

Civil Society Report on Commission of Social Determinants of Health¹

Introduction: Historic Mission before the Commission

A hundred and fifty years later we continue to be reminded of Virchow's comment: "***Do we not always find the diseases of the populace traceable to defects in society***"?² We continue to seek out "defects in society" that need to be remedied if Health is to be given its rightful place. Today, more so than ever before, we are reminded that, ultimately, politics played out at global scale, determines whether people live or die. Civil Society welcomes the opportunity provided by the Commission on Social Determinants of Health (CSDH) to explore these issues in detail. Civil Society has been consistent in arguing for an approach to Health that echoes Virchow's famous words.

The symptoms of the disease plaguing human society where diseases fester and health is just a word without substance, are too numerous and too well known. Let us, nonetheless, examine just one of them here. An estimated 30,000 children die every day, mainly from preventable and easily treatable causes.³ What is important is not just that so many children die unnecessarily, but also that they die in much larger numbers in certain regions of the world, and within regions in certain communities. We know that throughout the world, children (and other people) living in poverty become ill and die more frequently than those who enjoy a more privileged social status. What is particularly glaring is that the gap has broadened despite the fact that never before has the world had the wealth, knowledge, awareness, and concern for health issues that it has today. Thus, they die, not because we do not have the knowledge and the technology to prevent such deaths. They die because of the conditions in which they live. These conditions are determined by factors that are conventionally never addressed by medical science. For us, the CSDH represents an opportunity for us to collectively examine the factors responsible for a situation where there is a 16-fold difference in infant mortality between the 26 wealthiest nations and the 48 least developed countries.⁴ We welcome the Commission's vision of addressing those determinants of Health that are related to the situation in which people live and work. **We support the Commission's contention that it is largely futile to treat people and send them back to the same conditions, which were, in the first place, responsible for their illness.**

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

¹ This is an abridged version of the report submitted to the Commission on Social Determinants of Health, at the meeting of the Commission held in Vancouver between 7-9 June, 2007. It has been prepared based on inputs from CS Facilitators for the CSDH from Asia, Africa, Latin America, and the Eastern Mediterranean Region.

² Virchow R. 1848/1985. Collected essays on public health and epidemiology. Cambridge: Science History Publications.

³ Black R, Morris S, Bryce J. 2003. Where and why are 10 million children dying each year? *Lancet* 361:2226-34.

⁴ Guest G. ed. 2005. *Globalization, Health, and the Environment: An Integrated Perspective*. Lanham: Alta Mira Press

Health. Second, to examine the dominant cause of the failure and virtual abandonment of the vision presented in the Alma Ata Declaration and the Primary Health Care concept.

Primary Health Care Approach and the Ascent of Neoliberalism

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

The attack on the PHC concept was not accidental, neither did it arise in a set of fragmented policy prescriptions by multilateral agencies. The attack was ideological, globally orchestrated and globally co-ordinated. It found ideological legitimization in neoliberal economic theory and came to be known as globalisation, or to be more precise, neoliberal globalisation.

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

We would strongly suggest that the Commission must locate its work in an analysis of both the Primary Health Care approach and the role of neoliberal policies in deligitimising the approach. We welcome the approach proposed by the Commission in this regard when it states that “... *the neoliberal economic models that gained global ascendancy during the 1980s created obstacles to policy action on SDH*”.⁵

We also welcome the focus that the Commission has on addressing “inequity”. Addressing mere inequality is not enough, **because the extent of inequality in health cannot give us adequate information to assess health equity**⁶. By focusing on inequity, the Commission proposes an

⁵ Solar O, Irwin A. 2007. A Conceptual Framework for Action on the Social Determinants of Health, Draft Discussion paper for the Commission on Social Determinants of Health

⁶ Amartya Sen in: Anand S, Peter F, Sen A -- Eds. Public Health, Ethics and Equity. Oxford University Press, New Delhi

understanding of deeper structural factors that determine differential access to resources with deleterious health consequences. **We believe that the ultimate goal, is not merely to look for health policies that favour the poor. Rather we seek significant policies that directly address the social determinants of the inequitable distribution of resources. The Commission has a historic opportunity to advocate for equity and for the structural changes that will do away with the social, economic and political determinants of health.**

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

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

In order for Civil Society to play this role it is **imperative that it retains the right to formulate its own independent analysis of the Commission's work.** It is also important that Civil Society organisations drawn into the process do not feel that they are being "co-opted", i.e. they are being asked to implement or advocate for policies and processes in which they do not play a part in shaping.

