Resisting privatization and marketization of health care: People's Health Movement's experiences from India, Philippines and Europe

Resistindo à privatização e à comercialização dos cuidados de saúde: experiências do Movimento pela Saúde dos Povos na Índia, nas Filipinas e na Europa

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ABSTRACT For the last three decades, healthcare systems have been under pressure to adapt to a neoliberal world and incorporate market principles. The introduction of market-based instruments, increasing competition among health care providers, introducing publicly-funded private sector provisioning of healthcare through health insurance financing systems to replace public provisioning of health care, promoting individual responsibility for health and finally, the introduction of market relations through privatization, deregulation and decentralization of health care have been some common elements seen globally. These reforms, undertaken under the guise of increasing efficiency and quality through competition and choice, have in fact harmed the physical, emotional and mental health of communities around the world and also contributed to a significant rise in inequities in health and healthcare access. They have weakened the public healthcare systems of countries and led to commercialization of healthcare. This article presents three case studies of resistance, to the commercialization of health care, by the People's Health Movement (PHM) and associated networks. It aims to contribute to the understanding of the way neoliberal reforms, including those imposed under structural adjustment programmes and some promoted under the Universal Health Coverage (UHC) paradigm, have impacted country-level health systems and access of people to health care, and bring out lessons from the resistance against these reforms.

KEYWORDS Healthcare systems. Health services. Privatization. Political activism. Private sector.

RESUMO *Durante as últimas três décadas, os sistemas de saúde têm estado sob pressão para se adaptarem a um mundo neoliberal e incorporarem princípios de mercado. A introdução de instrumentos de mercado, o aumento da concorrência entre os prestadores de cuidados de saúde, a introdução de prestação de cuidados de saúde do sector privado com financiamento público através de sistemas de financiamento de seguros de saúde para substituir o fornecimento público de cuidados de saúde, a promoção da responsabilidade individual pela saúde e, finalmente, a introdução de relações de mercado através da privatização, desregulamentação e descentralização dos cuidados de saúde têm sido alguns elementos comuns vistos a nível global. Estas reformas, empreendidas sob o pretexto de aumentar a eficiência e a qualidade através da concorrência e da escolha, prejudicaram de facto a saúde física, emocional e mental das comunidades em todo o mundo e também contribuíram para um aumento significativo das desigualdades na saúde e no acesso aos cuidados de saúde. Elas enfraqueceram os sistemas públicos de saúde dos países e levaram à comercialização dos cuidados de saúde. Este artigo apresenta três estudos de caso de resistência à comercialização dos cuidados de saúde, pelo Movimento pela Saúde dos Povos (MSP) e redes associadas. Visa contribuir para a compreensão da forma como as reformas neoliberais, incluindo as impostas pelos programas de ajustamento estrutural e algumas promovidas no âmbito do paradigma da Cobertura Universal da Saúde (CUS), tiveram impacto nos sistemas de saúde dos países e no acesso das pessoas aos cuidados de saúde, e tirar lições da resistência contra estas reformas.*

PALAVRAS-CHAVE *Sistemas de saúde. Serviços de saúde. Privatizações. Ativismo politico. Setor privado.*

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Introduction

For the last three decades, health care systems have been put under great pressure to adapt to a neoliberal world and incorporate market principles. The strengthening of neoliberal policies across the world has been associated with a systematic reduction in state's intervention in different aspects of social welfare and protection, aiming to create new markets, "liberate the enormous creative energy of the markets"[1(48)], and foster investment.

Starting from the early 1980s, international financial institutions – mainly the International Monetary Fund (IMF) and World Bank (WB) – inspired a series of Structural Adjustment Programmes (SAPs) in Low-and-Middle-Income Countries (LMIC) that were supposed to ease the transition towards a market-driven world. Later on, particularly following the financial crisis from 2009, austerity policies similar in content were implemented in High Income Countries (HIC) in Europe and elsewhere as well.

