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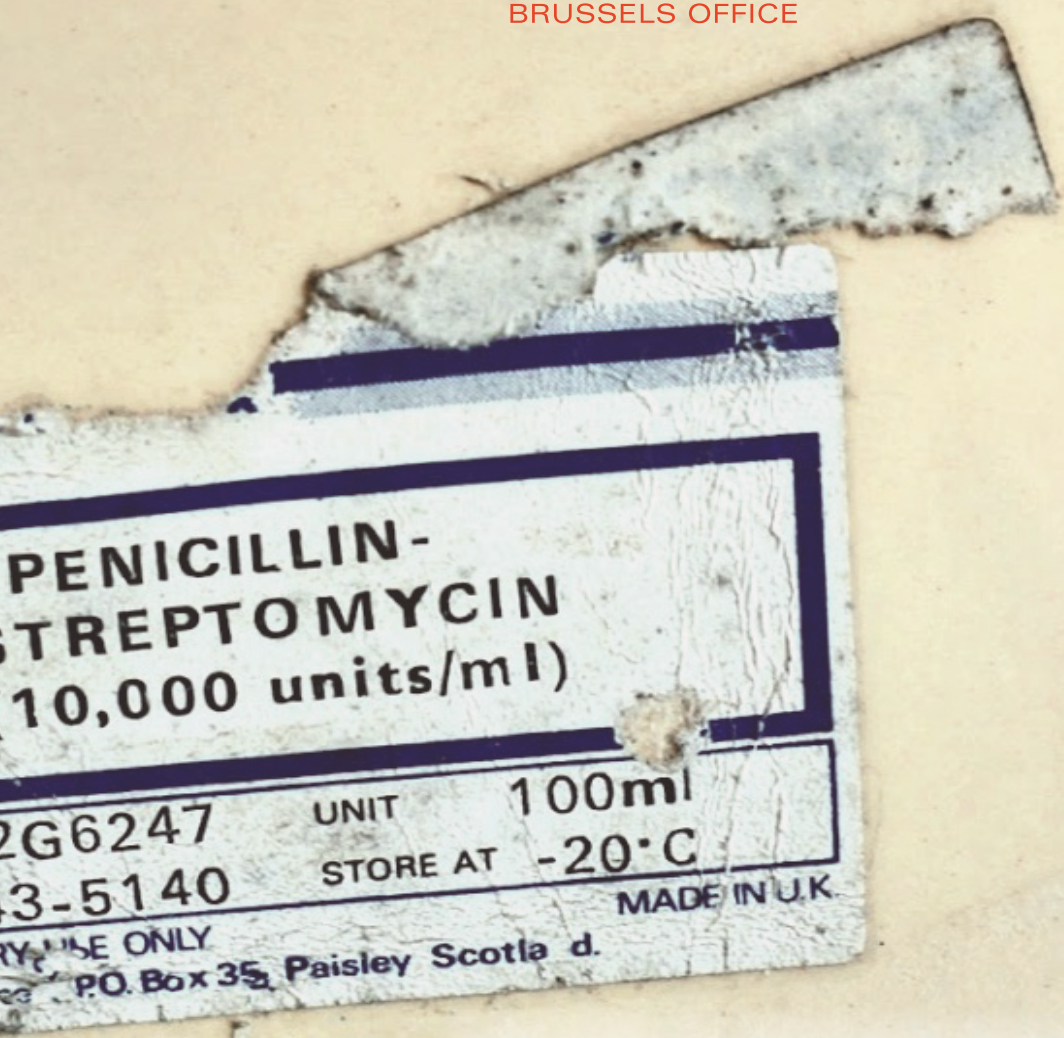

THE STRUGGLE FOR HEALTH

AN EMANCIPATORY APPROACH IN THE ERA OF NEOLIBERAL GLOBALIZATION

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SUMMARY

INTRODUCTION

This booklet has its origins in a meeting in autumn 2016, attended by over thirty activists, researchers and health professionals from Africa, Latin America, Asia, Europe and North America. After intensive discussions and debates the meeting concluded unanimously that the struggle for health is a political struggle which challenges the fundamental practices of our society and the trends which shape them.

Neoliberalism, the dominant economic system in the world today, with its principal objective of endless accumulation of capital and the creation of profits for a tiny elite, stands in contradiction to the rights of populations to health and health care.

The vast majority of people in the world are subjected to very similar economic realities, forces and dynamics: the extraction of natural resources and the destruction of the environment; a forced homogenization of their way of life; commodification and privatization of all human and material spheres of life; forced competition between workers at a global scale; exclusion of billions of people from the 'benefits' of the system; and a rapid expansion of the power of transnational companies.

Under the yoke of neoliberal policies it has become increasingly difficult to exercise the right to make legitimate demands for social entitlements. Education is being privatized; the number of homeless people has increased; family incomes have crashed due to rising unemployment brought about by austerity measures; the environment is constantly being degraded as a consequence of unsustainable fossil fuel based industrial development; and social solidarity has been weakened through divisions created among people who are prompted to seek individual solutions to their problems.

Health systems are a product of struggles and the balance of power in society. Most health systems developed after the end of the Second World War and in the post-colonial period, in response to social needs expressed by popular movements of the working people. The capitalist State, for its own requirement of a healthy workforce, has had a stake in developing health systems.

Health systems are therefore constructed through the interplay of social forces, shaped by historical changes in power relations in society, and hence in a state of constant evolution.

Interdisciplinary, intersectoral and international alliances for health, in all its dimensions, are already being built in different parts of the world. Various struggles are progressing towards the construction of communal and collective identities and these raise the real possibility of the emergence of a political force capable of transforming society.

The vast diversity of actors in this struggle – workers, farmers, indigenous people, health workers and professionals, patients, students and teachers, political and social activists, trade-unionists – all contribute to the development of an unified struggle which connects our countries and regions, and links our continents. In everyday life, these struggles conceive, elaborate and find concrete and immediate solutions to the needs of the people and their right (collective and individual) to life and health.

The consequences of climate change and its social, economic and political consequences will have an enormous impact on the general health of people (related to access to water, food, environmental pollution, massive population displacement and their impact on social systems, etc.).

New technologies have the potential to improve people's conditions of living and health. However, currently these technologies are controlled by global capitalism and their inappropriate utilization could have adverse effects on employment, and have a negative impact on healthcare related practices. Technologies that can store and search for huge amounts of personal data also threaten to become a major source of invasion of individual privacy.

This global situation represents an unprecedented challenge for humanity and without doubt the struggles for health will play an essential part in the popular mobilization required to address it.

GLOBALIZATION: IMPACT ON PEOPLE'S HEALTH

We live today in a deeply unequal world where financial capital, supported by technological and military power, decisively influences the entire range of human activities in most parts of the world. Capitalism is experiencing a prolonged crisis and is forcing structural changes in the global economic system to perpetuate its hegemony.

These changes are devastating livelihoods of people across continents. They are also promoting conflicts and wars in different parts of the world, while the planet itself stands on the brink of a catastrophe as a result of mindless exploitation of its resources by the 'extractivist' model of capitalist development[1].