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

A deeper understanding of Civil Society needs to take into account, not only its variegated nature but also the fact that Civil Society operates in a contested space. Our understanding of Civil Society is **contrary to the neo-liberal view which tends to look at Civil Society as a sanitised entity, stripped of its strong ideological, political and cultural roots.** We think it prudent to clarify that what we present in this document to the Commission is not the perspective of civil society. Nonetheless, we contend that this perspective is one that is widely shared across continents, and is one that has its roots in the historic role that Civil Society has played in shaping debates and policies on health, as well as on its Social Determinants.

Role of Civil Society in Health

Actions of civil society organizations and movements are also informed by different historical circumstances. The role of civil society has often been subservient to the dominant economic and political paradigm. CSOs have been used to replace the state or to encourage the market in

providing health services in many African, and Central Asian and Latin American countries⁷. At the same time, community and Civil Society resistance has always been prominent in challenging the dominant paradigm, i.e., the welfare state's historical dependence on the prescriptions of neo-liberal principles.

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

Most of these programs started as a humanitarian response to enormous unmet needs; they had a humanitarian rather than a political agenda. But institutionalized exploitation and routine violation of poor people's basic rights so clearly contributed to ill health and high death rates that many of these community-based programs were impelled to add strong sociopolitical components. The case of Nicaragua serves as an excellent example of how these "health" initiatives came to embrace a much larger canvas. Here, the people's quest for health became inseparable from their struggle against unjust social and political forces, both internal and external. The grassroots network of community-run health initiatives played a key role in the broad-based popular awakening and mobilization that eventually led to the overthrow of the oppressive Somoza regime. In Latin America, the seeds of a novel approach to health were also linked to an important event in its history: the Cuban Revolution.

These experiences, and the experience of numerous community-based initiatives in the developing world, promoted a revolutionary shift from the existing medical paradigm embraced by the Establishment to one with a strong community participation, with emphases on prevention and the prioritisation of rural areas. This literally meant turning the system upside down, from a top-down system to a bottom-up or bottom-centred approach. **As a culmination of this extremely rich process, in 1978, in Alma Ata, an unprecedented commitment was made by virtually all the governments in the world to actually locate health in an approach which put disease in its social context.**⁸

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

⁷ Brinkerhoff D, McEuen M (1999) New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan. Special Initiatives Report 19:1--29 . Cited By Lowenson 2003).

⁸ WHO/UNICEF. 1978. Declaration of Alma-Ata.
http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

People's Health Movement that evolved from it was a civil society effort to challenge health policy makers around the world with a Peoples Health Campaign for Health for All-Now!⁹

Factors Shaping Civil Society Action

The role of civil society has often been an adjunct to the dominant economic and political paradigm. CSOs have been used to replace the state or to encourage the market in providing health services in many African, and Central Asian and Latin American countries¹⁰. The promotion of market driven Health Care Systems has resulted in the disruption of solidarity between the middle social classes and the poor, the introduction of individual rights for those able to pay, targeted public assistance for the poor, and the use of NGO and civil society organization's activities as strategic instruments for a market driven health care system and its neo-liberal governance¹¹.

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

Very often, models of partnership in use assume that the state, civil society and markets share common interests. But do they? There is a tendency in the development community to question both the accuracy of knowledge generated by Civil Society, as well as the ability of Civil Society to be a source of credible research that can be relied upon. What cannot be denied today is that Civil Society has been instrumental in adding to the body of research and knowledge in many key areas. In settings where government data and information are virtually non-existent or extremely unreliable – as is the case for resource-poor settings in most developing countries – CSOs constitute the principal source of credible and current data and information. Globalisation and the discontent that has gone with its negative impacts has been instrumental in creating the conditions for the creation of several international civil society movements. The World Social Forum, the People's Health Movement, the Access Campaign on Medicines, the Anti-War Movement, are all examples of this.

A Rights Based Approach to Health

⁹ Narayan R. From Savar to Cuenca via Bangalore: A background paper by PHM Secretariat team for the PHM Transition / Strategy meeting in Frankfurt, 7-8 February 2006. www.phmovement.org

¹⁰ Brinkerhoff D, McEuen M (1999) New NGO partners for health sector reform in Central Asia: family group practice associations in Kazakhstan and Kyrgyzstan. Special Initiatives Report 19:1--29 . Cited By Lowenson 2003).

