

Civil Society's Report to the Commission on Social Determinants of Health

Representatives of the Civil Society to the Commission on Social Determinants of Health of the World Health Organization

Introduction:

The Historic Mission of the Commission

A hundred and fifty years after his death we continue to be reminded of Virchow's comment: "Do we not always find the diseases of the populace traceable to defects in society"?¹ We continue to seek "defects in society" that need to be remedied if health is to be given its rightful place. Today, more so than ever before, we are reminded that, ultimately, politics played out at the global scale, determines whether people live or die. Civil Society welcomes the opportunity provided by the Commission on Social Determinants of Health (CSDH) to explore these issues in detail. Civil Society has been consistent in arguing for an approach to health that echoes Virchow's famous words.

The symptoms of the disease plaguing our societies --where diseases fester and health is just a word without substance-- are too numerous and too well known. Let us, nonetheless, examine just one of them here. An estimated 30,000 children die every day, mainly from preventable and easily treatable diseases.² What is important is not just that so many children die unnecessarily, but also that they die in much larger numbers in certain regions of the world and, within regions, in certain communities. We know that throughout the world,

children (and other people) living in poverty become ill and die more frequently than those who enjoy a more privileged social status. What is particularly glaring is that the gap has broadened despite the fact that never before has the world had the wealth, knowledge, awareness, and concern for health issues that it has today. Thus, they die, not because we do not have the knowledge and the technology to prevent such deaths. They die because of the conditions in which they live. These conditions are determined by factors that are conventionally never addressed by medical science. For us, the CSDH represents an opportunity to collectively examine the factors responsible for a situation where there is a 16-fold difference in infant mortality between the 26 wealthiest nations and the 48 least developed countries.³ We welcome the Commission's vision of addressing those determinants of health that are related to the situation in which people live and work. *We support the Commission's contention that it is largely futile to treat people and send them back to the same conditions, which were, in the first place, responsible for their illness.*

It is also important to underline that the Commission's mission is *not arriving at novel insights* or radically departing from established evidence. The principal issue that we need to first address is: what prevented us in the past from harnessing compelling evidence to formulate cogent and comprehensive strategies for improving health outcomes at the global level. The short answer to this is that we did indeed have such a strategy! *We must, therefore, step back and ponder over two issues. The first, to recapitulate on the global vision that arose from the Alma Ata Declaration of 1978 that explicitly promoted a social determinants-led view of health. The second is to examine the main cause of the*

This is an abridged version of the report submitted to the Commission on Social Determinants of Health, at the meeting of the Commission held in Vancouver between 7-9 June, 2007. It has been prepared based on inputs from CS Facilitators for the CSDH from Asia, Africa, Latin America, and the Eastern Mediterranean Region.

failure (and virtual abandonment) of the vision presented in the Alma Ata Declaration and the Primary Health Care concept.

The Primary Health Care Approach and the Ascent of Neoliberalism

The true Primary Health Care (PHC) approach, abandoned by countries and international agencies soon after the Alma Ata Declaration, continues to be as relevant today as it was 30 years ago. The promises made in the Declaration have remained unfulfilled and, as we now seek to redeem the promise, we need to examine the reasons for this. Soon after the Declaration, an alternate strategy was promoted by the World Bank and the IMF; it led them to launch prescriptions under the broad rubric of “Health Sector Reforms”. The same contained a series of policy recommendations that were designed to systematically undermine the public health system and, at the same time, to promote the private health sector. The ideological background for these reforms was contained in the rise of neoliberal economic policies across the globe. The reforms were provided further impetus through global, regional and bilateral trade agreements. The three major elements of these policy prescriptions were: Introduction of user fees; segmentation of health care systems into public health care for the poor and private health care for the rich; and the commercialization of health care. The second major blow to the PHC approach came in the form of the concept of “selective health care” -- a limited focus on certain, mostly technical health care interventions, as distinct from comprehensive health care.

The attack on the PHC concept was neither accidental, nor did it arise in a set of fragmented policy prescriptions by multilateral agencies. The attack was ideological, globally orchestrated and globally co-coordinated. It found ideological legitimation in neoliberal economic theory and came to be known as globalization, or to be more precise, neoliberal globalization.

In the health sector, the adoption of neoliberal policies led to: a cut in investment on welfare and the gradual dismantling of public health services;

the introduction of service charges in public institutions (making the services inaccessible to the poor); and the handing over of the responsibility for providing health services to the private sector, as well as the resulting undermining of the rationale behind public health. In almost every developing country where prescriptions were based on the neoliberal approach, public health conditions deteriorated. Clearly, the failure to pursue the PHC approach is rooted in the ideological underpinnings of neoliberalism. *Without a clear reversal of the latter’s role in determining policies at a global level, it will be impossible to realize the profound vision of the Primary Health Care approach --and by extension the vision of the Commission in promoting the social determinants approach.*

We would strongly suggest that the Commission must locate its work in an analysis of both the Primary Health Care approach and the role of neoliberal policies in delegitimising the approach. We welcome the approach proposed by the Commission in this regard when it states that “... the neoliberal economic model that gained global ascendancy during the 1980s created obstacles to policy action on the SDH”.⁴

We also welcome the focus that the Commission has on addressing inequity. Addressing mere inequality is not enough, *because the extent of inequality in health cannot give us adequate information to assess health equity⁵*. By focusing on inequity, the Commission proposes an understanding of deeper structural factors that determine differential access to resources with deleterious health consequences. *We believe that the ultimate goal is not merely to look for health policies that favor the poor. Rather we seek significant policies that directly address the social determinants of the inequitable distribution of resources. The Commission has a historic opportunity to advocate for equity and for the structural changes that will do away with the social, economic and political determinants of health.*

Civil Society’s Expectations of the Commission on Social Determinants of Health

Civil Society organizations, believe that the Commission presents a major opportunity to address

key issues in the health sector. Civil Society also welcomes the fact that this is perhaps the first instance where it is seen as an active partner in a major global process initiated by WHO. *Civil Society views its role not as that of an instrument of advocacy for the Commission, but as a significant partner of the CSDH that brings in fresh, people and community centered, perspectives and has the potential to shape the Commission's work in many ways.* In order for Civil Society to play this role it is *imperative that it retains the right to formulate its own independent analysis of the Commission's work.*

It is also important that Civil Society organizations drawn into the process do not feel that they are being “co-opted”, i.e. they are being asked to implement or advocate for policies and processes that they did not play a part in shaping.

Civil Society is also engaging in the process, with the premise that they will have an independent framework of engagement with the Commission. *Such a framework need not always be very different from that of the Commission but nevertheless the scope for maintaining this independence is vital for real Civil Society engagement.* It is vital in order to draw in sections of Civil Society who have explicit concerns about the present paradigm of development, globally, as well as the trajectory of Governments and organizations such as the WHO in their endeavor to address issues related to human development and specifically to health and access to care. We understand that the Commission seeks to actively engage with views that are diverse and often rooted in experience of working with the people -- voices that often remain unheard. In order for this to be accomplished, it is necessary that Civil Society organizations feel that they are not constrained by any pre-determined framework.

