

Introduction

Origins

The *Global Health Watch* comes out of one of the largest ever civil society mobilizations in health. Its roots lie in the influential and lasting campaigns of the 1970s and 1980s when activists across the world challenged the global health divide between North and South and rich and poor. They formulated practical proposals for change and influenced the content of the ground-breaking 1978 Alma Ata Declaration. Community-based health care, the essential drugs list and controls on the marketing of infant formula are just some of the results of this advocacy, which has changed the lives of millions of people for the better.

During the 1990s, many activists came together again to take up more of the continually emerging challenges in global health – and to tackle some of the most intransigent ones such as poverty and inequality. A People’s Health Assembly, held in Savar, Bangladesh, in December 2000, was the first step towards launching a global social movement to attain the aim written into the Constitution of the World Health Organization (WHO): ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition’.

Some 1500 people from 75 nations attended the People’s Health Assembly and collectively drew up and endorsed a People’s Health Charter. The Charter is a call for action on the root causes of ill-health and many people’s lack of access to essential health care, and set the agenda for the People’s Health Movement that emerged out of the Assembly.

This first edition of the *Global Health Watch* takes up the Charter’s call for action and suggests ways in which the global movement of people concerned with health can take its principles forward. In the process, it has brought together health activists, health professionals and academics from around the world to put together an alternative world health report. It is aimed primarily at all those around the world who work in health care or for health and who represent an important section of civil society. They usually have a certain standing in society that enables them to be influential in promoting action on global health.

But aren’t there enough world health and development reports already? The

World Health Report, produced by the WHO; the *Human Development Report* compiled by the United Nations Development Programme; an annual report produced by UNAIDS; the annual State of the World's Children produced by UNICEF; and the *World Development Report* issued by the World Bank every year. The *Global Health Watch* is different, however. The paragraphs below outline how and why health workers from all over the world have expressed a need for such a report.

The politics of health

The co-existence of wealth and widespread, severe poverty suggests that the latter can be avoided. The cost of achieving and maintaining universal access to basic education, basic health care, adequate food, and safe water and sanitation for all has been estimated at less than 4% of the combined wealth of the 225 richest people in the world (UNDP 1998: 30). In many countries in which hunger is prevalent, there is enough productive land to feed their populations many times over. Alternative social, political and economic arrangements at a national and global level could change this stark reality.

The *Watch* therefore sets out an explicitly political understanding of the current state of health around the world. This is nothing new – public health has been recognized as a political concern for many years. As the famous nineteenth century German pathologist, Rudolf Virchow, explained, ‘medicine is a social science, and politics is nothing more than medicine practised on a larger stage’.

UNICEF has devised a conceptual model for explaining child morbidity and mortality. It states that, amongst other factors, the political, social and economic systems that determine how resources are used and controlled need to be considered so as to determine the number and distribution of children who do not have sufficient access to food, child care, clean water, sanitation and health services (Figure Intro.1).

The UNICEF model is applicable to other aspects of health (for example, AIDS and maternal health) and echoes the analytical approach used by the *Watch* to highlight how the distribution of power, political influence and economic resources shapes the pattern of health globally.

Poverty and development as a public health issue

Poverty is the biggest epidemic that the global public health community faces. It underlies most cases of under-nutrition, fuels the spread of many diseases and deepens vulnerability to the effects of illness and trauma. Poor countries are unable to give their health and social services adequate resour-

