

## INTRODUCTION

The fifth edition of the *Global Health Watch*, similar to the previous editions, provides an alternate discourse on health. The Global Health Watch was conceived in 2003 as a collaborative effort of activists and academics from across the world. *Global Health Watch 5* has been coordinated by six civil society organizations – the People’s Health Movement, Asociación Latinoamericana de Medicina Social (ALAMES), Health Poverty Action, Medico International, Third World Network and Medact. *Global Health Watch 5*, like the preceding volumes published in 2005, 2008, 2011 and 2014, provides policy analysis, debates technical issues and provides perspectives on current global processes that shape people’s health in different parts of the world.

The Watch provides information and analysis embedded in a vision of the world and of human society that is more just, more equal and more humane. As in the case of the previous editions, the contents of *Global Health Watch 5* are divided into five interlinked sections. The section on the ‘The global political and economic architecture’ draws causal links between decisions and choices that impact on health and the current structure of global power relations and global governance. The section ‘Health systems: current issues and debates’ looks at contemporary debates on health systems in different parts of the world, to draw appropriate lessons and propose concrete actions. The third section, ‘Beyond healthcare’, examines multiple social and structural determinants of health. The section on ‘Watching’ critically analyses global processes and institutions which have a significant impact on global health. The final section foregrounds stories of action and resistance, from different regions of the world.

While the book covers a very large canvas, this edition has a particular focus on two areas: the recently announced Sustainable Development Goals; and the rapid transition on global governance for health from a nation-driven process to one that promotes the influence of private foundations, consultancy firms and corporations.

### **The global political and economic architecture**

The section on political and economic architecture speaks to the urgent need for a new global economic and social policy platform. It asks the question: Can the new Sustainable Development Goals (SDGs) offer help in creating such a platform?

The broad struggle surrounding the SDGs is about constraining the predatory nature of capitalism. The headline intent of the SDGs appears to oppose the

premises of global capitalism. However critics argue that the SDGs represent a fundamental contradiction. They propose growth strategies that seek to perpetuate the current neoliberal model – ever-increasing levels of extraction, production and consumption. It is precisely this model of growth that has perpetuated poverty, destroyed the planet and is threatening the basis of our existence. It is clear that a change in this paradigm will not occur by itself, and definitely not by a mechanical application of the SDGs. Real change can only result from the clash of opposing forces, in which the Watch clearly positions itself on the side of ‘well-being for all’ and a healthy planet, and against profit for a few.

Latin America’s experience of the past decade in pushing for change that represented a departure from the neoliberal discourse on politics and economics in general, and on healthcare services in particular, is critically examined in this section. While impressive progress was made in expansion of public services to provide universal access, progressive movements and governments that emerged in the region were unable to complete the task of dismantling the power of the previous neoliberal regimes. An ideological counter-offensive is underway in the region that promotes the idea that the public health system is ‘poor healthcare for the poor’. The recent changes in Latin American countries are not isolated examples. In many European countries public health systems are being dismantled while resistance mounts from peoples’ and workers’ organizations. It is imperative that just as the neoliberal project seeks to globalize its policies, progressive forces must find a way to globalize their struggles and demands.

The final chapter in the section focuses on migration, especially in the context of the acute humanitarian crisis associated with flows of forced migration. Over the past four decades, globalization and neoliberal economic policies have become one of the most significant forces fuelling migration. Migrants face a triple burden of victimization. First, they suffer the consequences of a model of development that dislocates them and drastically reduces their options, while resulting in ecological mayhem that further disrupts their connection to the land. Second, they face isolation and detention imposed on them by those who benefit, at least in the short term, from that same model of development. And finally, they are victimized due to misconceptions, biases and hypocrisy that distort the largely technocratic and bureaucratized debate on global human displacement.

### **Health systems: current issues and debates**

The struggle for health is closely linked to demands for functioning health systems. The first chapter in the section on health systems notes that universal health coverage (UHC) is the *slogan de jour* in global health systems policy but its meaning is highly contested. At one pole are those who use the term simply to refer to financial protection. The other view recognizes the need to

advance tax-based funding, single payer systems, capped programme funding and effective clinical governance. The differences in emphasis between the primary healthcare (PHC) and UHC approaches are significant. The former involves a focus on building and supporting the primary healthcare sector and envisages a prominent role for community health workers and community involvement in planning, accountability and prevention. By contrast, the UHC discourse starts with a focus on financial protection and essentially argues for care that is ‘purchased’ from a range of private and public providers. This has legitimized the dismantling of public services in many parts of the world and the increased participation of private providers in the delivery of healthcare.