A deeper understanding of Civil Society needs to take into account, not only its variegated nature but also the fact that Civil Society often operates in a contested space. Our understanding of Civil Society is *contrary to the neo-liberal view which tends to look at Civil Society as a sanitized entity, stripped of its strong ideological, political and cultural roots.* We think it prudent to clarify that

what we present in this document to the Commission is not the perspective of civil society. Nonetheless, we contend that this perspective is one that is widely shared across continents, and is one that has its roots in the historic role that Civil Society has played in shaping debates and policies on health, as well as on its social determinants.

The Role of Civil Society in Health

Actions of Civil Society organizations (CSOs) and movements are also informed by different historical circumstances. The role of civil society has often been subservient to the dominant economic and political paradigm. CSOs have been used to replace the state or to encourage the market in providing health services in many African, Central Asian and Latin American countries⁶. At the same time, community and civil society resistance has always been prominent in challenging the dominant paradigm, i.e., the welfare state's historical dependence on the prescriptions of neo-liberal principles.

In the modern era, Civil Society's actions in health can be traced to its links with attempts by newly independent countries to break out of the model of health care imposed by the colonial powers in the middle of the last century. This was the period when CSOs gave a new orientation to the approach and paved the way for a truly innovative vision. That vision was spurred by the remarkable progress in health attained in China, which centred around its programme of training “barefoot doctors” in the 1960s. Throughout the 1960s and 70s, concerned groups of health workers and community organizers began to pioneer “Community-Based Health Programs,” (CBHP). These participatory, awareness-raising, grassroots initiatives arose in a number of countries, including Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, South Africa (while still under Apartheid), India, Bangladesh, and the Philippines.

Most of these programs started as humanitarian responses to enormous unmet needs; they had a humanitarian rather than a political agenda. But institutionalized exploitation and routine violation of poor people's rights so clearly contributed to

preventable ill-health and high death rates that many of these CBHPs were impelled to add strong socio-political components. The case of Nicaragua serves as an excellent example of how these “health” initiatives came to embrace a much larger political platform. Here, the people’s quest for health became inseparable from their struggle against unjust social and political forces, both internal and external. The grassroots network of community-run health initiatives played a key role in the broad-based popular awakening and mobilization that eventually led to the overthrow of the oppressive Somoza regime. In Latin America, the seeds of a novel approach to health were also linked to an important event in its history: the Cuban Revolution.

These experiences, and the experience of numerous community-based initiatives in the developing world, promoted a revolutionary shift from the existing medical paradigm embraced by the Establishment to one with a strong community participation, with emphases on prevention and the prioritisation of rural areas. This literally meant turning the system upside down, from a top-down system to a bottom-up or bottom-centred approach. *As a culmination of this extremely rich process, in 1978, in Alma Ata, an unprecedented commitment was made by virtually all the governments in the world to actually place the provision of health care in an approach that puts disease in its social context.*⁷

One of the principal reasons why the promise of Alma Ata and the PHC approach did not wither away entirely is to be found in countless civil society initiatives across the globe that strove to keep it alive – through advocacy and through community-based programs modeled on the PHC approach. In the past few years, a major achievement has been the attempt by CSOs from across the globe to co-ordinate their activities around the promise of Alma Ata. A major landmark in this endeavor was the First People’s Health Assembly, organized in 2000 in Bangladesh, attended by CS representatives from over 90 countries. The People’s Health Movement that evolved from it was a civil society effort to

challenge health policy makers around the world with a People’s Health Campaign for Health for All-Now!⁸

The Factors Shaping Civil Society Action

The role of civil society has often been co-opted by the dominant economic and political paradigm. CSOs have been used to replace the state or to encourage the market in providing health services in many African, Central Asian and Latin American countries⁹. The promotion of market-driven health care systems has resulted in the disruption of solidarity between the middle class and the poor, the introduction of individual rights for those able to pay, targeted public assistance for the poor, and the use of NGOs’ and CSOs’ activities as strategic instruments for a market-driven health care system with a neo-liberal governance¹⁰.

At the same time, community and civil society resistance has always been prominent in posing a challenge to the dominant paradigm --to welfare state dependence earlier, and now to the prescriptions of neo-liberal philosophy. In many parts of the world -- and particularly in Latin America-- a new political structure, able to impose a more distributive and inclusive model of economic and social development seems to be taking shape in response to the social and political crisis. However, such a new economic and social order requires a more democratic and participative political system and a more open public sphere able to promote new ways of participatory and self-governing practices within consensual rules and processes of governance where marginalized communities and social movements can play a stronger role in building more equitable health systems. *This is the new and exciting frontier that Civil Society needs to look towards, just as it did -- three decades back - while championing the cause of Primary Health Care.*

Very often, models of partnership in use assume that the state, Civil Society and markets share common interests. But do they? There is a tendency in the development community to question both the accuracy of knowledge generated by Civil Society, as well as the ability of Civil Society to be a source of credible research that can be relied upon. What cannot be denied today is that Civil Society has been

instrumental in adding to the body of research and knowledge in many key areas. In settings where government data and information are virtually non-existent or extremely unreliable -- as is the case in resource-poor settings in most developing countries-- CSOs constitute the principal source of credible and current data and information. Globalization and the discontent that has come with its negative impacts have been instrumental in creating the conditions for the formation of several international civil society movements. The World Social Forum, the People's Health Movement, the Access Campaign on Medicines, the Anti-War Movement, are all examples of this. With the locus of policy making moving to global institutions, or being globally determined by a few countries such as the United States, the value of such movements and associated international CSOs is undeniable.

At the same time, there lies the danger of the CS view being only articulated by such global networks, thereby marginalizing the voices of locally rooted CSOs. In other words, care must be taken to ensure that agendas are locally owned and not dictated by external influences - however well meaning such influences may be. Most international CSOs are conscious of this and do attempt to temper their global reach with local perceptions ("think globally and act locally" has been the key slogan of this consciousness). Nevertheless, the threat of local CSOs being made irrelevant in policy-making by this process does remain, and is often reinforced when multilateral institutions find it more convenient to attach importance primarily to internationally networked NGOs. Donor organizations naturally aim to work with research institutions that fit their criteria and understand their points of reference and ideas, especially with regards to financial matters¹¹. In reality, this is, more often than not, Northern NGOs, whose members share similar backgrounds, but have the benefit of local knowledge and influence. While a global approach is important, it should not act as a barrier to local initiatives. Examples of global NGOs dictating the agenda have been articulated, for example, in the aftermath of the South-East Asian Tsunami of December

2004. CSOs from Sri Lanka commented that, "INGOs arrived at the scene of the disaster in such large numbers that they sometimes pushed aside (even if unintentionally) local CSOs, undermining their capacity and forcing them to close down".¹²

A Rights Based Approach to Health

Human rights have come a long way – moving from the concept of philanthropy and charity to rights that can be demanded of the state. A rights-based approach, as we understand it, requires taking sides and mobilizing claim holders to force the cessation of human rights violation. This is very different from the early concept of human rights as purely individual rights and where the rights were sought to be located in a framework devoid of politics. For us, a rights-based approach needs to recognize that structural causes, (a prominent example today would be neoliberal globalization, but there can be many other like colonialism, structure of the state, etc.) determine the respect or the violation of rights.

