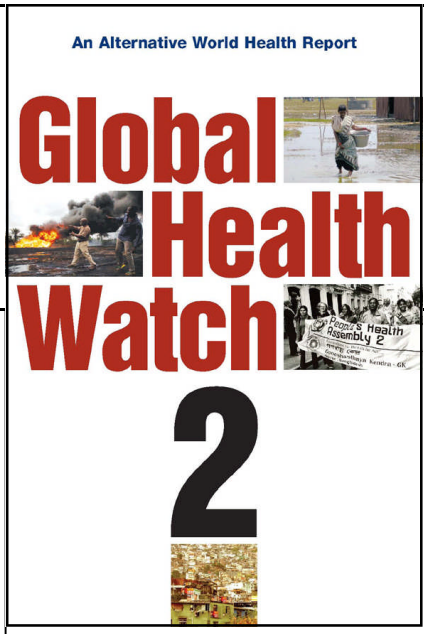
News & Events

Social Medicine
Health For All

An Alternative World Health Report

Global Health Watch 2

Global Health Watch



October 2008 saw the release of the second Global Health Watch report, created as an alternative to the WHO's World Health Report. It is an initiative coordinated by the People's Health Movement, the Global Equity Gauge Alliance, and Medact with input from 80 organizations and more than 130 individuals. It presents a progressive agenda for global health.

The Global Health Watch is important for several reasons. First, it provides a radical critique of the existing model of "global health" which is dominated by neoliberalism and a subservience to corporate interests. Secondly, it is a truly international critique which draws on the resources and experiences of academics, activists, and social movements throughout the world. This is a report born with a democratic spirit. Finally, in this international call to realize the vision of Alma Ata, we are reminded that another world is possible. Indeed, the very creation of the report shows us that there is a broad movement to create that other world. This is good news.

What follows is a summary of the report written by Marion Birch and Alison Whyte

- *The Editors*

What is the Global Health Watch?

Global Health Watch 1 was published in 2005. Global Health Watch 2 – like its predecessor - presents an alternative perspective on the state of global health in the 21st century. It places major health concerns in their political and economic context, highlighting the disparities in health between the rich and the poor and between the powerful and the marginalised. It emphasises the need to tackle the underlying determinants of ill-health and health inequalities.

GHW2 calls on governments, international institutions and civil society to reassert the principles, moral values and rationale expressed in the Alma Ata Declaration on primary health care in 1978, a call that has become increasingly urgent given globalisation, the ascendancy of a harmful neo-liberal doctrine, and the threat of global warming. Crucially, it stresses that global health institutions must be honest and accountable.

The report is aimed at the broad community of health sector workers and social activists. It reflects the belief that a transnational movement of public health advocates can mobilise against injustice, greed and political apathy. It brings together civil society organisations, academic institutions and non government organisations (NGOs) throughout

the world, and is underpinned by the global network of the People's Health Movement.

This document provides an overview of the contents of GHW2 and highlights some of the key chapters. Each chapter is referred to in the text by their designated letter and number.

Global health: a high profile masks a disturbing reality

Awareness of global health has increased significantly in recent years. This has partly been driven by the attention given to a number of high-profile diseases. Health activists, NGOs, the Gates Foundation and various celebrities have focussed media attention on the plight of millions of people suffering from untreated illnesses or dying prematurely. Health is now the focus of many international conferences and appears on the agenda of G8 meetings.
According to World Bank figures, development assistance for health increased from US$2.5 billion to almost US$14 billion between 1990 and 2005 (D1.1). There has also been a proliferation of global actors and there are now 40 bilateral donors, 26 UN agencies, 20 global and regional funds and over 90 global health initiatives (D1.1).

This increase in resources and actors, however, masks a more disturbing reality. Health inequalities have increased and the gap in life expectancy at birth between low-income countries and OECD members has widened in the last 30 years. Hundreds of millions of people still lack access to essential health care and the basic preconditions for health. Inadequate public finance in many countries means user fees for essential health care continue to act as barriers to care or to fuel poverty. Even in better-resourced countries, vulnerable groups such as migrants and asylum seekers, find it hard to access health care.

The rich world - with the exception of a handful of northern European countries – is still far from reaching the UN development assistance target of 0.7% of GNI. The so-called 'aid boom' of 2005-2006 was largely due to debt relief to Nigeria and Iraq and emergency aid following the Indian Ocean tsunami (D2).

While global health spending has risen, crucial public health priorities have been neglected. Four thousand five hundred children die every day because of poor hygiene and sanitation, and there are clear signs that the Millennium Development Goal on water and sanitation will not be met. The reality for 40% of the world's population who did not benefit from 'improved sanitation' is "a smelly world full of untreated shit", and a lack of the comfort and privacy that should accompany defecation and other intimate personal hygiene activities, resulting in many girls dropping out of school (C5). Yet the proportion of development assistance allocated to improving access to clean water and adequate sanitation has actually fallen since 1990 (C5); meanwhile slum-dwellers in Lagos pay 40 times as much for water as residents in downtown New York.