While efforts to promote UHC are largely concerned with ensuring the acceptability of health services, community control has the more ambitious goal of providing space for community power to control healthcare, to increase the community’s control over its own health and to improve the responsiveness of the health service to the local community. A number of health services in Australia have been transferred from state government management to community control, providing an opportunity to examine what benefits community control may bring. Experiences related to these indicate that involving citizens in the management of health services is likely to make them strong advocates for non-commercialized healthcare and provide a counter voice to the powerful corporate voices baying for more chances for profit. For indigenous peoples, it also provides greater self-determination and control over health and healthcare, and more culturally respectful services that take into account holistic, indigenous conceptions of health and healing.

The concept of a ‘Medical-Industrial Complex’ (MIC) was proposed more than four decades back in the United States to depict the functioning of its health system. The chapter ‘Healthcare in the USA: Understanding the Medical-Industrial Complex’ analyses how, in the USA, the essential problem with the health system is the commodification of health and the idea that health is an economic good. The US experience shows that, despite all claims to the contrary, healthcare does not make a good commodity and ‘marketplace solutions’ have been a failure.

The chapter on South Africa follows the development of civil society activism in South Africa on one hand and, on the other, the trail of broken promises that underpin the story of healthcare services in the country. The AIDS ‘denialism’ of the Mbeki era sparked the re-awakening of social movements in health with the launch of the Treatment Action Campaign (TAC). The central role that the TAC played in mobilising people and influencing policy showed how citizen action can bring about change from below. The rise and success of the TAC campaign occurred in a period when influential external donors started funding HIV/AIDS activities undertaken by non-governmental organizations (NGOs), which have come to dominate the health civil society. This NGO-ization of health civil society is not confined to South Africa and

reflects the changed nature of donor funding under neoliberalism, characterized by the directing of substantial funding through private and non-government recipients in a climate of cuts in public spending by the state under austerity.

Conservative economists often berate low and middle-income countries (LMICs) for their failure to pursue neoliberal reforms while restructuring healthcare services. The failures are sought to be explained as being caused by inefficient and corrupt financial and administrative systems in these countries. However evidence indicates that neoliberal reforms in restructuring healthcare services, such as through Public Private Partnerships (PPPs), are inherently flawed and represent a transfer of public resources to the private sector and do not lead to any increased efficiencies. This is illustrated in the chapter on the 'new' Karolinska hospital in Stockholm.

Over the last decades, issues related to migration have emerged as a fundamental and defining factor in European societies. The chapter on migrants' health in the EU discusses how there has been an increase in the number of countries in the EU who deny basic healthcare to migrants. Undocumented migrants are often blamed to divert attention from unpopular social sector cutbacks. Even in countries where the law allows access to healthcare for undocumented migrants, actual implementation is flawed and migrants continue to face exclusion from the healthcare system.

There is a perceptible trend towards use of non-standard forms of employment in public services in general and in the health sector in particular. The chapter on 'informalization of employment' presents evidence that the remuneration of health workers has decreased in relation to total health expenditure globally. Women are among the worst impacted -- while the global health workforce is predominantly female in many countries, women are concentrated in lower skilled jobs, with less pay and stay at the bottom of professional hierarchies. Of particular concern is the plight of community health workers, who make a major contribution to health outcomes of rural and poor communities in South Asia. Recently, CHWs have successfully organized themselves and finding avenues to improve their conditions of work.

### **Beyond healthcare**

Despite a broad consensus and a shared understanding that climate change requires concerted global action, the global response has been timid and late in coming. The chapter on climate change reviews the underlying forces within the broader crisis of environmental degradation, and the consequent effects on human health and health inequities. Although manifesting distinctly in different locales, environmental degradation and its health consequences are interrelated across the world, transcending place and ultimately affecting everyone. Addressing the myriad environmental challenges and their interconnected health effects is complex and difficult, and will require broad cooperation, creative ideas and intense political struggle. Unfortunately, the present reality is one

of substantial political recalcitrance to transformative change by some of the largest polluters.

