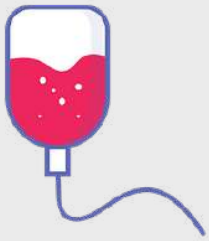
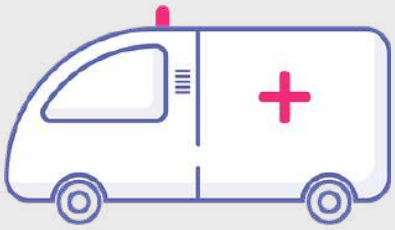
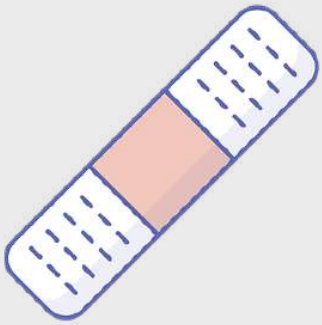
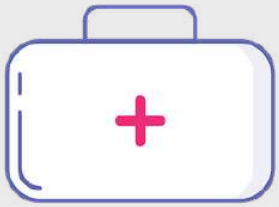





Reclaiming Public Health

Experiences and Insights from Europe



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Reclaiming Public Health: Experiences and Insights from Europe

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People's Health Movement Europe
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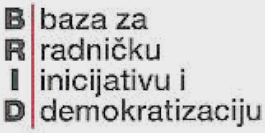

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Introduction: The privatization of public health

Leigh Kamore Haynes and Ana Vračar

Access to health services is a key determinant of health and necessary to realize the right to health[1] for all. However, across Europe governments increasingly fail to ensure that everyone has access to health care through strong, public health systems which the population may readily use. Health care systems struggle to retain their public nature, and diminished access to health services contributes to health inequities, the heavier burden often borne by the most vulnerable communities.

A person's ability to access health care may be determined by their ability to afford health insurance, co-pays, or medicines. Access to health care may also be determined geographically or temporally. In rural areas, for example, where a full service clinic is not available, a person may not have transportation to the nearest facility for treatment. In areas where services are readily available a person may not be able to take leave from work during certain hours to seek care.[2]

Through public health services, states have the power to make sure that all people receive the care and treatment they need, and there is democratic control or the health system through, for example, public participation and accountability mechanisms. However, with the purported aim of decreasing costs, increasing efficiency, or improving services, states have begun to relinquish this power to private actors–contracting out services or selling off parts of the health care infrastructure. They have also implemented measures that commercialize health services or apply "market logic" to the health system, often relying on private actors for implementation. As these practices have deepened, the broad access to health care that people expect has narrowed.

In anticipation of and response to government actions to privatize health services, communities have organized and movements have arisen across Europe to express their dissent with privatization of health services and demand that these services remain under public control. These movements have manifested through large, regional networks and national organizations that work to influence policy at higher levels and also through very localized groups, at the municipal level.

Privatization of healthcare

Privatization of health services is often interconnected with other processes, such as commercialization and marketization. This may entail, for example, the shifting of ownership of assets from public authorities to private companies while other

processes may include healthcare provision being done through market relationships with paying customers, health services being provided for income or profit, or healthcare being financed through individual payments and private insurances. These practices are most common with private entities but are also carried out by public authorities.[3] Despite how the process may look, it ultimately results in the diminution of health services controlled by the public sector and expansion of private actors determining what's best to meet the public's health needs.

No single factor can be pointed to as causing a shift from public to private control, but a few common factors have been identified across Europe. These include alleviating budgetary strain through containing costs, so-called "failure" of a troubled public sector, perceived affluence of health care services outside of the public sector, advancements in medical technology, or just the broader political climate.[4] Privatization has further been heavily driven by neoliberal policies that prioritize capital and private investment; the search for profitable investment opportunities in health care on the part of multinational healthcare companies has driven this transformation.[5]

Privatization affects the provision of care and people's experience of the health system in a multitude of ways. In reviewing long term effects of commercialization and privatization, scholars often point to the United States as the prime example of a system that has embraced privatization of the health sector and in which health care is heavily commercialized. It is a clear example of a health system that is dominated by private interests and where market principles have prevailed.

In the United States, commercialization impacts the affordability of health care as it incentivizes raising prices based on what the market will allow.[6] This is reflected in the high costs of healthcare in the United States, the highest in the world, with 16.9% of the nation's GDP being spent on healthcare in 2018; the next highest spender was Switzerland which spent 12.2% of GDP on healthcare. Private spending on healthcare in the United States, including payments for employer-sponsored health insurance coverage and health insurance premiums, was USD 4,092 per capita in 2018 while the next highest spender, Canada, spent less than a quarter of that amount at USD 759 per capita. Public spending on health in the U.S. is similar to that of other countries–USD 4,993 per capita, where only 34.1% percent of the population were covered by public programs in 2019[7]–a very similar level of spending to Norway (USD 5,289) and the Netherlands (USD 4,343) where many more people rely on publicly-funded health care. However, even with this amount of spending on healthcare, Americans have some of the worst health outcomes in the world.[8]

Privatization of healthcare and people's health

Privatization sets off changes which reverberate throughout the health system, including the experiences and outcomes of the people the system should serve.

Across Europe, privatization processes have brought about a fragmentation of services and increasing inequalities between regional supplies of services. In several countries, there have been cuts in hospital beds and closures of entire hospitals. Many governments have converted public hospitals to private facilities through sales to private investors, resulting in facilities that are generally smaller, employ fewer employees, and have fewer beds.

These changes have opened the door for more public-private partnerships (PPPs) in which the public authority and private sector company operate jointly or as a single

Image: Carlotta Cataldi. Based on Steendam, J., Bodini, C., and Crespin, A. (2019), "Why public health care is better". This infographic was part of an activist toolbox shared during an International People's Health University health activism course in Barcelona in 2021 organized by Health Rights Action (Salut Drets Acció) and People's Health Movement Europe. (http://salutdretsaccio.org/es/iphu-es)

entity. This has involved outsourcing services to private companies, which have included everything from cleaning and catering, IT, and accounting, to diagnostic services and management of entire hospitals. PPPs are also relied on to secure financing or lease of assets such as buildings and equipment.[9]

Health equity impacts, particularly concerning access to health services, have come along with these reforms. Geographic access to care suffers as private, for-profit companies prefer to build new facilities in the more profitable wealthy, urban areas, neglecting low-income and rural areas. The implementation of fee-for-service payments (providers are paid a fixed amount per visit) has resulted in providers prioritizing "more profitable" patients–those with minor, easier to treat health problems–while patients with more serious illnesses or health complications are deemed unprofitable because more complicated, lengthy or time-consuming treatment can cause the provider to lose money. In addition to this, health promotion and prevention programs are given much lower priority or are overlooked entirely.[10]

Reclaiming public health: democratic control and participatory processes

Healthcare has long been a sector dominated by professional groups and technical knowledge, with conservative views of community participation. The effects of private sector involvement have further mystified and complicated interactions with the health system through its introduction of business models, relationships, and priorities. Nevertheless, communities across Europe are organizing to resist privatization and reclaim public health services through implementation of democratic control of and participatory processes in the health system.

Historically, several attempts have been made to introduce more democratic and participatory mechanisms in healthcare. These mechanisms were crucial points of some of the strongest systems in Europe, especially following WW2. For example, the establishment of the NHS in the UK gave way to the formation of local boards to define health priorities on the municipal level. In a somewhat different context, the health system in Yugoslavia introduced an elaborated a structure for worker and patient participation in health planning which created an avenue for dialogue about health needs between the members of the community and health workers.

As privatization in the health sector began to expand, however, such models were among the first things to be sacrificed. Principles of democratic governance in these institutions waned as their focus turned from ensuring people's health to maximizing profit. Similarly, without people's participation in the planning of health systems, the inclusive nature of the healthcare system–to encompass the needs of all people–has deteriorated.

Faced with governments that embrace privatization and private actors who have become more entrenched in the health system, communities across Europe have begun to strategize and organize to reclaim health services back to public control and implement more democratic structures that are accountable to the public. These efforts have targeted all levels of policymaking, from European and national levels to the very local, municipal levels. And just as the privatization process has taken different forms, these efforts at deprivatization have implemented changes that range from implementing participatory processes to alternative forms of healthcare delivery.

