP) of the Justice and Development Party (AKP) has accelerated the efforts in health sector privatization that started during the 1980s.

Three main strategies of HTP were health care financing reform, primary care reform and hospitals' autonomy reform. One of the strategies of health care privatization was the reduction of personnel expenditures by narrowing employment in national health services.

This strategy gave way to important changes in both employment and payment systems for health care personnel. Some new employment forms have been introduced for physicians such as limited period work with a contract, part-time work, payment after performance assessment etc.

Since health system privatization efforts began, physicians have lost some privileges such as high wages which they had obtained through the Full Day Act of 1978.

This paper analyzes both the current working conditions of the physicians in public institutions and the impact of neo-liberal health policies on these conditions.

The Nursing Labour Process in Turkey: How Does Neo-liberal Economic Policies Effect?

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Abstract

The health system is being structured with the policies which are based on neo-liberal economic policies in Turkey

since 1980. This market based trends has negative effects on the health care workers including nurses as a natural component of it who have to sell his labour.

This study aims to determine the results and effects on nursing labour process of neo-liberal economic policies in health sector in Turkey.

Labour process was evaluated criterions with labour force participation, employment: population ratio, status in employment, employment by sectors, employment by geographic regions and residency (rural and urban), employment by graduated level of the nursing education, gender in employment, wage, unemployment rate, working conditions etc.

There are 85.000 nurses in Turkey today. The nurse labour is tended to be employed in private health sector especially later on 1990's.

The number of nurses in private health sector in 1998 increased with a triple jump to 10 thousand in 2006. There are approximately 11.000 contracted nurses in public health sector without job security in 2006, and this number has gradually increased. Eighth percent of the nurses work in hospitals.

The nurse employment rate in first level health institutions does not exceed 27%, and the rate is lower in rural area.

While this situation negatively affects the nurses, it also handicaps the supply of qualitative health services and nursing care.

Achieving Public Health Objectives – From Inter-Professional Learning to Organisational Re-alignment

Colin Thunhurst, Coventry University and West Midlands Teaching Public Health Network Patricia Bond, University of Wolverhampton and West Midlands Teaching Public Health Network

Abstract

Public health has always suffered from being siloed and compartmentalised at operational level. Agencies responsible for achieving public health objectives particularly in relation to reducing health inequalities have perilously ignored the effort required to achieve inter-sectoral engagement, and have employed stalling tactics to delay or ignore the structural organisational changes required to sustain complementary working across traditional organisational boundaries and professional demarcations.

This is clearly demonstrated by the way the health sector has been administered in isolation from other areas of social and economic policy.

The recently published Health and Well-being Strategy for the West Midlands which has responded by adopted a clear and commendable 'upstream' focus. It is framed around intersectoral working, and is designed to address, the wider social and economic determinants of health inequalities within the West Midlands Region.

Nonetheless, it is apparent that the regional Department of Health and the Regional Health Partnership that compiled the strategy have few levers that they can immediately pull. Instead, they must work to maximise the health dividend to

be achieved from the strategies, policies and actions of other sectors.

To achieve such Inter-sectoral action requires a solid foundation in inter-professional learning. In this paper, we report on a study recently undertaken by the West Midlands Teaching Public Health Network for the Department of Health (West Midlands).

We mapped the potential synergies and conflicts between the West Midlands Health and Well-being Strategy and the Regional Spatial Strategy for the West Midlands. We reviewed the current inter-professional learning provision within the spatial planning curriculum.

This enabled us to scope the opportunities provided for the development of inter-professional learning around the respective strategies and to develop an action plan for the further development of Inter-professional learning.

However, achieving the necessary and concomitant level of interprofessional action will require tackling the formidable organisational barriers posed by the isolation of the health sector.

Notwithstanding significant recent moves in the right direction, with for example the joint appointment of Directors of Public Health, we argue that the time is now long overdue for a fuller organisational re-alignment, one which will finally address one of Bevan's 'historic compromises' of 1948 – a compromise that he later explicitly regretted making.

NIHR CLAHRC for North West London: a new approach to using research to drive effective and high quality health care

Derek Bell Director, NIHR CLAHRC for North West London
Professor of Acute Medicine, Imperial College, London
Cathal Doyle Programme Lead for Evaluation NIHR CLAHRC for North West London
Gurmail Singh Communications and Marketing Manager NIHR CLAHRC for North West London
Julie Reed Research Strategy Manager NIHR CLAHRC for North West London
Ruth Barnes Fellow, NIHR CLAHRC for North West London

Abstract

Despite health policy attempting to incorporate "upstream" population needs assessment into healthcare planning, NHS funding is often based on "high-tech" solutions to ill-health.

