1 *Vision text*

Medics for the people is a network of 11 first line centres, scattered around all of Belgium. At the moment, about 75 health employees are working in those centres (doctors, nurses, dietists, physiotherapists, ...), together with around 60 employees in administration and a hundred volunteers.
30 000 patients have been subscribed to one of those centres.

Introduction: Medics for, by and of the people

"Rise up with me, ... against the organization of so much misery."
Pablo Neruda [1]

This vision text is the result of studies and discussion of a lot op people within and out Medics for the people. [2]. This text is written for students of medicine and nursing, for young doctors and for all those who are interested in the vision of Medics for the people. The text is complementary to the book "Doctor of the People", written by Kris Merckx, in which the history and daily routine of Medics for the people is described.

For a decade of years already, health labourers of Medics for the people take care of people for free, they fight for the maintenance of the public hospitals, for the kiwimodel, for the replacement of the undemocratic Order of Medics by a democratically controlled High Council for Medical Ethic, for more and better social residences, for a better environment, for the preservation of a local pool or post office and for better labour conditions in Hoboken, Deurne, Herstal, Lommel, Genk, Zelzate, Seraing, Schaarbeek, Molenbeek, Marcinelles and La Louvière. Where do all those health labourers find their inspiration and energy?

'Serve the people' has been our basis principle since the very beginning. We work for the daily needs of the people from our *heart*. "Small problems do not exist," Franc Van Acoleyen, doctor for the people in Zelzate, recapitulates. Apart from that, *the right to health* is a fundamental human right. By our work, we want to make people aware and participate to the project of Medics for the people to make a profound social change, who will realise this basic right in a durable way.

But Medics for the people is not alone. Around the world, people and organizations work for health in the large meaning of the word. In 1946 already, the World Health Organization (WHO) defined health in the following way: "*Health isn't just absence of disease, but also physic, psychic and social consent*".

In Belgium, Medics for the people is part of the action platform www.gezondheid-solidariteit.be, a cooperation of district health centres, trade unions, health insurance, social organizations, non-governmental organizations and scientists. Medics for the people is also part of the international network 'People's Health Movement' [3]. International solidarity and engagement of our health labourer in the Third World characterizes our working from the beginning. We also have signed the **"People's Charter for Health",** which defends following premises:

- *Reaching the most optimal level of* ***health*** *and well-being is* ***a fundamental human right.***
- *The principles of a universal and* ***integrated health system*** *in which* ***first line takes a central place,*** *like described in the Alma Ata declaration of 1978, are* ***the basis*** *of the formulation of all policy measures around health. Now more than ever, we need an accessible, qualitative, participative and intrasectoral approach of health and health care [4]. The Alma Ata declaration starts from the fundamental responsibility which lays with the governments to* ***ensure universal access to a qualitative health care, education and other social services following the needs of the people,*** *and not following their possibilities to pay.*
- ***The participation of the people and the work of a lot of social and syndical organizations are essential pillars*** *in the formulation, implementation and evaluation of all health and social programs.*
- ***Health is largely determined by the political, economic, social and physical environment*** *and*

should be a top priority at local, national and international level, together with equal and durable development."

Social conditions, conditions of life and labour are de terminating in a crucial manner for the big differences related to sickness and health in the society. The health gap is still increasing. Lots of doctors of Medics for the people are experts in investigation the relation between social conditions, conditions of life and labour on one hand and sickness and health on the other hand.
We want to engage not only with our heart but also with our *head*. Socially engaged and competent, that's the combination where we want to start with. How can we make this social engagement and competence cooperate? It's because of our willingness to action that we search for the real causes of injustice, and our hang to competence gives us the right perspectives. Together, they are the motor to make turn the injustice.
Apart from our *heart* and our *head*, we also want to use our *feet* and *hands* to act for the right to health.
Our health service is more and more exposed to the pursuit of profit, privatising and commercializing. Medics for people puts *solidarity* against all of this: 'put people first, not the profit'.

In part 1, this vision text explains why health care is a fundamental right and cannot be merchandise. In part 2, we discuss why standing up for the right to health for everyone is a way to fight social injustice. And why the labour movement plays such a crucial role in this case. In part 3, we elaborate the lever demands which Medics for the people will use to defend health care as a fundamental right in the actual Belgian situation. Finally, in part 4 we describe how Medics for the people will work concretely in 2010.

The design of this vision text has been read over and foreseen of useful comments by among others the next professors and specialists:
Jean-Jacques Amy (gynaecology VUB), Lieven Annemans (U-Gent), Dirk Avonts (general practitioners department U-Antwerpen, U-Gent), Bea Cantillon (sociology U-Antwerpen), Bart Criel (public health ITG), Jan De Maeseneer (general practitioners department U-Gent), Isabelle Heyman (Fédération des Maisons Médicales), Guy Kegels (public health ITG), Mark Leys (sociology VUB), Fred Louckx (medical sociology VUB), Ben Nemery (labourers medical science and social health care KU-Leuven), Michel Rolland (general practitioners department ULB), Patrick Vanderstuyft (epidemiology ITG en U-Gent), for which we thank them.

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“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. ”
Article 25 of the Universal Declaration of Human Rights

1. Our health care: more and more the American way?

“It is amazing that so many people in Europe or in Canada want to experiment marketing in health care, despite the fact that this marketing in the United States has proven to be a big failure”
Prof. Marcia Angell, previous chief-editor of The New England Journal of Medicine *5*.

Michael Moore, the rebel in world of movies, has made the movie SiCKO about American health care. A disconcerted documentary. SiCKO is not about the 47 million of Americans who do not have health insurance. The movie is about the 250 million people who do have private health insurance. A woman is in a serious traffic accident and is taken unconsciously to the hospital. The insurance refuses to pay for the ambulance because the women didn't grant permission for that transport in advance. Kafka? Kafka. The result is mortal.
A woman takes her infant, who is vomiting and suffering from diarrhoea and has a high fever, to the emergency room. Diagnosis: blood poisoning. The doctors want to give him intravenous antibiotics, but the insurance demands that the child is taken to another hospital, which has a contract with the insurance. Three hours later, upon arrival in the second hospital, the child dies.
It's a tragedy without an end. The most confronting part in Michael Moore's movie is the image of a control doctor who testifies in front of a *parliamentary* investigation commission she didn't allow treatment of a patient, who died shortly afterwards. The doctor got promoted. Because, she tells in an emotional way to the stunned members of the commission: 'It was my task to save money to the company, using my medical experience.' Health insurances refuse people for being “too thin” or “too big”, or suffer from health risks or certain diseases. Insurances act like detectives looking for diseases in the past the patient might have concealed upon inscription. In that case, they can exclude the patient because of fraud in case of serious medical costs. 'It's like investigating a murder,' someone in the movie tells. That's why in America, half of the insured cannot pay for medical costs in case of a serious health issue. In America the device is: no money, no help. Private medical science dominates. *7 8*
Despite a lot of counter-pressure of the medical-pharmaceutical complex, president Obama has passed through a certain number of reformations who have to take away the sharpest edges.

On the contrary, the obliged and general health and invalidity insurance in Belgium rests on solidarity, in which the strongest persons carry the heaviest weights. This system is totally different as a private health insurance system that selects in function of the risk and means to make a maximum profit. 2/3 of health expenses are still covered by federal solider health insurance. This is paid mostly by contributions on salaries. It contains a part of contributions of the employees (13% of the gross salary) and a part of contributions of employers (34% on the gross salary for servants and 41% for labourers). In fact, this makes social security mainly indirect salary. In that case, health care in Belgium is an *insured* fundamental right and social security is the expression of the common value of the class of employers. In addition to all that, social security also gets a part of her money by direct and indirect taxes, like TVA and consumer-taxes. The health care in Belgium is provided by a mixed public and private system with for profit and non profit organizations and doctors, physiotherapists, nurses, etc.

But also in our country the part paid by patients themselves gets bigger every year. This is due to the fact that every successive government, from any colour, cuts down the budgets and makes the patient pay for supplementary costs in for instance technological evolution in health care.
At the agreement of Maastricht in 1991, all European members have been obliged to cut down their budget enormously in public expenses. For the Belgian patient, this meant a big increase of the own contribution in health care. At the European top of 1993, the Witboek Delors has been voted, which means that European member states pledge themselves to decrease the employers social contribution in labour costs. In that way, the European competition position had to be reinforced compared to the American companies, since America does not know general social security or contributions to salary. But, less social contributions mean less income in social security. Those have to be compensated by income out of indirect taxes: consumer taxes and TVA, which is a more dishonest way of taxing. At the same tame, Europe stimulated the privatization of public services, among which health

insurance. These are exactly the politic measures who have lead to the marketing of our society in general and our health insurance in particular.
From 1997 to 2005, the part of health costs paid by the patient has increased from 23% to 28%. [9]
14 % of the Belgians postpone health care, because the costs are too high. This has been proved by the national health survey of 2008 [10]. In 2004, this was 10 percent and in 1997 8 percent. 35 percent of the families has difficulties to fit the contributions for health care in the family budget. A study of Testaankoop in 2009 learns that almost 30% of the Belgian families has difficulties every once in a while to pay for health costs. In the last year, 8% of the families has stopped a treatment, 26% postponed a treatment. [11].

An investigation by 6000 members of the Christelijke Mutualiteit (CM) learned that one eighth of the Belgian families has financial problems due to the costs on health insurance [12]. In case of chronic illness, this number increases to one third. The own expenses for health care in 2008 for the families without financial trouble were about 155 euro per month. For those families who did have problems, the amount increased to 226 euro. These are costs after intervention of the health insurance. Own contributions and supplementaries are still a heavy cost. Apart from that, health insurance does not interfere in certain expenses, like medication (f.e. painkillers) but also transport costs and help at home.

Today people speak more and more of “health care at two velocities”, in which highly prices new technologies are only accessible to the ones who can afford them, possibly by an extra private insurance. In our country, 7 million people already have a supplementary private insurance for hospitalization. But the charges are getting more and more expensive. In April 2008, the charges of Argenta for hospitalization insurance have decreased by 200 % and more. For people over 80, the charges went from 250 euro to 720 euro. Elderly aren't even permitted to hospitalization insurances. Costs for necessary health care are one of the main reasons for a family to have debts [13].