The recent rise in food prices has drawn attention to the fact that development assistance to the agricultural sector has been shrinking in recent years, with a devastating effect on poor families, particularly in rural areas.

The increased funds for global health have in many instances not been used wisely or efficiently. There is a lack of coordination and coherence among donors and global health institutions, and higher transaction costs among a bewildering number of actors, including increasing numbers of highly-paid consultants and bureaucrats. Few funds are invested in strengthening or expanding the public health workforce or in supporting long-term health systems development strategies (D1.3). The few positive developments in human resource strategies, such as Malawi's six-year Emergency Human Resource Programme for the health sector, are in sharp contrast to the continued IMF imposition of public sector wage ceilings.

Health research policy is heavily influenced by the distorting effect of power and profit. The medical and health research complex is dominated by the profit seeking agenda of the pharmaceutical

industry and by an intellectual property rights regime which causes inefficiency by discouraging scientific cooperation and innovative enquiry, and wastes money on marketing and over-consumption. Despite the fact that 60% of pharmaceutical R&D is paid for by the public sector, much of this money has been on developing drugs with doubtful incremental benefits for those who have the means to pay for them (B5).

Global health increasingly appears in 'global security' strategies, including those designed to combat the so-called 'war on terror'. This has led to HIV/AIDS, other global pandemic threats and bio-security concerns being used to further the foreign policy objectives or immigration controls of rich countries, with aid being diverted to this end. The US Department of Defence, for example, presently receives 22% of US ODA. Under-development and poor health are also framed as security threats that need containment and control, rather than being framed as urgent reasons to eradicate poverty.

Global health governance: accountable to whom?

Global health governance has become unnecessarily complicated at a time when there is an urgent need for clear and effective global health leadership and a rationalisation of roles, responsibilities and mandates.

A combination of disease-specific and vertical initiatives, 'do-it-alone' donors, and the proliferation of projects and private providers in many countries, has undermined country-ownership and coherent health systems development. The current approach to health systems development by donors and global agencies lacks consistency and a clear vision of the characteristics of a good primary health care system (B1) such as the District Health System, long promoted by WHO.

Global health partnerships such as the Global Fund for AIDS, Tuberculosis and Malaria (GF) have helped millions to access antiretroviral drugs, TB treatment and insecticide-treated bednets (D1.4). The GF has also encouraged participation and transparency through its Country Coordinating Mechanisms, which, although allowing for participation by civil society, often create a parallel structure that may duplicate government efforts and carry opportunity costs. However, despite the efforts of the GF to move away from vertical programmes only 13.1% of Round 7 (2007) grants were targeted at strengthening health systems.

The 'new philanthropists' are powerful new global health actors -none more so than the Gates Foundation. The benefits to health of the $29 billion endowment of the Gates Foundation in 2005 are undeniable. However, there are legitimate concerns that the Foundation has excessive influence on international health policy while fundamentally lacking democratic or public accountability (D1.3). There are also concerns that it pushes an overly technical and vertical approach to health improvement.

The World Health Organisation faces significant challenges in carrying out its mandate 'to enable international cooperation in pursuit of a common public good' (D1.2), and to promote health as a fundamental human right and a matter of social justice. New actors have undermined WHO's authority. And since 1990, donors have contributed proportionally more to extra budgetary funds than to the core budget, giving them greater control over their use, and making the organisation more vulnerable to donor and industry pressures. The controversy following the passing of avian flu viral material - contributed by Indonesia to WHO's Global Influenza Surveillance Network - to a pharmaceutical company without the permission of the Indonesian government is one example of this. The ongoing debate sparked by this incident – which includes the sovereign right of states over their biological resources, and the ethics of a patent-based system of commercial vaccine production - highlights the strong support and scrutiny WHO will need to be a 'moral arbiter on international health policy-making' (D1.2) as well as a glob-

ally recognised technical agency.

The setting up of the WHO Commission on the Social Determinants of Health (CSDH) in 2005 was a promising sign of greater priority being given to the economic, political and social determinants of health. The Commission's first Interim Statement (July 2007) emphasised equity and promoted health as a human right, but lacked analysis of political processes that have historically influenced equity and WHO will need strong support to implement its recommendations.

Politics and economics – crucial determinants of poverty and health

The World Bank estimated that 2.55m people or 40% of the world's population were living below the "$2-a-day" income poverty line in 2004 - a number that has risen steadily since the 1980s. A more realistic figure of between $2.80 and $3.90 - below which life expectancy is estimated to decrease - puts the number of those living in poverty at 51-60% of the world's population, or 3.2-3.8 billion human beings (A).