Systematic approaches remain the exception and when potential service improvements are identified, uptake is often piecemeal with slow translation into practice. Long-term, this approach is not sustainable, especially in the current economic climate.

More than ever, we need to account for resources and influence commissioners to ensure spending delivers high quality, equitable services. The CLAHRC for NW London is an alliance of academic and healthcare organisations developing and promoting innovative, cost-effective interventions. Key themes include integrated service improvements, whole health economy partnerships (to close the translational gap) and building capacity for change CLAHRC projects address high impact issues (high prevalence diseases such as COPD or high cost cases).

Using cross-cutting themes of community engagement,

collaborative learning and evaluation, the CLAHRC will translate lessons from small (disease or service based) interventions into more widespread benefits.

Outcome measures will help assess the impact of interventions, costs and potential benefits. Expected outcomes include identifying cost-effective interventions with clear patient benefits; building more sustainable systems; increasing capacity to deliver change through research and improvement; and supporting adoption of good practice.

"I would have switched off if it was just government legislation." The Simpsons and the Teaching of Public Health Policy.

Sarah Chipperfield and Pete Woodcock School of Human and Health Sciences, The University of Huddersfield
Sarah Chipperfield (MSc, MA, MCSP) is a senior lecturer in physiotherapy at the University of Huddersfield. Sarah teaches aspects of physiotherapy rehabilitation and public health policy and promotion to students at foundation, undergraduate and masters level. Sarah is a registered member of the Chartered Society of Physiotherapy and the Health Professions Council. Contact: s.r.chipperfield@hud.ac.uk 01484 473292

Dr Pete Woodcock is a senior lecturer in political thought at the University of Huddersfield, where he is course leader for the politics undergraduate programmes. He has published on using The Simpsons as a teaching aid for politics students. Contact: p.s.woodcock@hud.ac.uk 01484 473962

Abstract

In order to practise effectively in the health-care sector, undergraduate students on health professions courses need a critical appreciation of differing theories and values of health held between individuals, communities and cultures. In addition, students need to be introduced to public health policy and methods of promoting public health (especially important post-Darzi).

For students, this subject is often deemed uninspiring since, being largely practical and science-based programmes, government public health policy is considered outside their realms of interest, which presents a challenge for educators.

This paper presents an example of how to successfully engage health professions students in the teaching of public health policy and political thought by examining an episode of The Simpsons in which Marge Simpson, worried about rising obesity levels in Springfield, petitions for a ban on sugar food products to promote health in the city.

This example is then linked to J.S. Mill's 'Harm Principle' to enable students to discuss other potential applications to public health policy and state intervention such as the smoking ban, alcohol laws and schools' restriction of children's meals to healthy options.

This paper will outline the method used to enlighten students about topical health issues and evaluate the students' feedback.

COMBATING HEALTH INEQUALITIES AMIDST THE CREDIT CRISIS

O. Reddy*, L Wyman** & S Beauchant*** NHS Berkshire West, Reading *Lead for Obesity services, **Head of Health Improvement, *** Information Adviser This abstract has been accepted for a poster presentation at the UKPHA conference coming up on the 25th & 26th of March, 2009 at Brighton

Abstract

The NHS was always seen as a comprehensive and free healthcare service, accessible to even the poorest. The focus may now have to be prioritising basic healthcare, cutting down costs and improving productivity.

John Appleby, Chief Economist at the King's Fund, indicated on bmj.com that over the next 3 years, the NHS will have to face insufficient funding coupled with health impacts of unemployment and deprivation amidst the credit crisis.

Every 1% increase in inflation costs around £380 million, reducing the spending power of the NHS. Higher prices will mean more pressure on the disposable income of NHS staff. This could mean higher wage claims and calls for contract renegotiation.

The future of our health system depends on encouraging people to take better care of themselves.[Wanless]. Most lifestyle factors such as smoking, diet and exercise are responsible for as much as half the gap in health inequalities. Hence a need to elevate such public health issues to the top of the national agenda.

An increase in spend on preventative care and channeling clinical care more towards primary care could help fight health inequalities.

Markets for public health research in Europe

Mark McCarthy is lead for research for the European Public Health Association and professor of public health at University College London.

Abstract

How to achieve innovation without a profit incentive is the challenge for public health (seen broadly here as three joined sectors – health determinants, health behaviours, health service organisation).

There are no profits to capital for research without patents: yet investment in such 'market failure' research can have public benefit. Public-health services equally are rarely commercially profitable (although vaccines and screening services can be), yet population health is improved more by prevention than treatment.

At the same time, the tradition of not-for-profit in the biosciences has been broken with the emergence of genetic and cell technology – 'a gene for every disease' – so that governments now see biomedicine and pharmaceuticals together, treating disease as an economic 'benefit' rather than recognising wealth from health.