At a symposium of the Christelijke Mutualiteiten about commercialization in care people were warned for big foreign stock market listed groups that bait the most beneficial parts of Belgian health care [14]. *With about 10% of the gross domestic product, health care is in most European countries the biggest area. “The public possession of health care in Europe makes it difficult for private companies to penetrate those markets”, can be read in strategic planning reports of international multinationals in health care [15].*

2. Why health care can't be merchandise?

Health care is a fundamental human right, like the right to education and accommodation. The insured access to qualitative health care is an important condition to a good quality of life. However, we see a lot of differences in health and health care. We explain how those differences make that marketing is opposed to the fundamental right of equal access to health care. That's why health care cannot be merchandise, but the government has to organize equal access to qualitative health care by solidarity.

The three major differences are :

The difference in health care needs

The expenses for health care are concentrated with a small part of the population. In Belgium, 10% of the population – mostly elderly and chronicle patients – use 70% of the expenses in health care .[16] This is called an uneven or crooked division of risks. Taking into account the obsolescence, this risk will be increasing.

Social differences in health

People with a lower socio-economic status have the biggest chance to health problems, die sooner and have the biggest needs for care. A recent study proves that in our country, people who are less educated die 5.5 years earlier and women without a diploma live 25 years less in a healthy way then people with a university degree. [17]. The ones with the smallest possibilities need the most care. In a system based upon profits, there is no way they can be helped. “Illness makes poor and poverty makes ill,” thus the slogan of Welzijnszorg.

The social difference in access to health care

People with a lower socio-economic status have the most difficult access to health care. The poor people who need the most health care, enjoy the least the existing care. This is called 'the **inverse care law'** .[18]

If we want health care to be accessible for everyone, solidarity is an important issue. Solidarity means a transfer of "rich and healthy" to "not rich and ill" people, thus a devise of redistribution. At the side of receiving, the strongest pillars need to carry the heavy loads. At the side of expenses, we have to look at those who need the most help (needs) and not at those who can pay the most (purchasing power) like in case of marketing or where we can earn the most money (profit seeking). Solidarity and marketing logic are opposites. [19]
Private health insurance companies are mostly interested in young, healthy people with a lot of purchasing poser. If you do not suffice to one of those characteristics, you are less interesting. The market is opposite to equal access to health care for everyone.

3. Does the market make access more easily, quality better and efficiency better?

In Belgium, health care is largely financed by public resources. The health care as well is, however mainly private, largely organized by non-profit organizations. But the access to the system is more and more threatened by the growing marketing and commercialization of health insurance and health care [20]
In scientific literature, the next **three consequences of marketing, commercialization or privatization of health care** have been fully documented. [21] [22] [23] [24] [25] [26] [27]

Problem 1: No better access, but division and risk selection

The market doesn't know morality and is not interested in solidarity. Solidarity is the opposite of profit seeking. The market conducts us to a medical science at two velocities: one for the rich, and one for the non-rich. Everywhere private medical science is established or exists next to public health care, the most famous doctors and paramedics leave the public sector where the needs are the biggest, to the sector where the most money is (private). Also in Belgium, with its mostly public system of financing and mostly private system of health care, we see this happening more and more.
Private insurance companies try to exclude chronic patients, elderly, and people with elevated risk or earlier diseases or to make them pay very high rates.
On the opposite, national public and solider health insurance means security and safety for all, because the risk is divided over the biggest social basis possible: the entire society. This aspect drops out in case of commercialization, in which people's health is in hands of private insurance groups. Also, they work mostly with financial risk capital that depends on international stock exchanges.

Problem 2: loss of quality and lack of cooperation

The market does not think in long terms, which is very important in health care. Primary prevention, a part of long term care par excellence, will receive less attention. The market principle is to deliver care with a profit as high as possible and thus with a cost as low as possible. Consequence: cut down expenses to quality, education and labour conditions for the people. Commercialization and maximization of the profits lead to continuous decrease of working pressure and underpayment of the staff. Above all, health care is people care. The motivation, human attitude and capability of the staff and their time for the patient are crucial in all this. All of this is now under pressure.
In case of commercialization, the competition for the own maximization of profits is more important then the necessary cooperation. Marketing means disintegration, chaos and wastes instead of planning and cooperation. It means fragmentation and loss of health data necessary for the best possible treatment of a patient, for a rational guardian and organisation of science and care. In case of privatization of health care, scientists mostly need to pay a lot of money to obtain health date, whereas in public health care those data are general.

Problem 3: no better efficiency of cost reduction, but wastes, bad medical science, more bureaucracy and high control costs

For those who need care and cannot pay it, marketing provokes under consumption and for those who can pay it, marketing provokes overconsumption. In short: the market leads to unequal and bad medical science. For instance there is a great misuse of patients with extra health care policies to receive huge fees in hospitals.
Investigations as well in the United States as in Europe have shown that administrative costs, overhead costs, are twice to three times higher in private insurance companies then with non-profit or public systems. Private insurance companies in Belgium count about 19% of administrative costs, plus 7% of commissions (thus 26% of overhead), apart from the profit they make as well. Belgian health insurance needs less than 4% of administrative costs. This can be explained by the fact that top managers in the private business receive enormous rates, while competition for an employee makes increase the salaries. Health care personal with a responsible function are replaced by managers. The executive staff and their "clients" need to be strictly controlled, because their costs must be as low as possible. That's how a huge bureaucratic control device exists.
High administrative costs are also due to the fact that competition on the market means high marketing costs. For example: in the medication industry 30% of the sales price goes to publicity. [29] Marketing and competition also mean high costs for lawyers who must make all possible contracts or fight the competition, or for consultancy agencies that must resume the market and the competition.
Commercialization and marketing mean in the long run take-overs and fusions, market concentration and in the end market division and a monopoly situation. The choice of freedom the patient has is reduced, because only the strongest medical and pharmaceutical companies can survive. This concentration of economic power enables the monopolies to determine the offers and indicate prices: they will offer not what is necessary, but what returns the most to the company. This is what creates the profit. Also, this concentration of economic power enables the influencing of political decisions by means of lobbying or even worse. This is dangerous for democracy. Loads of practices of pharmaceutical multinationals are excellent examples of this. [30]

4. Why solidarity and no market?

When around the world the "free market" proves its failure in banking, the World Health Organization (WHO) publishes at the end of 2008 in a systematic scientific literature study the evidences of the consequences of marketing in health care. Its report on the influence of social determinants on health concludes: "Higher expenses in private health care are associated to a worse healthy life expectancy, while higher expenses in public health care and social security are associated to a better healthy life expectancy. The Commission thinks of health care as a common basic article, not as a merchandised item. It's an obligation for the government to organize accessible and qualitative health care, instead of leaving this up to the market." [31]
The performance of a health care system is determined by 4 criterions that require solidarity and NOT a health care based on marketing.

For criterion for the realization of health care as a fundamental right

1. Relevance.

Health care and health insurance as part of social security need to **respond to the real needs in the society.** This requires a scientific analysis of needs, initiated by the government. In this the advice and participation of the patients and different actors in health care is very important.

2. Quality and cost effectiveness.

Health care and health insurance need to be **organized in a most qualitative and cost effective way possible.** This requires a scientific analysis of the medical utility and effective cost of the available health care interventions. This is the base of an "Evidence Based Health Care", in which the Federaal Kenniscentrum van de Gezondheidszorg (KCE) can have a steering function, provided that independence, transparency and democratic control are guaranteed.

3. Equity

'Equity' means equal and easy access to health care for everyone in function to their needs. The society needs to be prepared to place the necessary mediates to the disposal of those who need them. These mediates need to be **divided according to who needs them most** as said earlier, and not in function of who pays the most (buying power) of who can earn the most (profit seeking).

4. Durable financing

The financing of health insurance needs to be in function of the needs following a solider principle in which the strongest persons carry the heaviest loads.

Solidarity: from ethic to science

"Solidarity is the tenderness of the people."
Thomas Borge, Nicaraguan minister under the Sandinists

Solidarity is, ethically spoken, against individualism and egocentric. Economically, solidarity opposes itself against profit gain and exploitation. Exploitation means that one person enriches himself thanks to the labour of others. *Solidarity on the other hand* means that one person can satisfy its needs thanks to the help of others.
The essential part in the process of exploitation is the difference between what employees produce with their labour and what they earn in exchange. This difference, this surplus value, is taken by the owner as profit, to enlarge his capital or to enrich him. This exploitation process creates roughly two opposite socio-economic classes with opposite interests: a minority which owns the great production mediates and enriches himself with the surplus value produced by a majority.
In case of *solidarity*, this surplus value does not disappear in the hands of some who use it to enrich their selves, but they are used for the needs of others who need them.
Karl Marx was the first one to describe scientifically economic exploitation. Marx has proven already in 1848 that poverty and non-equality are no natural phenomenons, but a consequence of the private possession of the great production measures, which leads to an unequal division of goods and receiving. The capitalist system, where haunting maximum profit is the greatest motive, creates extreme richness for some at the cost of increasing poverty for many, thus Marx. Economic exploitation is the source of social differences, and consequently of differences in health and access to care. Karl Marx has made the base to a scientific analysis of the history and the society which allows us to better understand society problems and thus to help people in their battle to a better life.

The commission of the WHO concludes in its study concerning the influence of social determinants on health [33] that social differences or the gap between rich and poor continues growing: "The advantages of the economic growth of the last 25 years – a period of quick globalisation – are divided very unequally. In 1980, 10% of the richest countries had a gross national product per inhabitant that was 60 times as big as the ones of the 10% of the poorest countries. In 2005, that proportion had expanded to 122. (.) Also within the countries, the part of the poorest 20% of the population in the gross national product has decreased during the last fifteen years."
Recent empiric research proves that the degree of salary differences within a society is a very important determinant for the well-being and health. Starting from an average national salary of more then 10,000$ per inhabitant, the degree of salary difference has a bigger influence on the extent of well-being and health then the average income.
160 years after Marx, the commission of the WHO says the following: "Poverty is not only a lack of income. The social gradient in health and the fact that the poorest people are the most unhealthy, this difference in health has been caused by the difference in salary, goods and services and thus of chances to lead a prosperous life. This unequal division is not a 'natural phenomenon', but the result of a politic that makes certain important things precede others, mostly in favour of a rich, powerful minority over a large, powerless majority."[34] Prof. Vicente Navarro, head of people's health of the John Hopkins University, notices: "it's not the differences that kill people, like the report poses, but it's those people responsible for the differences that kill people."[35]

The greediness is inside of the capitalist economic system. Who does not participate, is competed out of the market. "Capitalism makes ill, our health care is ill due to capitalism," poses Medics for the people since the very beginning.