While more people are tipped over into hunger and poverty by food price hikes, large multinational agribusinesses announce huge profits. The global 'credit crunch' caused by unethical and irresponsible lending by banks and other creditors is part of the neoliberal globalisation that has accumulated vast wealth for a few while locking the majority of the world's population in poverty.

This is a clear expression of the fact that the dominant model of development is not working. This model prioritises small or zero budget deficits, tight monetary policies, competitive exchange rates, the privatization of state-owned enterprises and public services, the removal of measures to protect domestic agriculture and industry, and the deregulation of markets and prices (A). It has resulted in an insidious drive towards privatisation – including of health care - hastened by fiscal constraints and often accompanied by policies that undermine the public sector.

Liberalisation and increased privatisation have influenced the volume and pattern of food trade, and food security for the majority of the world's population. For the average developing country food import bills more than doubled as a share of GDP between 1974 and 2004 while exports – particularly of fruit, vegetables and flowers – have increased (1980 – 2003) (C3). Exports of processed and less healthy foodstuffs from developed countries also grew. These patterns have been driven by the rapid growth and influence of Transnational Food Corporations (TFCs) over all components of the food chain since the 1990s (C3). International food standards often focus on the priorities of TFCs and can place severe constraints on developing countries' ability to export their agricultural products into northern markets.

There were an estimated 854 million undernourished people worldwide in 2001-3 (C3), and it is predicted that 700 million people will be obese by 2015. These levels are clearly unacceptable; globalisation has failed to provide healthy and safe food for all. Healthy food production and consumption need to be a global public health priority.

Half of the world's population now lives in urban areas. While natural population growth has been a cause of this rapid urbanisation, there has also been large scale rural-to-urban migration, caused by: a) the 'modernisation' of rural areas for export-oriented crops; b) the forced displacement of rural communities by mining and hydroelectric projects; c) a lack of rural planning and investment by national governments; and d) war and conflict (C4). Urban areas struggle to provide basic services and the physical and mental health of urban dwellers is affected by their environment, social exclusion and loss of social networks.

Power and priorities – who sets the agenda?

The world's global health 'crises' are often presented as problems that are unfortunate, unforeseen

or tragic. They are rarely presented as an outcome of policies that work in favour of the rich and powerful. The issue of power and the abuse of power is a central, cross-cutting theme of GHW2.

One illustration is the oil extraction industry in the Niger Delta (C6). The existence of oil should have been a gift to the people living there. Instead it has been a 'curse', leading to violence, oppression, poverty and exploitation which have devastated local communities (C6). Despite the billions of dollars of revenue generated from the sale of oil, only a small fraction has trickled down to local communities - insufficient even for them to set up a rudimentary health service.

Even in the rich developed world there is a lack of access to essential health care for asylum seekers and migrants (B3). The developed world hosts only 30% of official refugees and asylum seekers globally. But it implements increasingly harsh measures to prevent people from seeking and receiving asylum. In Australia, for example, AUS$160 million of foreign aid was used to detain asylum seekers in offshore detention centres. While rich countries benefit from the extraction of natural resources from many poor countries, the people from those countries who seek a better life are shunned, stigmatised and incarcerated. Many are denied their rights to essential health care. There is also a lack of treatment in detention centres where individuals suffer high levels of depression: 86% of those interviewed suffered from significant depression in one US study.

Another group disadvantaged by the downstream social consequences of poverty and inequality are the nine million people and over one million children in the world's prisons – often in horrific conditions - at the end of 2006. Higher than average rates of TB and HIV, overcrowding and inhumane conditions are common problems. Mental illness is prevalent and can also be a primary cause of imprisonment if 'community mental health services are fragmented, underfunded and unable to serve the poor' (B4).

The 'war on terror' has resulted in an erosion of civil liberties and human rights, and questionable preparedness measures such as a smallpox vaccination campaign which killed three people (C2). Meanwhile continued uncertainties around the definition of terrorism have meant that state terrorism stretching from Guatemala and El Salvador to Chechnya and Iraq has not been identified as such.

Health researchers can play a critical role in measuring the full human and social cost of conflict and in documenting contraventions of the Geneva Conventions. However there have been instances of their work being questioned when its results are politically uncomfortable. There is a need for universally accepted and understood methodologies which would make this harder to do (C2).

Inequalities are inherent in the social determinants of mental ill-health, which relates to language, culture and power (B2). A biomedical and 'individualistic view of self' has been exported as part of mental health and humanitarian programmes, contributing to the imposition of inappropriate policies and interventions.