Even though specific interventions have varied across countries, there are significant commonalities: the introduction of market-based instruments, increasing competition among health care providers, introducing publicly-funded private sector provisioning of healthcare through health insurance financing systems to replace public provisioning of health care, promoting individual responsibility for health and finally, the introduction of free market through privatization, deregulation and decentralization of health care[2,3]. SAPs and similar austerity programs have been complemented by policies specifically aiming to "shrink the public economy in preference for private enterprise"[4(424)]. Unsurprisingly, cutting costs in the field of social protection did not have a beneficial impact on people's lives and has instead harmed the physical, emotional and mental health of communities around the world[5]. It has also contributed to a significant global rise in inequities, meaning that more

people are dispossessed and in need of access to health care today, compared to decades preceding SAPs implementation[6]. Moreover, when cuts were implemented in the field of the health workforce, health institutions remained understaffed and existing workers overworked, leading to an increase of health worker migration, leaving public systems to work in other countries, in the private sector, or dropping out of health professions[7,8].

Even though neoliberal reforms have sometimes been done through a model of 'big bang' privatization, with time the same financial institutions started calling for a more nuanced approach, allowing the private sector to gradually take over public systems e.g. through operating health services or introducing Public-Private Partnerships (PPP), as well as to benefit from the introduction of state-subsidised health insurance schemes. Additionally, by the beginning of the 1990s it was clear that SAPs have had a disastrous impact on LMICs[9], and, in order to mitigate them, the WB, pushed their weight behind financing solutions such as 'strategic purchasing' and corporatization of public hospitals[10].

The World Health Organization (WHO) implicitly supported this through its articulation of 'new universalism', which conveyed that ownership and nature of provider did not matter in the provision of health care; instead efficiency, quality, competition and provision were key[11]. The proposed scenario envisioned the private sector playing a central role in the provisioning of services, with the government mainly playing the leadership, regulation and financing roles[11]. This was further cemented in the World Health Report of 2000[12] through the articulation of 'strategic purchasing', which underlay the increased role of the private sector in providing publicly funded services. These ideas have been consolidated under the dominant articulations of Universal Health Coverage (UHC)[13,14]. Many of the current privatization initiatives are being undertaken with the paradigm of 'strategic purchasing for UHC',

still under the pretext of achieving efficiency and quality by opening the door to competition (for providers) and choice (for people)[14].

The attempts to privatise healthcare and alienate health care systems from the communities using them has not gone through without opposition. According to Hans-Ulrich Deppe:

> A healthcare system mirrors a society. It reflects its development and its character [...] this means that the transformation of a health care system implies more than mere technical changes. Structural changes in a healthcare system are in fact always the result of social and political struggles: a given system of health care has always been fought for[15(30)].

This article presents three case studies of resistance against commercialization of health services by the People's Health Movement (PHM) (see article about PHM by Baum, Narayan, Sanders in this issue) and associated networks and organizations. It aims to contribute to the understanding on the way neoliberal reforms, which include those under SAPs and the UHC paradigm, have historically impacted country-level health systems and access of people to health care, and to bring out lessons from the resistance to these reforms.

Methods

The article brings together three case studies, contributed by PHM circles in response to a call that was put out regarding this article. The case study from Rajasthan has been contributed by Pachauli Cand the Chhattisgarh case study by Nandi S, both of whom are from Jan Swasthya Abhiyan(JSA)/Peoples's Health Movement India. The case study on the Philippines has been contributed by the Council for Health and Development, with the support of the Alliance of Health Workers (AHW), Health Alliance for Democracy and PHM-Philippines. The section on Europe has been elaborated by

Vračar A based on recent experiences of PHM activists around Europe, who participated in local and regional campaigns. The section also relies heavily on experiences and contributions collected by European Network Against Commercialization of Health and Social Protection (European Network) and PHM-North America. Secondary literature was also reviewed. Nandi S and Vračar A are members of the Steering Council of PHM Global and Pachauli C is member of JSA Rajasthan. The authors have been involved in the campaign in their respective regions (India and Europe) and states (Rajasthan and Chhattisgarh). Ethics approval was not required as this article has been based on analysis of secondary data and personal observations.