Historically, women's ability to make choices and exercise autonomy in matters of sexuality and reproduction have been conditioned and constrained by economic and political structures, based on a model that prescribes 'normative' behaviour and abhors 'deviant' behaviour. The chapter titled 'Gendered Approach to Reproductive and Sexual Health and Rights' through a discussion on the struggles of sex workers and transgender communities, and of women demanding abortion rights, argues for an alternate public health discourse that advances a more nuanced approach to sexual and reproductive health rights. A separate chapter on sexual and reproductive health rights in Chile depicts how, even in relatively high income countries, women's sexual and reproductive health rights are frequently ignored. Governments must not only commit to promoting women's health concerns but must simultaneously address the deeply embedded gendered norms within society and in healthcare systems.

Trade agreements have seldom been analysed in terms of their impact on the health of workers. The chapter 'Trade Agreements and Health of Workers' looks at the possible risks that free trade agreements (FTAs) pose to the health of workers. Changing power relations have shaped the global trade framework in the last few decades, and trade agreements impact on various aspects of health, such as government revenue (for funding social services), nutrition, and access to medicines and healthcare services. Importantly, trade agreements impact employment and working conditions, and the health of workers.

Countries rich in mineral resources also experience high levels of inequality and poverty—a situation often referred to as 'the resource curse'. The chapter on the extractive sector argues that while extraction and export of unprocessed raw materials may lead to rapid growth, this is often unsustainable and not accompanied by higher value-added processing activities in African countries. Of particular concern is the impact of the extractive sector on the health of workers in the sectors and of communities living in the vicinity of extractive activities.

A growing recognition of the failure of the war on drugs and a move towards adopting a public health approach are gathering pace around the world. The chapter on this issue argues that the debate is often polarized between two extremes – prohibition on the one hand and free market legalization on the other – and neither of these simplistic positions provides a viable solution to what is a complex public health problem.

### **Watching**

Underpinning the deficiencies in the World Health Organization (WHO) is its deep funding crisis, which constrains its ability to carry out its normative activities. The chapter on the WHO's funding crisis discusses how the WHO, similar to many UN agencies today, faces challenges to its norm-setting

activities, given its growing dependence on private donors and funding that is tied to specific programmes. This has implications for WHO's accountability to member states, and represents a serious erosion of the principles of democratic governance of the organization. With the shift to operational and implementation control by donors and their various 'stakeholder' partners, rights-based approaches and the governing role of member states in the public interest are being undermined, often intentionally.

In recent years, substantial attention has been focused on the growing influence of philanthropic foundations in global development and the risks and side-effects of this trend. The chapter on private philanthropic foundations argues that actions of philanthropic foundations are aimed at preserving rather than redistributing wealth, and are a way for elites to pursue and legitimate their actions. International organizations, individual governments and civil society organizations need to weigh the cost of engagement with such foundations against the role they play in undermining the accountability of public institutions.

While many global health actors have been critically examined, the role of management consulting firms, which can be linked to all significant global health institutions over the past decade and to critical junctures in countries in crises, has remained by and large hidden from the public eye. The activities of these firms are examined in a chapter that concludes that there is no evidence that the ascent of consulting firms in the health sector has led to approaches and solutions to radically improve health outcomes for the poor and most marginalized. The framing of health as a technical exercise and the related focus on 'value for money', 'efficiency gains' and rapid results has led to the exclusion of those most in need, the sidelining of systemic long-term solutions and the downgrading of community voices.

Global public private partnerships (PPPs) have emerged as the new medium of global governance, replacing over time the nation-state driven governance system which was embodied in the UN system. The examination of arguably the two largest PPPs in the health sector, the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) suggests that the unfettered power of both PPPs represent a threat to the hitherto nation-state driven system of global governance for health. They clearly represent instances of private sector influence on activities which are public funded and essentially take place in the public sphere.

Nearly all developing countries have signed bilateral investment treaties (BITs) with developed countries. Increasingly, free trade agreements (FTAs) also feature investment protection chapters. The discussion on investments treaties shows how they affect social, environmental and health policies of sovereign governments. National policies that promote public interest are now being challenged by foreign investors on the plea that they put their investments at risk. These challenges involve the Investor-State Dispute Settlement

(ISDS) mechanisms that are embedded in trade and investment treaties. ISDS mechanisms often place an onerous burden on countries as they are conducted outside the nation's own legal systems, in international courts of arbitration.

In the last couple of decades, political actors' perceptions of what constitutes a threat to international security has broadened – the subject of a chapter titled 'Framing of Health as a Security Issue'. The 'health security' discourse was extensively articulated in the aftermath of the Ebola epidemic in West Africa. This is symptomatic of how health issues, particularly those related to infectious diseases, have increasingly been presented as security threats. The 'securitization' of health encourages feelings of selfishness and fear rather than compassion. It can result in the misallocation of scarce resources in a manner that undermines efforts to secure access to healthcare and improve the social determinants of health.