Efforts to reclaim public services have taken hold across the globe in pushes for deprivatization through, for example, legislative action and remunicipalization, the "returning of previously privatised services to local authorities or to public control"[11]. Such initiatives have been heavily supported by trade unions and civil society who see them as long-needed alternatives to processes of privatization, commercialization, and marketization of public services, and ampaigns to this end have intensified in several sectors, especially in energy and water services. In the healthcare sector, similar efforts of deprivatization have become more widespread in recent years: from campaigning against the outsourcing of diagnostic services to the private sector in India[12] to the launch of publicly owned pharmacies in Chile[13]. In Europe, the failure of public-private partnerships and outsourcing of auxiliary services in hospitals has ignited similar initiatives, such as the fight for fair employment through industrial action among auxiliary workers at the Great Ormond Street Hospital in the United Kingdom.[14]

Case studies of collective action to reclaim public health services

In this collection, we present four case studies on deprivatization of public health services through democratic control and participatory process as well as through alternative approaches to health care when other options fall short of meeting the needs of communities:

- In Slovakia, high-profile litigation initiated by the health insurance company Achmea against the Republic of Slovakia to stop the government's attempt to regulate the distribution of the company's profits illustrates how limiting the privatization paradigm can be for countries - especially when it's enshrined in international trade and law regulation.

- In Croatia, changes in the main healthcare act have meant that local administration units can take a more active and inclusive approach to healthcare delivery and planning. In some regions the introduction of regional health councils has fostered the inclusion of patients'

associations and trade unions in the design of regional health plans.

- In Belgium, doctors united in the collective Doctors for the People have been providing free primary healthcare for all who need it for decades, independently of their capacity to pay.

- In a town in rural Sweden, health workers have chosen to counter the trend of privatization of primary health care centres trends by taking over operation of their local clinic through a cooperative which has grown to include wider community ownership.

The experiences of the case study authors and communities involved remind us, especially for the period of recovery from the COVID-19 pandemic, that healthcare can be grounded in ideals of solidarity and equal access, rather than be built on the basis of a marketized view of health. They serve as important inspiration for collective action for the right to health in Europe and across the globe.

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Slovakia: Healthcare financing through a ban on distribution of profits

Dominika Gornaľová

In most countries, health care is not only shaped by the local political context, but also through interactions with international institutions and the broader international community. As this international forum has become increasingly friendly towards the private sector, strengthening its position in health care systems and promoting it as the most efficient partner for health delivery, many national health systems have become hostage of big international companies. Such a thing happened to the Slovak Republic when the new government tried to impose limits on private health insurance companies' ability to extract profits they made on citizens' insurance policies. In a case that lasted around 10 years, the insurance company Achmea tried to prove that the Slovak government's policy moves were illegitimate. However, Achmea lost the case in 2018: the outcome should be seen as an example of how governments can act to protect and promote health policies which do not coincide with the dominant commercialized paradigm.

The health care system in the Slovak Republic is a question of disputes as far back as anyone can remember. One government after another has tried to fulfil the sacred, but still unachievable goal, of better-quality healthcare by increasing its financing. One of the steps taken in order to get more money into the health sector made Slovakia famous all around the world. In the *Achmea vs. Slovak Republic* arbitration proceeding[1], measures adopted by the Slovak Republic regulating private health insurance companies and imposing multiple restrictions were challenged.

Background of the case

The Slovak Republic is a Member State of the European Union, located in the middle of Europe. After the dissolution of the USSR, Czech and Slovak Federal Republic (later only Slovak Republic) completed the transition from a centrally planned economy to a market economy. Although the health status of Slovak citizens is currently improving, it still lags behind the EU average.

Healthcare in Slovakia is covered by public health insurance which is paid for by every Slovak citizen through salary deductions: the employee pays 4% and the employer pays 10%. The state pays for insurance for children, students, people with disabilities, women on maternity leave, and unemployed persons to some extent. The patient pays only for above-standard procedures such as plastic surgery, and dental care is only partially covered by the public health insurance.

Besides the public health insurance system, there is also individual health insurance which is based on an insurance contract concluded between an individual and the health insurance company. At this moment, three insurance companies operate in Slovakia: (1) Všeobecná zdravotná poisťovňa a.s., which is public insurance company

fully owned by the Slovak Republic insuring 65% of population; (2) UNION zdravotná poisťovňa a.s., a private insurance company owned by the Dutch company Achmea B.V.; and (3) Dôvera zdravotná poisťovňa a.s. which is fully owned by the Dutch company HICEE B.V., though its ultimate beneficiaries are two owners who are Slovak citizens. With two of the companies being privately owned and the third one being owned by the state, how might the current relationship between the health insurance providers be described? To be brief… tense.

Even though the healthcare system in the Slovak Republic improved over the last 30 years, when compared with other EU member states, health outcomes lag behind in almost every category. Life expectancy remains almost 4 years behind the EU average, the Slovak Republic spends less on healthcare than any other member state, and the ratio of nurses and physicians to patients is at a critical low[2] and predicted to be worse than ever through and after the corona crisis. In this situation, one would expect the state to do everything possible in order to put money into the health care system to resolve various problems starting with lack of essential personnel, mostly specialists, as well as reducing waiting time periods and commencing the more than necessary modernization of hospitals.

After the Slovak Republic joined the EU in 2004, the Slovak health care system and the legislation regulating it was liberalized, allowing private health insurance companies to operate in the health care insurance market. Other changes, made before Slovakia joined the EU or shortly after (between 2003-2005), were focused on privatization. The legislation changed the form of establishment of insurance companies, as well as that of state health facilities, to joint stock companies. The aim of the new legislation was mostly to introduce new budgetary restrictions (the state is not liable for insolvency, *i.e* in the event of bankruptcy, the debt shall not be relieved by the state), transparent financial relations, and mandatory independent audits. The law also restricted the distribution of profits of health insurance companies to its shareholders. Such dividends could only be paid if all claims of insured persons were satisfied.

Following the change in the Slovak government in 2006, strict measures regulating activities of private health insurance companies were adopted, diverting the Slovak health care system from liberalization. The new widely criticized all legislative changes adopted before and multiple amendments were adopted. The transformation of state health care facilities into a joint-stock company has stopped. Among others also the controversial law banning the accumulation of profits of private health insurance companies. In practice this means, that positive economic result from private health insurance must be returned to the health care system.

In 2006, the Dutch company Achmea established a subsidiary in Slovakia–called Union zdravotná poisťovňa a.s. (literally meaning Union Health insurance company). The company would go on to challenge the new regulation restricting the accumulation of profits for private health insurers.

The ban on the profits – one step forward, two steps back

The prohibition of distribution of profits is highly controversial, therefore the action from privately owned insurance companies was surely not a surprise. The chronology of events after filing an action was as follows:

1. Petition of 49 members of the Slovak Parliament to Slovak Constitutional Court (October 2008)
2. Submission of an action to the ad hoc arbitration tribunal in October 2008
3. Ad hoc Arbitration begins, the ad hoc arbitration tribunal rejected the objection of lack of jurisdiction in October 2010
4. Slovak Constitutional Court ruling on the ban of profits in January 2011
5. Arbitration award is delivered on December 2012
6. Proceeding at German courts (2012-2018)
7. Judgement of the Court of Justice of the European Union (CJEU) in March 2018

The proceeding was held before an ad hoc arbitration tribunal in accordance with article 8 of a bilateral investment treaty (BIT), concluded in 1991, between the Government of the Kingdom of the Netherlands and the Government of the Czech and Slovak Federal Republic.

Article 8 of the BIT states: Each Contracting Party hereby consents to submit a dispute referred to in paragraph of this Article, to an arbitral tribunal, if the dispute has not been settled amicably within a period of six months from the date either party to the dispute requested amicable settlement.