It's the haunting to maximum profits for the stock holders that leads, also in health care, to further marketing, commercialization and privatization and to differences in health.
Solidarity is the concrete expression of the opposite: *put people first, not the profit.*
In this way, the Marxism gives a scientific social fulfilment to the ethic conception of solidarity. For Marx, the ideal society is one without exploitation, where all people receive by needs and contribute to the society following the possibilities. This kind of society knows the highest form of solidarity.

The quality of a society can be measured by the care that is given to its weakest members. In this discussion, those are ill people. Its a large ethic consensus that qualitative and adequate health care is a fundamental right. This means concretely that the quality and accessibility of health care can not depend on the financial possibilities of the patient. No one can be treated by priority based on other then medic motives or grade of vulnerability. [36] Within the actual reality of health care, we realize this ethic principle is harmed more and more. Not the marketing and commercialization, but the solidarity and social combat are the best guarantee against all this. From this point of view, Medics for the people wants to support a large social basis and mobilise it so health care can remain a fundamental human right and does not become a merchandise.

Put people first, not the profit

Medics for the people is an initiative of the Workers' Party of Belgium (WPB). The WPB baseline "Put people first, not the profit" is also the measuring rod used by Medics for the people to measure developments and alternatives in health care. That what puts the profit seeking above the humans, leads to a system that is inaccessible, unhealthy and thus inhuman, and we oppose ourselves to that. Initiatives and proposition in which the (sick) human is more important than profit can lead to an accessible, healthy and human health care and that's something we support.

The biggest decrease in the curve was not after the development of medications against tbc (as from 1946), but much sooner: during the 19th and at the beginning of the 20th century, when the labour movement already forced some ameliorations of the living conditions thanks to social combat.

British investigator Margaret Whitehead shows in the next schedule the parameters who determine someone's health. The schedule indicates as well the nature of the levers one can use to take hold on socio-economic health differences.

I. Health risks in the 4 layers around the individual

People with a lower socio-economic status have bigger health risks in all 4 of the surrounding layers of Whiteheads schedule.

Layer 1: personal lifestyle factors

We know that in general, people from a lower social class have a less healthy lifestyle regarding food, smoking ... and they have fewer possibilities to make healthy lifestyle choices.

Layer 2: social, district and society influences:

People in lower socio-economic classes know less social networks and supporting systems

Layer 3: life and working conditions

Also in the third layer of the schedule there is an unequal division of health risks: healthy living, health services and (high) education cost a lot of money, which makes that the accessibility is more limited for people with a smaller income. Apart from that, the working conditions of those who earn less are mostly unhealthy and more dangerous than those of people with higher incomes.

Layer 4: general socio-economic, cultural and environmental circumstances

*Health risks deviate from country to country:

The commission of the WHO who studies the influence of social determinants on health poses in her report of 2008 that the life expectancy of children depends in the first place of the place they were born. In Japan or Sweden the expectancy is more than 80 years, in India 63 years, in a few African countries less then 50 years.

The Millennium Preston curve published in this report shows the relation between the average income of a country per habitant and the life expectancy.[37] Until an income around 5500 $ per inhabitant the following rule is correct: the poorer, the lower the life expectancy. Lack of elementary healthy life conditions means sickness and death. It's remarkable that China, with a high amount in population and a low gross domestic product, literally pulls the curve upwards. In the upper left corner we see Cuba, which, in spite of the national income per head of a developing country (4220 PPP $ in 2000) shows health indications (life expectancy: 76 years) comparable to rich western countries. In 2000, Belgium had a gross domestic product of 27,000 PPP $ and a life expectancy of 78 years, comparable to France at the image. Remarkable as well is the circle in the right upper corner, the United States, with the highest income and expenses for health care per habitant in the OESO-countries but also the worse life expectancy.

Health risks also varies within the countries

Above all that, we see a social gradient in health within the countries. A highly educated man of 25 years of age lives in average 5 years longer than a low educated man. The gap gets even bigger when you take a look at healthy years: a high educated 25 year old man still has 46 healthy years ahead of him, whereas the low educated man only has 28 healthy years to expect.

Michael Marmot and Wilkinson postulate that the material differences in the different social layers of the population are not enough to explain the differences in health. In the Whitehall II study, the old idea that managers at the top of the hierarchy suffer more from stress then the people underneath was replaces by two explicative models concerning stress at work.[38] The first model says that stress at work is determined by the control one has about his own job. The second model talks about the lack of balance between effort and salary or appreciation as a determinative factor on chronic stress. Recent investigations with 11,099 Belgian employees show that flexible working hours cause a lot of stress with a negative result on health. Emotional and physic pressure, repetitive movements, flexible working hours, insecure jobs, … have been associated to negative health results.[39]

II. How can we use these 4 layers as lever to seize the health differences?

If we want to improve the health situation of individuals, we need to work at the determinants that surround the individual in the 4 different layers.

Layer 1: Personal lifestyle factors

At individual level, you can work at health education but also at empowerment. Marmot and company propose the notion “empowerment” as a health enforcing factor. With this they talk about self-confidence, the strength and power of individuals and groups of people to control and determine their freedom and choice of life conditions.

Layer 2: Social and community/society influences

At the second level you can also use empowerment by reinforcing the communities (‘strengthening communities’). With this we mean all sorts of community issues who can improve the physical environment and the social climate, including security. Medical sociologist professor Fred Louckx (VUB) indicates however the ever growing critics on interventions on these first second levels: 'Campaigns of lifestyle are based on the idea that people control their own health behaviour and they can choose freely for a healthy lifestyle. (…) But lifestyle isn't just a matter of choice. The lifestyle of lower socio-economic categories is an answer to the life conditions they live in. Lifestyle interventions put the responsibility with the individual. This can provoke that instead of having a positive effect on the lifestyle, this type of interventions only provokes a negative effect on the self esteem of the target group. This is called 'victim blaming'. (…) Finally, there's the critic that the impact of this “healthy” publicity probably is annulled by the great number of “unhealthy” messages in the media (…) The advantage that lower socio-economic categories can take from this interventions, is rapidly undone by the structural disadvantages they are confronted with every day. This means that individual interventions can lead to a temporary reduction of the gap in health, but that it grows rather quickly to its original size. In reality, it's mostly a control of symptoms, without working on the real cause of health differences.”’[40]

Layer 3 and 4: life and working conditions and general socio-economic, cultural and environmental conditions

Historian Simon Szreter of the Cambridge University continued researching McKeown's thesis that posed that economic growth and as a result amelioration of the health conditions have improved the health indicatives. [41] [42] Szreter's conclusion is: the amelioration only took place when the labourers organized themselves and obliged governments to take measures concerning public health and social protection. The fact that people started to organize themselves collectively was just as important as the amelioration of their material life conditions. As said before, the differences in material conditions between different socio-economic layers of the population are caused by the exploitation of one social layer by another.

This means that stimulating “empowerment” also serves to the change of the power relations between the classes in society, temper the socio-economic differences and as a result, improve the health for a big part of the population. “Strategies of empowerment should help people to link their personal struggle for a better health to the collective battle to improve everyone's health. There are solid indications that show individuals who are aware of their limitations in health and the causes of these limitations can improve their health if they link their battle for a better health to the struggle of others who share the same limitations,” concludes Vicente Navarro, chief public health at the American Johns Hopkins Univeristy.[43]

In part one we have shown how our health care is following more and more the American model. But the “neo-liberalization of our society based on the American model” is even worse for our health: less social security, more privatisation, less taxes for the rich, more taxes for the others, less spending power for the majority of the population, increase of the gap between rich and poor, more flexibility in working hours and labour market (Mc Donaldjobs).

III. An example: operation procedure of the pollution in the quarter Sledderlo in Genk

Sledderlo is a quarter in Gent, around the metal factory Arcelor Mittal. Since years, presumptions are the there are high levels of heavy metals in the environment, causing important health risks for the population. Research has been done at the 4 layers of Whitehad to detect health risks, but also concrete propositions have been formulation to reduce the risks of the population in this area.

Layer 1: Personal lifestyle factors

At the doctor's practice of Medics for the people in Gent, a research starts concerning the health of the neighbours. The conclusion is an abnormal high level of respiration problems. Also, the life conditions of a lot of inhabitants are very unhealthy.

The enquiries on personal level at the doctor's practice cause a general concern about the pollution problem and individual solutions are offered to treat and protect the health of the patient.

Layer 2: Social and community/society influences
PVDA member of the council and general practitioner Harrie Dewitte shows the results of the research at the city council. The pollution "hot spot" is officially acknowledged. The city council decides to start an elaborated investigation to the different sources of pollution in the area.
Habitants start a petition against the pollution, and a manifestation of neighbourhood children around the factory.
The city decided to move the primary school out of the hotspot.

Layer 3: life and working conditions
The city decides urgently to the renovation of certain residences in the area. The regional government is obliged to start a general health investigation and to inform the population.

Layer 4: general socio-economic, cultural and environmental conditions
The federal government decides to a biomonitoring (by 4 universities) of the "hotspot" and starts up a continuous research to be able to detect other hotspots based on the same model.
Cleaning standards concerning the emission of the factory are obliged.

"Social injustice kills on a large scale"
World Health Organization 2008

"Lack of health care is not the cause of the huge worldwide health issues: diseases related to water aren't caused by a lack of antibiotics but by polluted water and by political, economical and social powers that are unable to put clean water at everyone's disposal; cardiac diseases aren't caused by a lack of coronary heart services, but by the way people lead their lives, influenced by the environment people live in; obesity isn't caused by individuals but by the exaggerated amount of greasy food rich in sugars. The most important interventions influencing social determinants of health have to find their origin outside the health care."
World Health Organization 2008

1. Social injustice causes sickness

Socio-economic determinants influence sickness and death more than medical science and her medical technical progress. Illustration: the schedule of British investigator McKeown that shows the decrease in time of the last 130 years of death caused by TBC in England and Wales.
Cuba

2. Labourer movement and health

2.1 Our solider social security thanks to the labourer movement

Our solider social health insurance and social security, al our achievements and social laws to make the job more human, more secure and more healthy, and al our democratic rights are the result of social combat. Our actual social security has been elaborated after World War II as an acknowledgement of the economic powers for the reinforcing labourer movement and communism in Europe. Almost every big struggle in the history of labourers started from bigger companies or sectors. Think about the general strikes in 1932, 1936 and 1960-61. Think about the big struggle against the global plan in 1993. Think about the struggles in steel, mines, ship-building. Think about the struggle against the Generation Pact in 2005. The power of these movements is mostly in the organization of labourers and servants in the big industrial companies and other important sectors (post, railways, airport, port...). Due to the fact that labourers in a fabric work together to make an accomplished product together, they learn to work together in a well organized way. This is necessary if we want to work together to a big social change. The big companies have this part of the labourers that is not only the most important in number, but even more in influence, conscientiousness and combat.
Since the eighties, industrial production has been strongly flexibilized and generalized. Apart from salaried

labourers in the big factories, a to the production process associated sector of services has developed itself. Informatics, technical maintenance, industrial cleaning companies, security, transportation, marketing, publication, recruitment. In these sectors, lots of boarded out (outsourced) jobs can be found, who were covered by industries earlier. In these sectors, salaries are lower, flexibility in working hours and contracts a lot higher, security worse. As we will show later on, these flexible working situations have a negative effect on health.