¹¹ Sen S.1999. Some aspects of state -- NGO relationships in India in the post- independence era. Development and Change 30:327--55

A rights based approach, as we understand it, requires taking sides and mobilising to force the retreat of human rights violation. This is very different from the early concept of human rights as individual rights and where the rights were sought to be located in a framework devoid of politics. For us, a rights based approach needs to recognise that structural causes, (a prominent example today would be neoliberal globalisation, but there can be many other like colonialism, structures of the state, etc.) determine the enjoyment or the violation of rights.

While advocating for particular rights, like in the case of the right to health, **we also recognise the need to locate such campaigns or struggles in the context of broader social mobilisation, one that transforms structural factors that give rise to human right violations in the first place.** We view rights as **rooted in social, economic and political structures and relations and put the analysis of rights violations in the broader context of power and social inequality.** While individual rights are important, for us, a rights-based approach is primarily about addressing rights at a societal level. We view the human rights framework **not as one that legitimises and helps maintain the status-quo, but one that questions the status-quo by pointing out how it is structurally violative of human rights.** Thus we strongly advocate that rights are realised by changing the prevailing power relations. Rights can and are conceived at various levels, but here we are specifically concerned about a set of rights that can be termed as “universal” or “global”. For the rights based approach to have sufficient ability to make an impact, there are certain globally accepted rights that need to be formulated, and which form the rallying point for mobilisations for the enjoyment of such rights.

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

The Committee on Economic, Social and Cultural Rights, which monitors the Covenant and issues General Comments has rightly recognised that the right to health is closely related to and dependent upon the realization of other rights, such as the rights to food, housing and freedom of movement. The Committee has also interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, expressly noting an adequate supply of food and nutrition, as well as access to safe and potable water and adequate sanitation as key determinants; in other words, they are determinative of the extent to which one can enjoy the best attainable standard of health.

We look upon the Commission as the appropriate medium for extending this analysis of the Committee. At present General Comment 14 of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000 is not a binding instrument¹². **We strongly urge the Commission to add its analytical weight towards recommending that Comment 14 is transformed into a binding commitment by signatories.** Further, the Commission needs to

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

recognise and articulate the impact of global factors that impinge upon the enjoyment of the right to health in all nations across the globe.

Empowerment for Health

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

Ultimately it is the people who wrest power and thereby empower themselves. This distinction is important for us as it demarcates a different territory from the position that it is possible to empower people or communities. In our view, thus, empowerment is a complex social and political process. In it resides the ability to change entire spectrum of power relations and to launch the processes required to change existing oppressive relations.

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

Civil Society’s Work with the CSDH

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

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

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

Civil Society Positions on Key Determinants

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

Globalisation

In the late 1970s, the global economy was overwhelmed by a crisis in which growth of production started slowing and rates of unemployment started growing alongside rises in the prices of commodities. These changes took place together with the collapse of the Soviet Union and the state controlled economies of the socialist world. They also led to a reshaping of the capitalist world, and led to complex changes that became the triad of globalisation, privatisation and liberalisation. They are also described, equally accurately, as corporate globalisation, or imperialist globalisation.

Economic policies that were now imposed by the developed countries, called "neoliberal" policies, reflected an ideological commitment towards market principles, ignoring the remarkable role that the government had played even in the advanced capitalist countries. These policies and processes increased the indebtedness of Third World countries that they were supposed to reduce by increasing the rate of exploitation of wage workers across the globe. This also shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid and insecure forms of employment. Resultant funding cuts in education and health also meant that already weak and under-funded systems of health, education and food security collapsed.

Laying down the fundamental prescriptions of neoliberal economic theory in the health sector, the World Bank document titled "Financing Health Services in Developing countries"¹³ made the following recommendations for developing countries.

- 1) Increase the amounts paid by patients for health care.
- 2) Develop private health insurance mechanisms (this requires a dismantling of state-supported health services since, if free or low cost health care is available, there is little interest in private insurance).
- 3) Expand the participation of the private sector.
- 4) Decentralise government health care services (not a real decentralisation but an euphemism for the "rolling back" of the state's responsibility and passing on the burden to local communities).

The implementation of these policies resulted in dramatic reversals of health gains made after the Second World War. Reversals took place in other sectors as well, with clear impact on health.

Different portions of the World Trade Organisation agreement, signed in 1994, have also had an impact on the health sector. Some of the important agreements under the WTO have had negative effects on health.