How does this play out across Europe? National medical research councils advise their governments and the European Commission to develop bioscience, but not public health science – which they regard as the province of the ministries of health. But ministries of health usually don't

have expertise in, or budgets for, commissioning research.

Where they do, they provide (expensive) support for clinical trials (of pharmaceuticals) and technology assessment (mainly of equipment and pharmaceuticals) rather than supporting public health research.

It's not helped by a focus on disease. Pharmaceutical companies are deeply committed to profit returns from research on the money-spinners – cancer, cardiovascular diseases, HIV-AIDS and rare diseases – while no-profit accidents and mental illnesses get very little research investment.

Disease charities show little interest in health services research, while health behaviours and health determinants research have major opposition from industry/capital (smoking, alcohol, the road lobby).

We need to organise across Europe. We need lobbies for public health-research in each country, and at European level, to create research for practice that delivers health improvements.

Equally, we must promote research on health impacts of existing and new policies, and challenge vague words such as 'tackling' health inequalities – since at the present we do not know what works. And we must make public-health practice, especially at community level, evidence-based through collaboration between researchers, practitioners and civil society organisations.

Doctor in overalls

Karel Van Bever Medicine for the people, Zelzate, Belgium
Frans Van Acoleyen Medicine for the people, Zelzate, Belgium
Pol De Vos Public Health Department Institute of Tropical Medicine, Antwerp, Belgium

Abstract

From November 2006 till July 2007 one of the authors (KVB), a young family physician of 'Medicine for the people' (MftP), worked undercover as an interim labourer in a logistics company for the polymer industry in the port of Antwerp.

Observations in medical practice and participation in trade union actions had made him decide to not only review literature on occupational hazards and flexibility, but also to directly expose himself to these precarious working conditions.

This direct experience made 'sterile' literature conclusions very tangible, increasing personal awareness and influencing medical practice in MftP. While the influence of job-insecurity on stress-levels is high, short time employment is known to increase the risk for accidents.

Flexible working conditions also put a serious strain on family and social life. Interim workers increase overall flexibility demands in a company, leading to precarisation of working conditions for all workers. The European model of "flexicurity" should be reviewed, based on existing evidence on health effects of job-insecurity and flexibility. Unions have a very important role in protecting temporary workers by supporting them in defending their basic rights and reporting on abuses.

In support of trade union work, a book on this experience was published in April 2008. It received wide media attention and brought the precarisation of working conditions in the spotlights.

'Save our hospital' campaigns in England

Sally Ruane, Health Policy Research Unit, De Montfort University sruane@dmu.ac.uk De Montfort University Health and Life Sciences Hawthorn Building The Gateway Leicester LE1 9BH

Abstract

Over the past few years, health policy has been dominated by the reconfiguration of health services.

This has involved the centralisation of some hospital services into fewer larger units (including some maternity and paediatric services and accident and emergency (A&E) services) on the one hand and the transfer of some other hospital services into the 'community' on the other.

This is undermining many district general hospitals across England and, partly because of the reduced local access which can result and partly because there are significant problems with the 'evidence base' for these policies, they have been and are being contested through the establishment of numerous 'save our hospital' type local campaigns.

Many of these exhibit great creativity and imagination but, to date, there has been limited academic interest in them. The paper presents and tries to interpret evidence concerning the nature and character of a sample of these campaigns.

It draws principally on internet-based data and is part of a wider study into hospital campaigning. Campaigns will be analysed in terms of their origins, alliances, strategies and tactics, use of evidence and outcomes.

There will be an attempt to draw some speculative conclusions regarding the characteristics of the 'successful' campaign.

Campaigning for the kiwi-model in Belgium: How the struggle for a rational drug policy led to broad consciousness on Big Pharma malpractices and to price decreases

Dirk Van Duppen Medicine for the People, Antwerp, Belgium Pol De Vos Public Health Department Institute of Tropical Medicine, Antwerp, Belgium

Abstract

In September 2004 a book on Big Pharma super profits was published by one of the authors (DVD), as a family doctor in Medicine for the People (MftP), a network of a dozen of community health centres in working class neighbourhoods in Belgium.

The publication launched a broad campaign for the "kiwi-model", a rational and cost saving drug policy based on a public tender, inspired on New Zealand. MftP was able to mobilize social organizations, mutualities and trade unions, which brought the debate in parliament.

At the end of 2005, 100.000 signatures for the application of the kiwi-model in Belgium were presented to the Ministry of Social Affairs.

A fierce lobby campaign of the Pharmaceutical industry successfully blocked the application of this proposal, until today. Nevertheless, public debate had a clear impact on drug prices. While drugs expenses of Belgian social security had a yearly increase with 6 to 9% over the last 10 years, in 2006 for the first time in history a decrease was observed.