The employees of big companies or in strategic sectors hold the levers of our economy thanks to their strategical position in the production process. That's why they are capable of putting the most pressure on the defence of our social rights in case of a social or union fight. At the beginning of 2008, a series of strikes in favour of the protection of purchasing power for subcontractors caused important interruptions in the industrial production. By the "just in time" production process there were no stocks left. In case one little part of the production chain is on strike, the whole production line has to be stopped. In that way, the employees in those flexible sectors have shown, despite their disintegration, that they have a real power in the economic process. 75% of the Belgian employees, servants and clerks (3 millions) have been organized in trade unions. Those trade unions are the most important organization of the working class. Also, they are the biggest social organization of the country and possess the biggest power to organize to stand up together and force changes.

Medics for the people chooses the side of the battle of labourers and – more largely – the battle of the entire working class, because those people are the most important to provoke a social change, in service of the people, not in service of the benefits, and can create the necessary conditions to guarantee the right to health for everyone.

2.2 in service of the labourer movement

Medics for the people has spend a lot of his attention to the influence of labour to health, since its foundation in 1971. Doing this, our support of the working class is filled in at the medical point of view. It also means a support of the union struggle for more healthy working conditions. Through the social history until today, unhealthy working conditions are the consequence of the urgency to maximize profits.

The medical literature shows abundantly that not only unhealthy working conditions, but also unemployment, reorganizations, flexibility and precarious jobs have a huge negative impact to the health of the employees.

The yearly report of the World Health Organization of 2008, 'Primary Healthcare: Now more than ever' contains a table that shows for which health issues there is scientific evidence they are caused by unemployment, reorganizations or flexibility.[44]

In the next table, you will see that the results are alike a recently published Belgian investigation of a representative number of 11,099 employees.[45]

The experience of Medics for the people regarding labour and health is translated in different initiatives:

Also illustrated in the book "Doctor of the people" of Kris Merckx (see attached file at the end), containing a number of stories, we can be sure that health employees in all group practices of Medics for the people help employees from the very beginning with their experience, in defending them in case of an industrial accident or professional disease, in case of concrete questions regarding exposition to chemical and other materials.

In the eighties and nineties, these experiences have been collected in different brochures and books to inform employees of the dangers of their working conditions and rights. For example, "The men of the night", about the influence of night work at health has been published by the group practice in Zelzate, "Fiberglas" talks about the risks of fibreglass in a company in Herstal and "The boss never is absent" about control medicine. In form of books, there was "The sweet Death" about the influence of heavy metals on health and environment in the Northern Campine and "The copper eaters" who tells the history of employees in zinc in the Northern Campine.

The first flower parade has been organized in 1999 after a deadly industrial accident in what was then Cockerill Sambre. Ever since, (too) many flower parades has followed in Liège, at the gates of Sidmar in Zelzate and at the port of Antwerp. Honouring and charging the insecure working conditions in which

employees need to work. Supporting their widows and families.

In 2002, in Seraing next to Liège, C-Dast (Centre de Défense et d'Action pour la Santé des Travailleurs) has been founded with the goal proposing the experience of Medics for the people to the defence of employees who are the victim of industrial accidents, and the families of the victims. The same thing happens for the victims of professional diseases. Apart from that, they propose concrete measures with regards to safety and health at the working place, together with employees and their representatives (the trade unions) and all other possible partners, for example labour medics who have the same concerns.

Karel Van Bever, a young doctor at Medics for the people in Zelzate, has been very impressed by the psychic, social and physical consequences of temporary employment with his patients. To understand better, he worked on a temporary basis for 9 months, incognito, at the port of Antwerp. He published his diary about this experience in a book “Doctor in overall”.
Hans Kramich and Staf Henderickx published a book on the influence of flexible working hours and stress to health: “Doctor I'm done!”
In the group practice of Medics for the People in Deurne, in 2004 history was written with the defence of a patient who was an employee at the port. His back issues have been acknowledged as being a consequence of the years he worked at the port. Even more, ever since than lower back pain is acknowledged a professional disease by a historical Royal Order under certain circumstances.
Thanks to our files, we were also able to support the trade unions in their battle against the generation pact and in favour of the maintenance of early retirement. Analysis of the electronic files of the patients of Medics for the people could prove that two to three patients suffer a chronic disease as from the age of 50, which can be influenced negatively by the working situation.
To be able to help even better in the case of labouring risks, in different group practices there are registration projects at the moment concerning educational and professional issues. By taking a certain test in a systematic way, we can have a better view on the labour risks of every patient independently. At the same time, we can make scientific investigations like for example the liaison between certain chronic diseases and working conditions.

3. Environment and health

Nowadays, more and more people are concerned about the environment and the heating of the earth.
The environment is of a big influence in health, as proven again by the report of the Commission of the World Health Organization (2008) after a systematic scientific literature study about the influence of social determinants on health. The report treats the influence of environmental factors like urbanization, air quality and noise, traffic and living. The authors emphasize the crucial role of the local governments in the follow up and sanitation of these environmental factors. The report describes a very interesting randomized comparative investigation (RCT) in South England in which in certain social quarters ad random half of the social residences has been renovated. These houses got new central heating, ventilation, new electricity cables, isolation and a new roof. The outcome of these renovations on the health and well-being of the habitants was spectacular: “The intervention was able to build warmer, dryer and more energy-efficient houses. The habitants appreciated the amelioration and reported better health and well-being as a consequence of the intervention. Also the relations within these families improved, together with the self-esteem of the habitants. The habitants of intervention houses did have a much better score of respiration tests, as well the non-asthma as the asthma, compared to the control group.”

The experience and actions of Medics for the people regarding environment and health

From the beginning, Medics for the people has put a lot of attention to the influence of environment to health. The first group practice in Hoboken has won the battle for the curing of the lead pollution by the formerly known Metallurgie. The group practice in Lommel was very important in the battle to pollution by cadmium. An abnormal big number of patients suffering from kidney problems and cancers was one of the reasons to start a big investigation to the connection between pollution by cadmium and sickness or early death. In Genk, Zelzate (Gentse Kanaalzone) and Deurne (Lange Wapperbrug) the group practices of Medics for the people are an important part of the struggle against air pollution (fine dust, dioxins, PAKs) and noise. In Genk, Hoboken, Deurne, Zelzate, Herstal, Marcinelle, La Louvière, Medics for the people struggle for more accessible social residences. Starting from concrete, daily health issues of the patients, linked to a scientific literature study and own investigations, with the support of important specialists and

the support of the local population, Medics for the people puts the problems and necessary measures at the politic agenda. The local chosen ones use the street – advice – street principle in this. This means that the first step is to listen to the problems of the people in the streets, take those themes to the city council to force a solution, and return it to the street for further follow up, discussions, etc.

For Medics for the people, there is no opposition between environment and work. On the contrary, environment starts in working situation. The employees are the most vulnerable for damaging production. For them, cleaning in and around the factory is the most important. For them, the same things are important as for the people living in the area. What's more, investments in environmental technology, renovations and sanitation create extra jobs.

Negative health effects		
Of unemployment	Of reorganizations	Of flexibility
• High blood pressure • Increased cases of depression and fear • More doctors visits • More symptoms of coronary diseases • Worse mental health and more stress • Increased psychological morbidity and more medical consults • Worse self reported health conditions and bigger number of health problems • Increase in family problems, mostly financial	• Less job satisfaction • Less devotion to the organization and more stress • Feelings of injustice in case of dismissal • Those who remain are confronted to new technologies and working processes, new physical and psychological issues (less autonomy, higher work intensity, changes in social relations and contracts and changes in personal behaviour) • Changes in psychological contact and loss of trust • Prolonged stress with physiological and psychological signs	• Higher number of industrial accidents and professional diseases then employees with a full-time, stable employment • Higher level of stress, lower work satisfaction and other negative health factors • More frequently in sub-sectors where people generally have a lower level in education and abilities • Less possibilities to claim employee compensations and less claims covered by employees • Higher health risks linked to professions following higher working pressure due to economic reasons • Insufficient education and bad communication caused by institutional disorganization and insufficient control measures • Employees are not capable of organizing their own protection • Cumulative damage claims are hard to trace because of the mobility of employees • Possibility to improve life conditions is more difficult because of the impossibility to get credits, find residences, arrange retirement and enjoy qualitative education • Less attention to environmental issues and health and safety at work

Medics for the people proposes 14 lever demands to make healthcare more accessible and qualitative. Lever demands are obvious, simple measures with an important positive effect for the patient, health insurance and health employees, for which a large social basis exists.
These demands frame mostly in the defence and reinforcement of or general and obligate social security.
As discussed earlier, in first place health isn't determined by medical science, but income, education and work and life conditions are much more important.
A good social security is the best guarantee for a human income. Containing a good retirement fund, payment for sickness and invalidity, unemployment benefit and child allowance is just as important as health care itself (cft p. 8)
Thanks to social security, in our country “only” 15 percent of the people is below the poverty threshold.

> According to recent numbers of the FOD Economics, 14.7 percent of the Belgian people is considered poor. These numbers date from 2006 and regard the yearly income of 2005. Who is below the poverty threshold, is considered poor. For singles, this is 860 euro a month, for a family with two children 1805 euro.