People's Health Movement

Since it was established in 2000, PHM has channelledcivil society efforts around the world, aiming to counter the marketised and commercialised vision of health care advanced through SAPs and comparable austerity programs. According to PHM,

> Social movements, operating at local, regional and national levels, have played and continue to play a critical role in creating the conditions for better health and access to affordable decent health care[16(18)].

Also,

> Strong people's organizations and movements, struggling for more democratic, transparent and accountable decision-making processes, are fundamental to address and reverse this situation [caused by commercialization of health][16(16)].

As a network of grassroots movements and initiatives around the world, and especially from LMIC, PHM has been vocal about the negative impacts of SAPs and neoliberal

policies generally on health. While its critique of the commercialization of health and the disregard for social determination of health has been global, efforts to organise for Health for All have often taken on a more local character. These efforts have focused on a diverse set of specific issues, ranging from the general concept of commercialization of health to specific problems arising from outsourcing.

Even though resistance to commercialization of health care has taken on different forms, it has, at the same time, addressed a common thread of problems arising from the general trend of marketization of healthcare. In the following section we describe experiences in the struggle against privatization in three regions – India, South East Asia (i.e.Philippines) and Europe in order to illustrate both the concerns and issues and strategies taken up in the campaigns. It is important to mention that the three cases described are meant to be illustrative and constitute only a part of the range of ongoing campaigns and initiatives in all other regions and country circles of PHM and by associated organizations and networks.

Illustration of struggles against privatization

Case 1: India: Rajasthan and Chhattisgarh

Since India faced the onslaught of SAPs and 'liberalization' in the 1990s, neoliberal trends have continued to inform social policies in the country, leading to unregulated expansion of the for-profit private sector[17,18]. In 2004, the government sought to undo the negative effects of the SAPs, initiated the National Rural Health Mission (NRHM), and increased health budgets. However, simultaneously they opened opportunities for outsourcing government health services and facilities, and increased subsidies to the private sector[18,19]. Privatization of healthcare services was cemented in India's health policy through the launch of the Publicly-Funded Health Insurance (PFHI) scheme, the Rashtriya Swasthya Bima Yojana (RSBY) in 2007 that brought in the for-profit sector to provide publicly-funded services. Despite evidence of inequity in utilization, 'cherry picking', and the lack of financial risk protection in the private sector[20,21], PFHI was expanded further in 2018 through the Pradhan Mantri Jan Arogya Yojana (PMJAY) under the right-wing government's Ayushman Bharat initiative[22]. Simultaneous reductions in budgets for the government health system and public health programmes have been seen over the years. Studies by JSA and others have shown that the neglect of the public health system has led to gaps and weaknesses in service provision, which was then used as a rationale to privatise or outsource these services[23]. However, these initiatives faced similar problems that they were supposed to address, e.g. attrition of health personnel[23].

JSA has been opposing the described moves in many ways. At the national level, JSA has been issuing statements on various issues that are related to the neglect of public health systems or promotion of private and market-based healthcare. For instance, in 2018, JSA published materials on the budget cuts to public healthcare[24], against the government's move to provide land and funds to the private sector to set up hospitals[25] and demanding that the government should abandon the PMJAY scheme[26]. JSA has also been developing popular material on privatization, politics of health care and the political economy of healthcare. Policy primers on privatization, health insurance and strengthening public health systems were developed in 2018 in the run-up to the National Health Assembly, where 2000 activists from 24 states demanded health and health care as a fundamental right.

State units that constitute JSA have undertaken campaigns against outsourcing of public health facilities and services such as primary health centres (e.g. in Rajasthan, Madhya Pradesh, Karnataka and Punjab), and diagnostic and radiology services (e.g. in

Chhattisgarh). Below we narrate struggles undertaken in the states of Chhattisgarh and Rajasthan.