Since July 2008 the kiwi-debate revived, as private insurers in the Netherlands applied this model on some 30 drugs, leading to prices that are 5 to 15 times cheaper than in Belgium. The struggle for a rational, cost effective and accessible drugs policy continues.

Community health and environmental action: the 'street-council-street' principle

Thomas Engelbeen Medicine for the People, Genk, Belgium Harrie Dewitte Medicine for the People, Genk, Belgium, Pol De Vos Public Health Department Institute of Tropical Medicine, Antwerp, Belgium

Abstract

In 2006, the press denounced long term environmental pollution with chrome, nickel and other toxics in Genk, Belgium. Besides carcinogenicity, literature also mentions higher risks for asthma and allergy.

The local health centre of 'Medicine for the People' (MftP) responded immediately with a small review of the files of their patients <2 years, of which near to 50% (50/103) had already used anti-asthmatic aerosols.

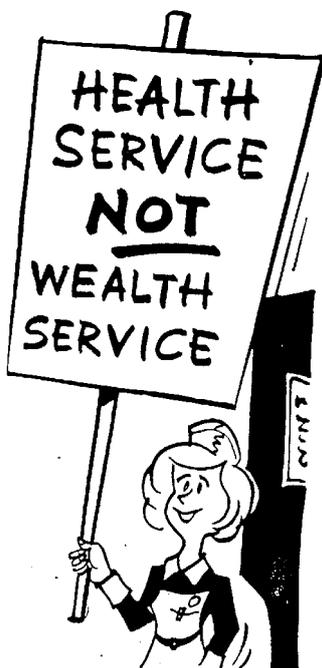
A participatory community survey was organised. Information was obtained on 1092 persons of the 2231 inhabitants of the neighbourhood. 75% of them had two or more respiratory infections during the last 3 months, and 14% had used aerosols in the last three months.

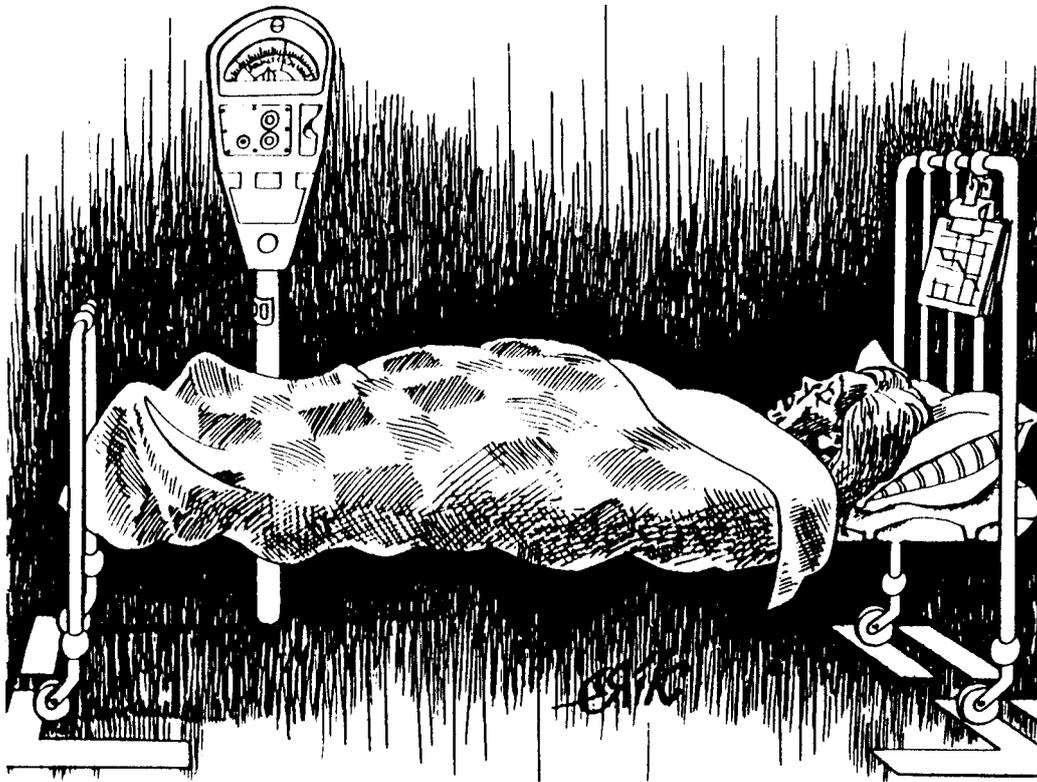
Based on its 'street-council-street'-strategy, MftP effectively links community mobilization to a direct political voice in local government.

