Global Health Action

2005-2006

GLOBAL HEALTH WATCH
campaign agenda

***Global Health Action* is a campaign tool based on the first Global Health Watch, published in July 2005.**

The *Watch* is a broad collaboration of public health experts, non-governmental organizations, civil society activists, community groups, health workers and academics. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact.

This alternative world health report is an evidence-based assessment of the political economy of health and health care – and is aimed at challenging the major institutions that influence health.

The *Watch* arises out of many civil society and professional campaigns and struggles for better health, and has been released to coincide with the second People's Health Assembly, held in Cuenca, Ecuador, at which two thousand people from across the world have gathered to discuss and debate strategies to overcome the political, economic and social barriers to better and fairer health

The Watch is available for free download at the website **www.ghwatch.org**, and on CD, available by contacting ghw@medact.org. It will be published by Zed Books in December 2005.

GEGA
Global Equity Gauge Alliance

People's Health Movement

Medact
challenging barriers to health

People's Health Movement ● www.phmovement.org
Global Equity Gauge Alliance ● www.gega.org.za
Medact ● www.medact.org

Reducing the world's health inequalities

Today's global health crisis reflects widening inequalities within and between countries. Scientific and technological advances have secured better health and longer lives for some. However more people live in poverty than ever before and 30,000 children die every day.

The *Global Health Watch 2005-2006* catalogues the disparities in health and draws attention to the ways in which government, international institutions and civil society can take action to combat them.

Health workers in particular can play a vital role in turning the ideas of universal health rights and global citizenship into meaningful reality (box 1). Those in wealthier parts of the world have a particular responsibility to press for change. The interdependence caused by globalization heightens these ethical duties.

The themes covered by the *Watch* are diverse (box 2), but all spotlight the various political, economic and social inequalities that undermine health.

This campaign document focuses on the following key areas:

Building a fairer world

Eliminating poverty and improving health implies changing the way the global economy is managed in the interests of greater fairness, as well as substantially increasing transfers of resources between developed and developing worlds.

Defending and extending the public sector

The repair and development of public health care systems is critical to stop the rot of commercialization and to reduce widening inequalities. *Global Health Action* proposes a 10 point agenda for action.

Migration, Pharma and big business

Health worker migration, global rules on intellectual property that hike the price of medicines and the impact of multinational activity on health are highlighted as three examples of how globalization and the subordination of health rights to commercial objectives directly affect health and health care systems across the world.

Taking action on climate change and militarism

Climate change and militarism are two of the biggest current and future causes of ill health across the world. The failure to address both of these issues in a significant manner signals the need for a greater mobilization of civil society and health workers to push for more effective and just solutions.

Enhancing global health leadership through the World Health Organization

The world needs a multilateral health agency capable of protecting and promoting health, reducing health inequalities and ensuring the fulfillment of universal rights to basic needs and essential health care. For this to happen, the WHO will require better funding, more responsiveness to the needs of poor countries and civil society, and better management.

Global Health Action draws on the *Watch* to set out an advocacy agenda that health workers and campaigners can organize around now.

BOX 1

Health workers can make a difference

There is a tremendous historical legacy within the disciplines of public health, medicine and nursing in addressing some of the world's biggest causes of ill health and mortality. Health professionals have also been prominent in the fight against social ills such as poverty, slavery, oppression and torture.

In both developed and developing countries, health workers are in a unique position to push for change.

The *Global Health Watch* represents a call to all health workers to broaden and strengthen the global community of health advocates who are taking action on global ill-health and inequalities, and their underlying political and economic determinants.

Health workers can act as individuals; through their employing organisations and professional associations; through civil society organisations promoting health or advocating on behalf of the health of poor and vulnerable groups. Health workers can also play their part by directly supporting the struggles of communities to gain access to basic natural resources such as land, food and water as well as health care.

Health and public policy researchers have an important role to disseminate knowledge and information to civil society about the underlying determinants of ill health or the reasons why health care systems may not function or even exist.

A central aim of the *Watch* is to encourage national and regional groupings of health professionals, in collaboration with other NGOs and other sections of civil society, to organise their own health watches to monitor the actions of their governments, the private sector and the international community, and to challenge them as required.

This is an important ingredient of the social mobilisation required to promote political change in favour of improved health and reduced inequalities.

A Latin American Health Watch and an Indian Health Report are two such examples, which are available from the Global Health Watch website.

Health workers in the developed world have a particular moral and professional duty to consider the health of people living in other countries. They can:

- Encourage their organisations (hospitals, primary care clinics or academic units) to develop long-term 'partnerships' with counterpart organisations in poor countries. These partnerships would involve long-term support, including the transfer of material resources or skills and technology.
- Campaign for changes in the policies of their governments and global institutions.
- Implement local purchasing, capital development and human resource policies that are ethical and sensitive to their impact on global health and the environment.

BOX 2

Global Health Watch 2005-2006 – Contents

Building a fairer world

- 2.7 billion people live on less than US$2 a day – a rise of 10% since 1987
- Healthy life expectancy is 39 in Africa compared to 66 in the developed world
- The annual amount of development assistance spent on health by all developed nations – US$10 billion – is equivalent to the amount spent on ice cream in Europe
- Whilst the wealth of the developed world has risen by more than 150% since 1960, aid per capita has risen by just 10%
- The power and wealth of multinational corporations has grown out of hand. Of the 100 largest economic entities in the world, 51 are businesses.
- The combined sales of the top 20 businesses are 18 times the combined income of the poorest 25% of the world's population

The world we live in is deeply polarised. Health and poverty statistics record the disparities but can only hint at the misery faced by those at the bottom of the pile.