In December 2012 the Chhattisgarh state government started the process of outsourcing diagnostics and radiology services in 379 government health facilities. Fearing the implications for patients and the public health system, JSA Chhattisgarh launched a campaign against the outsourcing[27]. Similarly, when in 2015, the Rajasthan government announced the outsourcing of 300 Primary Health Centres (PHC), JSA Rajasthan intervened[28]. In both cases, JSA developed an evidence-based critiques of the PPP proposals in order to investigate ambiguities between stated goals and actual operationalization, and the possible implications for patients and the government health system.

The stated objective for outsourcing in Rajasthan was to leverage the PPP policy and use the private sector to 'improve quality' by filling gaps in the government health system, especially in 'underserved' areas. However, JSA Rajasthan found that most of the PHCs to be outsourced, were in and around urban areas. Similarly, in Chhattisgarh the outsourcing proposal emerged from the state policy on PPPs and was aimed at improving lab services in urban and in 'underserved' areas. However, the government initially received bids only for the urbanised areas and not for the more 'remote' and tribal areas, indicating that the private sector was unwilling to operate in an area that may be in more need of services, but which might not yield profits.

In both states the private agencies were to be selected through a tender, with the 'lowest bidder' getting the contract, implicating changes in cost, quality and provision for patients. In Rajasthan the PHC infrastructure was to be handed over to the private agency for a minimum of five years and the government health staff replaced by staff appointed by the private entities. In Chhattisgarh the private agency could recruit staff or sub-contract the lab. The private lab was to operate inside the government facility, alongside the government lab, for ten years. Experiences from other states had shown that such arrangements resulted in redundancy of health staff, discontinuation of existing services and in the government facilities becoming dysfunctional.

The cost of the project to the government and to people seeking care was a major concern for JSA in both states. In Chhattisgarh payment for lab tests would be done by government on a per-test basis, and the labs would be operated as 'business centres'. This raised concerns regarding provider-induced demand and doctors prescribing irrational tests, as had been seen in other instances. In Rajasthan the government was to provide an annual budget of approximately INR 3 million per PHC (INR 1 = USD 0.014). There were provisions for the private agency to charge for additional services (in Rajasthan) and to charge non-poor and patients referred from the private sector (in Chhattisgarh). In both cases there was a concern that private agencies would have the opportunity to charge people for services that should be provided free of cost.

The campaigns against these privatization initiatives followed successful strategies used in the past. JSA Chhattisgarh forged a broader alliance with trade unions and organizations working on issues of social justice. They organised street action, rallies, a signature campaign, petitioning and advocacy with government and media, forcing Chhattisgarh government to stall the move[27]. JSA Rajasthan too brought together civil society organizations, networks, public health experts and a large group of community members from different parts of the state for the campaign. Memorandum campaigns addressed to the Chief Minister and Health Minister, village-level protests, demonstrations, media conferences and meetings with government officials were undertaken. The 'Right to Information' Act was used to access official documents. Pamphlets in the local language outlining the issue and demands, were distributed. In both states the Ministry of Health and Family

Welfare, Government of India was petitioned to intervene, which subsequently advised the states against implementing the plans.

The Rajasthan government withdrew its initial tender as a result of the campaign, but soon issued another tender for 215 PHCs. This time JSA Rajasthan filed multiple Public Interest Litigations. Nevertheless, about 100 PHCs have been handed over to the private sector, and JSA Rajasthan has been monitoring and providing feedback to the government about their work, with the aim to revert them to public ownership.

In order to address the broader context of privatization, national and state units of JSA advocated strengthening government health systems and forgoing privatization of health care during state (2018)and national elections (2019). Many of these demands were included in the manifesto of the opposition party.