15 percent is still too much, but without social security, 28 percent of our compatriots would be poor. [47]
As said earlier, the base of social security is the solidarity between habitants of the country: everybody contributes consistent with financial strength. For the employed, part of the salary is given to the fund of retirement, child allowances, unemployment and health insurance. These funds pay you when you are ill, unemployed, retiring or having children. People who work pay for unemployed, senior citizens, sick and child allowances.

The growing needs because of obsolescence, the growing costs because of new technological evolutions in care, but also the economic crisis by which more and more people are excluded, demand a reinforced social security.
A strong social security is after all the best dyke against growing marketing, commercialization and privatisation of healthcare.
Our social security is obtained by social struggle and only collective actions and defence of these achievements will be able to stop an increasing demolition.

Reinforce the accessibility of healthcare

1. Free first line support
2. Cheapen the best medication, vaccinations and medical material by the introduction of the kiwimodel
3. Cheapen hospitalization by a general prohibition of extra fees
4. Automatic allotment of the omnio-statute or system of enhanced refund

Reinforce the quality of healthcare

5. First line central with inscription and levelling
6. Doubling the budget of general practitioners to invest in cooperation, support and quality
7. Fixed medical care with a good basic income for all doctors and medical staff
8. Medical extra training paid by health insurance, defence of commercial sponsoring
9. Clinical scientific science must by solely publicly financed
10. Independent qualitative health education
11. Reinforcement of prevention and safety at work
12. Demolition of the Order of Medics

Reinforce solidarity in health care

13. Protect our health care against Europe's obliged privatization
14. In favour of a reinforced, federal, solider social security and all-risk health insurance
15. Reinforce finances by a millionaire tax
16. Contain the actual growth of 4.5%

Reinforce the accessibility of healthcare

1. Free first line support

Health care as a fundamental right means that the access to care cannot depend on financial possibilities of the patient. For that, the entire healthcare needs to start with a free first line support accessible for everyone. It's important to do that so everyone can get easy access to care. Belgium is one of the few European countries in which the visit to the general practitioner is not free. Free is not costless, it is costly. Free healthcare is based on a prepayment of social security and tax money to health insurance. Both are solider financial redistribution mechanisms.

2. Cheapen the best medication, vaccinations and medical material by the introduction of the kiwimodel

The kiwimodel is a national model of public tender of medication which can save the Riziv 1,5 milliard euro every year

A. The base of the kiwimodel is a scientific need analysis: which and how much medication do we need?
B. The kiwimodel chooses, based on objective scientific criteria and studies (Evidence Based Medicine), the best medication by an independent scientific commission.
C. The kiwimodel uses the common spending power of the society, by health insurance, to obtain the best buying conditions by a tender.

Those three conditions guarantee a rational and affordable policy of medication which ensures the patient and the community the best quality and the best price.

The kiwimodel is inspired by the medication policy used in New Zeeland since several years, cutting the costs for medication into half. In our country, the kiwimodel has been introduced by the book "The Cholesterol War" (2004), a critic book about the pharmaceutical industry by Dirk Van Duppen, general practitioner at Medics for the people in Deurne.
The 21st of December 2006, a deputation of Medics for the people, KWB and LBC-NVK have given, after a year of action across the country, to the minister of Social Affairs in that time, Demotte, an appeal with 102.585 signatures in favour of the kiwimodel. At a large scale, the people got to know the kiwimodel because of an action of Medics for the people together with KWB and Ziekenzorg CM at the 21st of April 2007, when chronic patients went to buy paracetamol in the border region Hulst. The reason for all this was simple: for the price of one box of Dafalgan in Belgium you can buy 8 boxes of paracetamol in Holland, because of the purchasing by tender of supermarkets and chains of pharmacists. We do not plead in favor of the selling of medication in supermarkets like in Holland – they have to stay with the pharmacists who can deliver them in a professional way. But what has to change are the immense prices they are sold to in Belgium. What a chain of supermarkets can do in Holland, our minister has to be able to do it for 10 millions of Belgians thanks to a tender. Since the 1st of July 2008, private health insurances use the kiwimodel in Holland for about 30 medications. The consequences are immense. The price of the most prescribed antidepressant Cipramil (citalopram) is 5 to 15 times cheaper in Holland then in Belgium. The most prescribed blood pressure medication Amlor (amlodipine) 6 to 9 times, the most prescribed medication against acidity of the stomach Losec (omeprazole) 9 to 17 times. [48]
Again, we do not plead in favour of private health insurances, on the contrary. The profits of the kiwimodel have to be returned to the society and the patients. If in Belgium, we would use the Dutch price for the 30 different medications, health insurance would gain yearly 300 million euro and the patient 110 millions. A global application of the kiwimodel would mean a saving of 1.5 milliard euro for the patient and health insurance.

Medication is an important expense for the patients and society:
In a questioning of pharmacists in June 2008, one to three says thee often see patients who cannot pay the co-payment to prescribed medication and buy them on credit. [49] But for our health insurance as well, expenses on medication are the fastest growing cost since the beginning of the nineties. 2005-2006 excepted, when suddenly the medications got a lot cheaper due to the pressure of the kiwimodel, thanks to which for the first time in social history in Belgium and as the only country in Europe the expenses for medication went down with 40 million of euro. In the curves of the expenses for medication, this is called the "kiwi-crack". Since 2007, the expenses are back on height, because of the refund of the very expensive vaccination against cervical cancer that costs 375 euro for one treatment. The application of the kiwimodel

by the Flemish society in April 2010 has made the price for one cure of vaccination go down to 60 euro!

Application of the kiwimodel for all vaccinations

The influenza vaccination and the vaccination against cervical cancer must be bought immediately by the government for the entire country but use of a tender. In that way, they could be free to the patient – without extra cost for the health insurance – and available at the general practitioner's office.
For all basic vaccinations by babies and the vaccination against tetanus for adults, public tenders are already used.

3. Cheapen hospitalization by a general prohibition of extra fees on wages and medical material

Costs for hospitalization are the biggest growing part of what needs to be paid by the patients themselves. Its also one of the main reasons families have debts.[50]
Extra fees on the wages of specialists can go up to 500% of extra cost for the patients and fees on medical material are the main reason for the growth of the hospital invoice. This puts into track a vicious circle that demolishes our solider health insurance. Some specialists and hospitals use patients who have a supplementary insurance policy to get enormous wages. Consequence: high expenses for the insurance companies, who at their turn raise the charges of their patients. In this way, access to supplementary hospitalization insurances gets more difficult so there's even more division in health care. That's why Medics for the people demands a prohibition of extra fees on wages and medical material in case of hospitalization.
There is no medical or deontological reason why a specialist can ask for a supplementary 50%, 100% , 300% of 500% because a patient is in a single room. The patient already pays extra himself when staying in such room. In case the specialist would have to transfer money to the hospital compensating the low finances, this problem has to be solved in another way – not at the expense of the patient. [53] Also, it is not correct deontological spoken since “you cannot put a price on health”, so doctors shouldn't be able to ask for extra fees.
The prohibition on extra fees needs to be general, because they are a measure in the competition against hospitals to get the most famous specialist to the hospitals with the richest patients, instead of dedicating themselves to where they are most needed.

Kiwimodel for medical material

The own contributions for medical material are as well in ambulant care (for instance hearing aids) and most certainly in hospital care an increasing part of the invoice for the patient. A study by Christelijke Mutualiteiten (CM) showed that the cost for the patient for medical material in case of hospitalization have increased with 103% over the last 5 years.[54] According to another study by CM, the Belgian patient paid in 2008 507 euro himself for an overnight stay in a general hospital. 181 euro were for the co-payment and 326 euro for extra fees and wages on medical material. [55] The prices for this medical material in Belgium are higher then in our surrounding countries, according to the following studies of the Federaal Kenniscentrum voor de Gezondheidszorg (KCE) – the difference is 25 to 44%. The KCE is in favour of the kiwimodel for medical material, which is happening already in the most European countries. “Public tenders for hearing aids with some of the most important technical characteristics, like in some European countries, would make a financial reference for a full-fledged hearing aid which would not need a personal fee paid by the patient,” says KCE in a recent study on the price of hearing aids. [56]
Another study, dated October 2005 about colostomy material, advices the use of tenders for the purchase of this medical material. [57] A study dated July 2007 about orthopaedic material also pleads in favour of the kiwimodel. [58]
The KCE has published comparable studies with comparable conclusions about coronary stents. Public tenders can also be organised around prosthesis of knee and hip, pacemaker and other medical implants, like is already happening in the Scandinavian countries. In Belgian, 600 millions of euro has been paid in 2008 for material costs for implants. 65 millions of the sum was paid by patients in form of co-payment and 70 million were personal fees. A price reduction of one third by using public tenders like suggested by KCE would mean a saving of 200 million on material costs.[59]
This means co-payments and fees for the patient can be demolished and the RIZIV would still save an extra 65 million euro.

4. Automatic allotment of the omnio-statute, alike maximum invoice

An estimated 800 000 Belgians are allowed to get the omnio-statute. These are people with a low income whom can benefit raised refund, decreased prices for public transport, exemption of a few taxes, etc. At the moment, only 190 000 people applied to this statute. The target group for this statute are mostly low educated people or people in a strategic of surviving. Exactly for those people it is difficult to apply to the statute. By using the Kruispuntbank, where the incomes of all people are known, this statute can be automatically assigned to all rightful claimants, like is done at the moment with the maximum invoice. [60]
It's a pity that a government talking all the time about administrative simplification isn't able to do this and in this way refuses advantages to 600,000 people.

Reinforce the quality

5. First line central with inscription and levelling

The World Health Organization (WHO) has published her yearly report in 2008 with the title: “Primary Health Care. More than ever’” First line medical care put in the centre, means that quality, accessibility, patient satisfaction and effectiveness in costs in healthcare are the highest. [61]

40% of the problems treated in a specialized polyclinic could be resolved by a general practitioner.[62]
A big part of the patients in emergency rooms could be treated by a general practitioner. The general practitioner manages the entire medical file, has a continuous relation of trust with the patient and his direct environment, the family and the society. Not only prevention and health promotion will be better accepted by the patient when he is in charge, but the same thing is correct for curative health, revalidation or palliative care. If necessary, he is the best person to refer the patient if necessary. A central first line is also a good initiative for the specialist, because in this case they can apply better to their real specialist jobs, in a better collaboration with the general practitioner.