Large amounts of the natural resources of developing countries have also been captured and brought under the control of rich countries through a variety of instruments that include unjust property rules, unfair terms of trade, collusion with despots and undemocratic governments and economic conditionalities imposed through development assistance. Many of these resources are extracted and controlled by unaccountable multinational corporations, and are used to feed the environmentally unsustainable lifestyle patterns of the wealthy minority.

These inequalities are ethically intolerable, especially in a world where globalization is bringing us closer together. What can be done to change this?

Reform trade and the governance of the global economy

The *Watch* describes the serious problems with the current structure and processes of global governance, which are rooted in the economic inequalities that exist between different nations. Decision-making power in the World Bank and the International Monetary Fund for example is based on financial contributions, which leads to deeply skewed representation. At the World Bank, the US alone holds 17% of the votes, whilst 47 countries in sub-Saharan Africa hold 7%.

Unfair trade drives the widening gap between rich and poor, keeping hundreds of millions of people locked into poverty and limiting the development prospects of low and middle-income countries. Trade is also promoted without enough attention to the safeguards and regulation required to prevent and reduce environmental degradation, unemployment, exploitative labour and exposure to health threats (box 3).

Whilst decision-making in the World Trade Organization is nominally based on one member one vote, in practice the developed countries, with their large trade delegations and financial bargaining power call the shots.

At the same time, large corporations wield huge and unaccountable influence on the governments of rich nations and promote global trade and financial regulations that weaken citizenship and the sovereignty of governments, particularly in developing countries.

What needs to happen

- Developed countries must meet their pledges to open their markets to goods from the developing world, especially in agriculture and textiles. They must keep their promises to reduce subsidies to their own producers when this results in unfair competition and destroys young industries in developing countries. Southern governments must also be given more room to protect their fragile economies from unfair competition.
- Global, bilateral and regional trade agreements must undergo health and equity impact assessments, and be subject to greater parliamentary and public scrutiny.
- The World Bank, WTO and IMF must be reformed to represent and act in the interests of the poorest people and held accountable for their part in perpetuating poverty and fuelling inequity.
- The United Nations system, an anachronistic institution governed by a structure and rules that were instituted in a bygone era, requires fundamental reform to promote greater equality between countries, fairer globalisation and the fulfilment of universal health rights.

Support human development through further debt cancellation and development assistance

The recent G8 Summit has made progress towards cancelling debt and improving levels of development assistance. This has followed upsurges in public mobilisation to demand a fairer deal for the poorest people (box 4).

However, progress is still far too little and too slow. Millions of people continue to bear the brunt of debt repayments for loans that they had no part in making or benefiting from. Most developed countries do not spend 0.7% of their national income on development assistance – as they agreed to 30 years ago.

The Watch also describes how development assistance is part of the problem when it is used to force countries to undertake neoliberal reforms and open up their markets – processes that often benefit donors and large multinational corporations. Some donor countries also insist that aid is used to purchase goods or services from them – what is known as 'tied aid'.

In the health sector, development assistance often comes in the form of uncoordinated programmes and initiatives which undermine the ability of governments to develop coherent, long-term, health care plans.

What needs to happen

- The recent developments on debt cancellation need to be deepened and expanded, but without being funded out of aid budgets. At the very least, public expenditure targets for health, education and household food security should take priority over any debt repayments.
- Donor countries must meet the UN target of 0.7% of GNP by 2010 and not by 2015 as promised by some countries.
- Debt cancellation and development assistance must have no conditions attached except with regards to standards of transparency and accountability in the use of money, and must be 'untied'.
- In the health sector, development assistance must be better coordinated, responsive to national priorities and contribute towards the formation of equitable health care systems in developing countries.

Extend the principle of fair taxation

A huge amount of wealth is created and traded at the global level, much of it inappropriately exempt from tax. The *Watch* contains details of how corporate tax evasion costs governments up to US$255 billion annually in lost tax revenues.

There are other potential sources of revenue to fund human development – a currency transaction tax, an arms trade tax, a global environmental tax and an airline tax. These could also provide incentives to avoid sources of social harm and environmental damage.

These proposals embody principles of fair distribution of the world's resources and should take precedence over the concept of charity and 'debt forgiveness'.

What needs to happen

- Governments should agree to set up an international tax authority with a mandate to eliminate tax evasion and raise revenue for development at the global level.
- Governments should explore – and implement – new forms of development financing such as the currency transaction tax.

Tackle corruption and oppression

The transfer of resources from rich to poor countries is often opposed by arguments that poor countries are corrupt and run by oppressive governments.

However, corruption exists in all societies and the agents of corruption and oppression in poor countries often involve actors from the developed world.

Corruption thrives when public administrations are underfunded, unaccountable or captured by vested interests. Oppression is sustained through illegitimate arms deals primarily benefiting the arms manufacturers of the developed world. Widening disparities between and within countries are in themselves catalysts for corruption, emphasising even further the importance of addressing inequalities.

What needs to happen

- More donor investment for publicly accountable legal and regulatory frameworks to monitor corruption.
- More investment in public sector budget monitoring processes within countries.
- Rules, procedures and funding for mechanisms to make corporate accounts transparent and open to public scrutiny.
- Citizens in rich countries should monitor the complicity of their own governments and businesses in sustaining corruption in poor countries and campaign for donors to sign the United Nations Convention Against Corruption.

BOX 3

Harmful effects of trade

While trade can raise living standards and improve health, it can also do harm. Examples of this are:

- Corporations seeking low-waged, non-unionised labour in poor countries and ignoring occupational and environmental health.
- Growing control over food production by a few global corporations squeezing out small producers and reducing access to nutritious food.
- Pressure from rich nations to open up markets to their corporations in essential services such as water – a process being facilitated by the General Agreement on Trade in Services (GATS).
- Greater distances between producers and consumers, leading to environmental damage through transportation of food and other goods.