Case 2: Philippines

Privatization of health care in the Philippines can be traced to the late 1970s, when a market-driven approach to healthcare infiltrated policies around the world. The budget for healthcare was one of the biggest casualties of the SAP in the Philippines. All forms of privatization – PPPs, corporatization, user's service fee schemes, revenue enhancement program, outsourcing etc. – have been the framework of almost all health policies since the late 1970s.

These policies included attempts to relocate, corporatiseor put up hospitals for sale, for them to generate their own resources through increasing user fees. Under the administration of Benigno Simenon Aquino III, privatization was undertaken through a PPP program which the Philippine Health Insurance Corporation (PHIC) framed under the slogan of UHC. Specific PPP projects included 'modernization' of the Philippine Orthopedic Hospital into a Center for Bone Diseases and Trauma and the San Lazaro Hospital into a Center for Infectious Diseases.Aquino's privatization program also entailed eliminating the

budget for Maintenance and Other Operating Expenses (MOOE) of public hospitals by 2014 and allocation for personal services by 2020.

The impacts of privatization of public healthcare have been felt by the Filipino people as costs for accessing healthcare, even in public facilities, have gone up. User fees, fees for service and revenue enhancement schemes are now part of the norm, so patients have to pay for practically everything when they go to public hospitals. For instance, the National Kidney and Transplant Institute implemented the 'No Pay, No Hook' policy which means no dialysis session will be started before a payment is made - patients undergoing dialysis have to pay P 6,000 for every treatment (PHP 1 = USD 0.02). Another example is the emergency room of the Philippine Heart Center, a Government-Owned and Controlled Corporation (GOCC) hospital that charges P 600 for the first four hours of stay and P 200 per hour for the succeeding hours. In other words, one needs to have money to access even government health services. Privatization has thus worsened the problem of inequitable access to health facilities, goods and services.

Privatization has impacted health workers too. The implementation of the Health Sector Reform Agenda and Executive Order 102 (1999) has dislodged thousands of government health workers and paved way for contractualization. The effects of this included demotion in rank and salary, loss of permanent status, optional retirement, voluntary resignation etc. At present *plantilla* (regular) positions vacated through retirement or death are permanently left unfilled. Overworked, underpaid and largely demoralised, more and more government health workers have left the country for 'greener pastures'.

There have been three waves of popular struggles against the privatization of healthcare sparked by these changes, particularly against the privatization of premier government hospitals in the Philippines.

The first wave occurred in the mid-1990s when the government's planned to

sell four government hospitals (Philippine Heart Center, Philippine Children's Medical Center, Lung Center of the Philippines and the National Kidney and Transplant Institute), phase out the Tala Leprosarium, relocate the National Center for Mental Health (NCMH) and sell the Welfareville estate. It was met with much opposition.

The Health Alliance for Democracy and other organizations came together under the umbrella of Network Opposed to Privatization (NOP) in 1997 and led the protests against government's plans. Together with other health activists, the NOP helped organize the International Conference against Privatization of Health Care in November 1998. The Alliance of Health Workers (AHW), an active member of the NOP, complemented the protest campaigns within the hospitals through the hospital employees' unions. Patients and patients' organization supported the campaign as well, leading to a halt in the government's plan.

During the second wave, beginning in 2003, the Macapagal-Arroyo administration attempted to relocate the NCMH outside Metro Manila and to sell the Welfareville land for commercial development. When the government revived the intention in 2012, it was assessed that this would lead to displacement of 2,000 health workers, 6,000 patients of the NCMH and tens of thousands residents living at the Welfareville Land.

Various organizations, including of patients and their relatives, rallied against the repeated attempts to relocate the NCMH. The NOP mobilised its members to support the health workers, patients and Welfareville residents, while AHW supported the NCMH Employees Union and rallied support from others hospital unions. As a result of the campaign, the plan was once again stopped.

Finally, during the third wave (2013-2017), the Aquino government laid down its PPP program with the 'modernization' of the POC as its centrepiece project, with Megawide Construction Corp. owned by Henry Sy being the most interested party. In 2016, the last

year of the Aquino administration, they also attempted to close down the Dr. Jose Fabella Memorial Hospital in Manila and planned to build a new facility into which the hospital would be relocated.