While advocating for particular rights, like in the case of the right to health, we also recognize the need to locate such campaigns or struggles in the broader mobilization of claim holders and duty bearers to transform structural causes that give rise to human right violations in the first place. We view rights as rooted in social, economic and political structures and relations and locate rights violations in the broader analyses of power and social inequality. While individual rights are important, for us, a rights-based approach is primarily about addressing them at a societal level. We view the human rights framework, not as one that legitimizes and helps maintain the status-quo, but one that challenges the status-quo by pointing out how it structurally violates human rights. We thus strongly advocate that rights are ultimately realized by changing the prevailing power relations. For the rights-based approach to have sufficient ability to make an impact, there are a whole set of globally accepted rights that need to be targeted for fulfillment, by the mobilizations of claim holders to defend the respect of such rights.

The focus of attention on health as a human right began after World War II with the Universal Declaration of Human Rights and the creation of the

World Health Organization. The real focus of these efforts, however, was on access to health care. It is only in the past two decades that this framework has been broadened to encompass not just access to health care, but also other determinants of health¹³. Substantial progress has been made in the understanding of the synergy between health and human rights and of the potential of this approach to transform public health policies and practice.

We welcome the fact that, in its approach, the CSDH has embraced the international human rights framework as the appropriate conceptual and legal structure within which to advance health equity through action on the SDH. *We believe that one of the Commission's principal mandates is to broaden and deepen our understanding of the "Right to Health" and, specifically, to formulate indicators that chart the progress made by governments in safeguarding the right to health.* In doing so, the Commission must be guided by existing covenants that describe in detail the obligations towards the provision of comprehensive health services. Even in the limited sphere of health care, we hope that the Commission, through the fulfillment of this mandate, shall unequivocally *challenge the dominant global discourse of 'Health care as a commodity' and 'safety nets for those left outside the benefits' and replace this with a 'Health care as a human right' discourse.*

The Right to Health: Going Beyond Health Care

The Committee on Economic, Social and Cultural Rights, which monitors the Right to Health Covenant and issues General Comments, has rightly recognized that the right to health is closely related to and depends on the realization of other rights, such as the rights to food, to housing and to the freedom of movement. The Committee has also interpreted the right to health as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health, expressly noting an adequate supply of food and nutrition, as well as access to safe and potable water and adequate sanitation as key determinants.

We look upon the Commission as the appropriate vehicle for extending this analysis of

the ECOSOC Committee. At present, General Comment 14 of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000 is not a binding instrument¹⁴. *We strongly urge the Commission to add its prestige and weight towards recommending that Comment 14 be made into a binding commitment by signatories.* Further, the Commission needs to recognize and denounce the impact of global factors that impinge upon the respect of the right to health in all nations across the globe. These factors include:

Those Related to Health Care and Health Services

- *Health systems:* The effect of globally-promoted health system reforms of the past two decades on equity in access to care through changes in financing, in delivery and in privatization policies. There is a need to establish universal norms regarding a basic standard of essential health care services that must be respected.
- *Health workers:* The impact of the global migration of health workers from countries in greater need to countries with greater resources for health, and mitigating policies to reduce global health inequities arising from such flows.
- *Trade in health services:* The role of trade liberalization in health services in impacting on global health equity (GATS).
- *Access to Essential medicines:* The effect of extension of intellectual property rights on access to essential medicines, and alternative policies to ensure such access is not compromised (TRIPS).

Other Determinants of the Right to Health

- *Water/sanitation:* Globalization's role in affecting access to potable water and sanitation, and measures that can ensure and safeguard equity in access and sustainability in use.
- *Food security:* The effect of an increasingly integrated global market in food production, marketing and distribution on food security at the national and household level,
- *Economic Sanctions:* Their use by nation states and international organizations and the impact on the right to health

- *Labor and Employment*: The impact of globally integrated production systems on labor markets, unemployment, conditions of employment and social security linked to employment.
- *Poverty*: The impact of neoliberal policies in the distribution of poverty among and within nations
- *Gender*: Global factors determining the position of women in society in different settings and their changing roles superimposed on existing inequities
- *Social Exclusions*: The role of neoliberal globalization in creating new kinds of exclusions and reinforcing existing ones.
- *War and Militarization*: The impact of militarization and war (or the threat of military aggression) on the right to health.

A proactive addressing of the above factors would clearly lead us to examining the social determinants of health that the Commission is seized with. We look towards the Commission to strongly locate its recommendations in the Rights framework, in a manner that places concrete demands on governments to act.

Empowerment for Health

The term “empowerment” has become an integral part of the discourse of most agencies linked to the state or to multilateral agencies, and even of donor agencies. It is necessary, however, to examine whether the liberating potential of the concept is retained during such usage. *We define empowerment as promoting actions that challenge established hegemonies basing itself in a discourse that recognizes human rights.* When we talk of empowerment in the context of health, we recognize the need for people to be aware of conditions that affect their health. But we also assert that empowerment is not just new knowledge. It is the recognition and the building of abilities to change power relations in society. For, ultimately, empowerment is about power. So we also contend that power is not something that is

voluntarily given up by established hegemonies, it is something that has to be fought for and won.

Ultimately it is the people who will wrest power and thereby empower themselves. This distinction is important for us as it demarcates a different territory from the position that it is possible to empower people or communities from without. In our view, empowerment is a complex social and political process. In it resides the ability to change the entire spectrum of power relations and to launch the processes required to change existing oppressive relations.

Turning specifically to health, what do we mean when we talk of empowering people to achieve better health? We do not just mean helping people to improve access to services or even just helping people to improve their conditions of living. These are important, but do not change power relations. Empowerment to achieve health means wresting the power to fundamentally change the causes of inequity. Thus empowerment for health is a process by which disadvantaged people work together to increase their control over events that determine their health. Using a social determinants lens to define health, this means gaining the momentum and the power to change economic relations, conditions of work and of living, and access to resources. Ultimately, it also means the ability to change global power relations that determine the status of health of a society.

If we were to explain the concept with greater clarity by the use of an example, let us consider the seemingly simple task of empowering a community to prevent deaths among children due to diarrhea¹⁵. At the first level, empowerment of a community to prevent diarrheal deaths would require access to knowledge --very importantly the knowledge to recognize symptoms of dehydration and the ability to prepare oral rehydration solution at home or locally. This is very important, but addresses a small part of the problem if children are to still continue living in conditions that make them vulnerable to repeated episodes of diarrhea. A higher level of empowerment would require the community to be able to organize and demand better access to clean drinking water and sanitation facilities. At yet another level, it would

require the community to be able to articulate and fight for policies that ensure access to food and control over land. Even this may not be enough, and the process of empowerment may have to extend to the ability to change global policies that give rise to inequity and the unequal distribution of wealth and resources.

In the current global context that is dominated by the neoliberal paradigm, the struggles for health, development, and social justice, even in a remote village or slum, are inseparable from the global struggle for a more just world economic and social order. *In our view, empowerment is a complex social and political process. In its essence resides the entire spectrum of power relations and the processes required to change existing relations.*

Civil Society's Work with the CSDH

Civil Society was invited to be one of the partners in the work of the Commission on Social Determinants of Health. Civil Society's engagement with the Commission was mediated by key CSOs in 4 geographical regions --Latin America, the Eastern Mediterranean, Asia and Africa - who were identified as Civil Society facilitators for the respective regions. Civil Society's work with the Commission included 2 phases of work. The First Phase involved a mapping of CSOs, resources and concerns around social determinants of health in all the four regions. The synthesis of the information collected from this process led to the development of Regional CS perspectives on social determinants of health and a strategy for long-term civil society engagement around the social determinants of health. It also resulted in an extensive mapping of civil society partners in the regions who were sensitized and showed interest in promoting a vision of health that centered around the social determinants' approach.

