Global Health Watch

An Alternative World Health Report

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People’s Health Movement
“Health for All” . Global Denial!

- In 1978, at the Alma-Ata Conference, 134 countries in association with WHO and UNICEF called for 'Health for All by the Year 2000' and selected PHC as the best tool to achieve it.
- Unfortunately, that commitment was denied
  - Health status of Third World populations has not improved. In many cases it has deteriorated further.
  - We are facing a global health crisis, characterized by growing inequalities within and between countries.
  - New threats to health are continually emerging. This is compounded by negative forces of globalization which prevent the equitable distribution of resources necessary for people's health, particularly the poor.
  - Within the health sector, failure to implement the principles of PHC has significantly aggravated the global health crisis. Governments and the international community are fully responsible for this failure.

People’s Charter for Health, Bangladesh 2000
### Health Indicators

**Declines in life expectancy between 1990 and 1999 (years of life)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>-17.4</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>-15.7</td>
</tr>
<tr>
<td>South Africa</td>
<td>-13.5</td>
</tr>
<tr>
<td>Lesotho</td>
<td>-13.0</td>
</tr>
<tr>
<td>Zambia</td>
<td>-10.7</td>
</tr>
<tr>
<td>Swaziland</td>
<td>-10.4</td>
</tr>
<tr>
<td>Kenya</td>
<td>-9.4</td>
</tr>
<tr>
<td>Namibia</td>
<td>-7.5</td>
</tr>
<tr>
<td>Congo, Dem. Rep.</td>
<td>-5.8</td>
</tr>
<tr>
<td>Korea, Dem. Rep</td>
<td>-5.3</td>
</tr>
<tr>
<td>Malawi</td>
<td>-5.2</td>
</tr>
<tr>
<td>Tanzania</td>
<td>-5.1</td>
</tr>
</tbody>
</table>

*Source: World Bank, World Development Indicators 2001.*
Disparities

Source (II.4): National Center for Health Statistics
Health Care Systems

What the insurance companies have done is to reverse the business, so that the public at large insures the insurance companies.

Gerry Spence, 2004

What we call health "insurance" in this country was never designed to insure the consumer. Instead, its purpose is to insure steady, reliable incomes for health care providers. True health insurance is the economist's equivalent of a unicorn - we can describe it, but none of us has actually seen it.

John C Goodman, 2004
## Causes

### Top 10 Pharmaceutical Companies by Sales, 2004

Source: Scrip’s Pharmaceutical League Tables 2005 provided by PJB Publications; company profit data (not necessarily limited to pharma sales) from 2005 Fortune Global 500.

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Pfizer</td>
<td>46,133</td>
<td>11,361</td>
<td>1</td>
</tr>
<tr>
<td>2. GlaxoSmithKline</td>
<td>32,853</td>
<td>8,095</td>
<td>4</td>
</tr>
<tr>
<td>3. Sanofi-Aventis</td>
<td>32,208</td>
<td>10,122</td>
<td>2</td>
</tr>
<tr>
<td>4. Johnson &amp; Johnson</td>
<td>22,128</td>
<td>8,509</td>
<td>3</td>
</tr>
<tr>
<td>5. Merck &amp; Co.</td>
<td>21,494</td>
<td>5,813</td>
<td>5</td>
</tr>
<tr>
<td>6. AstraZeneca</td>
<td>21,426</td>
<td>3,813</td>
<td>8</td>
</tr>
<tr>
<td>7. F. Hoffman-La Roche</td>
<td>19,115</td>
<td>5,344</td>
<td>7</td>
</tr>
<tr>
<td>8. Novartis</td>
<td>18,497</td>
<td>5,767</td>
<td>6</td>
</tr>
<tr>
<td>9. Bristol-Meyers Squibb</td>
<td>15,482</td>
<td>2,381</td>
<td>9</td>
</tr>
<tr>
<td>10. Wyeth</td>
<td>13,964</td>
<td>1,234</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>243,300</strong></td>
<td><strong>62,439</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Poverty in Southern Africa

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Zimbabwe</td>
<td>61%</td>
<td>75%</td>
</tr>
<tr>
<td>Zambia</td>
<td>69%</td>
<td>86%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>48%</td>
<td>66%</td>
</tr>
<tr>
<td>Malawi</td>
<td>60%</td>
<td>65%</td>
</tr>
<tr>
<td>Mozambiqu</td>
<td>69%</td>
<td>69%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>49%</td>
<td>49%</td>
</tr>
</tbody>
</table>

(Source: Cited in UNOCHA, July 2002)
Occupation, War, Sanctions, Conflicts, . .
First People’s Health Assembly

• Several international organizations, civil society movements, NGOs and women's groups decided to work together towards “Health for All”.