Both attempts were again met with strong opposition, mainly because the POC is the only public tertiary hospital for trauma and bone disease, while Fabella hospital is the only national maternal and child hospital, in the country. There were serious concerns raised as to where the poor patients and expectant mothers would go if the POC and Fabella hospital are privatised. The NOP rallied support for the issue, while AHW and tens of hospital unions supported the POC Employees Union in its fight against privatization. Two broad alliances, the 'Save the POC Movement'[29] and the 'Save Fabella Hospital Movement'[30] were formed to rally even more support against the plan to privatise the two hospitals. Religious and school institutions, business establishments in the vicinity of both hospitals were mobilised for support. Patients, their relatives, pregnant women and organizations also actively supported the campaign. Campaigning efforts were successful in this case as well: in November 2017, Megawide Construction Corp. terminated the POC Modernization Project contract with the Aquino government[31].

One of the key strategies in all the campaigns has been organizing and developing a people's health movement that included all those affected by privatization plans, such as patients and their families, communities surrounding the affected hospitals, hospital workers and professionals, etc. Building coalitions and alliances, both local (e.g. Save POC Movement and Save Fabella Hospital Movement) and national (e.g. NOP), helped gather the unity and strength of various groups against healthcare privatization. Alliance building with hospital management, campaign and education activities at the community level were also undertaken. To dramatize opposition against privatization, various forms of protests were used, including petitions,

arm band wearing, 'sit-in' and 'die-in', protest dances, and big rallies to the Department of Health and Malacanang Palace. Social media, TV documentaries, and radio interviews were used to amplify the reach. Active advocacy and lobbying campaigns were conducted at the House of Representatives and the Senate towards legislative measure to stop the privatization of healthcare. Lobbying efforts gained the support of House Representatives in the passage of the anti-privatization bill and the formation of Legislators United for Service Oriented Government Hospitals (Lusog). NOP also filed a petition for certiorari to stop the privatization of POC.

Case 3: Europe

For decades, health systems in Europe have been seen as rooted in an idea of social solidarity. European countries have been able to address a significant part of people's health needs, protecting them from high financial burden either by financing health systems through taxes (e.g. UK following WWII), or through the Bismarck model of social funds and pooling (e.g. Germany). However, it is often forgotten that the evolution of the welfare state in Europe was interconnected with social movements pressuring governments and employers to provide a social security net for everyone. As Sengupta[14(12)] notes:

> The introduction of universal health coverage schemes in Europe and elsewhere has its roots in attempts to quell rising discontent among the working class.

For a period, the desire to maintain social peace outweighed the pressure by capital to open new markets and allow privatization of social protection institutions, but this did not mean that pushes towards commercialization of health were absent. In fact, in most countries in Europe, the private sector remained involved in provision of health care, e.g. through the production of medicines and medical technologies[14].

A paradigm shift, followed by the increased representation of private providers can be tentatively timed as occurring in the 1970s. With neo-conservatives coming to power in different parts of Europe, cost-cutting measures were introduced at the national level. Subsequently austerity became (and still is) high on the European Union agenda[32]. This was accompanied by a push towards 'new public management' in healthcare institutions[33], on the grounds that applying private sector management practices would yield greater 'efficiency'.

Such a shift did not mean Europe switched to a private health system altogether, but it did impact how health is thought about and how healthcare is rationed for different segments of the population[32]. Privatization of health care in Europe comprised both direct and indirect approaches[34]. Some health systems were first exposed to forms of privatization not completely obvious to lay observers, as in the case of the NHS in UK. There, a first move towards privatization was made through by decentralization of responsibilities and autonomization of hospitals. In Croatia, health insurance and co-payments for patients were introduced[35]. This was not perceived as privatization of healthcare at the time, while in fact it allowed a commercialised view of healthcare to creep in. Other places faced outright privatization through outsourcing, or PPPs, as in the case of the Karolinska hospital in Sweden[36].