BOX 4

Jubilee 2000 – the power of global solidarity

Jubilee 2000 was launched in the mid-1990s to tackle the failure of rich governments, the World Bank and International Monetary Fund to recognise that debt cancellation was both moral and necessary for development.

The campaign successfully mobilised civil society across the world and 24 million people signed the world's largest petition. At the G7 Summit in Cologne in 1999 Jubilee 2000 persuaded creditors to promise US$100 billion of debt cancellation.

Although this promise has not been delivered in full, there has been some debt relief and campaigners have kept up the pressure.

Jubilee 2000 showed that a broad coalition – which included prominent groups of health professionals – can increase popular understanding of global problems, apply pressure and bring about change.

Medical students demand debt cancellation (Andrew Wiard)

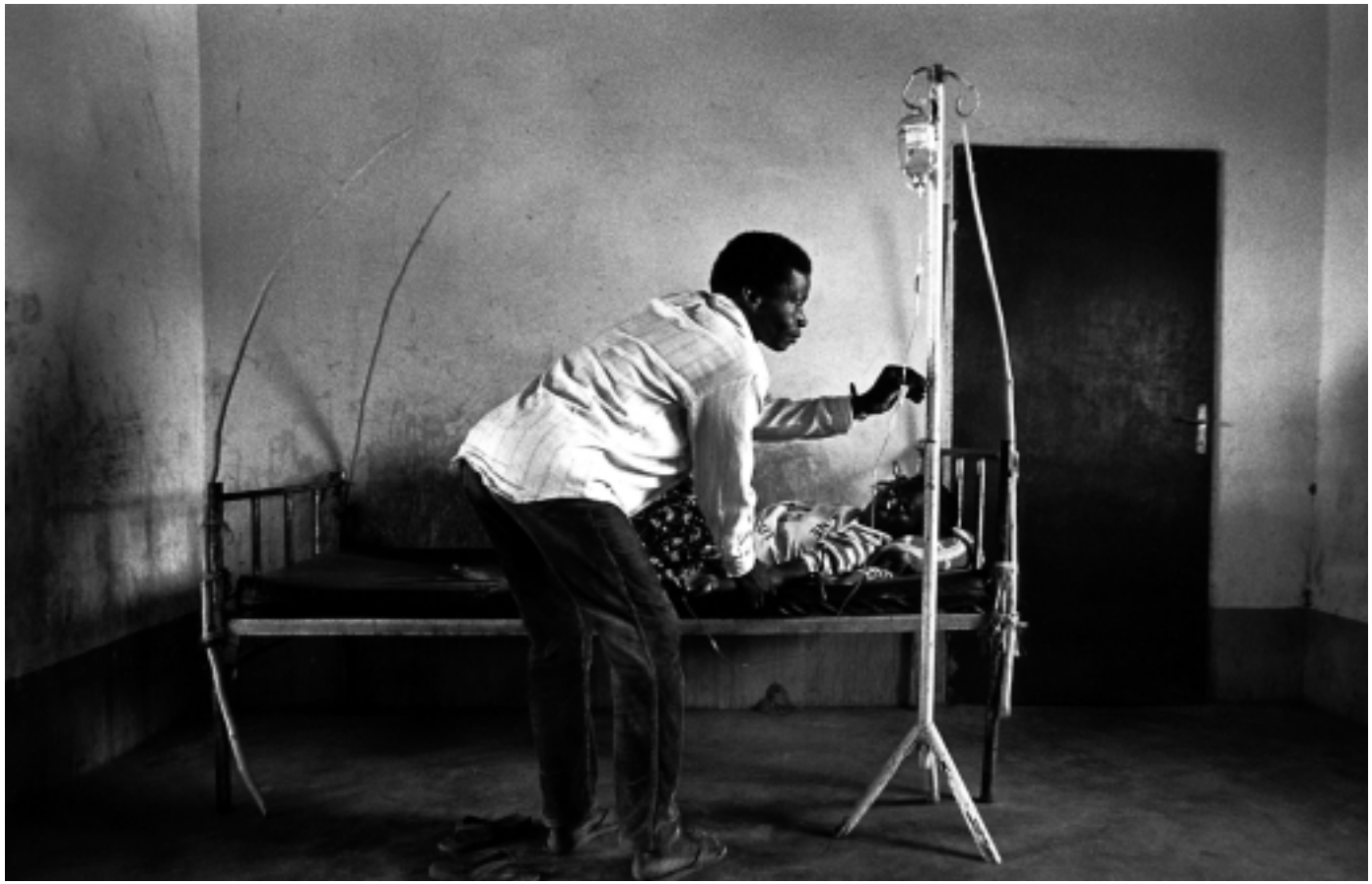
What can health workers and campaigners do to build a fairer world?

- Demand and campaign for:
  - An international delegation of public health and trade experts to be nominated and mandated to attend subsequent rounds of WTO negotiations. They would provide advice and public health warnings to the finance and trade ministries of developing countries and submit a high-level report on the health and equity impact of all WTO decisions. This should start with the Hong Kong talks in December 2005.
  - WHO to declare the reform of the UN, WTO, World Bank and IMF key global public health priorities.
  - An international tax authority and new sources of finance for development and health.
  - The independent monitoring and assessment of the policies, quality and health impact of official donor programmes

- Publicly endorse and support campaigns for fair trade, debt cancellation and more aid, for example the Global Call to Action against Poverty (http://www.whiteband.org), in the run up to the UN's Millennium Summit in September 2005 and beyond.

- Promote greater education for health workers and undergraduate health science students on the global health challenges highlighted in the *Watch*.

- Develop ethical procurement policies and 'fair trade' practices within the health care system.