• With others committed to the principles of PHC and people's perspectives, they organized the People's Health Assembly, 4-8 December 2000 in People's Health Centre of GK, Savar, Bangladesh.

• 1453 participants from 92 countries came to the Assembly, a culmination of 18 months of preparatory action around the globe, including thousands of village meetings, district level workshops and national gatherings.

• At the Assembly, they reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed the People's Charter for Health.
People’s Health Movement

Struggle for “Health for All” through Evidence-Based Action

• Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world –
  – a world in which a healthy life for all is a reality;
  – a world that respects, appreciates and celebrates all life and diversity;
  – a world that enables the flowering of people’s talents and abilities to enrich each other;
  – a world in which people’s voices guide the decisions that shape our lives.

• There are more than enough resources to achieve this vision.
People’s Charter for Health

Health is a social, economic and political issue and above all a fundamental human right.

Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people.

Health for all means that powerful interests have to be challenged, that globalization has to be opposed, and that political and economic priorities have to be drastically changed.
GHW Content: 27 chapters

Development
• An alternative paradigm for development

Health Sector
• Health systems advocacy
• Mental health: culture, language and power
• Health care for migrants and asylum-seekers
• Prisoners
• Medicine

Beyond health care
• Carbon trading and climate change
• Terror, war and health
• Globalisation, trade, food and health
• Urbanisation
• The sanitation and water crisis
• Oil extraction and health in the Niger delta
• Humanitarian aid
• Education

Global health governance
• The global health landscape
• The World Health Organization
• The Gates Foundation
• The Global Fund to Fight AIDS, TB and Malaria
• The World Bank

Government aid
• US foreign assistance and health
• Canadian and Australian health aid
• Security and health

Transnational corporations
• Protecting breastfeeding
• Tobacco control: moving governments from inaction to action

Postscript: Resistance
Key features …

1. Social and structural determinants emphasised
2. Clear and explicit set of positions
3. Multi-sectoral, development and ecological perspective
4. No chapters on diseases
5. An accountability instrument
6. Linked to existing advocacy, social action and active resistance
1. Social and structural determinants emphasised

Commission on the Social Determinants of Health
Poor health and health inequalities within and between countries “are caused by the unequal distribution of power, income, goods, and services, globally and nationally ..”

The unequal distribution of health-damaging experiences is the result of: “a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”

“….. social injustice is killing people on a grand scale”

Commission on Social Determinants in Health, 2008.
## Income Poverty (millions)

<table>
<thead>
<tr>
<th>Income Poverty line</th>
<th>1981</th>
<th>2004</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1</td>
<td>1,470</td>
<td>970</td>
<td>-500</td>
</tr>
<tr>
<td>(excl China)</td>
<td>836</td>
<td>841</td>
<td>+5</td>
</tr>
<tr>
<td>$2</td>
<td>2,450</td>
<td>2,550</td>
<td>+100</td>
</tr>
<tr>
<td>(excl China)</td>
<td>1,576</td>
<td>2,096</td>
<td>+520</td>
</tr>
</tbody>
</table>
10 million people have investable, liquid funds worth US$ 40 trillion

Richest 2% of adults owned 51% of global assets in 2000
Bottom half owned barely 1%


World Institute for Development Economics Research (WIDER)
We need an alternative development paradigm

• GHW2 describes three fundamental flaws with the current model of development:
  – Economic growth the primary objective – not social objectives
  – Predominant reliance on increasing exports as a source of economic growth, and the requirement for global consumption to grow in order to absorb these extra exports
  – Competition between countries
From economic growth to social growth

• **Orthodox:**
  – fixation with global economic growth
  – assumption that benefits will “trickle down” to the poor

• **Problem:**
  – the benefits *don’t* trickle down
  – carbon constraints limit global growth

• **Alternative:**
  – focus on social and environmental goals
From Top-Down to Bottom-Up

• **Orthodox:**
  – Policies imposed globally by IMF/WB/WTO, based on economic theory/neoliberal ideology