One of the physicians being an elected member of the community council, these preliminary results could oblige health authorities to further investigate.

The existence of a higher prevalence of respiratory problems compared to neighbouring communities (with less pollution) was confirmed (even if other causes were hypothesised).

By bringing the results back to the community, MftP could trigger further mobilization, prompting a local government response: 35 environmental measures were imposed on the company, a school has been moved from the exposed area to a healthier environment, and follow-up research on the population's health has been ensured.





KEYNOTE SPEAKERS

in order of appearance

Wednesday June 17: Opening session 17.30-19.30

■ Professor ALEXIS BENOS, Aristotle University, Thessaloniki (IAHPE President)

Introduction of IAHPE: conference introduction

■ Dr JOHN LISTER, Coventry University

“Media impact on public perception of health policies”

Thursday June 18: 9.30

■ ANNA MARRIOTT (Oxfam),

Blind optimism: Challenging the myths about private health care in poor countries

■ DR DONALD FREY Physicians for a National Health Program (USA)

Can we get single payer health insurance? Obama and the fight for progressive health reform

Friday June 19: 9.30

■ Dr JULIAN TUDOR HART (author of *The political economy of health care*)

FIRST STEPS FORWARD: ESCAPING THE INDUSTRIALISATION OF HEALTHCARE IN WALES

■ Professor DAVID HUNTER, University of Durham

“Moving upstream”: the dilemma of securing health in health policy

■ Professor HANS ULRICH DEPPE, Frankfurt

Health reform in Germany: the new health fund

Public session. Saturday June 20, (10.00am-3pm Student Union Sports Hall)

■ Dr EDWIN BORMAN, BMA National Council

Health tourism and the new international markets for health care

■ MICHELLE STANISTREET, Deputy General Secretary NUJ

The fight for quality journalism: do the public get the health news they deserve?

■ NATALIE MEHRA: Ontario Health Coalition

Hospital cuts threaten our health: how we are fighting back

Declaration of IAHPPE XIV conference, Thessaloniki

This XIVth Conference of the IAHPPE began with a reminder of the importance of the Hippocratic, humanist values that are under constant attack from the growing tendency towards market-style reforms and privatisation in health care systems.

This conference condemns the way in which governments and those directing health care across Europe are using the people of East and West Europe as guinea-pigs in a grotesque experiment in the use of untested market mechanisms in place of any planned allocation of health care resources, or any reference to principles of equity and social solidarity.

Conference further notes the lack of any systematic evidence to support these reforms or process of evaluation of their impact where they have been implemented. We reject the notion that greater use of private sector providers either reduces costs or improves efficiency, and note that this approach works strongly against equity and social solidarity.

This conference condemns the way in which the agenda at EU and national level is increasingly shaped around easing the level of regulation to favour the commercial interests of the pharmaceutical companies. These corporations rush to exploit profitable

markets for new patented drugs, while their research programmes largely ignore the burden of preventable disease and some of the major health care problems affecting the world's poor and disadvantaged.

Conference has noted the consequences of this line of policy:

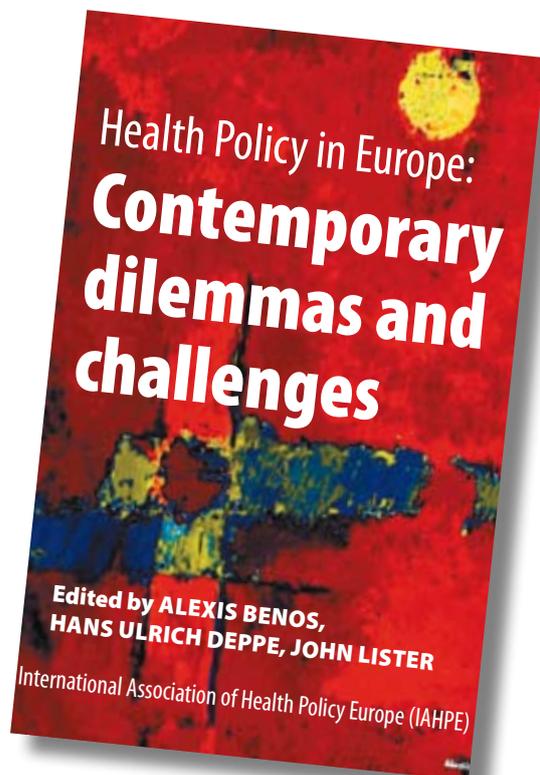
- In Germany, charges have been imposed for visiting a doctor, aimed at reducing the numbers accessing health care
- In the United Kingdom, a huge expansion of government spending on private provision of care for National Health Service patients threatens to destabilise the public sector provision in many areas
- In Turkey, the privatisation of hospital services has run alongside a growing inequality in access to health care
- Greece has emerged as the country in which the highest share of total health spending comes from private "out of pocket" payments, while public spending on health at just over 2% of GDP is one of the lowest in Europe.
- In Palestine, the drive to increased reliance on private for profit treatment is driven by the active policy of donor organisations
- In many European countries and around the world, co-payments or user fees are being imposed on health treatment, designed to reduce demand, and press more people towards private insurance cover.