Health care under pressure, village clinic, Mali. Low-income countries like Mali need a better deal in the global economy if health is to improve (Jan Banning/Panos Pictures)

Defend and extend the public sector

- Hundreds of millions of people lack basic health care
- Health care systems in many countries have deteriorated due to economic crises and a lack of government investment
- The collapse of public sector morale and quality has resulted in the growth of an unregulated private sector
- Neoliberal health sector reform policies and trade agreements have undermined even further the public sector and threaten to entrench the commercialization of health care
- Countries with more commercialized health care achieve poorer health outcomes

The *Watch* explains why market-driven health care and commercial provider behaviour results in inefficiency, poor quality care, widened inequalities in access to care, the erosion of trust between patients and providers and an inappropriate tilt in the balance towards medical technology and away from community-based initiatives.

These problems have also affected public sector activities in other important sectors (box 5).

What needs to happen

The *Watch* calls for the repair and development of health care systems based on the following 10-point agenda for action.

1. Provide adequate funding for health care systems

There is a need for a major international campaign calling for new sources of finance to sustain essential health care infrastructure in the medium to long-term in every country.

2. Take better care of public sector workers

Public sector health care workers are the lifeblood of health care systems. They need a living wage, good support and on-going training, especially those in isolated and under-resourced areas.

3. Ensure that public financing and provision underpin health care systems

Systems that are universal and inclusive offer the best hope for both equity and efficiency. Resources should be pooled at national level to enable cross-subsidization, risk-sharing and planning. The public sector should not be confined to providing services for the poor (box 6).

4. Abolish user fees

Governments and international agencies should abolish user fees for essential health care.

5. Adopt health systems indicators and targets

The international community should adopt a new set of targets and indicators to guide the repair and development of health systems (box 7).

6. Reverse the commercialization of health care systems

Governments should use their financial, legal and political muscle to ensure that private sector providers serve the public interest (box 9).

7. Strengthen health management and promote the District Health System model

More investment is needed to strengthen public sector health management at all levels. The District Health System model, as promoted by the 2005 *World Health Report,* should form the centrepiece of reforms to the organization of health services.

8. Improve donor assistance within the health sector

Donors and international agencies need to operate by a code of conduct that obliges improved coordination, places the institutional development of Ministries of Health and a coherent health systems development agenda at the centre of their respective programmes, and reduces pressure on countries to meet unreasonable, externally-imposed targets.

9. Promote community empowerment

Community empowerment, public accountability and social action are key requirements of a well functioning health care system – they help to ensure that the public sector and other agencies provide health care that is appropriate, fair, efficient and effective. Box 8 shows one example of how this is being done in India.

10. Promote trust and ethical behaviour

Health care systems should develop institutions that promote trust, professionalism and ethical behaviour that can act as a counterbalance to the corrosive effects of commercialization on ethics and equity. They are equally important for optimising the benefits of accountable public bureaucracies.

Effective clinical care is vital to the health and well-being of children. But the mother of this child will also need to be given appropriate advice and practical support on child care and nutrition (Neil Cooper/Panos Pictures)

BOX 5

Education and water are vital to health

The *Watch* describes how under-investment in the education sector results in serious health consequences – the failure to meet international targets on gender parity in primary and secondary education will, in 2005 alone, lead to the unnecessary deaths of 1 million children under five.

The *Watch* also describes the lack of public investment in providing adequate water supply to all, and how the deregulation and commercialization of the sector over the last 20 years has resulted in many injustices.

These threats present opportunities for joined-up campaigning by activists in different sectors. Together they can call for:

- Greater government and international funding for key health-sustaining sectors, in particular water, education and food production.
- Abolition of user charges for essential services.
- Blocks on multinational companies attempting to profit from the provision of services (this is especially important in the health and water fields).
- Monitoring of budgetery allocation to essential public services.

Protesting against the privatization of water in Cochabamba, Bolivia
(Tom Kruse, t.kruse@albatross.cnb.net)

BOX 6

Building universal services

Many Latin American countries suffer from fragmented health care systems. Some people are covered by insurance schemes, however, many people – particularly the poor – are not insured and rely on the underfunded public sector which provides limited health care.

In contrast, the local government of Mexico City, which had seen a decline in health care for the poor and in public health care facilities, has initiated a comprehensive policy based on social rights and the redistribution of resources.

Two new programmes launched in 2001 are reducing inequalities in access and providing valuable safety nets for the vulnerable:

- A programme of food support and health care for senior citizens provides residents over the age of 70 with food and free health care at a government facility
- Another programme enabling the uninsured to receive free health care and drugs

In addition, primary health care and public health programmes are being reinvigorated and hospitals are becoming redefined as part of a city network.

A 67% increase in the health budget helped to renew the public sector, along with a crackdown on tax evasion, government corruption and waste, which also enabled government purchases at lower costs.

Citizens can now see that their taxes are improving public services which makes their financing more sustainable.

These programmes are becoming well embedded and have raised the possibility of universal access to health care within Mexico City by 2006.

Source: Asa Cristina Laurell (2003). What does Latin American Social Medicine do when it governs? The case of the Mexico City Government. *American Journal of Public Health* **93**;12: 2028-31.

BOX 7

Indicators and targets for Health Care Systems

- Countries to raise the level of tax revenue to at least 20% of their GDP.
- Public health expenditure (from government and donors) to be at least 5% of GDP.
- Government expenditure on health to be at least 15% of total government expenditure.
- Direct out-of-pocket payments to be less than 20% of total health care expenditure, with actions towards abolition of user charges set out and timetabled.
- Spending on district health services (up to and including Level 1 hospital services) to be at least 50% of total public health expenditure, of which half (25% of total) should be on primary health care.
- Expenditure on district health services (up to and including Level 1 hospital services) to be at least 40% of total public and private health expenditure.
- A ratio of total expenditure on district health services in the highest spending district to that of the lowest spending district of not more than 1.5.