While efforts have been made to make humanitarian aid more rights based - through valuable and ongoing initiatives such as the Sphere Project - the global community still fails to distribute humanitarian aid equitably (C7). There is also an increasingly blurred line between humanitarian aid and military intervention.

Where to go from here - the need for a new paradigm

The achievement of 'health for all' is possible. But a transformation of the global political economy and of global governance structures will be required to address three of the main challenges of the 21st century: eradicating poverty, realising the right of all people to quality health care, and bringing climate change under control.

There is a need for an alternative development paradigm – one

with poverty eradication and the right to improved health and education at its centre - whilst also bringing climate change under control.

Controlling climate change will not be achieved by prioritising economic growth over more equal resource distribution. The general policy approach to reduce carbon emissions through 'carbon trading' is deeply flawed. For example, by assigning a uniform price to both the 'luxury' carbon emissions of the rich and the 'survival emissions' of the poor, carbon trading essentially mirrors and entrenches inequality. It also amounts to 'the privatisation of the world's capacity to maintain a life-sustaining climate '(C1) while distracting from the mobilisation and political organisation that is needed to address this planetary crisis.

An alternative pro-health model must be based on prioritising the livelihoods of the poor over ever-increasing non-essential consumption; encouraging micro-renewable technologies targeted at the poor; and providing stronger support for a democratic and accountable public sector. Debt, taxation, trade and intellectual property rights will all need to be re-appraised through the lens of human rights and in the light of increasing global inequities.

This is a daunting challenge but courage and inspiration can be found in many quarters, including amongst those most disadvantaged by the present global system and GHW2 describes many examples of this.

Inspiration, courage and resistance – civil society action for better health

Millions of people are already engaged in political and social action, including indigenous and rural communities taking direct action against the theft of land and water; health professionals ignoring official decrees to deny humane and essential health care to asylum seekers and refugees; workers fighting against the brutalisation of unions by big business; lawyers and accountants working for NGOs to highlight the crime of massive tax evasion by the rich; and journalists risking their lives to expose corruption within the arms industry (E).

The People's Health Movement (PHM) has launched a global Right to Health and Health Care campaign that is already active in a dozen countries, and growing. Jan Swasthya Abhiyan (PHM India) has fought for access to health care through public testimonies and consultations, culminating in a National Public Hearing on the Right to Health Care and a national plan to implement the Right to Health (E).

Alternatives to the general policy thrusts of the Washington Consensus are also offering hope. Examples include regional trade agreements such as the Bolivarian Alternative for the Americas and the Chiang Mai Initiativein Southeast Asia (A).

In reaction to the corporatisation of the world's food systems, civil society groups around the world, including the International Peasant Movement, La Via Campesina, are calling for 'food sovereignty' and control over their own food stocks (C3 & A).

There have been positive developments in the establishment of legal structures and instruments to protect human rights. There are presently four lawsuits against trans-national oil corporations operating in the Delta region of Nigeria. Initiatives such as the Voluntary Principles on Security and Human Rights code of conduct are also trying to hold the extractive industries and their powerful collaborators to account (C6).

A small victory against the global arms industry was scored in the UK when a civil society campaign, including the editorial staff of the Lancet, persuaded Reed Elsevier - a multinational which owns the Lancet and many other academic journals – to sell off its interests in international armaments fairs (C2).

There are community partnership initiatives to improve water and sanitation in urban areas with Water Communal Councils in Venezuela and the Slums Environmental Sanitation Initiative in Madhya Pradesh, India (C4). Im-

proved school sanitation has increased girls' school attendance by 11% in Bangladesh (C5). Cities and municipalities, including those which are part of the WHO Healthy Cities and Municipalities Movement, have established many positive initiatives such as Water Communal Councils (C4).

There has been inspiring work by many academics and activists to lower the price of essential medicines. They have led the way for the WHO Commission on Intellectual Property, Innovation and Public Health to consider better ways – such as prize funds - to fund research and development (R&D) for neglected diseases.

NGOs have also been instrumental in supporting low and middle income country governments to use compulsory licenses to provide life-saving treatments. The production of a treatment for Hepatitis C at 1.5% of the usual cost was brought about by an innovative alliance between non-profit academics and an Indian pharmaceutical company (B5).

There are serious attempts to meet the needs of vulnerable groups by civil society and some governments. Spain has incorporated the right of migrants to health care into national law irrespective of their status (B3). Meanwhile, actions are being taken to ensure access to ARV treatment for prison populations (B4).

GHW2 clearly describes why the present global order is bad for health and highlights priorities for action and resistance. It is a resource that can be used by all who are committed to a healthier and more equitable world.

Copies of GHW2 are available from Zed Books at http://www.zedbooks.co.uk/book.asp?bookdetail=4250
and online at www.ghwatch.org/.