Data, information and knowledge are core resources for policy, practice and activism in relation to healthcare and population health. However, as a chapter on this issue proposes, they are not simple representations of an objective reality but are produced in social practice and bear the imprint of power. This chapter calls for the need to develop a more nuanced understanding regarding the politics of data, information and knowledge.

In 2011 the members of the WHO adopted a Pandemic Influenza Preparedness Framework (PIP Framework), linking access to pathogens to fair and equitable sharing of benefits arising from their use. The chapter, analysing the framework, argues for extending similar mechanisms to other areas that involve the sharing of biological materials by countries with manufacturers of medicines and vaccines.

Campaigns on Community Led Total Sanitation (CLTS) are being extensively promoted in a range of resource poor settings. An integral part of these campaigns is the 'naming and shaming' of errant individuals and households. Practitioners of CLTS claim that the 'shame' comes from self-critique and not from externally imposed humiliation. The chapter on this subject, drawing on case studies from India, however, suggest that in practice CLTS programmes in many countries appear to thrive on coercive practices that often lead to gross violation of the rights of poor people.

### **Struggles, action and change**

Low and middle-income countries face challenges to adequately resource their health systems. In many countries, the challenge for people's movements is the lack of a political will to opt for a model that is truly fair and that effectively avoids wastages created by private interests and private sector participation in healthcare delivery. The chapter on advances made in El Salvador describes how the country's current government has exhibited the political will to propose and advance progressive reforms. Yet, this is not sufficient, as even a well-structured system needs to be adequately financed.

The case study on the situation in El Salvador shows that a transformation of economic and fiscal structures is required in order to achieve adequate financing for healthcare services. Further, as the case study highlights, private interests and local elites can take democratic institutions hostage and sabotage reforms that benefit the majority. In such a situation, strong and independent people's movements and organizations have a key role to play to protect and further progressive reforms. The dilemma faced by the progressive government in El Salvador is typical of what other progressive governments face. In a globalized world where the global economy is integrated through myriad mechanisms, countries find it extremely difficult to create the fiscal space for welfare. This calls for international mobilization designed to break the power of the international financial institutions, the international trade regime and multinational corporations.

India is among the 20 countries worst affected by hunger in the world. The alarming situation of malnutrition in India demands a comprehensive approach that addresses the needs of children who are malnourished and require treatment. Unfortunately, the approach followed has been informed by a biomedical rather than public health perspective, where malnutrition is often treated without considering its broader social determinants. The chapter on this issue provides evidence from community led initiatives which point to the efficacy and sustainability of comprehensive community-based nutrition programmes that incorporate the use of locally devised solutions.

A story of consistent struggles waged by People living with HIV (PLHIV) in India, supported by national and international solidarity, lies behind the successes achieved as regards HIV treatment in India. This is the story of the struggle conducted by People living with HIV in India. The Indian experience shows the benefits of using the legal system for making full use of the flexibilities under the TRIPS AGREEMENT. The story also illustrates how the struggles of community groups lie at the heart of successful struggles that are challenging unfair trade rules.

The neoliberal order affects people's lives in myriad ways and it is thus contingent that the struggle for health be conceived and constructed as a very broad struggle. It incorporates different strands, different objectives of an immediate nature and diverse strategies, while upholding the vision of a globe that is free of the ills of neoliberal globalization. The final chapter depicts two struggles from Italy of communities, defending and reclaiming their rights, in the face of the neoliberal onslaught. It tells the story of *Genuino Clandestino*, an Italian network of collectives, associations and individuals who advocate and practice the re-appropriation and collectivization of land for autonomous, self-managed small scale farming. The chapter also relates the story of citizens' resistance in Casale Monferrato against asbestos-related health and environmental hazards.



**Towards a shared narrative for change**

A single volume cannot claim to cover the complex terrain of health and healthcare. The analysis, proposed actions and stories of struggles and change are presented with the view that it is necessary to propose an alternate vision and alternate strategies. We hope that *Global Health Watch 5* will stimulate readers to reflect more concretely about what needs to change, how things can be done differently, and how people can be at the centre of bringing about desired change. This volume is essentially an effort to build a community of believers who believe that change is necessary and urgent. It hopes to contribute to the construction of a shared narrative, located in a vision of equity and justice, and imbued with the urgency that the present global health crisis demands.