It had been *initially envisaged in the first phase of work, that CSOs in the four regions were to participate in the development of regional strategies for more intensive engagement with the Commission's work. Resource constraints did not allow these regional strategies to be fully realized in the second phase.* Instead, it was decided that, in

order to maximize CS's inputs into the final report of the Commission, CS work in the four regions would largely limit itself to the identification and collection of knowledge from Civil Society.

Civil Society Positions on Key Determinants¹⁶

This section presents a selection of CS positions on issues considered of crucial importance. *The articulation of our positions in this section draws from the basic framework elaborated in the first section, i.e. presenting a critique of neoliberalism, and in an understanding that the social determinants approach must build upon the primary health care approach.*

Globalization

Public health is an obvious casualty of the globalization process. There is a clear contradiction between the principles of public health and neo-liberal economic theory. Public health is a "public good", i.e., its benefits cannot be individually enjoyed or computed, but have to be seen in the context of benefits that are enjoyed by the public. Thus public health outcomes are collectively shared and their accumulation lead to better living conditions; they do not mechanically translate into visible economic benefits, viz. income levels or rates of economic growth. Kerala, for example, has one of the lowest per capita incomes in India, but it has public health indicators that approach the levels of many developed countries. The infant mortality rate in Kerala is less than a third of that in any other large state in the country. But neo-liberal economic policies do not even acknowledge such benefits. Laying down the fundamental prescriptions of neoliberal economic theory in the health sector, the World Bank document titled "Financing Health Services in Developing countries"¹⁷ made the following recommendations for developing countries:

1. Increase the amounts paid by patients for health care provided by the public sector.
2. Develop private health insurance mechanisms (this requires a dismantling of state supported health services, because if free or low cost health

care is available, there is little interest in private insurance).

3. Expand the participation of the private sector.
4. Decentralize government health care services (not real decentralization, but an euphemism for "rolling back" of state responsibility and passing on the burden to local communities).

These recommendations were further fine-tuned and reiterated by the Bank's World Development Report of 1993 titled "Investing in Health". Today the Bank is the heavier decisive voice in the health sector, and tragically, organizations like WHO and UNICEF have been reduced to playing subsidiary roles.

The implementation of these policies resulted in dramatic reversals of health gains made after the Second World War. Reversals took place in other sectors as well, with clear impacts on health. Women and children were impacted the most. In many countries, more women entered the labour force, but typically at lower wages and with inferior working conditions than men; in many others, women were displaced from employment as levels of unemployment increased markedly. Simultaneously, the extent of unpaid labour in households, performed largely by women, increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and grossly underpaid informal labour market or to assist in running the household. Rising food prices, along with cuts in subsidies for the poor, meant that an increasing proportion of families with precarious resources were pushed under the poverty line, affecting women and girl children disproportionately. They had to work for longer hours to purchase the same amount of foods as before, thus getting increasingly exploited and destitute. This also meant an increase in young women --and indeed women in general-- being pushed into the sex industry, now increasingly global.

Given increasing levels of undernutrition, infant and child mortality rates, which had earlier shown a

decline, either stagnated or, in the case of some countries, actually increased. So widespread were these effects that UNICEF issued called for "a human face" in structural adjustment programs.

In the face of such evidence, even the World Bank was forced to modify its earlier recommendations. It started talking about investing in the poor through investments in health and education and about the promotion of safety nets and targeted social programs. This was a clear recognition that specific programs are necessary to protect the poor from the consequences of structural adjustment and that economic growth by itself *But these changes in the World Bank's thinking are still too inadequate and have come too late for millions who have died as a result of the policies it had earlier promoted.*

World Trade Organization and the Health Sector

Different portions of the World Trade Organization agreement, signed in 1994, have an impact on the health sector. Some of the important agreements under the WTO, which have an effect on health, are described below:

The General Agreement on Trade in Services (GATS)

At present, the services sector is growing at a much larger rate than the productive sector in developed and many developing countries. It accounts for two thirds of the economy and jobs in the European Union (EU), almost a quarter of the EU's total exports and a half of all foreign investment flowing from the EU to other parts of the world. In the US, more than a third of recent economic growth has been because of service exports.

As the service sectors of the economies of developed countries grew, trade in various types of services was exported. Transnational corporations (TNCs) started lobbying for new trading rules that would expand their share of the global market in services. This was a particularly lucrative segment, given that governments spend a considerable amount of their budget on social services¹⁸.

This is what the General Agreement on Trade in Services (GATS) under the WTO is targeting today. GATS covers some 160 separate sectors. GATS, as

all the other agreements, contains provisions which allow further deregulation of any national legislation which is seen to be hostile to “free” trade. GATS identifies the specific commitments of member states that indicate on a sector-by-sector basis the extent foreigners' may supply services in the country.

Today, private insurance companies, managed (health) care firms; health care technology companies and the pharmaceutical industry of the developed countries are looking for opportunities to expand health care markets. In the developing countries, much of private health services were, by and large, provided by non-governmental organizations like charities, religious societies and community oriented associations which were not entirely profit driven. This has started changing, with private investments in health services expanding and the corporate sector playing a prominent role, especially in countries where there is an affluent elite willing to pay or where there exists a private health service base. This move to open up the health and social sectors to allow privatization and competition from the private sector means that, the latter is encouraged to take over health and social services of countries for profit.

Trade Related Intellectual Property Rights (TRIPS) - No Medicines for the Poor

The WTO agreement on Patents (called the Trade Related Intellectual Property Rights - TRIPS) sanctifies monopoly rent incomes by pharmaceutical TNCs. The WTO defines 'Intellectual Property Rights' as, "the rights given to persons over the creations of their minds". They usually give the creator an exclusive right over the use of his/her creation for a certain period of time. TRIPS protects the interests of big biotechnology, pharmaceutical, computer software and other businesses and imposes the cost of policing on cash-strapped governments, while slowing down or preventing altogether the transfer of useful technology.

The TRIPS agreement, signed as a part of the WTO agreement, was the most bitterly fought

during the GATT negotiations. Till 1989, countries like India, Brazil, Argentina, Thailand and others had opposed even the inclusion of the issues in TRIPS in the negotiating agenda. They did so based on the sound argument that Intellectual Property Rights -- which includes patents over medicines - is a non-trade issue. India and others had argued that rights provided in domestic laws regarding intellectual property should not be linked with trade. They had further argued that the history of IPRs shows that all countries have evolved their domestic laws in consonance with the stage of economic development and development of science and technology (S&T) capabilities. Laws that provide strong patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Japan, for example, was able to enhance its domestic capabilities through the medium of weak patent protection for decades --well into the second half of the twentieth century. Italy changed to a stronger protection regime only in 1978 and Canada as late as in 1992. It was thus natural that many countries like India had domestic laws that did not favor strong protection to Patents before the WTO agreement was signed. It was illogical to thrust a single patent structure on all countries of the globe, irrespective of their stage of development¹⁹.