BOX 8

People power in India

Despite having one of the largest pools of health workers in the world, India's health outcomes are among the poorest. Public expenditure on health is less than 1% of GDP.

In 2003 *Jan Swasthya Abhiyan* (the People's Health Movement - India) launched a 'Right to Health Care' campaign to press for better and more accountable health services.

Campaigners organized surveys on the availability of health services in many states, as well as People's Health Tribunals in which ordinary people gave testimonies about the difficulty of getting safe, affordable health care to experts and government officials. The denial of women's health rights was a common violation.

The National Human Rights Commission (NHRC) contributed by organizing regional public hearings covering all states of the country culminating in a National Public Hearing on the Right to Health Care in Delhi in 2004. This was attended by the Central Health Minister of India and senior health officials and activists from all over the country.

The hearing resulted in NHRC and PHM-India formulating a national Action Plan based on the right to health care. The Action Plan was wide-ranging, but at its heart were calls for a new Public Health Services Act defining citizens' health rights and health care providers' duties. Regulation of the massive – and frequently unsafe – private health care sector was also prioritised, as was increased funding for the public health system.

The Right to Health Care campaign has been unique in the way it has opened a path for hundreds of ordinary people to submit testimonies about their health rights' violations. It has unleashed the energies of health activists, reached remote villages and helped shape national health policy. The campaign is continuing with mass actions, legal challenges and political dialogue.

Source: Dr Abhay Shukla, *Jan Swasthya Abhiyan*. Further information: www.phmovement.org/india

BOX 9

Reigning in Commercialization

What must governments do when faced with a health care market of many different types of providers, fragmented care and high co-payments for patients?

Regulation

Governments must develop the regulatory capacity to ensure that the private sector operates ethically, professionally and equitably. Regulation should include mechanisms for public and health providers to monitor their own performance.

Legislation

Governments can enact legislation to govern the medical insurance market. For example, community rating and prescribed minimum benefits can limit the ability of private insurers to 'cherry pick' healthy or rich clients or to 'dump' clients onto the public sector when their health care costs become too high.

Encourage co-operation and redistribution

Working towards fairer health care systems requires creative thinking and may involve taking incremental steps towards universal service. For instance, governments can use the licensing of private providers to promote sharing equipment and staff with the public sector. The private sector can provide services free or at low-cost to patients from the government sector.

Governments could also endorse private providers who offer good quality and affordable care as a good way of driving up standards and driving out profit-maximising, bad quality care.

What can health care workers and campaigners do to defend the public sector?

- Demand and campaign for:
  - WHO's Commission on the Social Determinants of Health to pay particular attention to the evidence of the negative effects of commercialization on health care systems and health-sustaining services.
  - The 10-point action agenda for the repair and development of health care systems outlined above.
  - The abolition of user charges for essential health, education and water services.
  - The monitoring and public debate of the pattern of public, donor and private health spending.
  - Private medical insurance schemes to come under proper systems of regulation and be prevented from 'cherry picking' clients and dumping costly patients onto the public sector.
  - Research to map out the remuneration levels and policies of different public and private health care providers within a country to determine if this is accelerating the public sector skills drain and creating instability within the labour market.
- Compare national indicators against the health care systems targets outlined in box 7.
- Work with trade, public policy and economic experts to protect the integrity of the health care system from potentially harmful decisions made by finance and trade ministries.
- Draw up 'report cards' on the quality of public and private health services, assessing in particular whether people are treated with respect, do not have to face insuperable financial barriers to care as well as the clinical effectiveness of treatment. Organize public meetings to discuss these report cards.
- Dispel the myth that the public sector is inherently inefficient and that market discipline and 'business-models' are appropriate for the health care sector.

Migration, Pharma and big business

- Globalization has accelerated since the 1980s and is a powerful force for change
- It is characterized by a surge in cross-border investment and trade; the growth of powerful, multinational companies; global, one-size-fits-all rules on trade and intellectual property; and improvements in global telecommunications
- The current form of globalization exacerbates inequality, facilitates the exploitation of poor countries' economic, natural and human resources and undermines public health care systems

This section highlights three aspects of the current form of globalization that undermine health – the exodus of health workers from low-income countries; the impact of the TRIPS agreement on access to medicines; and the impact of multinational activities on health.

The health worker exodus

The health care systems of developing countries are losing their most precious resources – people. There has been a sharp rise in the migration of health workers (and other skilled professionals) from poor to rich countries partly due to differences in wages, working conditions and future prospects.

Increased investment in private recruitment firms and the rapid spread of access to the internet has made migration easier.

The doctor : population ratio in the UK is about 1 : 400, while in Malawi, it is 1 : 75,000. And yet the UK estimates that it will still need 25,000 more doctors in 2008 than it had in 1997. In the US, there will be a shortfall of nearly a million nurses over the next 15 years – which will largely be met by overseas recruitment.

The *Watch* describes how the most well-established voluntary 'ethical recruitment' scheme in the developed world, run by England's National Health Service, has failed to work.

What needs to happen

- The primary response to the migration crisis of health care systems in poor countries should be based on the principle of compensation, particularly for the poorest countries with the greatest staff shortages. This reinforces the argument that the reform of the global political economy and the transfer of resources from rich to poor countries is a health sector priority.
- Financial compensation must be complemented by non-financial forms of partnership between health systems. There are already schemes that share equipment, staff and other resources which could be emulated and built on.
- Inappropriate restrictions on public sector wages imposed on countries by the IMF and World Bank should be challenged.
- Developing country governments and donor agencies must do all they can to improve conditions for public sector workers. This should include greater investment in human resource management systems and capacity within the public sector and taking action to close the relative difference in pay and working conditions between the public, private and non-government sectors.