Recently, the Federaal Kenniscentrum van de Gezondheidszorg (KCE) has published a study on how to promote the charms of the profession of general practitioner. [63] The report gives for instance next recommendations: 'encouraging work in a group practice; administrative support and multidisciplinary tasks; well organized guard-duty and initiatives like career interruption, maternity leave, part-time job and continuous medical education during working hours.' Finally, the report pleads for a change of the current payment per performance. The demands of Medics for the people approach these recommendations content wise and financially.

Next measures in the organization of health care should lead to more quality and better accessibility with lower costs:

A. A strong first line:
Inscription in a doctor's practice, levelling (reference to second line by general practitioner) and no co-payment. The general practitioner as a coordinator, who wants to see a specialist has to see his general practitioner first. This will avoid a lot of unnecessary technical researches or medical shopping. [64] [65] [66]

B. Doubling the budget of the general practitioners needs to make possible more cooperation and multidisciplinary working

C. A good basic income for all general practitioners, with extra fees according to quality and work pressure

D. Medical refresher courses during working hours, paid for by health insurance

These demands mean a win-win situation for the patient, general practitioner and solider common health insurance. They make the general practitioner the heart of healthcare.

6. Doubling the budget of general practitioners to invest in cooperation, logistic and multidisciplinary support

General practitioners cost 1 milliard of euro to the RIZIV or less than 5% of the total RIZIV budget. A recent study has shown that the Belgian general practitioner earns relatively little compared to his European colleagues. [67] Belgium is also far behind when it comes to investments to improve the quality of general medical science or commercially independent trainings. To get rid of this arrears and to lift the performance of general practice to the best European level, 10% of the RIZIV budget is necessary.
Application of the kiwimodel for 30 important medications like in Holland would mean a gain of 410 million of euro. Using half this amount, all co-payments in Belgium can be deleted.

7. Phasing out medics based on performance and application of an system of fixed paid medics with a good basic income for all doctors and medical staff

The general practitioner and other health staff at first line need to be able to choose a basic income according their level of education and experiences, complemented with stimuli for performances and pressure, like guard-duty and payment for each subscribed patient. The deletion of the pressure of medics by performance will allow the health employee to give more attention to the patients who need it the most. This is very important for the quality of care.
If the government above that would rationalize in the amount of certificates one needs in Belgium for almost everything (one day illness, school delay, …) that would take away a lot of unnecessary pressure at the doctor's office.
Above that, if the system of paid employment is used for doctors and other medical staff, they can benefit maternity leave, part-time job, etc. This payment system can replace the system of payment per performance, a system which has proven to be bad.
A recent study of the Federaal Kenniscentrum voor de Gezondheidszorg (KCE) shows that forfaitair group practices, who are free thus more accessible for patients, cost in a global way less to RIZIV and have a better quality then medics per performance. .[69]

Up to a dully financed, performant and democratically functioning National Health Service
"The Nordic model"

Medics for the people works in favour of the foundation of a performant democratically functioning National Health Service with sufficient financial power, comparable to the Nordic Model of the Scandinavian countries.
A National Health Service (NHS) has the following characteristics:
1) Free health service equal to all, independent on status and income.
"Judge and janitor on the same room"
2) Universal and at the same time decentralized. All barriers and quarters (also the poor ones) need to have access to good services.
3) All-embracing. The general and specialist medical services, prevention and health promotion, dental surgery, physiotherapy, mental health care, geriatrics … all are part of NHS and care for a total preventive and curative healthcare. The national structure allows the centralization of all data and results and based on that start scientific research.

The 'Nordic model' is well-known because of the best quality, best accessibility, best patient satisfaction, smallest differences and best cost effectiveness of healthcare.[79 80 81 82 83]

The original mission of the British NHS was "freedom of fear" - free everyone of the fear of disease and ensure its consequence to everyone, from birth to death. Founded in 1948 by Aneurin Beven, the NHS has taken care of an excellent care, appreciated by the population and praised in the international scientific literature. However, in the eighties Margaret Thatcher did under finance, dismantle and privatize parts of the British NHS. Her "socialistic" successor Tony Blair continued this politic and still finds itself with public counter-pressure. [84]
The British NHS model has been taken over by many countries, for example Canada and the Scandinavian countries. Today, this model is also under European or international pressure, forced to reduce expenses, demolition and

privatisation. “The problem in the Canadian Medicare is not the system, but the amount of money put into it. The problem with healthcare in the United States is the opposite. It's not the money, but the system,” writes Marcia Angell in a comparative study between the American and Canadian health care system. [85]

“Philosopher's have interpreted the world in different ways;
the necessity is changing it.”
Karl Marx

1. Our principles

Resumed once again:

a/ Health care is a fundamental right and can not be a merchandise. Right to health is a matter of struggling social injustice.

b/ The healthcare staff of Medics for the people choose a side and serve the needs of the people using their scientific knowledge and social engagement.

c/ Medics for the people wants to defend the right to a healthy life, together with its patients, social organizations, health insurances and trade unions. Concretely: the right to an accessible and qualitative health care and education, the right to healthy conditions to work, life, healthy environmental conditions and the right to social security. Medics for the people is is favour of cooperation with and support of the trade unions. The battle of the labour movement is at the base of our social security. The people need the labour movement to reinforce this.

d/ We do not only want to get rid of the symptoms, but also of the social causes of sickness. Or social stethoscope is an important instrument to do research. We want to work in a releasing, emancipating way. No charity, but solidarity in the struggle for the right to health. This is how we see the social responsibility of the doctors and other health staff.

e/ The more people understand what is happening in their body in case of sickness, the more they are challenged to take their own curative process in hands. The more people understand what can be (social, economical, environmental) causes of their illness, the more they are willing to take steps like the battle for the Lange Wapperbrug or the battle for better working conditions. Medics for the people wants to engage itself to support this process together with the people (individually and collectively). Together with the patients, we want to become a social power to change what is wrong and dishonest. This is “empowerment”.

Forfaitair medecine:
RIZIV knows 2 ways of refund: per performance (you pay the doctor, receive a prove of payment and the health insurance partially refunds you) or per forfait. In the last case you are inscribed within a doctor's office and sign a contract that you will always be at their office for first line support, RIZIV monthly pays this group a fixed amount. This means you don't have to pay yourself being a patient and that the doctor gets a same monthly fee, whether you come often to the office or not.

8. Medical extra training paid by health insurance, defence of commercial sponsoring

Comparable to Scandinavian countries, we suggest organizing the continuous medical educational during working hours and making it financed by health insurance. The government needs to defend the sponsoring of certain trainings by the pharmaceutical industry. Research has proven that this means better and cost efficient prescriptions, contrary to what actually happens in Belgium. A report of KCE about a study of quality promotion in the doctor's office says: “In Belgium, more than 73,000,000 euro is paid to doctors accreditation which has no proven effect to the quality of healthcare. These differences invite questioning the optimized budget for a doctor's quality system. [70]

The system of sponsoring medical training by the pharmaceutical industry, linked to publicity for certain treatments, means more irrational, high rated prescription behaviour and a negative spiral for health insurance. The health insurances finance the marketing that is at the base of the overuse and wrong use of

medication, which means derailment of the expenses of health insurance. Let's not forget that the costs for sponsoring are finally calculated in the price of the medication paid by the patient and by health insurance...
Also, this demand of Medics for the people will make it easier for the universities and scientific movements like Domus Medica to coach medical trainings thanks to commercially independent financing.

9. Independent and qualitative health education

Medics for the people demands a national policy of public, independent and qualitative prevention campaigns through media and education. In this, the construction of free, independent, scientifically based websites for health prevention and education are very important. The government needs to pass on to a general defence of publicity and sponsoring by the pharmaceutical industry, not only for medication but also for health education.

10. Reinforcement of prevention and safety at work

Medics for the people demand a good primary prevention at work: no exaggerated working pressure and stress, prevention of industrial accidents and protection against toxic products. Medics for the people demand the same protection for subcontractors or temporary employment. Medics for the people demand the abolition of control medics paid by employers to get sick employees back to work as soon as possible.

11. Clinical scientific science must be solely publicly financed

Today the major part of clinical investigation is paid by the pharmaceutical industry. This has large consequences. Investigations are not done in order to fulfil the most important needs, but investigations are done for the medication or therapies for which a powerful spending power exists. Sponsored scientific research enables profits instead of benefits for the people. The pharmaceutical industry uses research as marketing. Negative results are not published, positive results are blown up. No comparative research is done until then best available therapy or medication. A lot of manipulation is done in investigation. In short: who pays decides .[73] If we want to adjust scientific research to the most important needs, solely publicly financing is necessary. That's why Medics for the people supports the idea of Marcia Angell and loads of other international scientists to return research to universities and public investigation organizations, fully financed by public money. [74] These funds can be paid by an extra tax on big marketing budgets and big benefits of the pharmaceutical industry.

12. Replacement of the Order of Medics by a high council of medical ethics (Bill Demeyer, Detiège)

Medics for the people is in favour of the replacement of the Order of Medics by a high council of medical ethics, as described in the Bill Demeyer, Detiège and Peeters (SP.a). Apart from that, Medics for the people is in favour of the foundation of fora for the defence of patient rights. The Order is an undemocratic organization. Her jurisdiction is a mockery of all modern rules. It's a corporate organization for the defence of the doctors and above all the financial issues of rich doctors. The Order opposed itself several times against free and accessible healthcare and damages patient rights in that way. The Order was, and still is, an instrument in the hands of the very conservative Syndical Chambers of Dr. Wynen and her successor BVAS. We also conclude the Order is not able to ensure essential tasks concerning the ethic and deontology of healthcare. Other – new – organizations and structures, with a bigger democratic share, are now responsible for the development of the medical ethic. Examples: the Federaal Kenniscentrum (quality of healthcare), the federal Bio-ethic commission (ethical matters), the parliament that has voted the law to patient rights...
As intermediate step to the demolition of the Order, Medics for the people wants the demolition of the mandatory contribution to the Order. In public opinion, this “mandatory contribution” is seen as an attack to the free choice of association. The demolition of this obligation would permit to those in favour of the Order to prove the relevance of the Order as association of doctors thanks to their financial support. We think that the demolition of this obligation will make disappear rapidly the Order by lack of money.

Reinforce solidarity

13. Protect our health care against Europe's obliged privatization

Medics for the people is against a commercial marketing of Belgian healthcare under the pressure of the European right to competition. Therefore, Medics for the people works in favour of the European acknowledgement of the non-economic character of health care and health insurance as services of general importance.[75]
Complementary, we want to reinforce the existing mechanisms of solidarity within the Belgian healthcare at that point that it is protected from every deregulating influence of the European right to competition. This gives us the possibility to protect our social security against European laws for the privatisation of our healthcare.