However, these arguments were systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required all countries to change over to a strong patent protection regime. A regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between one twentieth and one hundredth of global prices. In India, for example, its 1970 Patent Act encouraged Indian companies to develop new processes for patented drugs, and facilitated the development of world class manufacturing facilities in a developing country.

The TRIPS agreement has placed enormous power in the hands of TNCs, by virtue of the monopoly that they have over knowledge. They have generated super profits through the patenting of top selling drugs. But drugs which sell in the market may

have little to do with the actual health needs of the global population --for, often, there is nobody to pay for drugs required to treat diseases in the poorest countries. Research and patenting in pharmaceuticals are driven, not so much by actual therapeutic needs, but by the need of companies to maintain their super profits at present levels. Simultaneously, new drugs development has become more expensive, because of more stringent regulatory laws. This is a major reason for the trend towards global mergers, as individual companies wishing to retain the huge growth rates of the 1970s and 80s, are trying to pool resources for R&D. As a consequence, we are looking at a situation, where 10 -12 large Transnational conglomerates will survive as "research based" companies.

Given their monopoly over knowledge, these companies will decide the kind of drugs that will be developed -- drugs that can be sold to people with the money to buy them. Thus, on the one hand, we have the development of "life-style" drugs, i.e., drugs like Viagra, which targets illusory ailments of the rich. On the other hand, we have a large number of "orphan" drugs --drugs that can cure life-threatening diseases in Asia and Africa, but are not produced because the poor cannot pay for them. Today's medical research is highly skewed in favour of heart disease and cancer as compared to other diseases like malaria, cholera, dengue fever and AIDS which kill many more people, especially in developing countries. Just 4% of drug research money is devoted to developing new pharmaceuticals specifically for diseases prevalent in the developing countries. Some drugs developed in the 1950s and 1960s to treat tropical diseases, on the other hand, have begun to disappear from the market because they are seldom or never used in the developed world.

Agreement on Agriculture -- Assault on Food Security

The present phase of globalization also has grave consequences for food security, which is an integral part of good health. The Agreement on Agriculture (AoA), under WTO has further skewed the balance against developing countries. In most

developing countries, the lifting of restrictions on imports, as required by the AoA has resulted in widespread disruption of the rural economy.

The AoA ensured that subsidies provided to domestic agriculture by developing countries would be phased out while those being provided by developed countries would be retained. This has resulted in exports of primary commodities by developing countries becoming uncompetitive while their domestic markets are being flooded by subsidized imports from developed countries. This has been compounded by pressures of the structural adjustment programs' induced policies to produce for the export market. Because a few developed countries control the global rules of the game, in the past decades the global prices of agriculture exports from developing countries have fallen steadily. As a result, farmers get less and less for their products, while the growth in production of staple food grains has fallen sharply.

Health Systems and Approaches to Health Care

What were the reasons for the abandonment of the Alma Ata PHC approach by the global community, within a few years of it being proposed?

Economic Factors

Health care systems need to be adequately financed and be resourced with trained human-power. *It has been estimated that low and lower middle-income countries need to spend at least US\$30–40 (2002 prices)²⁰ per person per year if they are to provide their populations with essential health care. This is over five times the average government health spending of the least developed countries and about three times that of other low-income countries.* The inability of poorer countries to pledge even a fraction of the resources required to sustain their health care systems has its origins in the economic crisis that engulfed poorer countries since the early 1970s. *This crisis came within a few years of the Alma Ata Declaration and prevented its bold and visionary aspirations from ever being put into practice.*

The crisis translated into savage cuts in government spending on social sectors such as health. Government health facilities suffered severely,

leading to their virtual dismantling and the severe loss of morale among public health workers. Thus, in less than a decade after the Alma Ata Declaration, instead of an increase in public spending on health (as the Declaration envisaged), what we saw was severe and sustained cuts on public expenditure.

This attack on the public system of health care led to it following into disarray and in its attracting criticism from those who depended on it. Ironically, the same forces which brought about this change (the World Bank and IMF, and even country governments themselves) joined in the chorus to blame public health services. It forced people to look for other options, leading to a boost to the private sector and its increasing legitimization.

Paying to Access the Public System

A prominent effect of the WB-induced health sector reforms was the promotion of a greater privatization of health care. This meant that people have to spend more money themselves to access health care. Curiously, this effect has been used as an argument to introduce systems of payment (in the form of “user fees”) in the public health care system as well. The argument used has been: if people are already paying in the private sector, they can also pay to access the public sector! The impact of this transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor. Global evidence suggests that the introduction of user fees is deterring more and more from accessing the public health system.²¹

Proponents of the use of user fees argue that the negative effects can be offset by not levying user fees on the poor. Unfortunately, this is something that almost never works. On the contrary, it encourages extortion and patronage when care providers are poorly remunerated. There is also no evidence that user fees prevent the so-called “frivolous” use of government health services.

Poor Health Care for the Poor

Also, promoted simultaneously, was the attempt to segment health care into public health care for

the poor and private health care for the rich. The Bank now advocates that governments in poorer countries should not attempt to provide comprehensive care to all. Instead, it says, they should only spend in providing a “minimum” package of services. Clearly this is in direct contrast to the PHC approach that recommends “comprehensive” primary health care services for all.

The argument in favor of this segmentation is obvious --government resources can be directed at those who cannot pay, while those who can are serviced by the private sector. Unfortunately, this argument is based on an extremely shallow and simplistic view of how health systems work. Segmentation of the health system results in the rich opting out of the public system and, at the same time, drawing away resources, political clout and accountability from the public system. What is left is a ‘poor service for poor people’. Thus, an expansion of the private sector sucks resources away to the extent that the public system is even more hard pressed to cope with its workload.

Promoting the “Market” for Health Care

The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in developing countries. It is being helped along in many countries by tax subsidies, and also directly by governments who decide to outsource parts of the functions of the public sector to private providers. The private sector also works through private insurance companies, which again are interested in targeting the affluent.

In many regions of the world, the private sector is the only available health care option, given the steady decline of the public sector. The experience with the private sector, however, shows that the motive for profit dominates over other considerations. This leads to poor quality of care or the elimination of the poor from their clientele - or often both. Unethical behaviour by private providers is common and includes recourse to unnecessary investigations and medication. Health care for profit promotes such behaviour at the expense of ethical and scientific treatment. Further, with profit from individual patients being the main focus, the private sector

rarely engages in preventive care or in the promotion of public health measures.

Proponents of commercialization argue that a market based system improves quality of care and efficiency, because of competition between providers and because consumers have more choices. Nothing could be farther from the truth. Patients --especially poor patients-- rarely have enough knowledge to choose between different options, or to negotiate better terms. Competition does not improve quality if people cannot make an informed choice. Instead multiple providers only target the affluent, and the poor are left with virtually no options. Private care is notorious for flouting regulations, and the necessity to regulate them places a burden on public finances. A system with multiple providers is inefficient, because it cannot make use of “economies of scale” in the case of purchases, or in the provision of services.

Selective Health Care and Cost-Effectiveness

Another blow to the PHC approach comes in the form of the concept of ‘Selective health care’ -- a limited focus on certain health care interventions, as distinct from comprehensive health care. It was propagated with the understanding that rather than wait for a fully resourced system that can provide comprehensive care, it is prudent to promote a few interventions that can produce the largest change in outcomes²². Selective care is associated with “vertical” programmes, i.e., separate programmes with specific structures and management, each targeting a specific problem. The approach reinforces the biomedical orientation of care that is premised on the belief that a specific technology can target a specific health problem.