Unable to extract itself from the crisis it faces, the capitalist system, operating at the global, regional and local levels, is adopting increasingly aggressive policies that aggravate the current economic, ecological and humanitarian crisis. Through the medium of increasing financialisation of the global economy that is producing ever increasing concentration of wealth and inequity, through unequal global and regional trade rules and often through direct encouragement of wars, capitalism is seeking to transfer the burden of the crisis on people in different parts the world. It is also promoting, in many parts of the world, extremely authoritarian regimes that combine the dismantling of democracy with the promotion of sectarian and fundamentalist forces.

1 For a detailed exposition of the extractivist model of development see: 'Extractivism and neoextractivism: two sides of the same curse' by Alberto Acosta, available here: https://www.tni.org/files/download/beyonddevelopment_extractivism.pdf.

The prime motivation behind interventions in third countries by advanced capitalist countries, led by the United States, is to secure control over strategic natural resources. The military interventions, especially in the Arab region, were initially aimed at securing control over petroleum reserves. Similarly, in Latin America, interventions aimed at destabilization of democratically elected governments, seek to reassert hegemony over mineral resources that are critical for the survival of key industries – both in the military and civilian sectors.

The quest for natural resources, necessary for the perpetuation of capitalist production premised on 'mindless consumption', has two major effects – both contributing to the global health crisis. The proliferation of wars has led to a massive influx of refugees, which has snowballed into a massive humanitarian crisis. Simultaneously, over-extraction of natural resources and the unsustainable use of fossil fuels have precipitated an ecological crisis of hitherto unknown proportions.

People's health is not merely a function of availability of healthcare services but is determined by social, economic and political factors that influence conditions of living. Rising inequity is impoverishing new sections of the people and the neoliberal order is further aggravating the impact of poverty by constantly eroding social protection systems. The capitalist crisis is also manifesting itself in rising unemployment, especially among the youth. So called 'flexible' employment conditions are replacing existing forms of employment security that earlier guaranteed access to a range of social security benefits, including secured access to healthcare services[2].

The corporate controlled media, increasingly concentrated in a few hands, is involved in legitimizing the neoliberal order and in rendering invisible popular mobilizations and resistance against neoliberal policies. The neoliberal project attempts to perpetuate itself by promoting ideas that privilege the notion of individual based solutions, rather than solidarity based actions. In the case of healthcare services this onslaught of ideas takes the form of propagation of the notion that private services are more efficient.

Across the world, as a consequence, public services are being privatized and healthcare services are being outsourced to private enterprises under

2 See Report by the International Labour Organization " -standard employment around the world: Understanding challenges, shaping prospects" available here: http://www.ilo.org/global/publications/books/WCMS_534326/lang--en/index.htm.

the garb of 'public private partnerships'. The commodification of healthcare services, where healthcare is converted into a commodity to be purchased from the market, is making healthcare inaccessible to larger and larger sections of people – both in the Global South and the Global North. Even in Europe, after decades of experience with a well functioning 'welfare state', public services are being dismantled. The major beneficiaries of the commodification of healthcare are mega insurance companies and manufacturers of medicines, medical devices and equipment.

Global governance for health

The global architecture of governance, trade and economics has come to be informed by neoliberal globalization and consequently national decision making and national policies are often subject to global influences. This is true in the health sector as well[3] and the advent of globalization marks a shift in institutions and structures that govern health at a global level.

Several new developments have had an impact on the structures and processes of global governance for health. The first is the emergence of the World Bank as a major player in the arena of health governance in the 1980s. Second, the growing importance of global trade in international relations, and its impact on health in different situations across countries, has led to a major role for the World Trade Organisation (WTO) and regional and bilateral trade agreements. Third, private foundations (such as the Bill and Melinda Gates Foundation) entering through public private partnerships and other avenues, have become big players in global health issues. Finally the erosion of the World Health Organisation's legitimacy as the premier organization on global health, has shifted mechanisms related to global governance for health away from intergovernmental forums.

Intergovernmental mechanisms are giving way to Global Public Private Initiatives (GPPIs). Several hundred such initiatives have been launched, with over 100 in the health sector alone (including mega initiatives such as Gavi, the vaccine alliance, and the Global Fund). GPPIs came to be developed based on an understanding that multilateral co-operation in the present globalized world could no longer adhere to the older principle of multilateralism which primarily involved nation states. Global partnerships

3 Woodward D, Drager N, Beaglehole R, Lipson D (2001) Globalization and health: a framework for analysis and action. *Bull WHO* 79: 875–881.

were, thus, imbued with a new meaning, that involved not just nation states, but also other entities, including, prominently, commercial organisations such as pharmaceutical companies.

These new partnerships are also increasingly supported by private philanthropic foundations. Partnerships with the private sector and civil society are thus held up as the way to achieve what governments and the United Nations cannot manage alone[4]. GPPIs address what neoliberal economists describe as 'market failures', but at the same time do not question the fundamental faith in the ability of the market to regulate the global flow of goods and services.

Developed countries which contribute the major share of finances for the functioning of the WHO have today a cynical disregard for the ability of the WHO to shape the global governance of health.

The WHO's legitimacy has been seriously compromised because of its inability to secure compliance of its own decisions, which are reflected in the various resolutions passed at the World Health Assembly. Developed countries which contribute the major share of finances for the functioning of the WHO have today a cynical disregard for the ability of the WHO to shape the global governance of health. They see the member state-driven process in the WHO (where each country has one vote) as a hindrance to their attempts to shape global health governance, and prefer to rely on institutions such as the World Bank and the WTO, where they can exercise their clout with greater ease. As with many other UN organizations, the WHO's core funding has remained static because of a virtual freeze in the contributions of member states. Its budget amounts to a tiny fraction of the health spending of high-income member states. In addition, a large proportion of the WHO's expenditure (above 80%) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries[5].

An analysis of structures and dynamics of global decision-making reveals the dominance of entrenched power structures – through the agency of more powerful nations, the Bretton Woods institutions, private philanthropy and large transnational corporations – and a democratic deficit in the structures and dynamics of global health governance. These power structures also operate directly through bilateral and regional trade agreements; through the

4 Martens, J, January 2007, Multistakeholder Partnerships – Future Models of Multilateralism?Dialogue on Globalization, Occasional Papers, No.29, Berlin, Friedrich Ebert Stiftung.

5 'WHO Reforms: For what purpose'. in: Global health watch 4. Zed Books, London; 2014: 247–266. Available at: http://www.ghwatch.org/sites/www.ghwatch.org/files/D1_1.pdf.

operations of bilateral health-related assistance; and through direct advice and influence. In many respects the regulatory, financing and policy outcomes of this system reflect an imbalance between the interests of a limited number of country governments and global institutions, many of them private, and the needs and priorities of a majority of the globe's population.

In the case of medicines, the structures of global governance for health currently promote strong Intellectual Property (IP) protection. Advocacy of strong IP protection (that is higher standards of patenting) is designed to secure the monopoly power and thereby financial interests of Multinational corporations (MNCs) in the pharmaceutical sector located in North America and Europe. The Agreement on Trade related Intellectual Property Rights (TRIPS) under the World Trade Organization (WTO) in 1995 was pushed by countries of the North to benefit their pharmaceutical companies. The TRIPS agreement harmonized IP laws across the world and prevented countries such as India from pursuing independent policies that were designed to curb the monopoly power of pharmaceutical MNCs. In recent years bilateral and plurilateral trade agreements that involve the powerful economic powers – EU, US and Japan – attempt to go beyond the remit of the TRIPS agreement to further ratchet up standards of IP protection.