The company Achmea initiated an arbitration proceeding claiming breach of multiple articles of the BIT:

- Article 3(1) of the BIT by denying to Achmea's investment fair and equitable treatment by altering health care framework conditions
- Article 3(1) of the BIT by adopting discriminatory measures including the cap on
- operating expenses, the Ban on Brokers, the Ban on Profit, etc.
- Article 3(2) of the BIT by denying Achmea's investment full security and protection
- Article 4 of the BIT by denying Achmea's investment the free transfer of profits and dividends through the Ban on Profits

- Article 5 of the BIT by expropriating Achmea's investment in 2007 through the Ban on Profits, the ban on portfolio transfer against value.[3]

The initiation of the arbitration proceeding was also related to a petition filed by 49 members of the Slovak Parliament at the Slovak Constitutional Court on the constitutionality of the ban on accumulation of profit of health insurance companies. In 2011, the Slovak Constitutional Court ruled that the law was unconstitutional and on August 1, 2011 the division of profits was allowed again.[4] In its decision, the Slovak Constitutional Court reasoned that the Act banning the distribution of profits interfered with expected economic results of the company, which could not be anticipated by the shareholders of health insurance companies. At the same time, the Act interfered with the constitutional right to do business, the right to make a profit and, foremost, interfered with fundamental principles of the rule of law.

A question of jurisdiction

The question which did not directly relate to healthcare was, after all, the most important for the Slovak Republic and changed the face of international state arbitration as we knew it. The question of the jurisdiction of the arbitration tribunal was crucial in this case since it was first challenged at the beginning of the arbitration proceeding, rejected by the arbitral tribunal, and subsequently re-opened by the Court of Justice of the EU (CJEU).

The Slovak Republic originally filed an Intra-EU jurisdictional objection, claiming that the jurisdiction of the arbitration tribunal is not in accordance with EU law. The ad hoc arbitration tribunal denied the objection and ruled in the favor of the private health insurance company (see below). The arbitral award stated that the Slovak Republic was obliged to pay more than EUR 22 mil to Achmea in damages.

Since the ad hoc arbitral tribunal, constituted under the UNCITRAL Rules (the United Nations Commission on International Trade Law), was seated in Frankfurt, Germany, the Slovak Republic initiated the proceeding to overturn the arbitration award in German courts. Consequently, the German court of appeals (Bundesgerichtshof) requested that the CJEU make a preliminary ruling on whether the arbitration clause was in accordance with the Articles 18, 264 and 344 of the Treaty on the functioning of the European Union (the "TFEU").

Although advocate general Wathelet's opinion argued that neither the intra-EU BIT nor clauses contained therein are in the breach of the EU law,[5] the CJEU stated that the arbitration clause in the BIT constitutes a dispute settlement mechanism which is not capable to ensure that possible disputes are resolved by a court within the EU judicial system.[6] Thus, the arbitration clause, the court ruled, was incompatible with EU law.

The most significant impact of the decision of the CJEU was in the context of international arbitration processes which are often included in international investment agreements such as that in the BIT between the Netherlands and the Slovak Republic. Through its decision, CJEU gave power to the domestic courts to settle international investment disputes, rather than to the arbitration tribunals. Further, although the CJEU is not concerned with procedure rather than the subject matter of the dispute, the ruling made it clear that subsequent similar cases in other countries potentially involve matters of EU law and should therefore be resolved by EU courts, not by arbitration tribunals. Ultimately, the decision of the CJEU strengthened the position of national law and courts in the dispute settlement process between investors and the state. Therefore, in the case that other countries face the same process as Slovakia, the Achmea decision would influence its procedural part.

The arbitration tribunal's decision on the merits of the case

Article 3 – Fair and Equal Treatment
The arbitration tribunal found that the ban on profits and the ban on distributing profits denied the company access to the value of the investment it had made. It concluded that the new law, being passed after the investment was made, was not compatible with the obligation under the BIT of fair and equitable treatment.

Article 4 – Free Transfer of Payments
The arbitration tribunal concluded that the government's ban on profits was inconsistent with its obligations under Article 4 of the BIT to allow payments related to the investment to be transferred without undue restriction or delay.

Article 5 – Expropriation
The arbitration tribunal noted that the ban on profits would have been an expropriation, in violation of Article 5, as it would have amounted to a deprivation of the company of its investment, amounting to an interference with enjoyment of its rights of ownership. However, because the ban was declared unconstitutional by the Court prior to the decision of the tribunal, no violation of Article 5 was found.

Aftermath in Slovak healthcare

Lessons learnt and the impact lies mostly for the international investment arbitration which was in the intra EU cases based on BIT's containing similar arbitration clauses. Later, all EU member states concluded an agreement for the termination of Bilateral Investment Treaties between the Member States of the European Union.

In the field of the Slovak healthcare system, the de-privatization process and discussions of subsequent governments to eliminate private health insurance companies in order to keep only one, owned by the state, have continued. The Slovak Republic defended its actions by pursuing legitimate public policy, and almost every government since 2006 has done the same.

The main problem of the Slovak health care system is the financing. Existence of the public as well as private health insurance companies did not have the expected effect and did not bring more money into the healthcare system to improve healthcare

itself. Thus, the Slovak government tends to support only one state-owned insurance company by approving massive financial aid to prevent its bankruptcy.

Even though the process of de-privatization of private health insurance companies is regarded by some experts as negative, it might be the only way to save Slovak healthcare. Existence of only one public health insurance company should bring improvement to the quality of healthcare for citizens as well as for doctors and patients. The other possible methods of healthcare financing through increasing taxes and other levies will only burden the population; therefore, it is unwanted.

However, this will not be enough. The provision of quality and sustainable health care shall not be regarded as a method for profit-making but as a method to continuously improve the healthcare system and the health of the population.

Key takeaways

Even in a health system which includes the participation of private providers and/or insurers, the government can take steps to ensure that they do not extract all the funds from the health system.

Big corporate firms can lose in court. These cases can be relied on as precedent and used by other countries to pursue policies which put people at the centre and to challenge international regulations that favor private interests.

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Croatia: Regional health councils as a mechanism for people's participation in health policy

People's Health Movement – Croatia

Health care and health systems are often perceived as a realm dominated by professionals, with little room for participation by people with no medical education or expertise. However, examples of how people and people's initiatives help shape health policy and health systems at different levels exist all over Europe. On a few occasions, the People's Health Movement (PHM) Scotland organized public hearings to advocate for progressive material to be included in Scottish public health policy, and at the moment PHM UK is coordinating the People's Health Watch: a space for people, organisations, and movements to share their ideas and actions that are resisting current systems of oppression and imagining what visions of health justice look like in practice. People's participation is sometimes enshrined in health policy itself. On the territory of socialist Yugoslavia, self-management was introduced in the health sector to ensure that the health care that is provided corresponds to people's real needs. Although this element of the health system was lost during the transition to capitalism, new mechanisms emerged in the early 2000s, building upon some of the public health

An overview of the health system in Croatia

The health care system in Croatia today is organized as a combination of a health insurance-based and tax-based system. The Constitution includes a provision that guarantees the right to health for all citizens, and most of the health care funds are public. However, to get a better sense of the newer developments in the system, it is useful to look back at the main trends that have shaped the system for the past decades: as it remains strongly influenced by different trends from the past.

We can speak of two main trends in health care in Croatia in the last 50 years. Until the 1990s, the health system was operated as a universal public health system based with a health insurance model similar to the ones in Central Europe. Differently from those, though, this system was built on the idea of social medicine as introduced by the physician Andrija Štampar between the two world wars.[1] Thanks to the movement Štampar ignited, health care in various parts of Yugoslavia focused a lot of its energy on preventive care and addressing social determinants of health.

At the time, the health system formally provided coverage for the whole population free of charge. In practice, coverage-related issues were not uncommon, especially among the rural population. Another important characteristic of the health system was the self-management model that was introduced in 1963, mirroring the way that the traditional industry was run since the early 50s. Self-management consisted of mechanisms that allowed workers and, in the case of social services, the community and users to have a say in how the system was run. For example, in the case of health care, the needs of a particular community were discussed by a representative body of

providers (i.e. health workers), and a similar one consisting of the users of the health system. The main intention of such a model was to ensure that the needs of a particular community are reflected in the way the health system was organized, but it also fostered learning and network building through direct exchange among groups.[2]

Beginning with the 1980s and during the 1990s, the system faced radical changes. Because of the conditionalities of the World Bank's loans, it was reformed in a way that allowed a more commercialized vision to replace the one based on social medicine and people's participation.[3] This trend continued during the next decade, and it has led to years of budget cuts, austerity measures, and the strengthening of private health insurance companies.[4] For the people using the health system, although they are still nominally entitled to universal access to primary and secondary health care, this has meant reduced access (especially in non-urban areas) and participation fees, either in the form of out-of-pocket payments or additional health insurance policies.