In many countries, the approach has disrupted the development of a comprehensive health system, through the promotion of multiple programs that have few elements of integration. Many of these programs are donor driven, and controlled, as well as implemented by international donor agencies. Multiple programs also lead to the de-skilling of health workers, and one is left with health workers trained to do only a limited set of tasks pertaining to the program she or he was attached to. Multiple

vertical programs also put the burden on consumers to access each of them separately through multiple visits.

Selective health care, we should recall, was introduced on the grounds that important interventions cannot wait for the setting up of basic health care infrastructure. However, experience suggests that when selective interventions are promoted, rarely are their simultaneous efforts to put in place a comprehensive infrastructure. As a result, the short-term gains of these interventions become difficult to sustain and follow-up on. Worse still, selective interventions can actually undermine the development of health care systems. Mass immunization campaigns, for example, have often been prioritized to such an extent that other services have been disrupted.

Today, the Millennium Development Goals set by the United Nations are also placing health services under pressure to achieve targets through selective interventions. It has been calculated that, in order to achieve the MDGs, 15 preventive interventions and 8 treatment interventions would need to be made universally available in 42 countries. There is further pressure to launch selective interventions, as governments join the race to apply for funds such as the Global Fund to fight AIDS, TB and Malaria (GFATM). Importantly, many of the new selective health care initiatives operate as Global Public-Private Initiatives thus introducing a much higher level of involvement from the commercial/private sector.

Resurrecting the Public Sector

The “public” has virtually disappeared from health care systems in many parts of the world. It is necessary to nail the wrong perceptions and blatant untruths about the public sector. There have been systematic attempts to portray the private sector as more “efficient” and to argue that market-based competition and incentives lead to better care and more choices. Such arguments turn a blind eye to the fact that the public sector has played the major role in almost all situations where health outcomes have improved significantly. Health systems that have depended on the public sector have been the norm,

rather than the exception, in almost the whole of Europe. *The success stories of health system development, viz. Sri Lanka, Costa Rica, Cuba, are success stories of public sector health systems. The success of the public sector is not limited to health care systems.* Publicly-funded research in national institutes of science and universities has laid the foundations for many, if not most, developments in the medical sciences.

There are important reasons why the public sector needs to play a leading role in health care systems --no matter which part of the world we are talking about. First, *people have a right to health care that is not dependent on their ability to pay.* Not markets, but Governments, can ensure that health systems address the needs of the poorest and the most marginalized. This does not mean that public health services are “poor services for poor people”. They should be seen as attempts to provide the best services possible to all, while addressing the special needs of those who are most vulnerable. Second, *an equitable and efficient health care system requires planning systematically based on local conditions.* It is impossible for a profit-driven, fragmented system with multiple (often contradictory) objectives, to do so. Third, *only an adequately financed public service can break the link between the income of health care providers and the delivery of health care.* Unethical behaviour of health care providers is directly linked with the fact that if care is linked to profit, more ill health means more profit!

Gender Dimensions of Health

In the current context of globalization and health sector reform, the health sector debate is defined more by the language of costs, efficiency, adjustment and low budgets. Reform, financing mechanisms and health insurance further promote gender inequities in the funding of health practices, as well as gender discrimination in (contributory) risk-based coverage by insurance companies.

The UN International Conference on Population and Development, held in Cairo in 1994 marked a change in approach to Sexual and Reproductive Health²³. The Cairo Conference shifted focus away

from the earlier approach, which was technocentric and obsessed with controlling population through the delivery of a set of services. The Cairo Conference proposed a rights-based framework for population stabilization, discrediting the old population control programs²⁴. Despite some advances, a ten-year review showed that the program charted was still far from being implemented. Much of the reason for this gap in implementation lies in global economic factors that have a negative impact on the vulnerable and the marginalized --and women are often the first victims. In the name of “morality”, fundamentalist tendencies are eroding the emerging consensus reached in Cairo. The US has been the global leader in pursuing this agenda, as exemplified by the US Government prohibiting overseas NGOs from receiving US government aid if they promote or provide referrals for abortion²⁵. Given this emerging understanding, women’s movements have started linking their demands on health and reproductive rights to issues of trade, globalization and fundamentalism. The links between neoliberal globalization and fundamentalism are becoming clear, with both joining forces to deny women the right to livelihoods, economic security and control over their lives and bodies.

Employment Conditions

Employment conditions are a product of economic relations in a specific historical context and relate to the negotiated terms under which workers sell their labour in return for some form of remuneration and other benefits. Till the 1970s, in the developed countries, it was possible to trace a secular accretion of positive benefits in the conditions of employment, as well as in the conditions of work. The situation in developing countries has been very different. Employment conditions in developing countries -- constituting more than 80% of the globe’s population-- never matched what could be achieved in developed countries. In these countries, there was a very large “informal” sector that was largely out of the purview of secure employment conditions. Moreover, with a majority of the workforce engaged in agriculture, the welfare model of employment never was a prominent feature in the world’s poorest countries. However, democratic aspirations in the

post-colonial era in developing countries did give rise to some improvements in employment conditions, clearly traceable to the improved bargaining capacity of labour.

While vastly different in actual achievements, it still is a fact that there was a discernible improvement in employment conditions in most parts of the world till the 1970s. A radical break is seen in the 1970s with the economic crisis in the developed world and the rise of neoliberal policies led to a reversal of much of the gains that labour had made in the past decades. Unemployment increased in most parts of the world, secure tenures of employment were replaced by “labour market flexibility” where large parts of a the workforce who were in a secure employment environment suddenly found themselves in insecure or “precarious” forms of employment, i.e., in the informal sector, as contract workers, etc.²⁶.

Another feature of neo-liberal globalization, the dumping of hazardous industries and hazardous work in developing countries, also needs to be addressed as does the phenomenon of EPZs. Some of the worst working conditions and the virtual non-respect of labor laws (often as part of explicit state policy) exist in such zones. There is the added dimension of the displacement of people from where such zones are set up, without adequate compensation. The Commission needs to pay special attention to the issue of working conditions and their impact on health, that is occupational safety and health. This also needs to be contextualized in how hazardous industries and hazardous work are being moved to poorer countries.

War and Militarization

War accounts for more deaths and disability than many major diseases; war destroys families, communities, and sometimes entire nations and cultures; it diverts limited resources from health and other human services and damages the infrastructure that supports them; and it blatantly violates human rights. The mindset of war --that violence is the best way to resolve conflicts-- contributes to depression, domestic violence, street

crime, and many other kinds of violence. War also damages the environment. In sum, it threatens not only health, but also the very fabric of our civilization²⁷.

The health-supporting infrastructure, which in many countries is in poor condition before a war begins, often gets destroyed, including health-care facilities, electricity-generating plants, food-supply systems, water-treatment and sanitation facilities, and transport and communication systems. The 2003 attack on Iraq led by the US and the UK devastated much of its infrastructure, leading again to numerous civilian deaths²⁸.

Armed conflict, or the threat of it, accounts for most of the refugees and internally displaced persons in the world today. Refugees and internally displaced persons are vulnerable to malnutrition, infectious diseases, injuries, violence, rape and criminal and military attacks.