Impact of neoliberal polices in different countries

While inequity is rising in most countries, many countries in Europe now exhibit rising rates of poverty, and the number of people without social security continues to rise. In Spain, for example, almost 60% of the population is not covered by adequate social security measures[6] and over 3,000,000 can be classified as poor. Even among those in employment, wages are depressed and some earn as low as 300-400 € per month.

Across Europe, the European Union (EU) attempts to promote harmonized systems which promote market mechanisms. EU rules, mediated by the European Court of Justice, protect the freedom of movement of people, services, goods and capital. This ensures the uniform application of market friendly policies across the countries which are members of the EU and benefits insurance companies and manufacturers of medicines and medical devices and equipment. In relatively less developed

6 See Factsheet on Spain by the Centre for Economic and Social Rights, available here: http://www.cesr.org/sites/default/files/FACTSHEET_Spain_2015_web.pdf.

countries in the EU, such as Croatia, EU rules influence health policy and privilege market mechanisms and privatization of the healthcare system. Harmonized mechanisms are particularly problematic in a situation where all countries in the EU do not have similar healthcare systems and there are large variations in financing patterns. Freedom of movement for services in the EU allows cross-border delivery of medical, dental, and other health services. While this offers a potential choice to patients it also provides an opportunity to care providers, including those in the private sector, to recruit patients and health workers from across the continent. Such rules also promote 'medical tourism', essentially to service health needs of those who can buy care from the market, instead of addressing real needs of local patients. Thus, in Croatia, the government provides support for the development of medical tourism and public investments in medical tourism are disproportionately higher than support to public hospitals. Many of the latter are in debt and are then accused of providing poor quality services.

The imbalance in power relations – both political and financial – among EU member states, also characterizes trade agreements that disproportionately further the interests of the more developed countries, and especially their corporations, and also have an impact on healthcare by actively promoting the 'marketisation' of healthcare services. An example of such trade deals is the Comprehensive Economic and Trade Agreement (CETA)[7], which was, negotiated in secret between the EU and Canada between 2009 and 2014.

In many countries of Europe, such as France and the UK, there are clear attempts to weaken public systems by privatizing public hospitals through the medium of Public Private Partnerships. Further, in France for example, avenues are being provided to grant private control over mutual health insurance funds, which seek to benefit private health insurance companies.

Global and regional financial and political institutions are today replacing the role that should legitimately be played by sovereign democratically elected governments. The power of the Troika (IMF, European Central Bank and European Commission) over democratic decision making in European countries is being challenged through the creation of European Networks that coordinate resistance to the EU and Troika's imposed polices and conditionalities in countries such as Spain, Belgium, Italy and France.

7 For a more detailed discussion on CETA see here: https://corporateeurope.org/international-trade/2016/11/great-ceta-swindle.

Greece provides a clear example of how sovereign decision making in countries is being supplanted by powerful global and regional institutions that seek the hegemony of capital over human welfare. Since the start of the economic crisis in Greece, the Troika imposed radical austerity measures and other reforms, such as radical cuts of public expenses, drastic tax increase, reductions of unemployment benefits, privatization of public infrastructure, etc. These austerity measures have affected all social indicators[8]. In 2016, 35.6% of the total population (3.8 million people) was at risk of poverty or social exclusion while eight years earlier the same index was 28.1%.

Historical evidence indicates that in times of austerity the public health system needs to be strengthened in order to avoid a sharp decline in the health status of the population. However, the EU's diktats in Greece forced the governments to continue to implement a health reform program with the objective of keeping public health expenditure at or below 6% of a GDP (in 2007 Greece's healthcare expenditure was 9.6% of GDP). This has led to an increase of out-of-pocket expenditure on healthcare, with an increase of co-payments on medicines to up to 25%[9]. Households are either forced into poverty in order to access healthcare services or are forced to avoid accessing services. To understand who have been the real beneficiaries of reduction in public expenditure one needs to turn to the announcement in October 2017 that the debt of 100 public hospitals and other public health services had been bought by an Italian bank.

As we discuss earlier the refugee crisis, brought upon by fuelling of conflicts in the Arab region, has precipitated a huge humanitarian crisis. The response to this crisis, which also embeds a health crisis among the refugee population, typifies how neoliberalism is fundamentally opposed to public services. The European Commission has dedicated more than 500 million euros to fund Greece's costs for border control and refugee protection programs. The biggest proportion of this money has been allocated – not for the strengthening of the public health system in Greece – but to support parallel vertical programs for primary level care, run by international or national NGOs, active mainly within the refugee camps.

8 Kondilis E. et al (2013) Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case, American Journal of Public Health 18 April 2013.

9 Gouvalas A, Igoumenidis M, Theodorou M, Athanasakis K. Cost-Sharing Rates Increase During Deep Recession: Preliminary Data From Greece. *International Journal of Health Policy and Management*. 2016;5(12):687-692. doi:10.15171/ijhpm.2016.62. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5144875/.

THE SOCIAL DIMENSIONS OF HEALTH

Too often, even among groups and organizations active in the struggle for health, the dominant vision is that health care services are primarily responsible for improvements in the health of individuals and communities. However, there is powerful evidence that the main factors affecting our health are the socioeconomic conditions in which we are born, grow, live, work and age. Founding epidemiological studies showed that the mortality rates for the majority of deadly diseases in the past century declined steeply long before modern medicine was able to detect the responsible pathogen, or to discover a vaccine or a treatment[1,2].

The comprehensive Primary Health Care (cPHC)[3] approach, enunciated at the Conference of Alma Ata in 1978, clearly acknowledged this fact by stating that:

1 McKinlay JB, McKinlay SM. The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century. The Milbank Memorial Fund Quarterly Health and Society. 1977;55(3):405–28.

2 McKeown T, Record RG. Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century. Population Studies. 1962;16(2):94–122.

3 cPHC includes: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education,housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

"Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainmentof health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace."[4]

In more recent years, the World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH) documented the impact of resource distribution and living conditions on health inequalities, both within and between countries. The final report, "Closing the gap in a generation", states that health and disease are not distributed equally in society, and that disease disproportionately affects those who have less access to resources such as food, clean water and environment,

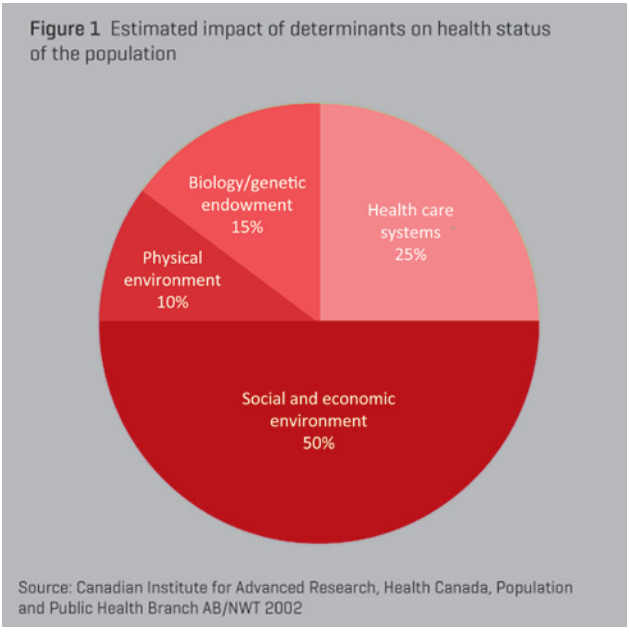

Figure 1: The impact of social determinants on health[5]

4 WHO. Declaration of Alma-Ata [Internet].World Health Organization; 1978. Available at: http://www.who.int/publications/almaata_declaration_en.pdf.