This Conference rejects these policies as detrimental to the health needs of the people of Europe. We call instead for a new initiative that will link up campaigners, academics, health professionals, trade unionists and progressive social movements that will seek to:

EXPOSE the real content of the policies and so-called "reforms" based on neoliberalism, privatisation and marketisation

CHALLENGE governments and political leaders to examine, discuss and debate the impact of these policies and the possibility of a very different approach based on principles of multi-disciplinary cooperation, equity, and social solidarity

PURSUE the campaign for the strict regulation and control of the pharmaceutical corporations, and the establishment of health care systems that are universal, democratically controlled and accountable to local people, responsive to service users, supportive to health care staff, publicly funded, and delivered free to all at point of use.



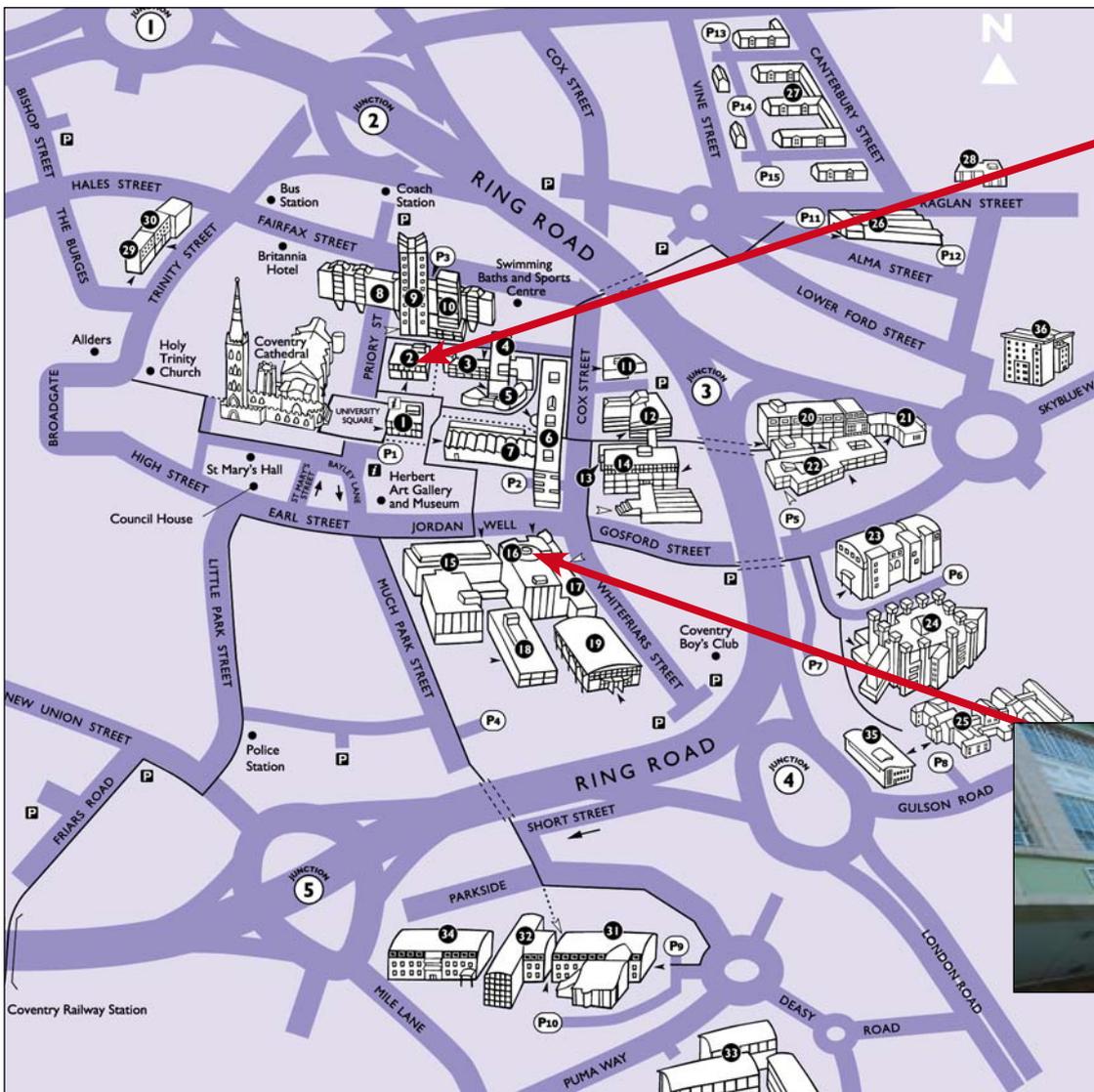
On the record: the papers from the Thessaloniki conference, still available. Watch out for the papers from the XVth conference in Coventry!
www.healthp.org