Decentralization

One of the most important reforms that were introduced during the transition to capitalism is the decentralization of the health system. The self-management model already implied a high level of decentralization, as a lot of the decisions that impacted people's access to care were taken at the level of the commune, or even in the workplace. However, this was a different kind of decentralization than the one that was being introduced in the West to improve efficiency and shift responsibilities from the state government to other levels of administration. The new government replaced socialist decentralization with a centralized model that allowed a complete reorganization of the system.[5] But, as early as 2000, decentralization was again on the agenda – this time reflecting the idea propagated by international financial institutions and neoliberal governments.

Today, many of the responsibilities for providing and organizing health car fall upon the regional administration of the 21 regional units. The responsibilities are probably most visible when it comes primary health care, as the regions are the main coordinator of primary health care on their territory. At first, this sounds more than reasonable, as the regional administration should be more aware of specific needs that need to be addressed than the central government. However, as a region's ability to actually strengthen health infrastructure and develop its health programs depends on the budget available, over the years differences among the different regions have appeared and widened. Today, the largest part of the health network gravitates towards urban settlements, particularly those in richer regions, while rural areas tend to get limited access to even basic health care.

Transition to capitalism has also increased the space available to private providers of health care. Although usage of private services in secondary care has remained low

until quite recently, and providers that work on out of pocket payments in in primary health care are rare, the primary health care system is actually dependent on private contractors. Approximately 70%[6] of primary health care practices are privately owned by physicians, but financed through contracts with the state owned Croatian Health Insurance Fund (CHIF). Although this is usually not perceived as an issue, as it is argued that the patients do not perceive a difference in the care provided by private providers paid with public money and that provided by public service employees, such a model has siphoned off public funds from the public system, and has had a negative impact on working conditions, primarily on those of the nurses in the primary health care system.

Since the regions are responsible for organizing primary health care, such an arrangement directly impacts them, and we will cite in the case study below practical concerns that have come out it. What should be said now is that, because for a long time they were not expected to, most regions neglected to develop their own capacities for shaping health policy. This has meant that they had been less able to track and address even those things that require little funding, as well as taking a stand on the percentage of private providers that operate on their territory. To address the first issue – building health policy capacities – a new provision in the Health Care Act of 2008 was introduced, building upon structures that were built in past decades.

Introducing regional health councils

Most elements that included people's participation present in the self-management era were lost in the transition, but some of the public health programs from the late socialist era continued to function in changed circumstances. One of these programs is the local network of the WHO Healthy Cities project, which was used in to launch a policy reform that would again contain an element of participation in shaping health policy, this time in the form of regional health councils (Croatian: *županijski savjeti za zdravlje*).

After an initial round of project-based consultations, health councils were introduced in 2008 as a formal obligation of each region. They are imagined as interdisciplinary groups made of health workers, employers, policy officers, patients' delegates and local administration representatives that guide the local health policy making process in a way that it reflects local needs. Although the healthcare act defines only the minimum of their obligations – specifically, developing the regional health plan and monitoring the quality of healthcare in the region – there is no limitation to what the local government can chose to consult the councils about.

One of the intentions of introducing the health councils was to build the capacities for regional health policy making on the resources that already existed locally, but were often not interlinked. The implementation of the councils did not go the same

way in all regions, though. In some places, like in the regions of Istria and Primorsko-goranska, the councils took off with some success and managed to make progress with local health policies. Other regions established their health councils because they had to, but their practical involvement in shaping health policies remains feeble even today.

As an illustration of how the councils can become important (and useful) factors in the regional health system, we bring the story of the regional health council in Istria, based on an analysis of available policy documents and an in-depth interview with the local health commissioner Sonja Grozić Živolić.

Istria: The regional health council as policy creator

The first attempts to build a stronger network among health professionals, health institutions, and the community in Istria began in 2002, through the activities of the Healthy Cities project. This came after the changes of the healthcare act of 2000, when there was the first significant shift towards decentralization. The regional health council was established after it was made a legal prerequisite, but by then the region had already taken steps towards developing its own health programs.

The council is made of representatives from the local government, the professional chambers of physicians and nurses, the biggest trade unions present in the health sector locally, employers, as well as a representative of the patients. By law, the patients' representative should come from a patients' association, but since locally there are no associations that fit this brief, they are chosen among the workers of the local office for patients' rights. The work of the council's members is voluntary, although they are reimbursed for travel expenses and other expenses that are associated with the work they do in such capacity. The members of the council are named by the regional health authority and appointed by the regional assembly.

According to the local health commissioner, the post-2000 decentralization has opened up more space for the local administration to organize the work of the health institutions as fit for the community's needs, at least in theory. In Istria, this means coordinating the work of a 3-year Regional Health Plan, and shaping preventive programs that differ from those proposed by the Ministry of Health. Istria's health council has developed an efficient and participative approach to designing the health plan, as they consult the whole community about its content. They also collaborate with the regional unit responsible for social care, so the plan has a certain social determinants of health dimension to it.

The consultations with the community are done through focus groups and surveys, and people who use the health care system also take part in the process of selecting the priorities of the local health policy for the next 4 years. The priority selection process is organized in the form of a conference, which decides by consensus on the

priorities, and also feeds into the plan. Through this approach, the region has already had 3 regional health plans and additional preventive programs that address issues such as mental health, nutrition, and safe and affordable housing.

One of the most recent activities of the health council involved developing a health workforce plan for Istria. In fact, although the whole country faces a serious lack of health workers, the plan devised in Istria is the only document that approaches the issue based on the analysis of regional resources and particular needs. Among the different measures put forward in the plan, aside the most obvious ones like increasing salaries in the public health system, we can single out the introduction of scholarships for students of health professions, as well as a housing scheme for health workers.

What works and what doesn't

It has to be said that the work of this particular health council is influenced by the fact that Istria is one of the richest regions in the country. Additionally, as Sonja Grozić Živolić has stressed, the budget of the regional office for health and social protection in Istria accounts for almost 60% of the overall regional budget, and additional funds are often secured. The work of the regional health council has definitely been a moderate success in the terms of improving the responsiveness of local health policy to actual needs, but it is difficult to know if the effect would have been the same in a region with a comparable level of effort, but less funds available.

Second, the local health commissioner also stressed that even though the region is formally responsible for coordinating most of the health care network locally and there is a material basis for fulfilling this responsibility, there are unresolved issues with central state institutions. For example, although the regional health council and health authority are supposed to draft a map of the regional primary health care network, their inputs are often sidelined by the CHIF, the institution that makes things happen in practice. According to her, through the current form of decentralization regions have gained "formal and legal responsibility to ensure health care is accessible on their territory, but they have been left without any real mechanisms for implementing these responsibilities". For example, the CHIF does not take into account the guidance of regional health bodies when it is deciding on the distribution of funds to primary health care providers, nor it allows the regional health councils to suggest which area is most in need for additional teams. This, says Sonja Grozić Živolić, makes no sense, because it is the regional institutions that know local needs best.

In Istria, the regional health council brought along concrete improvements in the health system: its work led to implementation of health policy that reflects regional needs, and in some cases it has been the first one in the whole country to address issues that are shared, but ignored. This, for example, has been the case with the

regional health workforce plan. An additional positive result of the work of the regional health council in Istria has been the initiative taken by some cities and administrative units in the region to form their own health councils, which replicate the policy making process on a smaller scale and create additional space for discussing issues related to health.
On the other hand, we have to consider that the introduction of the regional health councils has been a top-down initiative, and that this does impact the scope of their work. Although the regional health council described here has put in place mechanisms to ensure community participation, this is not a prerequisite, and in other places the council's work can easily be reduced to consultations among its members. Therefore, one of the ways to make sure the councils are representing a broad set of views and needs is to make them more inclusive towards the community, and more proactive in finding ways for the community to take part in the making of the regional health activities.

This would also help to make the health councils more recognizable in the eyes of the community, which would strengthen their position and provide them with more legitimacy towards the different levels of government and the CHIF.

A movement's perspective of regional health councils

As the introduction of regional health councils did not come about through grassroots initiatives, but through policy change, their use for people's movements can be limited. We can observe just that through some of the key aspects of the health council in Istria, even though it is one of the most successful instances. For example, the members of the health council there are appointed, rather than selected in a more democratic process. A similar process takes place in other regions too, which implies that regional health councils might not always have the legitimacy (or desire, even) to represent the community's health needs. By developing a different path for selecting the members of the council and relying on a broader consultation process as in the case of developing the regional health plan in Istria, the councils could be a space to provide more diverse inputs for health policy.