Making Medicines Accessible

The *Watch* describes how access to cheap medicines has been threatened by the World Trade Organization's agreement on intellectual property rights (TRIPS).

All but the poorest 30 WTO member states must now grant patents on new medicines for 20 years.

Flexibilities within TRIPS - to allow compulsory licensing and parallel importing in the event of 'health emergencies' - are being undermined.

Furthermore, bullying by rich countries (and the pharmaceutical lobby) of developing countries to sign 'TRIPS-plus' agreements compromises access to essential medicines even further by, for example, forcing even higher levels of patent protection and undermining the ability of governments to regulate the pharmaceutical sector.

The *Watch* also explains how TRIPS and the current systems for financing pharmaceutical research and development are geared towards the interests of the global pharmaceutical corporations and result in inefficiency, high prices and a neglect of research into diseases which mainly affect the world's poorest people.

What needs to happen

- Intellectual Property Rights related to essential medicines and other essential health technologies should not be governed by the WTO and trade agreements, but by public health considerations and public health institutions.
- The generic supply pipeline must be kept open through the pro-active use of the flexibilities in TRIPS and by resisting pressures placed on developing countries by the United States and Europe.
- WHO and civil society should take a stand against countries being forced to enter into TRIPS-plus agreements.
- There should be an expansion of mechanisms to finance health- and needs-driven (rather than profit-driven) research, and faster progress towards an international Medical Research and Development Treaty that combines minimum national obligations for supporting medical research and development with flexibility on intellectual property rules.
- The protection and strengthening of WHO's pre-qualification initiative to create a faster and more efficient system for countries' access to affordable medicines.
- WHO should call for regular country-by-country review of pricing policies, prescribing practices and the effectiveness of the pharmaceutical regulatory system in ensuring access to essential medicines and good clinical practice.

The rise and rise of big business

The growth in the power and influence of multinational corporations requires strong regulatory checks and balances to protect universal rights to health care.

Efforts to promote voluntary codes of conduct have sometimes failed. However, the relative success of the International Code on the Marketing of Breast Milk Substitutes (box 10) and the Framework Convention on Tobacco Control (box 12) show how civil society working internationally can help bring about change.

Other struggles to promote and protect health include the campaign to reduce the 136,000 annual occupational deaths in China; the actions to challenge the harmful and unjust impact of Shell's oil extraction activities in Ogoniland, Nigeria; and the campaign to extract compensation from Union Carbide for the death and disability caused by its pesticide factory in Bhopal, India.

Another major issue is emerging. Over the last decade, there has been a steady decline in the taxation of corporate profits as a result of lower corporate tax rates, financial deregulation and the active evasion of taxes by big business, aided by teams of accountants and lawyers.

These trends erode the capacity of governments to fund health and social services. Ironically, many health programmes are now dependent on corporate donations or on so-called 'public-private partnerships'. These not only provide the corporate sector with good PR, but can also help them to capture new markets.

What needs to happen

- The UN must renew attempts to ensure that transnational business operates responsibly and in the interests of global health. Governments and international bodies should extend regulatory controls on transnational corporations, and give the UN a strong mandate to monitor their practices.
- The UN must free itself from the influence of big business. WHO especially must develop its safeguards against conflicts of interest in the funding and priority-setting of international health initiatives.
- Companies should be forced to declare both where they pay tax and how much they pay. An international tax authority is necessary for profits to be properly accounted for and taxed at a global level. Tax justice should become a key public health demand.

Marlboro billboard in Hong Kong (Corporate Accountability International)

BOX 10

Codes of Conduct – the example of breastfeeding

Breastfeeding is a matter of life and death for babies in poor countries, but can be undermined by companies promoting breast milk substitutes.

In the 1970s and 80s public health practitioners, NGOs and civil society successfully campaigned to curb harmful marketing practices.

Their tireless efforts resulted in the International Code of Marketing of Breastmilk Substitutes, adopted by the World Health Assembly in 1981, which set an important precedent in regulating transnational corporations.

The WHO failed to ensure compliance with the code, but two organisations - the International Baby Food Action Network and the World Alliance for Breastfeeding Action – identified non-adherence and pressed for action.

In countries that have not fully adopted the code, baby milk companies are still trying to influence mothers and staff by offering free supplies and by claiming that their products boost immunity to disease, and promote intelligence and healthy growth.

What can health workers and health professional associations do to respond to the human resource crisis, intellectual property rights and the negative health impacts of big business?

- Demand and campaign for:
  - The principle of compensation for the migration of skilled health workers from low-income countries with severe staff-shortages.
  - Research to measure and monitor the financial gain brought by migrant health workers to the health care systems of rich countries.
  - The removal of inappropriate IMF/World Bank public spending restrictions.
  - WHO to publicise and help implement the recommendations of the Joint Learning Initiative report on Human Resources (http://www.globalhealthtrust.org/Report.html).
- Fight against efforts to impose 'TRIPS-plus' agreements.
- Apply pressure during the forthcoming TRIPS review process and lobby WHO's Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH) for a much bigger investment in public, non-profit pharmaceutical research and a reform of the current patents regime.
- Strengthen policies and practices to promote rational prescribing; de-link continuing medical education from pharmaceutical sponsorship; open up the publication of the results of all clinical trials; and prohibit unethical pharmaceutical advertising to the public and health care providers.
- Call on the UN and its specialized agencies to formulate stronger regulatory mechanisms to monitor and curb the harmful effects of multinational companies.