5 Kuznetsova D. Healthy Places: Councils leading on public health [Internet]. New Local Government Network; 2012. Available at: http://www.nlgn.org.uk/public/2012/healthy-places-councils-leading-on-public-health/.

education, safe and stable job, solidarity-based welfare systems. While being aware of the necessity to make available adequate access to comprehensive health care services for those who fall ill, we should also be concerned about the means to reduce the unnecessary disease burden linked to social injustice. In fact, as the CSDH report states:

> *"(The) toxic combination of bad policies, economics, and politics is, in large measure responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible [...]. Social injustice is killing people on a grand scale."*[6]

If we look at the issue from the perspective of social movements, there are two important alternate visions that can help forge a broader unity in our struggles. Both are rooted in a vision of health that is deeply linked with the political, economic, cultural and social aspects that frame our societies.

The first vision focuses not only on the factors that impact on health, but on the processes that determine their unequal distribution within society. In other words, the emphasis is not on the 'determinants' of health, but on health 'determination'. While developing the concept of health 'determination', scholars and activists from the Latin American Social Medicine movement argue that specific socioeconomic and political systems (and people/groups that have interests and/or make profit in maintaining them) are responsible for generating inequality in society, that also translates into health inequalities.[7] The very way in which our societies are organised, and the power dynamics that are at play in shaping them, have to be questioned and addressed. We need to ask why we have inequalities in health, and not only how different 'determinants' promote health inequality.

A recent report by Oxfam found that just eight men have wealth that is equivalent to that of the poorest half of the world, thus reinforcing earlier evidence that global inequality is growing.[8] The report says that "the

6 WHO. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. 1 edition. Geneva, Switzerland: World Health Organization; 2008. p246.

7 Rocha PR da, David HMSL, Rocha PR da, David HMSL. Determination or determinants? A debate based on the Theory on the Social Production of Health. Revista da Escola de Enfermagem da USP. February 2015;49(1):129–35.

8 Hardoon D. An economy for the 99% | Oxfam International [Internet]. Oxfam. 2017. Available at: https://www.oxfam.org/en/research/economy-99.

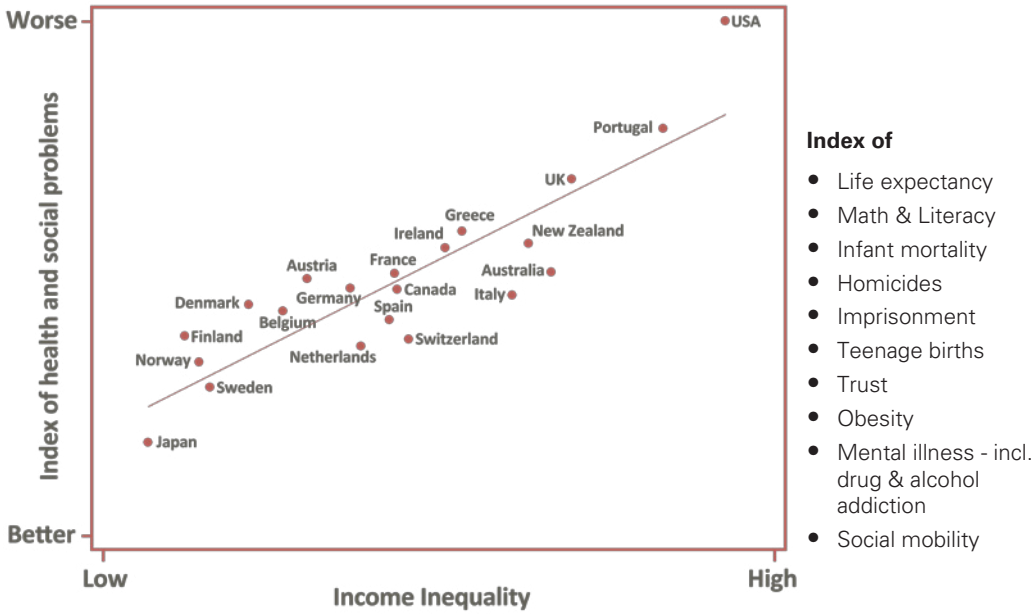

Figure 2: Relation between income inequality and health and social problems in high income countries[8]

very design of our economies and the principles of our economics have taken us to this extreme, unsustainable and unjust point", a process that has been accelerating since the implementation of neoliberal policies in the early eighties. Moreover, epidemiological evidence shows that inequality itself is related to adverse health and social outcomes (see Figure 2).

Besides generating inequality, the economic and political system in place has detrimental effects on a number of health determinants, including the environment (increasing pollution, climate change, accumulation of toxic waste, etc.), water, land and public services (through increasing privatization and dismantling of public and/or solidarity-based systems). In all these sectors, the social gradient between those who have more resources and those who have less is constantly at play. For example, the concept of 'environmental racism' is used to describe the unequal consequences of climate change and environmental degradation on poorer and marginalised communities. Similarly, the so-called 'inverse care law' doc-

9 Wilkinson RG, Pickett K. The spirit level: why more equal societies almost always do better. London: Allen Lane; 2009. p.330.

uments the inverse relation between health needs and health resources in society. Importantly, power relations operate in the domains of several societal divisions, such as class, gender and race. And, quite problematically, technology intensive healthcare - which we increasingly rely on - is deeply embedded in this system and power dynamics, and is one of the most profit-making sectors of our times (investments in pharmaceuticals and medical products are constantly on the rise).

A second important contribution to a social vision of health comes from the indigenous movements of Latin America, and their (cosmo)vision of Buen Vivir or Sumak Kawsay (see Figure 3). This idea is rooted in the interdependence of human life and the life of all beings on earth, including earth itself. This interconnected perspective helps us to build a strong and unitary vision of the processes that harm our health while at the same time threatening the very possibility of life on and of the planet. Moreover, this perspective helps us to reconnect to the land and territory in which we live, decreasing our mental and physical dependence on a harmful system of production. Such a vision appears utopian and unrealistic in the light, for example, of the growing urbanisation of the world's population. However the increase in forms of self organisation for organic food production and distribution, and the survival of solidarity-based systems that run in parallel with the market society, show that alternatives are not only possible but also already in place.

In summary, there are important benefits in adopting a perspective on health that is rooted in its social dimensions:

1. We are more able to understand why ill-health disproportionately affects some population groups and individuals, the so called 'root causes' of disease. Naming the processes in place, and who is taking advantage of this situation, helps us connect our struggle with all those who fight for a socioeconomic and political system rooted in social justice and environmental sustainability.
2. By emphasizing on the 'causes of the causes', we can concentrate on what is needed to keep people healthy before (and in addition to) worrying about how to care for them once they are ill. There is much to be done in terms of health promotion and disease prevention, both in terms of research (e.g. on the environmental causes of disease) and of application of existing knowledge (for example, epidemiologists in the

Figure 3: A visual representation of the approach of Buen Vivir

UK have advocated for more progressive taxation, as the one measure that could be most cost-effective in reducing health inequalities).