It is also useful to reflect on something that the decentralization process in Croatia, along with those in other places, have shown when it comes to implementing such solutions. In the case of regional health councils, as well as in everything else, expanding public budgets to answer to local needs is necessary to make the wanted changes work. In this case, the work of the regional health council is supported by the fact that there is a large amount of the public budget already attributed to health, and that the region is in a significantly better financial position than others. Although it is true that organizing the provision of health care at the local level might be a better way to address local specificities, it should be guaranteed that these kinds of initiatives get enough financial support from the state government, so that regions with less funds of their own are not left behind.

Finally, in order to make the regional health councils more useful, it is necessary to make their existence known more widely. At the moment, most people are not aware that such bodies exist, and that limits the impact and reach of the councils. An effort by right to health groups to reach out to their local council, building relationships with its members, and then spreading the word about what the councils do, could be a path to making good use of existing policy solutions and ensuring the inclusion of more progressive materials in local health policy.

Key takeaways

Decentralization must not mean reducing public funds available for the implementation of new structures, like local health councils. The fulfilment of such programs must happen where there are material grounds to do so.

Broad participation can be achieved even though it might not be planned in an original framework. When avenues of participation do exist, it is important to make sure that they are visible and that the public is aware of them in order to guarantee more participation and accountability.

Even though the structure in this case is top-down, it is still very instructive. Spaces like this that can build bridges between policy makers and community. They are an opportunity to implement our vision as health activists.

Health councils often seem quite harmless, even from the perspective of more traditional policy makers. They make for very useful advocacy targets and can be used strategically if activists come prepared.

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Belgium: Health workers organize to provide care and advocate for the right to health

Geneeskunde voor het Volk/Médecine pour le Peuple

It is needless to say that health workers are a crucial driver of health for all. Over the course of the past few decades, we have witnessed their working conditions become harder, while their rights in the workplace diminished at the same time. Many countries in the Global South face a great shortage of nurses and physicians, and this is made worse by migration towards the Global North where the working conditions are more consistent. Regardless of the place where they find themselves, health workers are sometimes also key actors in the struggle for the right to health: from strikes to protests, they show how our right to healthcare is intertwined with their right to a safe workplace. Sometimes, these efforts have a wider dimension to them, as in the case where health workers organize to provide healthcare outside the formal health system, especially to those who cannot access them. In Belgium, many people remain excluded from the primary health care system because of their inability to pay, and a health workers' network has been working to counter that trend for the last 50 years. The example of Doctors for the People shows how health workers can make existing health systems more accessible to people, while at the same time building alternative narratives that put the human right to health at the center.

Origins

Geneeskunde voor het Volk (GVHV)/ Médecine pour le Peuple (MPLP) (Doctors for the People) is a Belgian national association of 11 health centres located in working-class neighbourhoods on both sides of Belgium's language border and taking care of around 25,000 patients. Celebrating its 50th anniversary in 2021, MPLP traces its origins to the student movement of the late 1960s and the then established Marxist Workers' Party of Belgium (Partij van de Arbeid van België (PVDA)/Parti du Travail de Belgique (PTB)).

MPLP's first health centre was founded in Antwerp in 1971 when a group of young doctors joined the striking dockworkers in a show of solidarity. This solidarity action spontaneously morphed into the project that gave birth to a medicine for, by, and from the people, instead of a medicine for profit.

As an association, MPLP is economically and organisationally independent but links with the PTB remain strong. In an interview with Solidair, a Belgian magazine, Janneke Ronse, MPLP's national chairwoman, and Sofie Merckx, doctor at MPLP and member of parliament for PTB, explain the relationship between MPLP and PTB:

> "Many of the problems we encounter cannot be solved between the four white walls of our health posts, but we can translate them into

> political discussions and actions. For example, many people today are reluctant to respect quarantine measures because it reduces their income or because they risk losing their job. As a doctor or nurse, it's hard to deal with such an issue. But turning it into a political demand makes it something we can collectively push for."

This broad understanding of health, turning health problems into political issues, forms the backbone of MPLP's vision and work. Three principles stand at the heart of that vision: accessibility, quality and solidarity.

Accessibility

In Belgium's last national survey on the matter, 900,000 people stated that they could not afford a doctor. Belgium has an expensive health care system, with patients paying about 19 % of health care expenses out of their own pockets. On average, that is €666 per year. Despite being one of the richest countries in the world, Belgium can be counted as one of the worst students of the class when it comes to access to medical services in the EU.

MPLP's mission is to prove that it is possible to organise accessible and high-quality health care. In Belgium, social security works on the basis of a pay-as-you-go system grounded in solidarity through taxation on labour. National health insurance is part of this social security system. Belgium has a liberal model, which means that patients pay per service for a doctor's visit. National health insurance repays approximately 75% of health care expenses.

Belgian law also provides space for alternative reimbursement schemes for health care expenses. On the basis of a contract between patient, care provider or group of care providers, the national health insurance pays the health centre a fixed amount each month regardless of how many patients rely upon their services. MPLP's health centres work according to this flat-rate system. The lump sum MPLP receives for all registered patients goes into a common pot from which expenses and wages are paid.

This system has multiple advantages. Patients visit doctors without having to pay out-of-pocket expenses, removing financial concerns and barriers considerably as a result. The system also enables healthcare providers to work both in a multidisciplinary and preventive way as in a curative capacity. In short, healthcare providers can fully focus their attention on the quality of care. In addition, resources saved are used for health promotion, MPLP's national study service and national campaigns.

Budget cuts and the dominance of neoliberal ideas and policies have put this funding model under considerable pressure. Policy makers favor performance-oriented medicine over the flat-rate funding system, with patients paying for every doctor's

visit as a result. MPLPactively advocates for the protection and expansion of the flat-rate system, including through its campaign "Save our Medical Homes" (www.reddesocialegeneeskunde.be).

Quality

Our view of health is consistent with that of the World Health Organisation and the Universal Declaration of Human Rights. Health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

Multidisciplinary cooperation and knowledge sharing

MPLP's health centres have long ceased to be ordinary general medical practices. In recent years, they have developed into fully-fledged multidisciplinary centres. The complexity of the patients' conditions poses a great challenge.

All health centres employ general practitioners, nurses and a reception and administration team. Most also have a psychologist and/or a social worker. Some practices have dieticians and physiotherapists. The staff works together on an equal footing to provide the best care for the patient. This cooperation takes place through consultations, briefings, medical and team meetings. The medical staff work together in one electronic file. At registration, we inform the patients about our way of working.

Together, these services provide follow-up, treatment, prevention, guidance and health promotion. Multidisciplinary working groups organise various activities with patients on specific themes: diabetes, young mothers, long-term pain, stress, sleep, etc.
For patients with a chronic condition, we strive for a permanent care team to ensure continuity, customised care and a relationship of trust between care providers and patients. MPLP employees organise themselves into multidisciplinary networks on a local and national level.

Prevention

The COVID-19 pandemic very clearly showed the importance of a strong public health system. For an effective preventive approach and a firm grip on emerging epidemics, three pillars are essential: a centralised first line, patient-based (and not performance-based), financing and a nationally organised public health service with

one central leadership (and not, as is currently the case in Belgium, with 9 different ministers of health). During the early months of the COVID-19 pandemic, MPLP demonstrated these importance of these three pillars through its contact tracing project and its outreach to elderly patients who were more susceptible to severe illness and death from infection.

Pioneering role in contact tracing

In Belgium, the government was slow to roll out contact tracing at the beginning of the COVID-19 pandemic. To fill this gap and meet the news of the community it serves, MPLP started its own pilot project in Hoboken in the spring of 2020 to test, detect and isolate potential cases of COVID-19. Over 120 patients were contacted with 89 willing to participate in the project. Through this proactive effort, MPLP was able to take preventative steps to protect participant patients and their families by informing them about the virus and supporting them with measures to prevent infection. Such a contact investigation requires substantial effort and knowledge of the field. It requires time, not only to get everyone on the phone but also–above all–to gain the trust of those you are talking to in order for successful implementation. From this research, MPLP drew recommendations for policy makers. Primary care providers know their patients best, and contact tracing can only be successful if it is done in close cooperation with primary health care centres.