Climate Change

- An average global temperature rise of 2°C by 2100 over pre-industrial levels marks the danger threshold for irreversible and calamitous climate change. The current predicted rise is between 1.4 and 5.8°C
- The seas, expected to rise by 9 to 88cm by 2100, could engulf the Maldives, Pacific islands and parts of Bangladesh, and destroy vast quantities of freshwater supplies
- The violent weather we have seen in recent years is set to increase. It is predicted there will be 150 million environmental refugees by 2050. Long-term environmental degradation will threaten the food security and livelihoods of millions
- WHO estimates that globally, for the year 2000, there were 150,000 deaths and 5.5 million disability-adjusted life years lost due to climate change
- Global health inequalities will be exacerbated by climate change

One and a half centuries of burning ever greater quantities of fossil fuels, together with deforestation, have increased the amount of greenhouse gases in the atmosphere – the main cause of global warming.

But the governments and citizens of all countries are burying their heads in the sand. The US and Australian governments haven't even signed up to the Kyoto Protocol, which contains modest targets for reductions of emissions of greenhouse gas.

The US, with 4% of the global population, is responsible for 25% of global carbon dioxide emissions. It is a bitter irony that the effects of the climate change caused overwhelmingly by the richest countries, will have a disproportionate effect upon the poorest people who have contributed least to the problem.

Citizens around the world are waking up to the ecological crisis. But action by concerned individuals will not be enough. In the long term, a complete rethink of the way we live is needed.

Droughts threaten the food security of millions in the developing world (Kittprempool/UNEP-Still Pictures)

What needs to happen

- Cuts in greenhouse gas emissions by industrialised countries of between 60-80% by 2050
- Rich countries to make compulsory contributions to a new Climate Change Fund to enable poor countries to adapt
- Health and environmental assessments of the impact of trade and economic activities
- More small-scale renewable energy projects to tackle poverty and reduce climate change

What can health workers and campaigners do to combat climate change?

- Demand and campaign for
  - cuts in greenhouse gases beyond the Kyoto targets
  - rich nations to contribute to the Climate Change Fund to enable poor countries to adapt
  - efforts to make the health care system where you work carbon neutral and environment-friendly
- Publicise the serious health threats posed by climate change and prescribe ways of tackling them.
- Promote health programmes that simultaneously improve health and protect the environment by reducing car travel and increasing time spent walking or cycling

Transport and travel are major drivers of climate change (NRSC/Still Pictures)

War and Conflict

- An estimated 191 million people died as a result of conflict in the 20th century
- Between 1991 and 2003 up to 500,000 children perished due to a lack of food, clean water or medicines as a result of war
- Between 1990-2001 there were 57 armed conflicts in 45 locations
- In 2003, world military spending increased by 11% to US$ 956 billion. 50% of this expenditure was by the US government

Wars and conflict devastate families, communities, nations, cultures and the environment.

Survivors may be chronically disabled or scarred for life. The psychological damage of war is incalculable – among raped women, child soldiers, people forced to watch family members being tortured or killed, their homes and communities destroyed. Children are especially vulnerable.

Military spending has spiralled out of control. Money and resources which could be used to strengthen health services are being diverted into preparation for war, further increasing the costs of conflict. Aid is even being used to fight the 'war on terror'.

Military power is all too often used to defend and increase the political and economic advantages of the wealthy nations.

According to the Commission on Human Security (CHS), four nations – France, the Russian Federation, the United States and the United Kingdom – are responsible for 78% of global exports of conventional weapons. Germany, the remaining major contributor, is responsible for a further 5%. Two-thirds of these exports go to the developing world.

Small arms are a particular threat in poorer countries. There are around 640 million small arms in the world – and many are inexpensive. Although the data are poor, the CHS estimates that these weapons kill 500,000 people a year. Campaigns on this issue are growing, but need further backing.

Meanwhile, the threat posed by nuclear weapons has not gone away, and may even increase through proliferation and setbacks in progress towards nuclear disarmament. Treaties on chemical and biological weapons must be implemented too.

What needs to happen

- An international treaty on the arms trade is urgently needed, and is being now being taken up by some governments. A key focus needs to be on campaigning against the weapons' producers in the developed countries named above. In developing countries civil society groups should monitor government spending on armaments.
- Donors should increase funding for effective interventions that break the cycle of violence (these currently receive less than 1% of the funds available for military intervention).

Chechnya destroyed. War has wide ranging implications for people's health (Heidi Bradner/Panos Pictures)

BOX 11

Health professionals' responses to war

Health professionals have a long record of responding to war and have been at the forefront of efforts to measure and mitigate its effects and in actively seeking to prevent its occurrence.

In 1985, for example, International Physicians for the Prevention of Nuclear War won the Nobel Peace Prize for dispelling the myth that nuclear war was survivable and for helping to build bridges between doctors and politicians on both sides of the Cold War.

Health researchers, as the *Watch* shows, have studied the effects of conflict around the world, identifying causes of violence and exposing the hidden costs of war, particularly for the livelihoods and health of ordinary people.

Recent work on the health effects of war in Iraq has been debated worldwide. WHO has also promoted greater understanding of the costs of war in its *World Report on Violence and Health*, including the need for improved efforts in health sector reconstruction after conflict.

What can health workers and campaigners do to promote peace?