3. By framing the problem as a societal problem, we can start to reflect on the interconnections between the current production system and the current paradigm of modern medicine, which relies almost entirely on biomedical solutions. This is in turn linked to the commodification of health. While it is beyond doubt that medical technology has improved living conditions and increased life expectancy, there is also evidence that shows that profit – more than health and social justice – is what drives health research and development. Popular movements need to address the issue of how to disentangle health research and healthcare delivery from profit-making. Both health research and healthcare services need to be seen as public goods that are clearly under people's control.

There are positive examples of initiatives to translate these ideas into action. In Latin America, there are networks that work on the protection and promotion of ancestral plant-based medicine as a way to treat common ailments by means that are controlled by the people, closely linked to food sovereignty and environmental protection and safety.[10] The preservation of cultural, environmental and social ways of life that are not based on market principles is key to the promotion and protection of people's health.

In countries such as Greece, Spain and Italy, many of the solidarity-based primary care centres, which arose in the aftermath of the economic cri-

10 Declaration of Rosario, 2017. Available at: www.madretierraunasolasalud.org.

sis and the dismantling of the welfare state, question the biomedical approach, and are deeply connected with solidarity movements acting to protect the environment, safe and decent working conditions, food sovereignty, rights and dignity for all.

The solidarity clinics are political projects. Their purpose is not only to provide outpatient health care to patients without insurance, they also exert pressure on politicians to ensure universal and free healthcare. The clinics have built up a solidarity-based economy, which is supported through donations of money and products. Solidarity is understood as a non-hierarchically organized action, not as a gesture of philanthropy. Here relations of solidarity are understood as relations of resistance and subversion against inequality and racism, and an unjust economic order that harms us all.

Table 1. Tips for staying health according to a social determinants of health approach

Ten tips for BETTER HEALTH (Donaldson 1999)	
1.	Don't smoke. If you can, stop. If you can't, cut down.
2.	Follow a balanced diet with plenty of fruit and vegetables.
3.	Keep physically active.
4.	Manage stress by, for example, talking things through and making time to relax.
5.	If you drink alcohol, do so in moderation.
6.	Cover up in the sun, and protect children from sunburn.
7.	Practice safer sex.
8.	Take up cancer screening opportunities.
9.	Be safe on the roads: follow the Highway Code.
10.	Learn the First Aid ABC: airways, breathing, circulation.

Ten tips for STAYING HEALTHY (Gordon 1999)	
1.	Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2.	Don't have poor parents.
3.	Own a car.
4.	Don't work in a stressful, low paid manual job.
5.	Don't live in damp, low quality housing.
6.	Be able to afford to go on a foreign holiday and sunbathe.
7.	Practice not losing your job and don't become unemployed.
8.	Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.
9.	Don't live next to a busy major road or near a polluting factory.
10.	Learn how to fill in the complex housing benefit/asylum application forms before you become homeless and destitute.


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COMMODIFICATION OF HEALTH: THE CHALLENGE FACING HEALTH SYSTEMS

The WHO defines a health system in a country as the sum of all the organizations, resources and people whose main objective is to improve health.

Health systems are generally composed of subsystems: a public system financed by taxes or social contributions; a private not-for-profit system (run by associations, charities, NGOs, etc.); and (in most countries) a private profit-making or commercial system. In some contexts they also include systems of traditional medicine and the informal sector (see box).

One characteristic of most health systems is the large number of actors and interest groups: political authorities and national, regional or local public institutions; users/patients; citizen taxpayers; health professionals (doctors, nurses, other health workers, chemists, technicians, and administrative staff); enterprises and insurance companies; and charities or non-profit-making organizations.

Despite variations – mainly due to differences in how they have evolved – health systems in most countries are today confronted with similar problems closely linked with the increasing commodification of health.

While health has been converted into a commodity that is transacted through the medium of the market, this has also led to an increase in human and financial resources dedicated to healthcare. Expenditure on health represents around 10% of the global GDP – more than 7,000 billion dollars.

The proportion of public expenditure on health is about 60% of this amount.[1] There are several powerful actors that benefit from the commodification of health, including big pharmaceutical corporations, private facilities providing medical care (private hospitals, clinics and laboratories), and even investment funds and banks. Those who benefit have pushed forwards local, national and international policies and legislations that promote the commoditization of health.

The strategy employed to push for further commodification of health works at two levels:

1. Through the commodification of various dimensions of health and social needs, influencing both health and healthcare.
2. Through the capture of public or socialized resources by for-profit care providers, commercial insurance companies and private investors.

Commodification and privatization

Today, sustained propaganda by the votaries of neoliberalism seeks to promote a vision of the human body and of health which is rooted in the principle that all human activities can be converted into market-based contractual relations of a commercial nature. The process of commodification extends beyond healthcare to include other social aspects which determine health.[2] By such a strategy, working at the cultural and ideological planes, institutional processes and healthcare practices are being transformed.

Consequently, new practices and concepts that help convert health and healthcare into a commodity, have taken shape. These include, for example, 'standardization' of medical interventions (through hospital 'reform' policies, 'pay-as-you-go' principle, etc.); promotion of the notion that ill health and disease are merely individual conditions and influenced only by medical factors; and management techniques (human resources management,

1 These figures may differ significantly from one country to another. They enable us, however, to get an idea of the size of the health sector and consequently a measure of its strategic relevance. It should be noted that there are large inequalities in health between countries and within countries.

2 While quality and accessibility to a care system are essential, the latter contributes only a quarter to health. Social aspects (income, education, food, housing) and environmental factors determine the other three quarters.

The globalization of the world's economy and global governance mechanisms (covenants, international laws, trade agreements) are having a profound impact on health even at local levels

training, creation of indicators). These are transforming care into a commercial relationship between a supplier (health professional, care institution) and a buyer (patient or 'client').[3]

Private capital, as a result, is continuously increasing its 'market share' in activities related to provision of healthcare. This is happening, for example, through the promotion of private insurance (basic cover or complementary insurances), through the supply of care by commercial enterprises (by outsourcing activities in hospitals such as cleaning, catering or imaging services), through the encouragement of private investments in healthcare services (public-private partnerships), and by aggressively creating markets for different medical products. Above all, in order to establish complete control over the 'market' for health, fundamental changes in health systems are being instituted through legislative changes, which are designed to minimize the role of the State and of not-for-profit healthcare providers.[4]

Further, the globalization of the world's economy and global governance mechanisms (covenants, international laws, trade agreements) are having a profound impact on health even at local levels. Issues related to health and healthcare are captive to global governance structures and mechanisms which are dominated by powerful commercial actors (transnational companies, banks, investment funds) that are provided political support at the highest levels.

'Shock therapy'

There is evidence that private capital stands to gain when social and health systems are in crisis and there is increased economic hardship (see Box).

3 These trends are more marked in hospitals given the size of these institutions, the diversity of health professions, the specialism of practices and the sizeable financing needed to access expensive medical and pharmaceutical technologies.

4 For more details on process and forms of privatisation, see: https://healthcampaignstogether.com/pdf/Kondilis%20(2016%20Brussels)%20Healthcare%20privatization.pdf. We also invite you to complete the privatisations database at http://www.health-is-not-for-sale.org/?lang=en.