¹³ World Bank. 1987. Financing health services in developing countries: An agenda for reform. Washington DC: World Bank.

As the service sectors of the economy of developed countries grew, trade in various types of services was exported. Multinational Corporations started lobbying for new trading rules that would expand their share of the global market in services -- as governments everywhere spend a considerable amount of their budget on social services¹⁴. This is what the General Agreement on Trade in Services (GATS) under the WTO is targeting to do today. GATS covers some 160 separate sectors, including health.

The WTO agreement on Patents (called the Trade Related Intellectual Property Rights - TRIPS) sanctifies monopoly rent incomes by pharmaceutical corporations. The TRIPS agreement required all countries to change over to a strong patent protection regime -- a regime that no longer allows countries have domestic laws that enable domestic companies to manufacture new drugs invented elsewhere, at prices that are anything between one twentieth and one hundredth of their global price. The TRIPS agreement has placed enormous power in the hands of MNCs, by virtue of the monopoly that they have over knowledge (including the power to decide which medicines will be developed).

The present phase of globalisation also has grave consequences for food security, which is an integral part of good health. The Agreement on Agriculture (AoA), under WTO, has further skewed the balance against developing countries. The AoA ensures that subsidies provided to domestic agriculture by developing countries are phased out while those being provided by developed countries are retained. This has resulted in exports of primary commodities by developing countries becoming uncompetitive while their domestic markets are being flooded by subsidized imports from developed countries.

Health Systems and Approaches to Health Care

Health care systems need to be adequately financed and be able to use the services of trained manpower. It has been estimated that low and lower middle-income countries need to spend at least US\$30–40 (2002 prices)¹⁵ per person each year if they are to provide their populations with essential health care. This is over five times the average government health spending of the least developed countries and about three times that of other low-income countries.

The impact of the transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor. **Global evidence suggests that the introduction of user fees is deterring more and more people from accessing the public health system.**¹⁶ Going hand in hand with the levying of user fees is the global trend to segment health care into public health care for the poor and private health care for the rich. An expansion of the private sector also draws away resources from the public system in different ways. The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in developing countries. In middle and high income countries, the private sector takes many forms – ranging from not-for-profit charitable institutions to large corporate run institutions.

Ultimately, this kind of behaviour **converts health into a purchasable commodity in the market – with only those who can afford the costs being able to access it. This trend is**

¹⁴ Hilary J. 2001. The wrong model: GATS, trade liberalisation and children's right to health. London, Save the Children

¹⁵ Commission on Macroeconomics and Health. 2001. Macroeconomics and Health: Investing in Health for Economic Development. Geneva, WHO.

¹⁶ Whitehead M, Dahlgren G, Evans T. 2001. Equity and health sector reforms: can lowincome countries escape the medical poverty trap? Lancet 358:833–36

backed by the medical-industrial complex and pharmaceutical companies. In many countries, the approach has disrupted the development of a comprehensive health system, because of the promotion of multiple programmes that had very few elements of integration. Selective health care, we would recall, was introduced on the grounds that important interventions cannot wait for the setting up of a basic health care infrastructure. However, experience suggests that when selective interventions are promoted, rarely are there simultaneous efforts to put in place a comprehensive infrastructure.

Finally, it needs to be remembered that the success stories of health systems development – viz. Sri Lanka, Costa Rica, Cuba – are success stories of public sector health systems.

Gender Dimensions of Health

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

The UN International Conference on Population and Development, held in Cairo in 1994 marked a change in approach to Sexual and Reproductive Health¹⁷. The Cairo Conference shifted focus away from the earlier approach, which was techno-centric and obsessed with controlling population through the delivery of a set of services. The Cairo Conference proposed a rights-based framework for population stabilization, discrediting the old population control programmes¹⁸. Despite some advances, a ten-year review showed that the programme charted was still far from being implemented. Much of the reason for this gap in implementation lies in global economic factors that have a negative impact on the vulnerable and the marginalized -- and women are often the first victims. In the name of “morality” fundamentalist tendencies are eroding the emerging consensus reached in Cairo. The US has been the global leader in pursuing this agenda, as exemplified by the US Government prohibiting overseas NGOs from receiving US government aid if they promote or provide referrals for abortion¹⁹. Given this emerging understanding, women’s movements have started linking their demands on health and reproductive rights to issues of trade, globalization and fundamentalism. The links between neoliberal globalization and fundamentalism are becoming clear, with both joining forces to deny women the right to livelihoods, economic security and control over their lives and bodies.