• **Problem:**
  – Policies aren’t working

• **Alternative:**
  – Design policies locally and pragmatically to meet social and environmental goals
  – Design national policies/system around them
  – Design global policies/systems to foster and support
From Sticking Plasters to a Systemic Approach

• **Orthodox:**
  – ‘Add-on’ policies to off-set negative impacts

• **Problem:**
  – Limited benefits
  – Only needed because main policies don’t work

• **Alternative:**
  – *Systemic approach with* social/environmental goals at the centre
• **Orthodox:** From Globalisation to Localisation
  – Reliance on export markets and foreign investment

• **Problems:**
  – Export markets are limited
  – Foreign investment creates fewer jobs
  – Profits taken out

• **Alternative:**
  – Develop *local* markets and encourage *local* investment
• **Orthodox:**
  – Promote export production

• **Problem:**
  – Export markets are limited (adding-up problem)

• **Alternative:**
  – Increase demand and supply *in parallel*
  – Go beyond aggregates: consider *whose* supply and demand is increased
  – Promote production of goods which will be consumed locally as poverty is reduced
From Competition to Collaboration

• **Orthodox:**
  – Competition between countries “to promote efficiency”

• **Problem:**
  – Who benefits?
  – False logic….

• **Alternative:**
  – Foster a collaborative approach at the global level
  – A new global governance system
Section B: The health care sector

B1 Health systems advocacy

B2 Mental health: culture, language and power

B3 Health care for migrants and asylum-seekers

B5 Medicines
Photo of a remand cell in Malawi (Credit: Joao Silva)
Section D: Holding to account

D1 Global health governance
   D1.1 The global health landscape
   D1.2 The World Health Organization
   D1.3 The Gates Foundation
   D1.4 The Global Fund to Fight AIDS, Tuberculosis and Malaria
   D1.5 The World Bank

D2 Government aid
   D2.1 US foreign assistance and health
   D2.2 Canadian and Australian health aid
   D2.3 Security and health
WHO: Under-funded and donor-driven

- Extra-budgetary funds: now about three-quarters of WHO’s expenditure (previously one-fifth)

- Greater reliance on EBFs reflects growing donor control over the WHO and the period of financial austerity imposed upon the UN.

- Policy of zero real growth in 1980 of assessed contributions to all UN organisations. Then in 1993, a policy of zero nominal growth was introduced.

- Problems associated with a heavy reliance on EBFs include unhealthy competition amongst departments within WHO and with NGOs and other organisations chasing donor funding, and limitations to WHO’s ability to plan, budget and implement its strategic aims coherently.
WHO: Putting health first

- Margaret Chan says that WHO will “speak the truth to power”

- WHO has resisted pressure from powerful interests in the past
  - Framework Convention on Tobacco Control
  - International Code on the marketing of Breastmilk Substitutes
  - Global Strategy on Diet
  - Essential Medicines

- But not enough?

- On other occasions it has buckled under pressure
Section D: Holding to account

D1  Global health governance
   D1.1  The global health landscape
   D1.2  The World Health Organization
   D1.3  The Gates Foundation
   D1.4  The Global Fund to Fight AIDS, Tuberculosis and Malaria
   D1.5  The World Bank

D2  Government aid
   D2.1  US foreign assistance and health
   D2.2  Canadian and Australian health aid
   D2.3  Security and health
Commission on Social Determinants in Health

“Any serious effort to reduce health inequities will involve changing the distribution of power within society and global regions .....

“The Commission seeks to foster a global movement for change”.

The Peoples Health Movement

“The struggle for health in the South needs to take place in the corridors of power within Washington, Geneva and London .....

but it is also already taking place across the world through many acts of resistance and direct action”
The struggle of indigenous peoples’ to hang on to their lands and cultures ...
The successful struggle against water privatisation in Cochabamba (Bolivia) followed days of street protests and police retaliation.
Other ‘launches’

| Belgium | Zimbabwe | Netherlands | Canada | USA | Egypt | South Africa | Switzerland | Australia | Lebanon | Ecuador | Germany | Italy | Iran | Bangladesh | France | Sri Lanka | India | Philippines | Nicaragua | Brazil | Thailand | Morocco | Pakistan | Kenya |

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People’s Health Movement

Health for ALL NOW!!
What next?

• Watching at the country and regional level

• A campaign agenda for civil society and the progressive international public health community

• GHW 3