POSSIBLE COMBINATIONS OF PUBLIC AND PRIVATE SECTOR FINANCING AND PROVISION			
FINANCING / PROVISION	PUBLIC	PRIVATE NOT-FOR-PROFIT	PRIVATE FOR-PROFIT
PUBLIC	A) Generic tax revenues used for direct public provision	B) Public insurance contributions used to purchase the services of NFP providers	C) General revenues used to purchase the services of PFP providers
PRIVATE	D) User fees paid for private use of public facilities	E) User fees paid of NFP facilities	F) Private insurance payments paid to providers in private practice

Table 2: Source: WHO tasks force on health economic, 1995, in Ellias Kondilis "Privatization of healthcare in Europe", 2016

In such situations, the State and public institutions find it difficult to maintain necessary financial support for comprehensive healthcare services. Neither are they able to increase support necessary for addressing new pathologies, needs of an ageing population, life style related conditions, or for the use of new medical and pharmaceutical technologies.

As a result commercial, for-profit entities move in to areas that are now not supported by the State. Private enterprises thus 'compete' in providing services with public providers in a 'market' for healthcare services. In the market, private providers have several advantages as they are able to curtail costs borne by providers by reducing wages and by resorting to unscrupulous practices such as compromising on quality of care. They also push unnecessary interventions and medical products, and thus actually increase the cost of care to be borne by patients. Patients often lack the knowledge and the information to be able to make a choice between private and public interventions and are lured by the (often unethical) marketing tactics employed by private institutions. Over time, private providers garner larger and larger proportion of the 'market share' and in many situations end up by becoming the dominant provider of services.

It needs to be emphasized that the under-financing of healthcare services by the State, which opens up opportunities for private enterprises, is often a deliberate ploy employed by States under the influence of neoliberal pol-

icies. Neoliberal polices encourage decrease in social contributions and taxes paid by corporations and the rich, and are lenient towards fiscal fraud and tax evasion by the richest strata. Corruption in public services and poor management practices also undermine their efficiency. The sum total of these influences is a reduction in State budget for public services. This opens up opportunities for institutionalization of a system that converts health into a commodity, encourages commercialization of healthcare and benefits private health management organizations, insurance companies and pharmaceutical companies.[5]

The limits to privatization[6]

There are, for obvious reasons, limits to the ability the commercial sector to provide comprehensive and accessible care to all citizens. People needing care the most – old people, young children, the mentally or chronically ill, often poor – cannot generally afford the 'market price'.

In order to be profitable, the commercial sector needs public or socialized financing in order to broaden its scope of operations beyond a minority of wealthy individuals who can afford the full cost of private care. Thus, the commercial sector, while competing for 'market share' with public services, also accesses support through public or socialized financing.

Moreover, the commercial sector is loathe to provide comprehensive services to all patients, given that avenues for profit maximization are variable because of the inability of most people to pay full costs of private care and the fact that many medical procedures are likely to be less profitable. For example it is far more profitable to run a private clinic rather than an Accidents and Emergency Ward.

It is therefore in the interest of the commercial sector to promote a 'segmentation' of the health system. In such an approach 'centres of excellence' are set apart and privatized as they are likely to provide opportunities for higher profits.

5 For a discussion on the strategy of 'shock', refer to Naomi Klein's *The Shock Doctrine: The Rise of Disaster Capitalism*, 2007.

6 See https://healthcampaignstogether.com/pdf/Privatisation-in-all-its-guises.pdf.

This pattern fosters the development of skewed priorities, and the poor, the aged, the most vulnerable, migrants, etc. are denied care as it is more expensive (and not profitable) to have systems in place that can reach out to them.

Experiences from the ground

The multiplicity of operators in the health system, brought about by privatization, fragments care systems, making it even more difficult to manage and plan in a coherent and integrated manner. New costs are generated: running costs, advertising and promotion costs, profits to distributors and proprietors, etc.

Commercial dynamics modify the distribution of resources in favour of the needs for profit-maximization and to the detriment of the true social needs of health (thus, for example, the pharmaceutical industry would rather not invest in finding solutions for malaria which affects mainly poor and debt ridden populations). This pattern fosters the development of skewed priorities, and the poor, the aged, the most vulnerable, migrants, etc. are denied care as it is more expensive (and not profitable) to have systems in place that can reach out to them.

Commodification and its contractual view of care challenge the aspirations and principles of health professionals for whom caring with dignity (and efficiently) for a human being is a prime objective. Besides, a Taylorist approach to care (designed to improve economic efficiency, in other words to maximize profits) compromises the ability of staff in the health sector to apply rational and scientific principles of care, and to show solidarity and initiative when confronted with difficult situations.

In the health sector, working conditions are deteriorating. In its frantic attempts to abolish 'superfluous' costs, the sector is putting pressure on wages, working hours, social benefits, etc. Poor and insecure working conditions have an obvious negative impact on the quality of care.

Most patients are unable to afford comprehensive healthcare services – they are available to only those who can pay. This leads to the creation of

a multi-tiered health system, which caters selectively to patients based on their capacity to pay cost of treatment.[7]

Finally, commodification of healthcare is changing the relationship between users (patients) and health professionals. A shift towards a dehumanized relationship is leading to a feeling of unease at work for health professionals (with increasing incidence of depression, suicides, etc.). The changed relationship also alienates the user(patient) from his or her health, since it is now a product, mediated through a commercial relationship.

Towards health & democracy

Public health needs to be based on the principles of solidarity and separated from relations based on the market. Citizens must have the right to collectively define the objectives, priorities and needs of their health system. Further, health systems and all involved actors should be bound by clear and democratically defined objectives which foster the common good.[8] The anticipation of collective health needs in the light of the evolution in life-style and pathologies, the state of the planet, society and its populations, must also be at the core of health policies.

Our analysis and local experiences show that commercial interests run contrary to public health interests and more generally to the right to health. This is true at a practical level as regards efficient management of a health system in relation to the fair allocation of financial resources, and also at a philosophical, cultural and political level given how dehumanizing the commercial approach to health is.

It is thus essential and urgent to reject the commercial and mercantile logic being pursued in most regions as regards the health sector. It is no mere coincidence that several struggles across the world are making this demand.

7 It has been noted that nowadays, even in the most 'advanced' health systems a considerable number of people postpone or abandon treatment. At least 400 millions people in the world do not have access to one or several essential health services. Each year, 100 million people are thrown into poverty and 150 million people are in financial difficulties due to personal expenses incurred while accessing health care.

8 On the basis of certain principles such as: 1) financial, geographic or cultural accessibility to healthcare for all and particularly for the poorest and marginalised populations 2) health prevention and promotional policies together with an efficient front line system (community health, see Alma Ata Declaration by the World Health Organisation) and 3) to make available to all best-adapted and resourced medical techniques (with a diversity of medical practices) thus ensuring the fastest, most efficient and dignified treatment access.