Employment Conditions

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

¹⁷ UNICPD. 1994. Programme of action of the UN International Conference on Population and Development

¹⁸ The Corner House and WGNRR. 2004. A decade after Cairo: women’s health in a free market economy. Corner House Briefing, 31 June.

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

Moreover, with a majority of the workforce engaged in agriculture, the welfare model of employment never was a prominent feature in the world's poorest countries. However, democratic aspirations in the post-colonial era in developing countries did give rise to some improvements in employment conditions, clearly traceable to the improved bargaining capacity of labour.

While vastly different in actual achievements, it still is a fact that there was a discernible improvement in employment conditions in most parts of the world till the 1970s. A radical break is seen in the 1970s with the economic crisis in the developed world and the rise of neoliberal policies. Specifically, it led to a reversal of much of the gains that labour had made in the past decades. Unemployment increased in most parts of the world, secure tenures of employment were replaced by "labour market flexibility" where large parts of a the workforce who were in a secure employment environment suddenly found themselves in insecure or "precarious" forms of employment – in the informal sector, as contract workers, etc.²⁰.

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

War and Militarisation

War accounts for more deaths and disability than many major diseases; war destroys families, communities, and sometimes entire nations and cultures; it diverts limited resources from health and other human services and damages the infrastructure that supports them; and it blatantly violates human rights. The mindset of war – that violence is the best way to resolve conflicts – contributes to depression, domestic violence, street crime, and many other kinds of violence. War also damages the environment. In sum, it threatens not only health, but also the very fabric of our civilization²¹.

The health-supporting infrastructure, which in many countries is in poor condition before a war begins, often gets destroyed – including health-care facilities, electricity-generating plants, food-supply systems, water-treatment and sanitation facilities, and transport and communication systems. The 2003 attack on Iraq led by the US and the UK devastated much of its infrastructure, leading again to numerous civilian deaths²².

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

Further, war and the preparation for war divert huge resources from health and human services and other productive societal endeavours. War often creates a vicious circle of violence, increasing domestic and community violence in the countries engaged in war. War and the

²⁰ See for example: International Labour Organization. 2004. Definitions: What we mean when we say 'economic security', Socio-Economic Security Programme fact sheet. Geneva, ILO

²¹ Levy BS, Sidel VW. 1997. War and Public Health. New York, Oxford University Press.

²² Medact. 2004. Enduring effects of war: health in Iraq 2004. London, Medact.

preparations for war have profound impacts on the environment. Overall, war takes an increasing toll on civilians, both by direct attack on them or by ‘collateral damage’ caused by weapons directed at military targets. During some wars in the 1990s, approximately 90% of the people killed were noncombatants²³.

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

Food Security and Nutrition

Undernutrition is by far the most important single underlying cause of illness and death globally, accounting for 12% of all deaths²⁴. Every day, 799 million people in developing countries – about 18% of the world’s population – go hungry. In South Asia, one person in four goes hungry, and in Sub-Saharan Africa the share is as high as one in three. There were reductions in the number of chronically hungry people in the first half of the 1990s, but the number increased by over 18 million between 1995 and 1997. The global value of trading in food grew from US\$ 224 billion in 1972 to US\$ 438 billion in 1998. The globalization of food systems is nothing new, but the current pace and scale of change are unprecedented. Food now constitutes 11% of global trade in terms of value, a higher percentage than fuel²⁵. The overproduction of food, supported by massive subsidies in the US and in Europe in particular, has led to the ‘dumping’ of food on developing countries.

The story is similar in nearly all developing countries. For example, the average Indian family of four reduced its consumption of food grains by 76 kg between 1998 and 2003 – to levels last seen just after Independence²⁶. This dramatic fall can be traced to the collapse in rural employment and incomes resulting from liberalization of the agricultural sector.

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

²³ Garfield RM, Neugut AI. 2000. The human consequences of war. In: BS Levy,

²⁴ Pelletier D, et al. 1995. The effects of malnutrition on child mortality in developing countries. *Bulletin of the World Health Organization*, 73:443–8.

²⁵ Pinstруп-Andersen P, Babinard J. 2001. Globalisation and human nutrition: Opportunities and risks for the poor in developing countries. *African Journal of Food and Nutritional Sciences*, 1:9–18.