What all European countries had in common throughout this period was the reduction of access to parts of the healthcare system for many, either on the basis of introduction of financial obstacles, or reduction/termination of healthcare services in specific areas under the pretext of achieving cost-efficiency. Given the diversity of privatization initiatives in Europe, it is understandable that responses had an equally diverse character, adapting themselves to the local context. A recent project undertaken by PHM-North America has helped document some of these cases[37].

In England, the re-organization of NHS institutions and the drive towards outsourcing led to a community campaign for protecting a hospital in Gloucestershire from 2010 to 2012[38]. The regional administration had pushed for transforming the local NHS hospital into a social enterprise, a move that would mean transferring staff from NHS employment to less secure employment with an autonomous non-profit organization. Activists also feared that it could lead to a subsequent taking over of the hospital by a private healthcare company. Some of the hospital workers joined forces with trade union campaigners, and began mobilizing against this plan. They distributed leaflets debunking the language and articulation used by policy makers to market privatization under the pretext of introducing a private, yet 'socially responsible' model of providing healthcare. At the same time, they pressured local politicians through the media and directly. Their efforts were successful and led to a public consultation where more than 90% of the public opted for keeping the hospital public.

A similar example occurred in Sweden starting from 2012[39]. In this case, health activists and their neighbours organized against the closure of hospitals and wards due to austerity policies. In January 2012, the county council of Västerbotten closed a cottage hospital providing primary and emergency care in the town of Dorotea. As a result, patients faced a two-hour drive to get basic healthcare, so townspeople physically took over the building. The local government tried to suppress the action by imposing surveillance on the protesters, at the same time trying to reduce the possibility of a referendum in favour of re-opening the hospital.

Nevertheless, in 2016 the activists were successful in their attempt to reinitiate the work of the cottage hospital. In the same year (2016), a similar action was undertaken in the town of Sollefteå, following the announcement of closure of the maternity ward in the local hospital. The occupation of the hospital was carried out with the help of over two thousand people who took shifts to ensure continuous presence in the building. In both cases, activists focused on different ways of direct communication and informing each other – either by canvassing, where the size of the community would allow for it, or through social media and text messages on phone – and involving new people in the initiative. The media was also used in the Gloucestershire campaign for providing greater visibility to the struggle, along with distribution of popular material with information on the possible consequences of shutting down of healthcare institutions.

Other campaigns and mobilizations around Europe have focused on healthcare legislature and limitations to access, like in the case of Spain's previous healthcare act and privatization plans[40], and more recently, understaffing and working conditions in Germany[41]. Examples from Greece, Belgium, and other European countries described in the fourth edition of Global Health Watch[42] illustrate how health activists and workers have come together to provide healthcare through networks and solidarity clinics on the local level, while at the same time they continue to oppose global threats like Transatlantic Trade and Investment Partnership (TTIP). Whatever the particular focus of the recent campaigns in Europe may have been, they have all underscored the need for a shift in the dominant commercialised view of healthcare pushed for through policy, legislation and practice.

PHM Europe has engaged in efforts to bring the different initiatives together and use each other's experiences for achieving a Health for All agenda in the region. Together with European Network, PHM Europe has engaged in a thematic campaign around April 7th – World Health Day and, informally, Day of Action Against Commercialization of Health since 2016.

The campaign is comprised of local actions, which reflect the needs and concerns of particular groups, but it also offers a platform for exchanging knowledge and support across the region. For example, in 2019 European

Network launched a booklet with requests for Members of the European Parliament, which could be used for advocacy[43]. This allows PHM units to build upon the work they usually do locally, ensuring continuity and coherence inside particular organizations, while at the same time they are able to work with regional contacts, building activist and organising capacities on different levels.