BOX

PHASES OF PRIVATIZATION

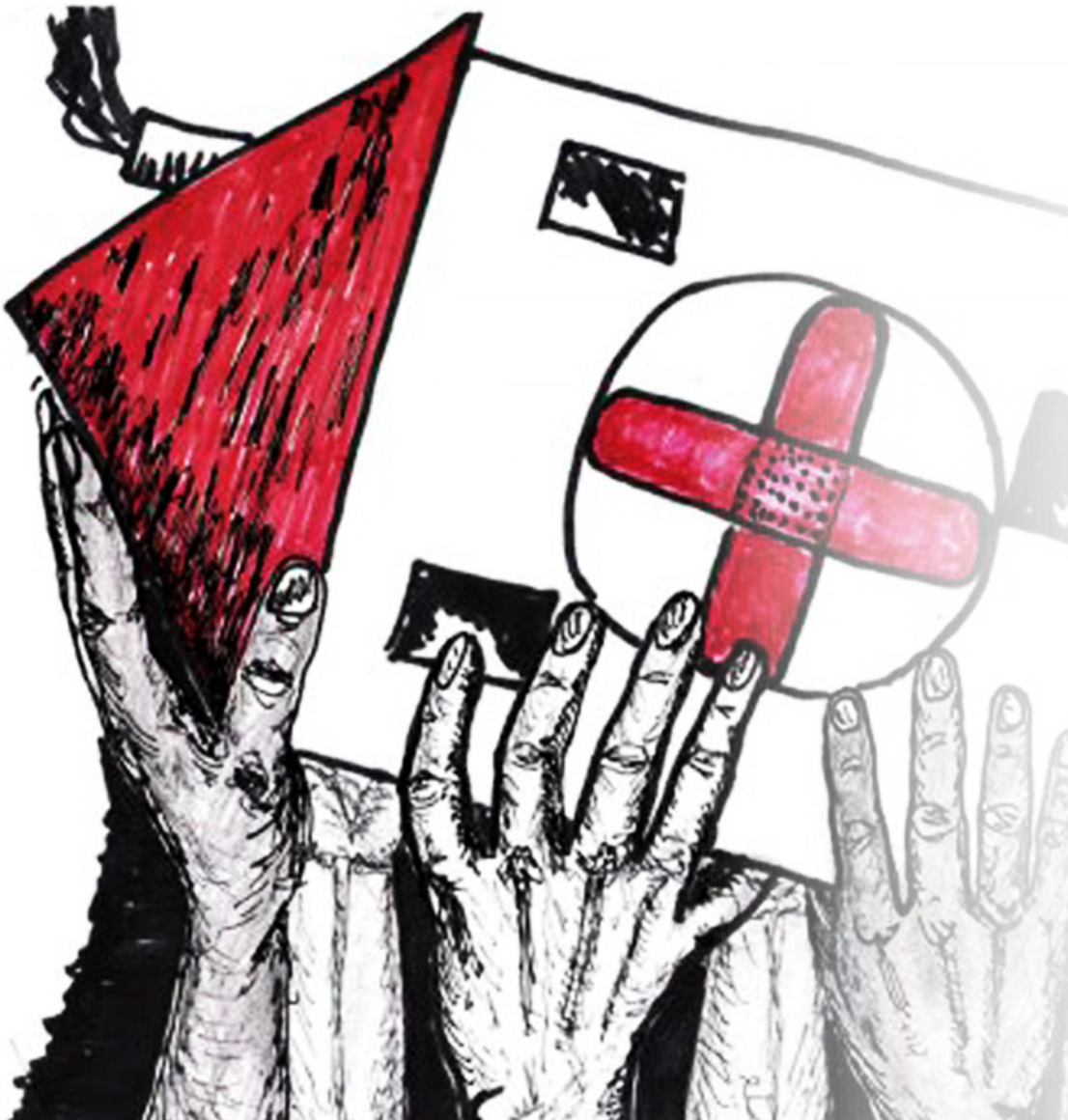
We identify three phases in the penetration of private capital in health systems:

- **In developing countries since the early 1980s** after the sovereign debt crisis. International institutions (International Monetary Fund, World Bank) oversee national economic and budgetary policies and through the structural adjustment programs (SAPs), promote the entry of commercial operators into the health sector. The health systems resulting from decolonization processes are characterized by limited access to care, the strong presence of an informal sector and a public system generally centred on hospitals. They have a structural presence of international NGOs compensating for the shortcomings of a largely underfunded system. Colonial care systems imported Western methods, rejecting the benefits of local practices and know-how.

- **In the former communist countries in the early 1990s** following the fall of the Berlin Wall. The health systems of the communist countries were characterized by a high degree of centralization of health activities, public funding, entirely State-run health services, and the predominance of hospitals over primary care. In the 1990s, major reforms were introduced allowing private healthcare structures and a decentralization of the entire system.

- **In 'Western' countries following the economic and financial crisis of 2008** and the ensuing 'austerity' policies. These 'Western' systems are usually operated by public or non-profit operators. However, since the 1980s they have gradually opened up to commercial operators. Since the financial and economic crisis of 2007/2008, this trend has accelerated rapidly.

These three phases highlight a strategy for the penetration of private capital in crises affecting individual States. Economic difficulties are used to institutionalize a market vision of health and its practices.



BUILDING A GLOBAL MOVEMENT FOR HEALTH

Capturing the essence of all the struggles on health, around the globe, is a huge challenge. Health professionals who demand decent working conditions in order to do their job diligently, communities defending their territories from the clutches of a transnational company or even patients who demand access to existing care that is the preserve of a few. Health transcends the entire spectrum of social movement and feeds diverse struggles.

At another level, health is what brings together various movements, a shared claim, a common flag which unites us in struggle. It could be in the form of a struggle to prevent a paediatric ward or a hospital from closing down. Or it could be a struggle in opposition to the exclusion of people from a privatized care system. Another could involve voicing indignation about the adverse effects of a gold mine on livelihoods and health.

From whichever angle you look at it, health is a powerful call to mobilise. What else could it be? How could we ignore the vital importance of the right to health, the right to access healthcare services, the right that everyone of us has to well-being? Not to be subjected to degrading situations or conditions which undermine this right?

This is the very force for mobilisation that lies at the core of our struggles, which helps them surmount the harshest difficulties and obstacles, which enables or forces alliances, and which can lead to victories, this force is our strength!

The struggle for health is a common struggle

Our struggle will have to adapt to the World's new realities (see introduction), understand their fundamental dynamics but also develop alternative perspectives, policies and practices.

For the moment however, we probably have more questions than answers.

- How can we build a social force capable of changing these global dynamics?
- What contours could and should such a force have?
- What could be a common and shared agenda able to build a global mobilization?
- How do we link this common task to our daily work? How to meet immediate needs at the same time?

Our earlier analysis leads us to state that a profound social, economic and cultural change is needed and it requires building a mass movement sufficiently powerful to threaten the interests of the global elite.

This will not happen overnight. A medium- and long-term strategy is therefore necessary to build: 1) a shared political vision; 2) a social and political alliance that will flesh out the vision; and 3) the organization(s) that will coordinate our actions. It will be necessary to take into account the different spatial (local, national, international) and temporal dimensions (as every region and locality has its own rhythm and pace).

Our demands, our proposals and our vision must be articulated in a clear, coherent and radical narrative and will have to be widely communicated. Counterpoised to the right to private property we shall propose common good, social justice and ecology; against client satisfaction, respect and dignity; against individual responsibility for illness, its social determination. Against the mainstream paradigm, that of an individual anthropocentric and biomedical approach to health, a new paradigm: a collective awareness of social determination and a bio-centric approach to health (which links humans to their ecosystem).