- Demand and campaign for:
  WHO to take a leading role in promoting a global arms treaty – similar to their efforts on other health hazards such as tobacco.
- Call on WHO to follow up on its *World Report on Violence and Health* by focussing on actions that health sector agencies can take to promote conflict prevention.
- Join existing campaigns against small arms (http://www.iansa.org) and weapons of mass destruction (http://www.ippnw.org).
- Monitor government spending on arms production and arms sales.
- Encourage debate on and implementation of the recommendations of the Commission on Human Security (http//:www.humansecurity-chs.org)

In Najaf, Iraq, a child is carried across the street by his father on the outskirts of the city (Kael Alford/Panos Pictures)

A World Health Organization for the 21st Century

- The WHO has played a key role in some of the most important health initiatives of the last three decades
- But at the beginning of the 21st century it is underfunded and operating in a difficult and hostile environment
- Aside from more money and a more enabling environment, greater openness to civil society and internal management reform are necessary if WHO is to regain its position as leader in world health

WHO is an unrivalled source of objective, evidence-based health information and effectively performs global communicable disease surveillance and control. Over the last thirty years it has demonstrated its potential to be an agent for good, helping to devise a list of essential drugs, a code on breastmilk substitutes, a convention on tobacco and the Alma Ata Declaration.

However, starved of core resources due to UN budget cuts, WHO has proved no match for the World Bank which has exerted a greater influence on the public policy decisions that governments make, or the WTO which is able to influence the design and orientation of health care and food security systems through trade rules.

The proliferation of global health initiatives, many of which are unaccountable and strongly influenced by corporate 'partnerships', also undermine WHO's position and mandate. The lack of health leadership at the global level results in Ministries of Health being forced to operate in a circus of multiple and uncoordinated demands from global institutions, donor agencies and international NGOs.

WHO has been poorly led by its governance structures. The World Health Assembly and its Executive Board have weakened WHO's resolve to act as a 'global health conscience' and its mandate to address the social and economic determinants of ill health.

They have also allowed WHO to be part of the proliferation of narrow, technology-focussed disease based programmes;

WHO – up in the clouds? (P Virot/WHO)

failed to protect WHO from undue and inappropriate bilateral influence and political pressure; and ignored the need to ensure a revitalisation of WHO's internal management processes and staff morale.

A strong, effective and more publicly accountable WHO, able to respond to the major global health challenges of the day, is needed. Signs that WHO is returning to the values encapsulated in the Alma-Ata declaration are welcome; but the challenges in a world focussed on technological and market-driven solutions to health problems are great.

What needs to happen

Steering the global health ship

- Funding for WHO must be substantially increased, with more proportionately devoted to its core budget with fewer strings attached.
- The fragmentary nature of global health governance requires a greater clarity of roles and mandates. WHO's role should be strengthened at country level and include helping governments co-ordinate global, multilateral, bilateral and international NGO initiatives to improve health.
- WHO's record of acting as the world's health conscience should be revitalised, and governments should not be afraid of creating a rod for their own backs. History shows that change happens when governments and civil society work together under strong WHO leadership – even when it is uncomfortable for powerful interests (see box 12).
- A debate needs to be opened on WHO's key roles in the future to avoid mission-creep and to develop consensus within and beyond the organization.

An organization of the people not just of governments

- The democratization of the institutions of global governance is high on the political agenda. Today's complex global problems need increasingly wide representation, especially from civil society actors. WHO should not be exempt from the 'democracy wave'.
- The Civil Society Initiative at WHO should be expanded. Southern civil society organizations in particular need to be given a more direct voice. Care must be taken to differentiate public-interest organizations from those acting as a front for commercial interests.
- The politicised nature of the WHO leadership elections should be tempered: possible solutions include a wider franchise, perhaps of international public health experts and civil society organizations. Candidates should be required to publish a manifesto and debate their vision for the organization publicly.

Improving the Organization

- Radical changes are needed within the organization – a wider variety of health professionals, more social scientists, economists, pharmacists, lawyers, and public policy specialists, more representation from developing countries, stronger regional offices run by experienced professionals, and greater transparency and accountability leading to a more collaborative way of working.
- Proof of effective leadership and management should be a criterion for staff recruitment, especially at senior levels. There should be a special emphasis on learning from good practice and sharing ideas.
- Stronger capacity and independence of WHO personnel departments with better staff support, and more effective mechanisms which can eradicate corruption, nepotism and abuse of staff.

Health ministers gather for the 57th World Health Assembly (P Virot/WHO)

BOX 12

Working together to promote health

An estimated four million people die each year from a tobacco-related illness.

In 2001, the World Health Assembly called on WHO to monitor the global impact of tobacco, paving the way for the world's first public health treaty, unanimously adopted by the 192 WHA countries in 2003.

The resulting Framework Convention on Tobacco Control (FCTC) shows how the WHO, supported by national governments and civil society, can challenge a global threat to health – and win.

From the beginning, some governments – including from developing countries – pushed hard for effective measures to reverse the global tobacco epidemic and to hold the giant transnational tobacco companies to account.

More than 200 NGOs were involved in the formation of the treaty. These NGOs monitored and exposed tobacco industry abuses, created a media furore and raised public awareness.

This effective and powerful joint action has exposed the truth behind the corporate image of tobacco, reduced its political and economic influence and saved millions of lives.

Watching WHO

Health workers and campaigners can act to make WHO more effective and accountable. They can:

- Demand and campaign for:
  - governments to make greater financial contributions to WHO.
  - the proliferation of public-private partnerships be opened up to independent review and critical scrutiny.
  - WHO to be given the funds and mandate to perform the function of ensuring better coordination amongst donors and international health agencies within developing countries.
- Organize meetings with their health ministries to discuss the issues raised above in advance of the next World Health Assembly.
- Demand that WHO be given a stronger health protecting role and mandate in global and regional trade discussions and negotiations.
- Call on WHO to increase its engagement with civil society, through expanding the Civil Society Initiative at headquarters; ensuring that country and regional offices are conducting outreach; and revising its rules on interactions with non governmental organizations.
- Initiate local and regional Watches of WHO activities (WHO has country and regional offices).
- Initiate local and regional Watches of other relevant bodies such as the World Bank, International Monetary Fund and World Trade Organization.

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