14. In favour of a reinforced, federal, solider social security and all-risk health insurance…

The most important opposition in this country isn't the one between North (Flanders) and South (Walloon provinces), but the opposition between rich and non-rich. Social differences are the most important player in the difference in health, regardless the language of the person. This land does not need a separation, but it needs solidarity. Solidarity means transfers, not between “Dutch speaking persons” and “French speaking persons” but of “rich and healthy” to “sick and poor” people. Defederalization weakens this principle of solidarity.
A unified solider healthcare has got a much wider social basis to divide the risks over as many people as possible. It benefits the advantage of a big scale and can guarantee at the same time enough decentralization and autonomy to organize care up close and personal to the people. The actors in healthcare, mostly doctors, can delete or prevent unjust transfers by means of scientific recommendations. Using the Evidence Based Medicine, we can investigate the use of the most medical interventions. This is not a matter of language or culture, but a matter of science, applicable to all. In that point of view, there is no Flemish or French medical culture. The Federaal Kenniscentrum has developed a recommendation (“The pro-operative investigation”) as an answer to an enormously high number of pro-operative investigations, mostly in Walloon hospitals.[76] Why, in case of an operation, a French-speaking patient has to be prepared differently than a Flemish-speaking one? The fact that the Walloon patient can enjoy less a well build medical science compared to a Flemish patient has a lot to do with the bigger power of the conservative syndicate of doctors, in which rich doctors have the power, in Walloon and Brussels then in Flanders. Division would not solve the problem, on the contrary. Flemish, Walloon, Brussels... everyone need to work together to obtain a progressive, qualitative, accessible healthcare.

15. Reinforce finances by a millionaires tax

The financing of Social Security is done by social taxes on salaries, by progressive tax in income and indirect taxes. Medics for the people is opposed to financing by indirect taxes (TVA, consumer taxes). Indirect taxes are unjust because the poor pay relatively more than the rich. This is not conform the principle of solidarity. This happens more and more to compensate the continuous increase of the patronal social compensations. Successive governments have increased these compensations in a few years with almost 6 milliards of euro. This means 6 milliards less for social security. [77] The financing needs to be completed regarding the growth of real needs or technological evolutions in medics, with a solidarity tax for high incomes, like in the most European countries. Two percent of income tax above 1 million euro would mean in Belgium 7 milliard of euro.

In De Morgen and De Standaard, Tine Van Rompuy published the day after the appointment of her brother Herman as president of the European Union the following contribution. Tine is “godmother” of the millionaire tax and has a great sympathy for Medics for the people. We join her argumentation about millionaire tax in this vision text because she takes a leave starting from healthcare.

Two presents for my brother, president Herman

by Tine Van Rompuy

"For Herman, I got two presents. For the grandfather Herman I bought a Cuban cigar. Because he enjoys a cigar to conclude a party. For the politician Herman I have another surprise. A nice box with the recipe for the so-called millionaires tax. On the box is written: “This product will change your life!”. The millionaires tax, this means that 2 percent of the population, the very rich, would pay 2 percent extra on their capital, because there would be money for a Europe of the people, instead of a Europe of profits of a few shareholders. I'm proud to be “godmother” of the millionaire tax-campaign, and we are looking for ten thousands of “fans” of the tax.
As a nurse and an active unionist, I live between simply people who do not like the EU because our EU does not function at the size of humans. The Union does bring so few positive messages, it's all about competition and commerce. The capitalism sells soap bubbles on which the banks have crashed. Almost our entire system seemed to crash, but suddenly one has found milliards of euro to save it! Normal people get sacked. In UK, the railways are privatized, trains arrive too late, trains look terrible. The market of electricity is opened to the market and everything has become more expensive. And the big giants of energy get milliards of profit.
Europe has to make a choice. And now, my brother has to make that chose. Who will pay for the crisis? Who will pay the milliards of euro given to the banks? The working class or those responsible for the crisis? I would like to expand the Belgian millionaires tax to Europe. By using a European millionaires tax, the common people do not have to pay for the crisis. We need jobs. Everywhere in Europe. Well, the millionaires tax will create jobs. The money of it will create jobs in healthcare, well-being and education, can take care of a green economy and a European social security system, for a program of public scientific research instead of private.
We see the outcome of commercialization in Belgium in the sector of homes for elderly. During the last 5 years, 10,000 commercial beds have been bought of the non-profit sector. Proprietors get maximum benefits, while this sector needs so many extra money. Father Damiaan, who has been canonized a few weeks ago in Tremelo, a village at 10 kilometers from where I live, has a home for elderly named after him. It has been bought by the commercial Senior Living Group. Last year, this home divided 28 millions of euro between the shareholders. 28 million euro is the yearly salary of 620 nurses. No, you cannot gain profits at the expense of weaker and poorer. Privatisation means less personal and less good care.
We need money for home for elderly and day care centres. That's why I want a Europe in which the government has the right to subsidize these homes for elderly and these day care centres. If my granddaughter needs day care, I want to leave her there feeling comfortable, I want there is qualitative supervision by the government and not something like privatized day care in Holland where the government has no longer the right to supervision. I work in the university hospital Gasthuisberg in Leuven, the biggest hospital in Europe with more than 8,000 employees. Healthcare is a right to everyone. No gaining of profits because of the sick, the ones who need help, the elderly.
European politicians decide far away from our bed, but luckily there are loads of fresh, green ideas we can realize together with trade unions, non-governmental organizations and progressive politicians. Put people first, not profit. Also in Europe.

(De Morgen and De Standaard, 21st of November 2009)

16. Contain the actual growth of 4.5% in de healthcare

First of all, this growth is necessary because being ill gets more and more unaffordable, as shown in the latest national health survey of 2008.[78]

This survey has been made in 2008 just before the financial crisis. The health survey shows that "bad health is socially determined". We know that the economic crisis will make more people ill the coming years and that the needs of healthcare will decrease.
Finally, there are the supplementary costs of obsolescence. According to the health survey, "the percentage of people indication to have (had) one or more long term illnesses between 2004 and 2008 has increased from 23.8 to 27.2%, partially following the obsolescence. The percentage of the people too limited to do their daily tasks, following long time illnesses, has increased between 2004 and 2008 from 13.7 to 17.1%."

2. Eight important features for a "Medics for the people" group practice

Accessibility

1. Easy accessible healthcare

Quality

2. Permanent quality promotion
3. Multidisciplinary approach and cooperation
4. Management a must for a good direction
5. Research and education following concrete needs

Solidarity

6. Participation and society-wise working
7. National unity, international solidarity and anti-racism
8. Medics for the people chooses its side

Accessibility

1. Easy accessible healthcare

In this, financial accessibility is essential. The most practices of Medics for the people work with the forfait payment system and have a fixed inscribed patient population. This means the patients enjoy free medical services. Earlier, patients were taken care of at the refund-rate (no co-payment was asked for). People already pay for healthcare by taxes and social contributions to their salary. Why pay a second time? Healthcare is a fundamental human right and should not be blocked by all sorts of co-payments.

Easy accessible also means that patients feel comfortable in the offices. It's their home. In the most cases you can take this rather literally. Hundreds of patients have volunteered building or renovation numerous houses for practices.

Easy accessible also means that health staff; doctors and other employees, work at a normal employee rate, comparable to the one received by most of the patients. Concretely, this permits to keep consultations for free and to invest in projects of society change.

Easy accessible is also shown in the fact that most of the health staff live near the office and between the people they work for. This increases involvement for the problems of the people in the neighbourhood and is good for the doctor-patient-relationship.

Quality

2. Permanent quality promotion

For Medics for the people, quality means primary: offering the patient as a human being a qualitative care

and service. We want to help the patient with all our empathy. But to be able to do that, you also have to take good care of yourself and you need a team in which you can work in a good atmosphere, with enough attention and care for each other.
Quality means that you listen to the patient with enough time from a bio-psycho-social or holistic point of view. For Medics for the people, the social context is very important in this.
Quality means that the patient can be offered a mix of treatment, prevention, health promotion, revalidation or palliative care according to his/her needs.

Medics for the people spends a lot of time and attention to prevention and health education:

1) Health education (lifestyle factors: food, movement, stress, conflicts, quit smoking, against misuse of alcohol and other drugs..). In this point of view, some practices have support groups. To use the power within the patients. And because ill people are often helped by the exchange of experiences with others and their support.
2) Prevention also means attention for and battle against unhealthy and insecure working conditions, environmental pollution and traffic accidents. In case of working conditions, Medics for the people works together with trade unions, syndical delegations, professors in labour medical science and some other services. In case of environment, there is a close collaboration with habitant groups and environmental experts.

Medics for the people bases the medical treatment on the Evidence Based Medicine and checks thus the scientific quality of care.
Since 2000, the paper files have been changed into electronic medical files (Medidoc). Some of the Medics for the people offices are known as pioneers in “Online-on-the-spot”: the research of the newest clinical medical evidences and medical directions for the resolution of clinical questions by use of the internet with the patient at the moment of consult. The general practitioner brings and translates the latest directions directly to the patient. This is democratization of scientific information. This is also “empowerment” at individual level: increase the tenability of people with correct information against the manipulative publicity for medication in the media.
At other innovative areas in modern techniques, Medics for the people offices also have an important part. Some examples: the use of cognitive behavioural therapy, a scientific form of psychotherapy, in the daily practices as a general practitioner. The integration of professional risks in the medical file.
The Medics for the people offices have an active, continuous, project-based direction of quality improvement. Medics for the people uses the method of “social constructivism”. It is a competence in which we can construct better quality in our work, thanks to collaboration, exchange, discussion, help, literature studies and the continuous use of the 'Plan, Do, Check, Act'-circle. Which is good for the satisfaction of patients and medical staff. Illustration: the numerous participations, nominations and prices of doctors and the yearly scientific first line symposium.

3. Multidisciplinary approach and collaboration

Apart doctors, at some Medics for the people offices you will find a doctor-acupuncturist, a dietician and nurses. The offices also work in close collaboration with other services in nursing (OCMW, health insurance, some private nurses), physiotherapists, speech therapists, mental care specialists and specialists in second and third line.