²⁶ Patnaik U. 2004. External trade, domestic employment and food security: Recent outcomes of trade liberalisation and neo-liberal economic reforms in India. at: International Workshop on Policies against Hunger III. Berlin, German Federal Ministry of Consumer Protection, Food and Agriculture, 20–22 October.

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

Urbanisation, urban settings and health equity

The world is becoming increasingly urbanized and poverty is also becoming an increasingly urban phenomenon. In 2007, more people live in urban centres than in rural areas. According to recent projections, the world's urban population will increase from 2.86 billion to 4.98 billion by 2030, when about 60 per cent of the world's population will live in urban settings. Poverty is growing and living conditions are deteriorating in *all* cities²⁷. However, in low and middle-income countries the population living in densely populated, informal settlements ("slums") is likely to double in less than 30 years²⁸.

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

Urban services and infrastructure have not kept pace with rapid urbanisation and an increasing proportion of the people in urban areas will live without adequate social infrastructures, especially housing, water supply, drainage and sanitation facilities. While still exposed to the traditional health hazards related to poverty, unemployment, malnutrition, poor shelter and inadequate environmental and social services, the urban poor are also more exposed to hazards related to "modernization" such as pollution - while the lack of social support systems in cities and social exclusion increases the risk of mental health problems. Cities also concentrate resources and wealth and social exclusion in this context is particularly felt. In Cape Town, for example, rapidly growing townships where children die of preventable diseases as diarrhea are located near to exclusive beaches and tourist centres, while in many cities expensive shopping malls arise next to informal settlements where people lack even basic sanitation.

Conclusions

Principals that this report embodies

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

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

²⁷ UN Habitat. 2004

²⁸ UN Millennium Project 2005. UN-Habitat 2003

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

More 150 years ago, Virchow, the father of public health, said that health is politics on a large scale. We too believe that the attainment of health can only take place if the necessary political will is mustered -- and it is only through political action on the part of the masses and global decision makers that these issues can be addressed. **The attainment of the above goals cannot be achieved without policies that aim, in the end, to reverse the policies that reproduce the neoliberal framework.**

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

Specific recommendations

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

- Clearly declare that health is not a commodity to be purchased in the marketplace and neither is it an item that should be traded.
- Promote physical and economic access to health care and to medicines by suggesting changes in the present framework on global trade. Specifically, suggest that the TRIPS Agreement and the General Agreement on Trade in Services keep matters related to health – including medicines and health services – out of its purview.
- Call for the reversal of unequal terms of trade embodied in the WTO.
- Encourage countries to selectively delink from the global economy , especially from global financial markets, when required, in order to secure the interests of the poor and the marginalized.
- Promote real debt cancellation and not just transfers from one account to another to reverse the unacceptable situation where the world’s poorest countries still pay back more than what they receive
- Promote a system of agriculture that places food security and food sovereignty of the poorest nations at its core.
- Promote a global consensus that reverses the trend towards non-secure and casual forms of employment.
- Promote a global consensus so that country Governments adopt laws that prevent all forms of violence against women.
- Suggest concrete measures to address climate change and environmental degradation and their effects on the equity gap.
- Ensure protection of populations, health workers, and infrastructure in situations of conflict and war.
- Secure for the WHO, once again, the leading role at the global level in health policy making.

- Most importantly, recognize that structural changes in the world's political and economic architecture are necessary in order to make a meaningful difference in current health inequities.

The report that we present to the Commission suggests that things can change for the better. The Cuban and the Brazilian case studies in the report show that health systems can be made to work for the people, if premised on the principles of comprehensive care that is accessible to all, irrespective of the capacity to pay. The examples of the Literacy Campaign in India and the growing global Right to Health campaign are but two examples of the power of Civil Society to change situations. The case studies from Africa on Female Genital Mutilation and Rape as an instrument of hegemony, and the case studies from the Eastern Mediterranean on the brutal side of conflict are reminders from Civil Society about the magnitude of change that needs to be brought about. We do hope that the Commission shall prove to be equal to the enormous task it has set for itself.

A Global Movement for an Idea Whose Time Has Come

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

We realise that the final product from the Commission will be a “negotiated” document. But we would also like to underline that if it is negotiated to please everybody, it will please nobody or say nothing. There is a very large constituency waiting to embrace a report that clearly defines the root causes of health equity. Today a majority of countries and communities (the poor and the disadvantaged, comprising the majority of the globe's population) are starting to say “enough is enough”. The manufactured global compact built by neoliberal ideology and promoted by some rich nations and multilateral agencies is starting to come apart

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