Preventive care for elderly in case of pandemic outbreak

When the COVID-19 pandemic broke out in Belgium, MPLP's eleven health centres worked to ensure protection for elderly patients. The centres selected 3,367 elderly patients on the basis of data from their medical files with the aim of calling all of them to inquire about medical or social needs that may arise due to the pandemic. In the midst of rapidly changing organizing and re-organizing during sudden waves of infection, health centers were committed to make the effort to reach out to these patients proactively. In addition to a lot of gratitude, MPLP received a lot of information about the needs and concerns of vulnerable groups. Many were anxious and sometimes slightly panicked, others were not yet fully aware of the danger and recommended sanitary measures. Elderly citizens living alone faced multiple problems.

After speaking with patients, medical questions would be passed on to MPLP doctors to be answered and social questions went to the

coordinator of volunteers to find a solution. For example, several dozen patients received help from volunteers in the neighbourhood for several weeks or months to do their shopping. One patient wrote a thank you note to the MPLP team after one such phone call: "Your concern about loneliness in single elderly people really touched me. Especially now, more than ever, good healthcare is crucial."

Projects such as calling the elderly show how critical proactive prevention initiatives are in combating an epidemic, and it is during crises like the COVID-19 pandemic that the importance of the work of MPLP becomes clear. It enables reaching people who are not yet sufficiently informed, thus increasing the respect for sanitary measures. The work also facilitates detection of additional needs that must be taken into account, because health – even in times of a pandemic – is more than being virus-free. It is also about mental well-being and the ability to take care of one's self.

Solidarity

MPLP's health workers' take strong, public positions on issues that affect their patients and communities and put their scientific knowledge and social commitment to the service of people's needs. Alongside patients, social organisations, mutual health organisations and trade unions, MPLP defends the right to a healthy life. More concretely, this means defending the right to accessible and high-quality healthcare and education, the right to healthy working, living and environmental conditions and the right to social security. In this context, MPLP attaches great importance to cooperation with and support for trade unions. The struggle of the labour movement lies at the basis of Belgium's social security system and is critical to maintaining and strengthening the people's acquired social rights.

There is a strong sense within MPLP that doctors and other health professionals have a social responsibility beyond ensuring the physical and mental health of patients. MPLP's health workers do not just fight symptoms; they also tackle the social causes of illness and health. Their "social stethoscope", with particular attention to the social and societal context, is the main research tool they use. Rather than reinforcing the current system, MPLP's health workers focus on liberation and emancipation. Solidarity–not charity–takes up a central place in their fight for the right to health.

The more people understand for themselves what happens in their bodies when they get ill, the more resilient they become in taking control of their own healing process. Likewise, the more people understand what possible causes (social, societal, economic, environmental) are behind their illness, the more resilient and militant they become in taking steps together to address those possible causes. MPLP is

committed to supporting this awareness-raising process alongside people, individually and collectively. It aims to form a social force with patients to change what is wrong and unfair. And *that* is empowering.

Addressing air pollution in Antwerp

It started with a patient who came to ask if we knew more about the sign in her street announcing that the Beheersmaatschappij Antwerpen Mobiel (BAM), the company responsible for traffic infrastructure in Antwerp, would be renovating the Antwerp ring road which encircles the city of Antwerp. Part of the project included building a bridge directly over residential areas–expanding the busiest traffic junction in Europe which already cuts directly through the residential agglomeration.

MPLP health workers had already noticed that many of the patients in its practice had respiratory problems and were using inhalers, and began to investigate what the underlying causes may be. MPLP compared inhaler use between children living in a rural town in Belgium, Baarle-Hertog, and those living in the city of Antwerp. The results revealed an alarming disparity: 6/10 children in Antwerp used inhalers and only 1/10 in Baarle-Hertog. This pattern confirmed the results of researchers' literature review showing similar patterns in other parts of the world.

In the spring of 2008, MPLP organized a demonstration against the project with Ademloos, a collective that campaigns for clean air. Later that year, in June they organized an even bigger action with students of a school for children with disabilities, including cystic fibrosis. The school is located exactly in the area where the planned bridge would cross. It was a very inspiring action, which drew a lot of indignation and a lot of press. This began a long struggle of more than 10 years, with patients, local organizations, and residents, which included organizing demonstrations and holding information evenings about the effects of air and noise pollution on health in all the districts and neighbourhoods of the city.

MPLP also worked with Ademloos and Staten Generaal, another citizens' collective, to circulate a petition calling for a people's consultation on the project. The petition gathered more than 50,000 signatures. The bridge over the residential area was voted down. BAM withdrew its building application.

The fight for affordable medicines

In 2003, MPLP health workers noticed that patients who needed cholesterol-lowering drugs were not reimbursed for them, while many others who did not need them were. Dr. Dirk van Duppen and the team of MPLP Deurne investigated this further and noticed even more illogical waste in the National Drug Policy. They discovered the vast pharmaceutical industry lobby that influences the Ministry of Health. Profit was the driving force of the wasteful decisions, instead of health.

Partnering with concerned allies from the health insurance funds (mutualities), MPLP explored how these reimbursements are handled in other countries, namely New Zealand which employs its 'kiwi model'. With the kiwi model a national institution coordinates medicine purchases for the entire country, which has led to a 50-90% drop in the price of medicines. If this model were applied in Belgium, EUR 1.5 billion would be saved on social security. Along with other organizations, MPLP drew up a petition that gathered 100,000 signatures. Dr Dirk van Duppen also wrote a book on the matter in 2004: *The Cholesterol War, Why Medicines are so Expensive*. In May 2021, the Belgian Court of Audit issued a remarkably positive statement on the 'kiwi model' as a solution for exploding medicine bills noting that it is "cheaper, more transparent and healthier".

International solidarity

In the 1970s, doctors from MPLP travelled to Lebanon provide medical services and support in Palestinian refugee camps. After returning to Belgium in the mid-1980s, they founded Third World Health Aid (Médecine pour le Tiers Monde - M3M), now Viva Salud, with other doctors in the country. Their goal was to develop solidarity with organisations in Latin America, the Middle East, Asia and Africa that organise healthcare in the service of the people as well as give Belgian healthcare workers the opportunity to make a practical contribution.

MPLP and Viva Salud continue to organise activities together, and there is great solidarity between health workers in Belgium and in other parts of the world. Viva Salud is part of the campaign for the European Citizens' Initiative "No Profit on Pandemic", co-organized by one of MPLP's doctors, which urges the European Commission to initiate legislation that would guarantee access to medicines *globally* for COVID-19 related illnesses.

Vision and future

In 2021 MPLP celebrated the 50th anniversary of Doctors for the People. A new generation took the helm. The online celebration of the 50 years was followed live by many patients, friends and sympathisers across the country and beyond. The 11 health centres continue their work, and the rejuvenated leadership wants to put extra effort into strengthening national staff, in order to make even more campaigns and projects possible. Because the fight for the right to health will become more important than ever in the coming years.

Key takeaways

Addressing the underlying causes of poor health contributes as much to a patient's health as the care provided. Health workers can effectively investigate and identify these causes as part of their practice.

Health workers can–and *should*–take concrete steps to express solidarity with their patients and the communities they serve. As MPLP demonstrates, community organizing and political action are very powerful ways to to address local health challenges.

Our existing, imperfect health systems can be partially reclaimed through collectives like MPLP. While they may not be permanent solutions to the problem, they go a long way towards addressing immediate needs and lay the groundwork for different and better health systems.

Sweden: Creation of a cooperative to ensure local healthcare provision

Desirée Enlund

Privatization of health services has creeped in even those systems which are generally perceived as accessible to all. The health system in Sweden, for example, has seen numerous attempts—with various degrees of success—to introduce private elements. In addition to a well documented case of public-private partnership in building the new Karolinska Hospital in Stockholm, there have been various instances of local governments' intentions to shut down smaller hospitals which were deemed non-essential. On more than one occasion, these attempts have been met by resistance from the community, and by alternatives thought of by the community to ensure that health care delivery is not impeded by public budget cuts. On some occasions, people's initiatives were not successful in preserving public delivery of health care, but they managed to keep the services going through health cooperatives. Although these should not be perceived as an alternative to universal public health systems, health cooperatives represent a more democratic and participative model of health care delivery than the one offered by large profit-driven companies.