Photo provided by PHM (CC BY 4.0)

Health at the heart of politics

Starting from this new paradigm and our analysis of the current conjuncture, we can imagine a true action programme:

- Ambitious environmental policies for the transformation of the productive apparatus to one that is protective of the planet's ecology;
- A firm commitment to peace;
- An unrelenting fight against poverty and for the realization of a living wage for all, accessible and quality education, access to housing, etc.
- Democratisation of civic institutions and of all spheres of society;
- Accessible, comprehensive and efficient health systems which take into account the real needs of people.

But how do we implement such a program? Is there the political will to do so? Are countries today capable of doing so?

The role of the State in the financing and the regulation of healthcare systems or even the supply of health services is still being debated. Between

the proponents of public control and those who propose self-organisation and autonomy, the jury is still out. The notion of the common good can guide us in developing the methodology for defining needs and priorities, and in facilitating popular participation.

But thanks to our action we can build and strengthen networks of professionals and users, who through their voluntary and activist work can meet certain needs. This is already the case in many countries, particularly where the health system is failing. For instance in Greece, movement of solidarity clinics and movement to support migrants have converged to defend health and healthcare for all. It goes to show how different struggles, confronting different realities, can collaborate to strengthen each other and bring about solutions to the people's needs[1].

We must however remain vigilant: popular participation is key to building our common struggles but should not be channelized (as defenders of commercialization wish to) against public services. Despite its defects, the State is still the guarantor of public interest. Popular participation and public service are complementary and any health policy should be based on these two realities.

Furthermore, it is important to insist on the development of an efficient outreach system for healthcare services and policies to rapidly address pressing health issues. It would also be invaluable to preserve and disseminate traditional wisdom which promotes good health and makes available a network of professionals who are aligned to the priorities and cultural preferences of people.

The training of professionals must take into account these proposals, and must also reassess inherited hierarchies and endeavour to democratize health and its practices. An alliance between health workers and patients (users) is a key requirement to accomplish this.

Our collective processes

Thanks to our broad and popular struggles we are ideally placed to sense the felt needs of people. This can be further strengthened through popular education.

1 See: http://solidarity2refugees.gr/support-city-plaza-refugee-accommodation-solidarity-center-athens-greece/.

The gendered separation of social reproduction from economic production constitutes the principal institutional basis for women's subordination in capitalist societies.

Collective processes addressing specific issues or popular demands build awareness: illness is no longer individual, collective solutions exist, the right to health asserts itself, authorities opposing it are exposed.

How can we link specific demands with general positions? How can the current neoliberal climate be challenged to bring about structural changes. How can defensive struggles be pooled in order to propose alternative systems and policies? How can we link, enunciate and coordinate our struggles and take into account our different rhythms and locations when they divide us?

Such questions will be answered in our collective processes by listening to each other, and by being sensitive towards different needs and opinions. Because our struggles are also the place for individual and collective reappropriation of health, our struggles democratise health. In doing so, they contribute to freeing health and body from the function of reproduction of a labour force essential to the economic system.

The current financialized form of capitalism is systematically consuming our capacities to sustain social bonds. The gendered separation of social reproduction from economic production constitutes the principal institutional basis for women's subordination in capitalist societies. Our struggles must contribute to liberate social reproduction of its submission to capitalist processes. In this regard, feminist struggles would be a natural ally[2].

Towards a global organisation

Struggles for health have the double advantage of being, on the one hand, anchored locally and on the other capable of carrying a simple message which is globally understood. While doing so, they can illustrate in a concrete manner the fundamental link which today connects the local to the global dimension.

These two dimensions are now more intertwined than ever before: decisions that modify our local realities are often taken as a response to global processes (trade agreements, G7, G20, WTO, etc.). Conversely, local prac-

2 https://www.dissentmagazine.org/article/nancy-fraser-interview-capitalism-crisis-of-care.

tices can have a global impact: consider the signing of the free trade agreement between the European Union and Canada, which was blocked because of local resistance in Wallonia (Belgium). In the same way, it is possible, through coordinated action, to destabilise a multinational company by challenging its local operations in different locations. Not taking into account either of these two dimensions would be a disadvantage for our struggles.

Day after day mobilisation gathers impetus, fuelled by the increasingly evident contradictions embedded in a harmful and oppressive economic system.

The awareness that for the realization of the right to health, it is necessary to multiply actions at all levels, is growing.

Because it straddles different social movements, health can be common thread for different struggles, connecting causes and favouring collaborations. Could we, for example, while promoting the right to health and the health of the planet, connect and organize indigenous people fighting against a coal mining company in Colombia with young activists fighting the coal industry in Germany?

We have now the communication tools to facilitate these collaborations worldwide, and also to share our views, analysis and practices, our messages and campaigns and activate the solidarity networks.

Conclusion

The struggle for health has multiple facets and variations. It has left its mark over centuries. Struggles have mushroomed in the current epoch and still mobilise millions of people, communities, groups and organisations throughout the world. Their shape reflects the issues and practices of a society and its times.

The urgency of the health, economic and social situation of millions of people throughout the world, and associated challenges ranging from wars, climate and environment changes to poverty and forced migration must not prevent us from conceiving our mid and long term struggles.

Day after day mobilisation gathers impetus, fuelled by the increasingly evident contradictions embedded in a harmful and oppressive economic system. The awareness that for the realization of the right to health, it is necessary to multiply actions at all levels, is growing. The globalized nature of the forces that threaten us makes it necessary to organize our struggles at the global level as well.

It is a major challenge that we must and can take up thanks to our awareness of the real situation, our desire to confront it collectively, our experience on the ground and the new tools at our disposal.

Our struggles are designed to bring about social change and collective empowerment. Our struggles are premised on the respect for all efforts that are directed at improving the conditions of living of all the people who live on this planet, as well as respect for the planet's ecology.

Figure 4: Representation of the social solidarity clinic of Thessaloniki, Greece

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European Network against privatization and commercialization of health and social protection

The Network's objective is to defend universal, solidarity-funded health and social protection. The Network's member organizations fight against its commercialization and privatization locally. The Network brings together users and health care workers, trade unions and associations, parties and social platforms.

www.europe-health-network.net

People's Health Movement (PHM)

The PHM is a global network bringing together grassroots health activists, civil society organizations and academic institutions from around the world, particularly from low and middle income countries (L&MIC). PHM currently has a presence in over 70 countries. Guided by the People's Charter for Health (PCH), PHM works on various programmes and activities and is committed to Comprehensive Primary Health Care and to addressing the Social, Environmental and Economic Determinants of Health.

www.phmovement.org

ROSA-LUXEMBURG-STIFTUNG

The Rosa-Luxemburg-Stiftung is an internationally operating, left-wing non-profit organisation providing civic education. It is affiliated with Germany's 'Die Linke' (Left Party). Active since 1990, the foundation has been committed to the analysis of social and political processes and developments worldwide. The Stiftung works in the context of the growing multiple crises facing our current political and economic system. In cooperation with other progressive organisations around the globe, the Stiftung focuses on democratic and social participation, the empowerment of disadvantaged groups, and alternative economic and social development. The Stiftung's international activities aim to provide civic education by means of academic analyses, public programmes, and projects conducted together with partner institutions towards a more just world and a system based on international solidarity.

www.rosalux.eu

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« We are witnessing a profound humanitarian crisis. We are confronted with the consequences of anthropocentric, patriarchal, neo-colonial, extractive, individualistic, ultra-competitive and rampant capitalism which lead to an ***accelerated destruction*** *of the conditions which generate and support life »*