4. Management a must for a good direction

A professional approach is a must for all modern, multidisciplinary, first line health centres. Our group practices all have the same directions regarding administration and direction, personnel department and HRM, patients, financial rules and infrastructure. In every Medics for the people centre, there's a “responsible for organization and direction” (VOB) that makes part of the national coordination and gets the necessary accompaniment and education. This local VOB is responsible together with the responsible of

practice.
At Medics for the people, all employees are equal.
Doctors, doctors in education, nurses, other medical staff, people at reception desk of volunteers all have the possibility to give their opinion and are involved in the direction of the practice.
Every two weeks there's a team meeting with all fix employees. Every two weeks there's a medical reunion about extra training. Apart from that, there are regularly meetings with the volunteers.
The most important agreements are written down in scenarios or protocols.
In every practice decisions are taken together and everyone is responsible for their realization. Apart from national project, every practice has its own projects and initiatives.

5. Research and education following concrete needs

Medics for the people uses the dates of the EMD (Electronisch Medisch Dossier or Electronical Medical File) for all scientific research.
At the times of the generation pact, Medics for the people has shown for instance that taking away the right to early retirement or the right to time credit has implications to health, since the majority of patients above 50 suffers from at least 1 chronicle disease. Another investigation was about the use of puffers with patients as an indicative for possible air pollution like in Genk and Deurne. Thanks to this study, Dr Harrie De Witte could active the debate of the council in Genk. Finally, he obtained some cleaning measures in the area.
Medics for the people also defends patients in case of expertises regarding sickness or industrial accidents.
In loads of cases, Medics for the people is also involved in scientific science, presented at scientific congresses and published in scientific magazines.
The most practices of Medics for the people have been acknowledged by the University Centres of General Practitioners as educational practices. Medics for the people has trainee posts for students of medics and those who need a trainee for two years after graduating. Students of dietician, nurses and social services can be a trainee.
For engaged students, Medics for the people organizes days to accent the social dimension of our job. Yearly, there is for them also the “social investigation”.

Dirk Avonts, professor general practitioners in Antwerp, has written in a column for “De Huisarts” about the book of Kris Merckx, “Doctor of the People”: “Not without reason, these practices of Medics for the people are often called the fifth University of Flanders. The people have the right to get the best medics, based on reality and against affordable prices, preferably for free. That's how you become a doctor of the people.”

Solidarity

6. Participation and society-wise working

Practices of Medics for the people are first line health centres and centres of action.
Our engagement as health staff is not limited to our office. If the causes of an unhealthy situation are social, you have to dare to go out of the office and try to actively change the social environment. This means that as being a health staff member you also have social responsibility.

Medics for the people stimulates her staff and patients to volunteer. Volunteers are strongly involved in planning and working. Volunteers support the job of the fix employees or help with administrative tasks (mailings).
Volunteers help with the construction, renovation, maintenance of our infrastructure. Volunteers also participate in the numerous actions started or supported by Medics for the people: the kiwimodel, a more healthy environment, more healthy working conditions, peace, Third World, against the Order of Medics, against the closing of hospitals, solidarity to employees on strike … This happens often in collaboration with the chosen-ones for PVDA.

Volunteers help at the numerous parties, fraternizations (for example with other practices), cultural events...

7. National unity, international solidarity and anti-racism

“Those who fight injustice, wherever they are, are our brothers.”
Camilo Cienfuegos, resistant member in Cuba and friend of Che Guevarra

At the moment, Medics for the people have 11 group practices divided over Flanders, Walloon and Brussels. It's a national, multilingual organization. It's a collective solider organisation in which one practice can literally ask help by the others for everything. This can be by lending manpower, financial issues, support with actions... Medics for the people is directed nationally. Year planning is discussed collectively with national projects like the Kiwiproject, the quality project, campaigns for the book of Kris Merckx. Managerial projects can also be collective year projects.
In the Third World and some countries of the previous Eastern bloc, problems concerning health and healthcare are even bigger then over here. Medics for the people wants to help them, because all people are equal and have the same right to well-being, good healthcare and luck. That's why at the end of the eighties, the organization Medics for the Third World has been founded. Today they are into the group www.intal.be, you will find more information on their website.
Loads of our health staff has worked in another country for a short or long period: in refugee camps of Palestinian people in Lebanon, Filipinos, Burkina Faso, Eritrea, Congo, Nicaragua, Iraq, Mexico, Cuba, Venezuela...
Together with Medics for the Third World, Medics for the people organizes voyages and internships for students in Third World countries.
Working in the Third World is possible within Medics for the people by means of job rotation. Somme Medics for the people doctors work for a while at a project in the Third World. Upon their return, they help organize the solidarity for the people they have worked with. Like Dr. Elly Van Reusel who has returned after two years of working with Gabriella in Manilla, Filipinos. You can read more at www.alyado.info.

Against the international unity of big multinational economic powers, we must put our international solidarity. Racism, discrimination, chauvinism and nationalism divide an dilute the working people.
One or several times a year, all practices have concrete solidarity campaigns for the Third World. Patients are extra sensibilized when “their” doctor is on a mission.

Globalization has turned our world into a village. Most certainly in labour communities, where our group practices can be found, multi-nationalising and colouring of our society is an important issue. We take care of all people in an equal way, independently of their origin and colour. We try to work at objective problems like discrimination, formation of ghettos, problems living together … by the cooperation of “migrants” and “Belgians”. For Medics for the people, all people are in the same class, regardless language, race, colour, religion or background. “In the mine, everyone's black” one could read on the banners of Belgian and Turkish miners at a manifestation against the closing of the mines in 1985.

8. Medics for the people chooses its side

Medics for the people is an initiative of the Workers’ Party of Belgium (WPB).
Where material causes of sickness and illness can be solved in a social way, you need a political combat to be able to proceed with those changes. Many members of the health staff of Medics for the People therefore participate in a politic engagement within WPB.
In the practices of Zelzate, Hoboken, Deurne, Lommel, Genk, Herstal, Seraing and La Louvière, doctors or other medical staff of Medics for the People has been chosen as a PVDA council member in the city council. Their principle is: street – council – street. They get to know the concrete problems of the people in the streets, talk about it at the council and return to the street with the answers.
Political engagement within PVDA is not a condition to work for Medics for the people. Although, loyalty is expected of all employees regarding our link to PVDA and shared efforts for more solidarity or a society of “put people first, not the profit”. Not only on medical point of view, but also socially Medics for the people stimulates critical reflections and discussions.

"*Free food and education for all children is the biggest work of Social Healthcare done in Cuba.*"
Che Guevara

There are hard evidences that socialistic countries like Cuba have superior health numbers compared to rich capitalist countries. Despite the fact a country like Cuba only has the very limited possibilities of a developing country. [86]
The Yearly report of the World Health Organization in 2008 writes: "In Cuba, the life expectancy at birth is the second of all the Americas, in 2006, it was 78 years, only 7.1 on 1000 children died before the age of 5. Indicatives for education for young children are among the best of all Latin America. Cuba has obtained these results despite huge economic difficulties, until today. The gross domestic product per head was only 4,500$ (to compare: in Belgium 30,000$).
Cuba's success in child prosperity reflects its devotion to a politic of national healthcare and intersectoral actions. The education of health staff is a national priority. Educations in first line aid devote special attention to the social determinants of health. They work in multidisciplinary teams in a large first line structure, where they are responsible for the health of a geographical determined population, in the curative sense as well as preventive care. They collaborate closely with the societies, social services and schools, where all children are medically investigated twice a year in collaboration with the teachers." [87]
These results and way of working is closely merged into the social system. Cuba has the lowest gini-coefficent (to measure socio-economic injustice in a country) of all Latin America. Basic needs are taken care of for everyone: food security, right to work, living, education, healthcare, retirement, maternity leave, public transport and even culture. [88] [89] To be able to do this in a social society, everyone contributes according to their needs. It's a society build from solidarity between people and not exploitation. Not the haunting of maximum profit, but the human is in the centre.

Read more…

Doctor of the People

"In "Doctor of the People", Kris Merckx has described the history of a generation of doctors that has taken the opportunity given by society, because they had the possibility to go to university by democratization of education. They want to answer the question: which doctors do we need in society? Building a status has been replaced by social engagement, with special attention for the people in need, here and in developing countries.

Kris Merckx was a visionair in 3 points of view. He was clearly convinced that social determinants (conditions of living, working, and habitation) are essential in understanding sickness and health. The report "Closing the gap in one generation" (October 2008) confirms the relevancy of this analysis. Second of all, Kris Merckx has clearly chosen working in a first line healthcare that has to be accessible, qualitative and cost efficient. The "World Health Report 2008": "Primary Health care: now more then ever" demands the worldwide attention for first line healthcare. In third place, this book shows the importance of joining patients and population actively in all processes of healthcare. The book has been written with a big "heart" for the daily health of many people, in which a general practitioner is involved on a daily base. The fact that Kris Merckx also critically takes a look at the choices made by himself, make that it is an important and inspiring document for all those involved in healthcare."

Prof. dr. J. De Maeseneer

Doctor in overall

"Due to the fact he sees more often patients suffering high working pressure, he decided to work himself undercover as an employee at the port of Antwerp. "In my live I have never worked that hard, been so tired and had to pull down my social life", says Van Bever."

Psychically, the system of temporary employment is very heavy. As a day contractor, he only heard the day before if he could work the day after. There is no possibility to a normal family life. Physically as well it's a heavy job. Tennis elbows and offended hands are there on a daily basis. Also, despite of the protective clothing, doctor Van Bever questions the charging and decharging of chemical products. Welzijnszorg **(ACW) 2008**

The cholesterol war

"With a lot of interest and attention, I have read the engaged but also scientific text of dr. Van Duppen about the (lack of) medication policy in Belgium. He wanders around the history of well known and less known medication, international laws and cost prices, the direction of big pharmaceutical holdings and the reactions of health staff, patients and government. With the scalpel of a doctor he systematically exposes all difficult matters and at the end does a concrete proposition for a healthy, open direction and a large social debate. Hopefully we will come to the

point we can do this concretely and one will have to find loads of good arguments to make his points of view sway."

Prof. Dr. Josse Van Steenberge, previous rector UIA, professor social security law and chairman of the Associatie Universiteit & Hogescholen Antwerpen

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Verantwoordelijke uitgever Dirk Van Duppen
Sint Rochusstraat 57-59, 2100 Deurne
dirk.vanduppen@gvhv.be
Voor meer info www.gvhv.be

Visietekst
2010