A threat to primary healthcare in Offerdal

Sweden is often held up as a model of what universal health care should look like everywhere: affordable, accessible, quality care for all. However, the welfare state and public healthcare system in Sweden has been slowly dismantled by processes of marketization and privatization.

The Swedish public healthcare system is organized at a regional level with 21 Regions in charge of both public transport, regional development and healthcare services. The regions are governed by regional assemblies for which there are elections every four years. The division of power is such that while the national state implements laws that dictate the overarching framework for the delivery of healthcare, it is the task of the regions to organize the healthcare services. Furthermore, some parts of care services, such as elderly care and care for people with functional variations, are organized at the municipal level. This three-fold organization means that there can be different ideological/party constellations at different levels of government with different views on how to organize the public healthcare services.

Over the last three decades, the Swedish government has introduced various forms of market-based systems for the operation of the public healthcare system. There has been a drive to both introduce market incentives into the public system[1] as well as efforts to privatize parts of the healthcare system, particularly primary care services where 37% is provided by private companies and personal assistance[2]. Depending on how one views these reforms, the changes to the public healthcare system appear rather comprehensive. If one looks only at the levels of privatization of healthcare, a large part of public healthcare is still provided by public entities. On the other hand,

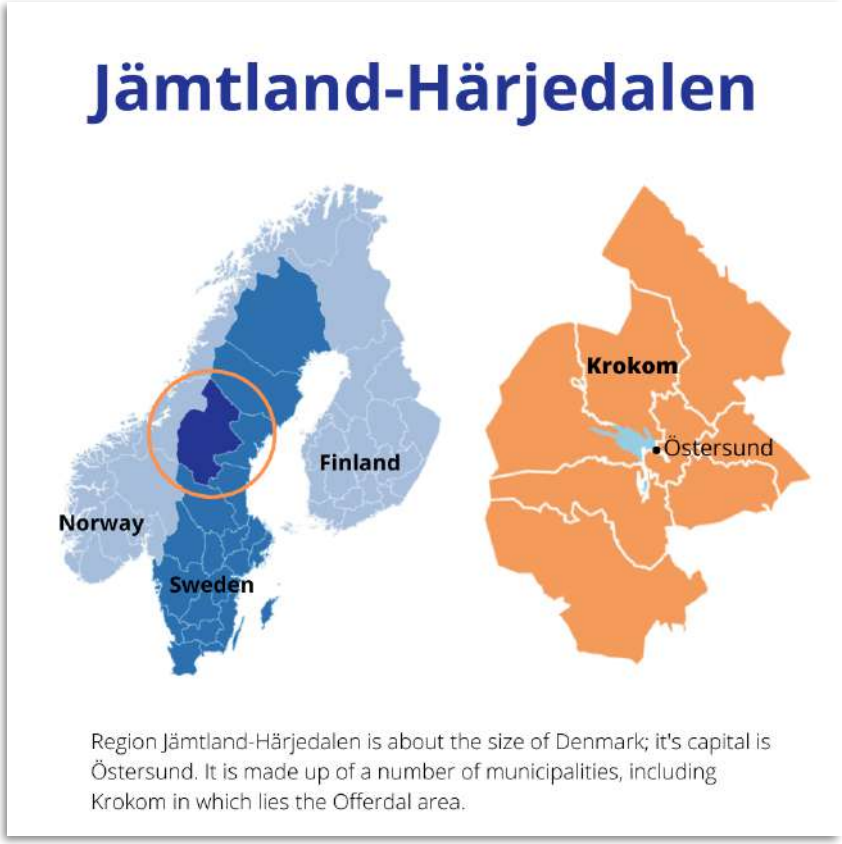
more profound changes are evident if one looks at the governance of the public healthcare system which is operated according to market logic.[3]

Specific reforms have included increased specialization and concentration of hospital services and increased privatization of the primary care and the pharmacy sectors.[4] It is important to remember that the privatization process is most often only directed at one aspect of healthcare, the provision side. Otherwise, healthcare services in Sweden are still almost entirely financed by public funds. One of the most important reforms that has led to an increased privatization of healthcare services is the Primary Care Choice Reform (LOV in Swedish), promulgated by the national government in 2009-2010, which forces the regions to implement market systems. In particular, the law stipulates that as long as a private company fulfills the region's requirements, the region cannot prohibit the private company from opening a primary care center funded with public money. Thus, a region must allow private, for-profit companies to open primary care centers in any location they want, regardless whether that area is over-serviced, which has lead to concentration of private primary care centers in affluent urban areas. At the same time the regions have an obligation to first fund the private primary care centres before they fund their own public primary care centres. This impedes their capacity to compensate for the over-establishment of private, for-profit primary care centres in certain areas by redistributing more funds to other under-serviced areas.[5] Regional authorities have thus centralized services in order to cut costs.

As a result, many people in Sweden have seen health services in their communities move farther and farther away.[6] Moreover, changes in the structure of the healthcare system has affected the work environment in that care provision is increasingly influenced or dictated by politicians and bureaucrats, creating undesirable working conditions.[7, 8]

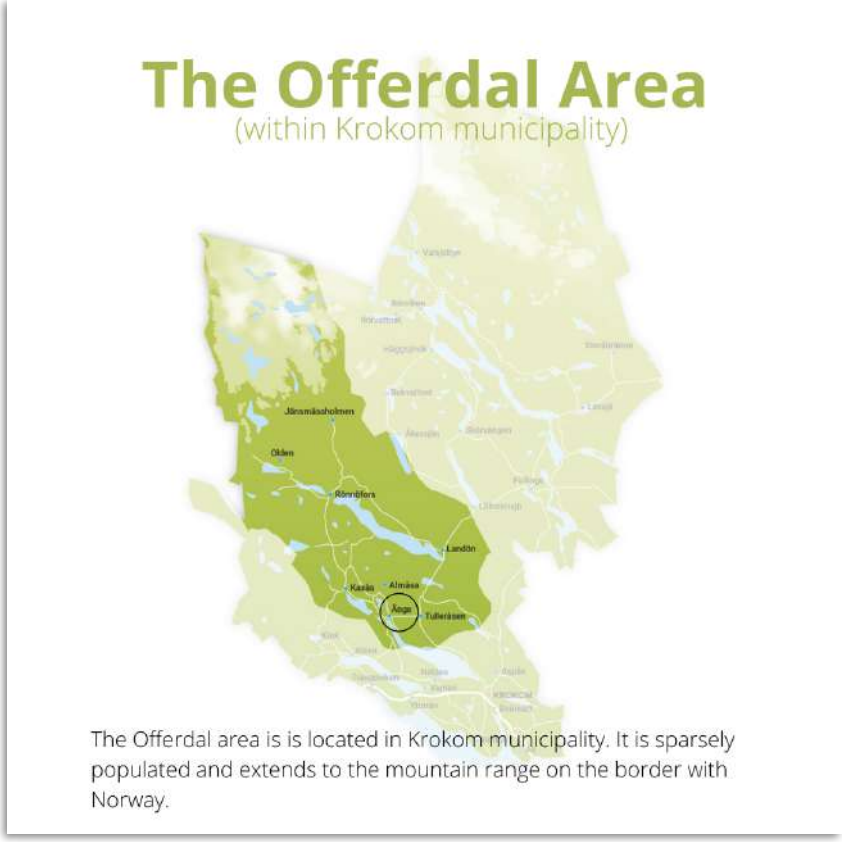
In order to counter the effects of the decisions of municipal authorities and, importantly, retain health care services in the community, residents in rural areas have come together to protest the decisions and even organize to provide healthcare services themselves. One such situation is the Offerdal Healthcare Center in the small town of Änge, located in the northeastern part of Region Jämtland-Härjedalen.

The region is the size of Denmark and one of the largest in Sweden. Despite its size, the region has only one hospital, located in the regional capital Östersund. The Region is made up of a number of municipalities, one of which is Krokom. Krokom spans a vast area where the Offerdal area can be found. Offerdal is a sparsely populated area stretching from the town of Änge up to the mountain range on the border with Norway.