Plans in different countries are announced through regional calls and presented using an interactive online map, which helps illustrating the reach of attempts to mobilize against commercialization of healthcare (available as Google Map)[44]. Recent actions ranged from public rallies (Marea Blanca) in Spain[45], over discussions on health inequities in Italy, to a central conference with representatives of political parties in the European parliament[46]. All action revolves around the same key demands for policy makers and governments: removing market logics from healthcare systems; increasing public spending for health; and organising healthcare systems which are accountable, accessible, and useful from the perspective of the people.

Discussion and conclusions

The article illustrates the process of neo-liberal reforms in three regions and their impact on health systems. It describes campaigns and initiatives resisting such reforms, narratingthe various processes leading to commercialization of health care. The specific privatization strategies include (i) direct privatization through handing over health services or facilities to private sector agencies and providing public funds for their functioning; (ii) austerity measures and budget cuts leading to closure of public hospitals or reduction in public healthcare; (iii) engaging the private sector for government schemes such as publicly funded health insurance schemes.

The cases show that the reforms undertaken under the guise of ensuring efficiency,

quality, competition and choice on one hand and 'modernization', services improvement and decentralization on the other, have in fact weakened public healthcare systems and led to commercialization of care. The breakdown of public health systems, caused by these practices, has been used as the rationale for further privatization, including involvement of the private sector to provide publicly funded services. Examples from countries and regions not elaborated in the article indicate a similar trajectory. A number of African countries have noted continuous increase of out-of-pocket payments and stronger presence of private healthcare facilities because state budgets have become inadequate to address people's needs following SAPs and austerity measures[47]. Pressure to apply market values to healthcare has also put into question the state's role in providing equitable and accessible healthcare. In some countries, e.g. Malaysia, this has gone so far that governments have become investors in private commercial hospitals[8].

In driving neoliberal policies, WB and others have argued that governments would be able to cut public expenditure and at the same time make their health systems more efficient, dynamic and technologically up-to-date. However, serious concerns regarding the negative consequences with respect to equity, quality and accessibility of healthcare, especially among disadvantaged and poor populations remain. Such reforms have led to problems in organising and providing healthcare around the world[2].

Neoliberal reforms in healthcare have been met with resistance in many countries, with PHM at the forefront of many of these struggles. These have been based on evidence-based critiques of commercialization of health and situated within the larger political economy of healthcare, underlining the implications of market-logic in healthcare for governments and people. Struggles have also focused on changes faced by health workers, such as contractualization and layoffs. Therefore, monitoring and gathering evidence on the

performance of existing privatization initiatives has been a critical task. Of no less importance has been the analyses of the impact of privatization on access to services and provision of quality and rational healthcare, especially for vulnerable and marginalised groups.

The campaigns, though undertaken in different points in space and time, have used similar strategies: they focused on mobilising different groups potentially affected by the plans through publishing reports, organising directs street action, insisting on advocacy, as well as media and legal recourse, and building broad alliances with other social movements against neoliberal policies. By doing so, a clear message was sent: that privatization moves are, and will continue to be, resisted by the people.

Naturally, the struggles have often been challenged by the overall political situation in the country and faced repression by governments. A recent instance is the vilification and smear campaign by the Philippines government against health rights organizations and threats, harassments and intimidation of health activists[48].

The illustrated examples show clearly that the implementation of neoliberal policies in healthcare continues to harm people around the world. Even though pressures from the private sector remain strong, the cases of resistance reported here show that an alternative to commercialization of health can still be imagined. An evidence-based campaign that directly involves affected communities, a joint front of organizations and groups, including activists, patients and health workers, and building links among different initiatives of locally adapted resistances to commercialization of health, can lead to solid opposition to neoliberal policies on various levels.

It might be difficult to imagine a complete reversal of the decades-long commercialization process healthcare has been exposed to. However, as has already been stated at the beginning, health systems have always been a result of people's struggles: as these struggles continue in their resistance to neoliberal policies, they might just succeed to achieve a vision of health accessible to all.

Collaborators

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