Further, war and the preparation for war divert huge resources from health and human services and other productive societal endeavors. War often creates a vicious circle of violence, increasing domestic and community violence in the countries engaged in war. War and the preparations for war have profound impacts on the environment. Overall, war takes an increasing toll on civilians, both by direct attack on them or by ‘collateral damage’ caused by weapons directed at military targets. During some wars in the 1990s, approximately 90% of the people killed were noncombatants²⁹.

The underlying causes of armed conflict and militarism include poverty, social inequities, adverse effects of globalisation, as well as shame and humiliation. Some of the underlying causes of war are becoming more prevalent or are worsening, including the persistence of socio-economic disparities and other forms of social injustice. The consequences of colonialism are still felt in many countries as well. Colonialism destroyed political systems, replaced them with new ones unrelated to the population’s cultural values and created economic dependence. Neo-colonialism, through multilateral agencies, transnational corporations and international organizations, and in some instances with the use of military force, is responsible for social inequality,

control of natural resources, and lack of democratic processes.

Food Security and Nutrition

Malnutrition is by far the most important single underlying cause of illness and death globally, accounting for 12% of all deaths³⁰. Every day, 799 million people in developing countries --about 18% of the world's population-- go hungry. In South Asia, one person in four goes hungry and in Sub-Saharan Africa the share is as high as one in three. There were reductions in the number of chronically hungry people in the first half of the 1990s, but the number increased by over 18 million between 1995 and 1997. The global value of trading in food grew from US\$ 224 billion in 1972 to US\$ 438 billion in 1998. The globalization of food systems is nothing new, but the current pace and scale of change are unprecedented. Food now constitutes 11% of global trade in terms of value, a higher percentage than fuel³¹. The overproduction of food, supported by massive subsidies in the US and in Europe in particular, has led to the 'dumping' of food on developing countries.

The story is similar in nearly all developing countries. For example, the average Indian family of four reduced its consumption of food grains by 76 kg between 1998 and 2003 (to levels last seen just after Independence³²). This dramatic fall can be traced to the collapse in rural employment and incomes resulting from liberalization of the agricultural sector.

In summary, the current wave of liberalization is concomitant with a massive concentration in and control of the food system by a handful of corporations based in developed countries. Liberalization of agricultural trade has, therefore, further strengthened and consolidated an international division of labor in agriculture. In 1990, the OECD countries controlled 90% of the global seeds market. From 1970–1996, the OECD share of the volume of world cereal exports rose from 73% to 82%; the US remained the world's major exporter of commercial crops such as maize, soya bean and wheat; and the share of Africa, Latin America and Asia in world cereal imports increased

to nearly 60%. Liberalization has, on the whole, contributed to increasing inequalities within both developed and developing countries.

Urbanisation, urban settings and health equity

The world is becoming increasingly urbanized and poverty is also becoming an increasingly urban phenomenon. In 2007, more people live in urban centres than in rural areas. According to recent projections, the world's urban population will increase from 2.86 billion to 4.98 billion by 2030, when about 60 per cent of the world's population will live in urban settings. Poverty is growing and living conditions are deteriorating in *all* cities³³. However, in low and middle-income countries the population living in densely populated, informal settlements ("slums") is likely to double in less than 30 years³⁴.

Rapid urban growth is increasingly attributed to natural population growth (UN Habitat, 2006). However, there are important regional differences and there is also a need to examine the process of urbanization within the political economy of capitalism in order to understand the impact of wider social, economic and political changes in rural areas (Harvey, 1985; Castells, 1997). Policies implemented in the agricultural sector of many developing countries in Asia and Africa, that have reinforced colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops, have dramatically increased rural poverty and pushed and pulled people into the cities.

Urban services and infrastructure have not kept pace with rapid urbanization and an increasing proportion of the people in urban areas will live without adequate social infrastructures, especially housing, water supply, drainage and sanitation facilities. While still exposed to the traditional health hazards related to poverty, unemployment, malnutrition, poor shelter and inadequate environmental and social services, the urban poor are also more exposed to hazards related to "modernization" such as pollution --while the lack of social support

systems in cities and social exclusion increases the risk of mental health problems. Cities also concentrate resources and wealth and social exclusion in this context is particularly felt. In Cape Town, for example, rapidly growing townships where children die of preventable diseases as diarrhea are located near to exclusive beaches and tourist centres, while in many cities expensive shopping malls arise next to informal settlements where people lack even basic sanitation.

Conclusions

Principals that this report embodies

We present this report to the Commission with the following principles guiding it:

- Health is an inalienable human right guaranteed by the United Nations and signed by all governments around the world more than six decades ago.
- Health is not a commodity but a public good.
- As defined by the WHO in its charter, health is a complete state of physical, mental and social well being and not merely the absence of disease.
- Accordingly, the attainment of health, does not revolve around bio-medical curative interventions alone, but basically on comprehensively addressing the structural social determinants of health including, but not limited to factors such as food security, safe water, sanitation, housing and working conditions.

The major factors that hindered and continue to hinder the attainment of this goal and that increase the gap between people are the ruling neoliberal paradigm of development led by and reflecting the narrow interests of the rich, of transnational corporations and of financial capital.

More than 150 years ago, Virchow, the father of public health, said that health is politics on a large

scale. We too believe that the attainment of health can only take place if the necessary political will is mustered --and it is only through political action on the part of the masses and global decision makers that these issues can be addressed. *The attainment of the above goals cannot be achieved without policies that aim, in the end, to reverse the policies that reproduce the neoliberal framework.*

We welcome the revival of the concept of Primary Health Care as declared by WHO in its 60th WHA session. However, to be successful, such an approach must be seen in the context of comprehensively addressing the Social Determinants of Health. Accordingly, we stress the importance of reviving the spirit and basic principles and values of the Alma Ata Declaration, and stress the responsibility, in 2007 as much as before, of governments to provide health for all.

Specific recommendations

We strongly suggest that the Commission makes specific recommendations --addressed to WHO, as well as to public and global institutions and country governments-- that address key issues, backed by the considerable evidence it has been able to harness since its inception, in the following areas:

- Clearly declare that health is not a commodity to be purchased in the marketplace and neither is it an item that should be traded.
- Promote physical and economic access to health care and to medicines by suggesting changes in the present framework on global trade. Specifically, suggest that the TRIPS Agreement and the General Agreement on Trade in Services keep matters related to health - including medicines and health services-- out of their respective purviews.
- Call for the reversal of unequal terms of trade embodied in the WTO.
- Encourage countries to selectively delink from the global economy, especially from global financial markets, when required, in order to secure the interests of the poor and the marginalized.

- Promote real debt cancellation and not just transfers from one account to another to reverse the unacceptable situation where the world's poorest countries still pay back more than what they receive
- Promote a system of agriculture that places food security and food sovereignty of the poorest nations at its core.
- Working with trade unions and political parties, promote a global consensus that reverses the trend towards non-secure and casual forms of employment.
- Promote a global consensus so that country governments adopt laws that prevent all forms of violence against women.
- Suggest concrete measures to address climate change and environmental degradation and their effects on the equity gap.
- On top of promoting the peaceful resolution of conflicts, ensure protection of populations, health workers, and infrastructure in situations of conflict and war.
- Once again secure for WHO the leading role at the global level in health policy making.
- Most importantly, recognize that structural changes in the world's political and economic architecture are indispensable in order to make meaningful changes in the current health inequities.