Opening a cooperative to provide healthcare in the community

In 1991, the Jämtland County Council (now Region Jämtland-Härjedalen) began to explore the idea of closing the primary care center in the small town of Änge. This led to broader discussions between the workers at the primary care center about the future of primary healthcare in the Offerdal area which is serviced by the Änge primary care center and the municipality of Krokom. The workers at the primary care center wanted to carry on working with the public health service in the area and saw an opportunity to continue this work if they could figure out a way to run the primary care center themselves. The idea of taking over the primary care center in the form of a cooperative owned by the workers was received positively both by the public authorities, the region and the municipality, and the process started to transform the primary care center from being publicly run to being operated by the workers themselves. In this process the workers received a great deal of help from the region, which itself was very interested in seeing how this might work out. Over the past decades there had been a critique that public services had become overly bureaucratic and were no longer in touch with citizens' wants and needs.[9] The region was thus very open to experimentation with other forms of public service delivery. The Hälsorum Offerdal worker cooperative opened on 1 January 1992, the first of its kind in Sweden.[10,11]



Map from Municipality of Krokom (https://krokom.se).

Operating the cooperative primary care center was not without its problems. At regular intervals the region would broach the idea of closing the primary care center, and because the region's contract was with the cooperative and not individual employees, it was much easier for them to do so than before. Each time this happened, the cooperative managed to mobilize resistance to these plans for closure. Often this resistance was based in recalling the positive results the cooperative primary care center had produced throughout the various evaluations the region had conducted. These positive evaluations helped the cooperative demonstrate the value they created by operating in a sparsely populated area. Several times they called for public meetings with politicians and the local community where they would explain the situation and their good work to the public and also confront the politicians. In this way the cooperative managed to avert several threats of closures over the next 10-15 years.

By the mid-2000's though, many of the members of the cooperative had retired and the new workers were not always keen to become members of the cooperative and share in the responsibility of operating it. At the same time, the funding situation for healthcare had been continuously deteriorating. Together with the Primary Care Choice Reform (PCCR, described above) that came in the end of the 2000's the still existing members had to rethink the cooperative. They first went to the region to ask if they were willing to support the cooperative to enter into the market-based system that the PCCR meant, but got no positive reply. The region also wouldn't confirm

whether it was willing to take back the primary care center and operate it themselves as a public primary care center. So, the cooperative again turned to the community and organized a large community meeting to explain the situation and to ask if they were willing to support the cooperative. At that meeting it was decided that the community was willing to go in and help in the operation of the cooperative as they saw the benefit of having primary care close by. Over the summer of 2010 the cooperative transformed from a workers' cooperative with just a few members to a citizens' cooperative owned by the people of the Offerdal area with some 600-650 members.

Now, in 2021, more than 700 people have invested in the cooperative. The primary health center has not been easy to sustain with the current healthcare funding system in Sweden. With little public funding, the cooperative opened an occupational healthcare center to increase revenue. However, the cooperative maintains a democratic governance approach and operation of the center is informed by employees and local residents. Employees and cooperative members play a meaningful, participatory role in decision-making concerning the activities of the health center.[12,13]

Challenges and lessons learned

Taking ownership of the cooperative primary care center worked to maintain health care in the town, and workers were able to keep their jobs and ultimately care for the community. The culture of cooperatives in Sweden contributed to this success, especially rural Sweden where communities have a long history of organizing and providing for themselves when the region fails to do so.[14] [15]

The cooperative was not insulated from external pressures, however, such as the economic crisis of the 1990s and cutbacks in the public sector. The ensuing–and constant–squeeze on public funding of healthcare over the following decades made it a struggle to continue operating the Offerdal primary care center. This is a reflection of the previously mentioned issue with the allocation of funding which makes it necessary to have both healthy and sick patients registered at a primary care center so that amounts received for healthy people who may never visit the center cover the costs of those that visit many times or have multiple illnesses. This allocation of funding makes it more profitable for private, for-profit primary care centers to open in affluent and upper middle class areas of urban Sweden rather than in the countryside. The people of Offerdal organized to overcome the effects of this, but were not able to fully escape policies that threatened the operation of the clinic.

The case of the Offerdal Healthcare Center also demonstrates the costs of communities assuming the responsibility for maintaining social reproduction. There have been many struggles, including the unpaid hours that go into keeping the cooperative alive as well as provision of services for which payment may never be

received. The creation of the cooperative responded to the deterioration of working conditions and prevented the closing of the health care center. However, it also allowed for the public authority to step back from its responsibility to ensure healthcare in the community, continuing the trend of privatization.

Key takeaways

Often the knowledge, skills, and solutions to fill gaps left by governments lie in the community. In the case of the Offerdal Healthcare Center, building on traditions of local organizing and community support have added to the longevity of the co-operative.

Alternative models of care provision may still experience the limitations and impacts of policy and political decisions. Organizers should anticipate and try to plan ahead as to how they may continue operations during these times.

Partnering with the community, meaningfully, for decision-making and long-term planning can contribute to the longevity of a project and the sense of ownership among community members and improves the likelihood of continued success.

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[6] PHM-North America. Sweden: Occupy Our Hospitals. https://phm-na.org/resisting-privatization/sweden-occupy-our-hospitals/

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[8] Enlund, D. (2020) Offerdal and the long struggle for rural healthcare. In: Contentious Countrysides. Umea University (p. 182-228). http://umu.diva-portal.org/smash/get/diva2:1417251/FULLTEXT01.pdf

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[10] Enlund, D. (2020) Offerdal and the long struggle for rural healthcare. In: Contentious Countrysides. Umea University (p. 182-228). http://umu.diva-portal.org/smash/get/diva2:1417251/FULLTEXT01.pdf

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[12] Nordregio (2012) Offerdal Healthcare Center. https://archive.nordregio.se/en/Publications/Publications-2016/Territorial-Social-Innovation/Nordic-case-examples-What-does-TSi-look-like/Offerdal-Hea/index.html

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Lessons for Organizing

From sweeping changes in legislation and implementation of people-centered policies to envisioning and bringing to fruition new avenues for healthcare delivery, the case studies presented in this collection demonstrate a range of ways by which health services may be reclaimed as a public good. They offer lessons that health activists, advocates, and community organizers can their own adapt to their contexts and apply to their own campaigns.

Prioritizing community participation

Meaningfully involving the community in decision-making and long-term planning can contribute to the longevity of campaigns as well as the sense of ownership of an initiative.

Broad community participation can be achieved even though it may have been just a small aspect of an original policy framework. When these even very slight spaces exist, activists must amplify them and make the public aware of their existence.

Advocacy and action

Addressing the underlying causes of poor health contributes as much to a patient's health as much as the care provided. Health workers can–and should–take concrete steps to express solidarity with their patients and the communities they serve.

While articulating demands directed at policymakers, organizers should also work to move people to action. Making sure that demands include mechanisms to create fertile ground for participation and fulfilment of proposed programs can help mobilize communities.

Activists can strategically take advantage of many types of spaces and processes to push forward their demands. For example, engaging in program implementation and evaluation processes can be important for advocacy.

Grasping opportunities for change

While working towards the desired transformation of our existing imperfect health systems, we can still partially reclaim them through alternative models. They can address immediate needs, demonstrate what is possible, and build a foundation for reimagined health systems.

Alternative models of care provision may still experience shocks and limitations brought on by external politics and political decisions. Anticipating and navigating such times may be unique opportunities to highlight the potential of people-centered decision-making.

Often the knowledge, skills, and solutions to fill gaps left by governments lie in the community. Diverse partnerships and community organizing create pathways to develop innovative solutions to local challenges and mobilize resources to realize them.

Resources

Organizations

European Network Against Privatization and Commercialization of Health and Social Protection
http://europe-health-network.net

Institute for Political Ecology
www.ipe.hr

The Global Initiative for Economic Social and Cultural Rights
https://www.gi-escr.org/private-actors-public-services

People's Health Movement
www.phmovement.org

Organization for Workers' Initiative and Democratization
www.udrugabrid.hr

Materials

Global Health Watch
https://phmovement.org/global-health-watch/

PHM North America, Resisting Privatization of Health Services
https://phm-na.org/resisting-privatization/

PHM Thematic Group on Equitable Health Systems, resources and articles
https://phmovement.org/health-for-all-campaign/equitable-health-systems/

Saude em debate (special issue): The People's Health Movement - global action in defence of the human right to health (PT/EN)
https://saudeemdebate.org.br/sed/issue/view/33

Transnational Institute, *The Future is Public*
https://www.tni.org/en/futureispublic

Reclaiming Public Health

Experiences and Insights from Europe