IAHPE
Thessaloniki 2005

IAHPE XVth Conference timetable June 17-20

Conference venue (Wednesday - Friday)

Ellen Terry Building, Jordan Well, Coventry CV1 5FB



Student Union building (sports hall on lower level): venue for Saturday session

Ellen Terry Building

Wednesday 17th June 2009

16:00

Registration & coffee, Ellen Terry Building foyer and student Lounge

17:30 Ellen Terry Building G34

OPENING SESSION:

Introduction of IAHPE, thanks – **Alexis Benos**, IAHPE President

Welcome from Coventry University: Faculty of Health & Life Sciences, School of Art & Design

Organisational overview – venues, facilities, meals, events, etc. – John Lister (Conference organiser)

Political context of the conference – **Alexis Benos**

Opening presentation: "Media impact on public perception of health policies" John Lister (England)

DISCUSSION

19:30 **CONFERENCE RECEPTION:** Riley Lounge, Richard Crossman building

Conference timetable June 17-20

Thursday 18th June Ellen Terry Building G34

GLOBAL ISSUES IN HEALTH CARE

9:30

ANNA MARRIOTT – “Blind optimism: Challenging the myths about private health care in poor countries”

9:50

DISCUSSION

10:00

Failure of international policies to control diseases in LDC – **Jean-Pierre Unger, P.De Paepe, W.Soors (Belgium)**

Identifying the experiment in neo-liberal marketing approach to public health -1980-2008 – **Garance Upham, (People’s Health Movement) and Moses Okinyi (Kenya)**

Are international policies on health care evidence based? A light shed from Latin America – **Jean-Pierre Unger, Werner Soors, Pierre De Paepe. (Belgium)**

Privatization of the health care system in Egypt: History, opposition and future prospects – **Alaa Shukrallah (Egypt)**

10:45

DISCUSSION

11:10

COFFEE: student lounge

“MEDIA IMPACT ON HEALTH POLICIES”

11:30

Reporting Health and Health Policy in Northern Ireland post devolution – **Brian Laughlin (N. Ireland)**

Myths, misconceptions and the media - Irish health ‘crises’ through the lens of the media – **Sara Burke (Ireland)**

Changing attitudes in the media to HIV and how public opinion is affected – **Danielle Cox (England)**

Health Journalism: Advertising Masked as News; Courtesy of Charities – **Marisa de Andrade (Scotland)**

Brazil: national newspapers and the public health system – **Patricia Resende (Brazil)**

12:25

DISCUSSION

12.50 **LUNCH** (Riley Lounge, Richard Crossman Bldg)

14:15

PRIVATISATION AND MARKETISATION OF HEALTH SERVICES

Global Neoliberalism and the consequences for healthcare policy in the English NHS – **Clive Peedell (England)**

Choice, Voice and Marketisation in the NHS – **Paul Dorfman (England)**

Neo-liberal transition of health in Turkey – **Tok Mehmet, Kılıç Güray, Öztürk Osman, (Turkey)**

The effect of health reforms in Turkey: Out-of-pocket payments are increasing – **Kayıhan Pala, Harika Gerçek, Alpaslan Türkkan, Hamdi Aytekin (Turkey)**

For whom is the Turkish health system being restructured? AKP Government, TUSIAD and World Bank – **Hamzaoglu O, Ozkan O, Erkoc M (Turkey)**

15.10

DISCUSSION

15:35

COFFEE: student lounge

15:35

PUBLIC v PRIVATE

Comparative quality evaluation of public vs private health sector: evidence from Greece, – **Elias Kondilis, Lila Antonopoulou, A. Andreou, Alexis Benos (Greece)**

1990-2008: The continuous and complementary spectrum of neoliberal policies in the Greek NHS – **Aristomenis Syngelakis & Chris Tassis (Greece)**

Privatization of health care services in Greece: recent trends – **Theodore Zdoukos, Stathis Giannakopoulos, Magda Gavana, Elias Kondilis, Alexis Benos (Greece)**

Private sector providers in Ireland & England – **Sara Burke (Ireland)**

World champions in privatization: The case of Germany’s hospitals – **Nils Boehlke, Ian Greer, Thorsten Schulten (Germany)**