The report that we present to the Commission suggests that things can change for the better. A series of case studies, collected as a companion volume to this report, are indicative of ways to move forward. The Cuban and the Brazilian experiences show that health systems can be made to work for the people, if premised on the principles of a comprehensive care that is accessible to all, irrespective of the capacity to pay. The examples of the Literacy Campaign in India and the growing Global Right to Health Campaign of the People's health Movement are but two examples of the power of Civil Society to change situations. The case studies from Africa on Female Genital Mutilation and Rape as an instrument of hegemony, and the case studies from the Eastern

Mediterranean on the brutal side of war and conflict are reminders from Civil Society about the magnitude of changes that need to be brought about. We do hope that the Commission shall prove to be consequent and committed to the enormous task it has set for itself.

A Global Movement for an Idea Whose Time Has Come

Finally, looking forward to the Commission's Report itself and issues around its promotion, Civil Society strongly supports the vision of a global movement around the Commission's report. But for that to happen, people around the world must see themselves reflected in the Report in a way that they see the story of their lives being told in the Report. This is important because the Report must inspire people to be part of the movement. CS will be fully supportive of such a movement modeled around its concerns as reflected in the report.

We realize that the final product from the Commission will be a "negotiated" document. We would thus like to underline that if it is negotiated to please everybody, it will please nobody (or say nothing). There is a very large constituency waiting to embrace a report that clearly defines the root causes of health inequity. Today, a majority of countries and communities (the poor and the disadvantaged, comprising the majority of the globe's population) are starting to say "enough is enough". The global compact built using a neoliberal ideology and being promoted by most rich nations and multilateral agencies is starting to fall apart.

The Commission's work has the potential to bring to the fore an idea whose time has come an idea that can grab the imagination of people across the globe. Civil Society welcomes the Statement's intent to involve it in the global campaign and believes that there are movements waiting to embrace the idea. We hope that the Commission will be unhesitating in realizing the full potential and dimension of this idea.

References

¹ Virchow R. 1848/1985. Collected essays on public health and epidemiology. Cambridge: Science History Publications.

² Black R, Morris S, Bryce J. 2003. Where and why are 10 million children dying each year? *Lancet* 361:2226–34.

³ Guest G. ed. 2005. *Globalization, Health, and the Environment: An Integrated Perspective*. Lanham: Alta Mira Press

⁴ Solar O, Irwin A. 2007. *A Conceptual Framework for Action on the Social Determinants of Health*, Draft Discussion paper for the Commission on Social Determinants of Health

⁵ Amartya Sen in: Anand S, Peter F, Sen A -- Eds. *Public Health, Ethics and Equity*. Oxford University Press, New Delhi

⁶ Brinkerhoff D, McEuen M (1999) *New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan*. Special Initiatives Report 19:1--29 . Cited By Lowenson (2003).

⁷ WHO/UNICEF. 1978. *Declaration of Alma-Ata*. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

⁸ Narayan R. *From Savar to Cuenca via Bangalore: A background paper by PHM Secretariat team for the PHM Transition / Strategy meeting in Frankfurt, 7-8 February 2006*. www.phmovement.org

⁹ Brinkerhoff D, McEuen M (1999) *New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan*. Special Initiatives Report 19:1--29 . Cited By Lowenson (2003).

¹⁰ Sen S. 1999. Some aspects of state -- NGO relationships in India in the post- independence era. *Development and Change* 30:327--55

¹¹ Chowdhury N, Finlay-Notman C, Hovland I. *CSO Capacity for Policy Engagement: Lessons Learned from the CSPP Consultations in Africa, Asia and Latin America*. Working Paper 272. Overseas Development Institute

¹² Dr Vishaka Hidellage of ITDG Sri Lanka and Dr Vinya Ariyaratni of Sarvodaya quoted in Menocal and Rogerson, 2006.

¹³ The Universal Declaration of Human Rights 1948 was followed subsequently by two international treaties, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights have made these rights part of international law.

¹⁴ Committee on Economic, Social and Cultural Rights, General comment 14: The right to the highest attainable standard of health, E/C.12/2000/4, 12 August 2000

¹⁵ Example adapted from: Werner D, Sanders D. 1997. *Questioning the Solution: The Politics of Primary Health Care and Child Survival*. Palo Alto, CA

¹⁶ A substantial part of this section is developed from ideas developed in a major Civil Society initiative called the “Global Health Watch: An Alternate World Health Report” (Global Health Available from: <http://www.ghwatch.org/index.php>). The first edition of the Watch was published in 2006. It is a collaborative effort led by three CS organisations – Medact, U.K, GEGA (Global Equity Gague Alliance), and the Peoples Health Movement – and partnered by several other CS organisations. The first edition of the Global Health Watch received contributions from several hundred scholars and activists. The next edition of the Watch is scheduled to be released in 2008.

¹⁷ World Bank. 1987. *Financing health services in developing countries: An agenda for reform*. Washington DC: World Bank.

¹⁸ Hilary J. 2001. *The wrong model: GATS, trade liberalisation and children’s right to health*. London, Save the Children

¹⁹ Drahos P, Braithwaite J. 2004. *Who owns the knowledge economy: political organizing behinds TRIPS*. Corner House briefing 32

²⁰ Commission on Macroeconomics and Health. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, WHO.

²¹ Whitehead M, Dahlgren G, Evans T. 2001. *Equity and health sector reforms: can low income countries escape the medical poverty trap?* *Lancet* 358:833–36

²² Walsh J, Warren K. 1979. *Selective primary health care: an interim strategy for disease control in developing countries*. *New England Journal of Medicine* 301: 967–74.

²³ UNICPD. 1994. *Programme of action of the UN International Conference on Population and Development*

²⁴ The Corner House and WGNRR. 2004. *A decade after Cairo: women’s health in a free market economy*. Corner House Briefing, 31 June.

²⁵ Jacobson J. 2003. *First global women’s scorecard on Bush administration*. *Women’s Global Network for Reproductive Rights Newsletter*, 80, 12–19, November

²⁶ See for example: International Labour Organization. 2004. *Definitions: What we mean when we say ‘economic security’*, *Socio-Economic Security Programme fact sheet*. Geneva, ILO

²⁷ Levy BS, Sidel VW. 1997. *War and Public Health*. New York, Oxford University Press.

²⁸ Medact. 2004. *Enduring effects of war: health in Iraq 2004*. London, Medact.

²⁹ Garfield RM, Neugut AI. 2000. *The human consequences of war*. In: BS Levy,

³⁰ Pelletier D, et al. 1995. *The effects of malnutrition on child mortality in developing countries*. *Bulletin of the World Health Organization*, 73:443–8.

³¹ Pinstrup-Andersen P, Babinard J. 2001. Globalisation and human nutrition: Opportunities and risks for the poor in developing countries. *African Journal of Food and Nutritional Sciences*, 1:9–18.

³² Patnaik U. 2004. External trade, domestic employment and food security: Recent outcomes of trade

liberalisation and neo-liberal economic reforms in India. at: International Workshop on Policies against Hunger III. Berlin, German Federal Ministry of Consumer Protection, Food and Agriculture, 20–22 October.

³³ UN Habitat. 2004

³⁴ UN Millennium Project 2005. UN-Habitat 2003