The impact of European free market rules on Belgian health care organisation. Which way

forward? – **Pol De Vos, Freek Louckx (Belgium)**

16:40

DISCUSSION

17:10

COFFEE: student lounge

17:30

DONALD FREY, Physicians for a National Health Program (USA)

17.50

DISCUSSION

18.15: CLOSE

19:30

IAHPE business meeting (venue to be announced)

FRIDAY 19th JUNE 2009 Ellen Terry Building G34

9:30

JULIAN TUDOR HART : "First Steps Forward: Escaping the Industrialisation of Healthcare in Wales"

9:50

DISCUSSION

PRIMARY CARE and the RIGHT TO HEALTH

10:00

Patients, profit and primary care. England and international lessons – **Gilles de Wildt (England)**

Struggle for right to health in Turkey: 2003-2009 – **Öztürk Osman, Çerkezoglu Ali, Ağkoç Süheyla (Turkey)**

Health transformation programme in Turkey: a critical comparative review – **Gulbiye Yenimahalleli Yasar, Pinar Guven-Uslu (Turkey)**

10:35

DISCUSSION

11.00

COFFEE: student lounge

11:20

MENTAL HEALTH

Adult Forensic Mental Health Services in England & Wales: Ten years of progress? – **Geoff Dickens (England)**

Reducing senility to 'bare life': are we heading for a new Holocaust at mid-c.21? – **Andrea Capstick (England)**

"The case of mental health reform in Greece: masking privatization behind de-asylumization, corporate interests behind NGOs and dominant ideology behind humanitarianism" – **George Nikolaidis (Greece)**

11:55

DISCUSSION

12.20

THE WORKFORCE

Medical Workforce Planning in the National Health Service: 1948 -2008 – **Vanessa Jessop (Scotland)**

Working Conditions of Physicians Employed in Public Institutions in Turkey – **Nilay Etiler, Betül Urhan (Turkey)**

The Nursing Labour Process in Turkey: How Do Neo-liberal Economic Policies Effect? – **Ozkan O, Ulker S, Hamzaoglu O (Turkey)**

12:50

DISCUSSION

13.10

LUNCH (Riley Lounge, Richard Crossman building)

14.10

POSTER SESSION

14:35

PUBLIC HEALTH

DAVID HUNTER 'Moving Upstream: the dilemma of securing health in health policy'

14.55

DISCUSSION

15:15

Achieving Public Health Objectives: From Inter-Professional Learning to Organisational Re-alignment – **Colin Thunhurst, Patricia Bond (England)**

NIHR CLAHRC for Northwest London: Using research to drive cost-effective high-quality healthcare – **Derek Bell, Cathal Doyle, Gurmail Singh, Julie Reed, Ruth Barnes (England)**

"I would have switched off if it was just government legislation." The Simpsons and the teaching

Conference timetable June 17-20

of Public Health Policy – **Sarah Chipperfield and Pete Woodcock (England)**

Combating health inequalities amidst the credit crisis – **O. Reddy (England)**

Markets for public health research in Europe – **Mark McCarthy(England)**

Doctor in overalls – **Karel Van Bever, Frans Van Acoleyen, Pol De Vos (Belgium)**

16.15

COFFEE: student lounge

16.30

DISCUSSION

16:55

CAMPAIGNING

'Save our hospital' campaigns in England – **Sally Ruane (England)**

Campaigning for the kiwi-model in Belgium: How the struggle for a rational drug policy led to broad consciousness on Big Pharma malpractices and to price decreases – **Dirk Van Duppen, Pol De Vos (Belgium)**

Community health and environmental action:

the 'street-council-street' principle – **Thomas Engelbeen, Harrie Dewitte, Pol De Vos (Belgium)**

17.25

DISCUSSION

17.40

COFFEE: student lounge

17.55

HANS ULRICH DEPPE: Health reform in Germany – the new health fund

18.15

DISCUSSION,

18.40

Presentations and Conference Overview – **Alexis Benos, IAHPE President**

18.55: CLOSE

20.00

CONFERENCE DINNER –
Aqua, 117-118 Gosford St.

SATURDAY 20th JUNE

Student Union Sports
Hall, Priory St, Coventry

(see map)

**International Open Meeting,
10.00am-3.00pm**

**The International drive towards
privatisation and marketisation of health
care – and how to resist it**

Featured speakers to include:

- Natalie Mehra, Ontario Health Coalition,
- BMA speaker,
- Michelle Stanistreet, Deputy General Secretary

National Union of Journalists,

- Keep Our NHS Public
- trade union speakers

FACILITATOR: **Sue Lister** (Coventry University)

Lunch provided