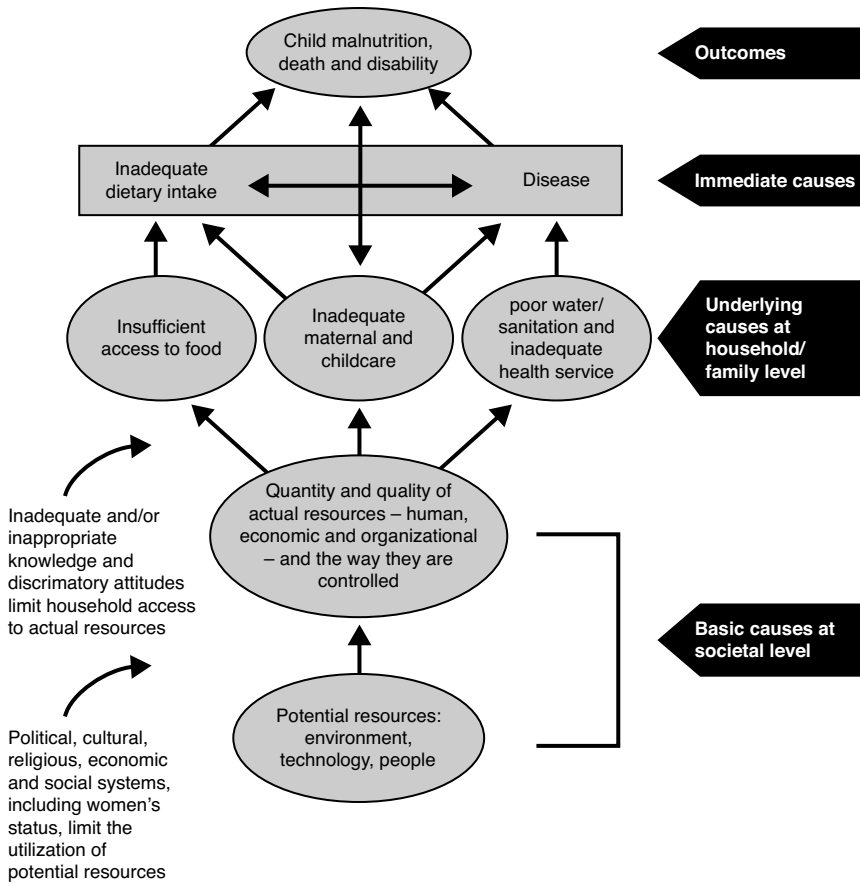


Figure Intro.1 Immediate and underlying causes of child mortality and morbidity (Source: Unicef 1998)

ces, resulting in a poverty of health systems that compounds poverty at the household and community levels.

The challenge of improving global health is therefore inextricably linked to the challenge of addressing widespread and growing poverty. According to the official statistics of the World Bank, the number of very poor people has increased by 10.4 percent between 1987 and 2001 to 2735 million – almost half the world’s population (Chen and Ravallion 2004). Furthermore, there is reason to believe that the World Bank’s methodology for measuring poverty is flawed and underestimates the true breadth and depth of poverty worldwide (Reddy and Pogge 2006). The extent of poverty demands that tackling it is at the centre of health programmes and health policy analysis, and that understanding its causes and engaging with the political and economic reforms is essential to abolishing it.

Health workers engage with the health effects of illiteracy; the lack of access to clean water and sanitation; hunger and food insecurity; the degradation of the environment; and militarism and conflict. These public health issues highlight the common challenges shared by health workers, teachers, engineers, geographers, farmers and biologists, to name just a few professions in fulfilling the universal right to health and dignity. The *Watch* aims to promote health as a theme that can bring together different sectors of civil society around a common agenda for human development and social justice.

Inequity

Increasing levels of poverty have been accompanied by growing inequality. The income gap between the fifth of the world's people living in the richest countries and the fifth of the poorest was 74 to 1 in 1997, up from 60 to 1 in 1990, 30 to 1 in 1960, and 11 to 1 in 1913. The world's 200 richest people more than doubled their net worth in the four years to 1998 to more than \$1 trillion. The assets of the top three billionaires are worth more than the combined GNP of all least developed countries and their 600 million people (UNDP 1999).

Although inequality is commonly described in terms of differences between rich and poor countries, one fifth of the richest people in the world come from developing countries (Navarro 2004). Similarly, poverty and widening disparities are not confined to poor countries – inequalities have risen in wealthy nations over the past two decades.

An 'equity lens' is important because political and economic institutions are shaped in ways that can reinforce unfair advantages and widen socio-economic disparities. International trade rules and regulations are stacked in favour of richer countries and multinational corporations; debt cancellation is given at the whim of rich nation creditors rather than as a response to the pressing needs of citizens of poorer countries. The conditionalities imposed upon poor governments by the World Bank and International Monetary Fund (IMF) are undemocratic and have included the privatization of public assets, thereby undermining public education and health care systems, and eroding social safety nets.

The *Watch* therefore emphasizes not just poverty, but also the relationship between rich and poor, between the powerful and the marginalized. Improving the situation of the world's poor cannot be achieved through aid or charity alone; profoundly unequal power relationships need to be tackled first and foremost. Health professionals can influence many of the decisions that will lead to a fairer distribution of wealth.

Human rights and responsibilities

Article 25.1 of the Universal Declaration of Human Rights states that ‘everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services’. Article 12.1 of the International Covenant on Economic, Social and Cultural Rights recognizes the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.

Such declarations are a reminder that human rights encompass more than political and civil liberty human rights; they also incorporate social, economic and cultural rights. Universal human rights are not limited to a vote, free speech and freedom from oppression, but include a right to household food security, essential health care and other requirements that underpin human dignity.

Human rights discourse is often centred on the duties of states and governments. Violations committed against people by governments, under the guise of officialdom and the law, or with the complicity of the state, are rightly condemned because they not only deprive people of the objects of their rights (such as food and essential health care), but also attack and subvert the very notion of rights and justice. There is in addition an acceptance that governments are in breach of their duty if they fail to ensure in a reasonable manner the progressive realization of human rights through the use of resources under their control. Governments that allow corruption and fraud, for example, or inappropriate public expenditure on armaments when large sections of the population lack access to the basic means of survival and dignity, are committing human rights violations.

However, a moral conception of human rights implies that social, political and economic institutions must also be held to account. This is enshrined in Article 28 of the Universal Declaration of Human Rights, which states that ‘everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized’.

For example, while a legal right to adequate food is important, and while governments are obliged to ensure the progressive realization of this right, political and economic arrangements that determine how food is produced, controlled and sold may be as important, if not more so, in determining whether this right is fulfilled. Such arrangements might include historically unjust patterns of land ownership; the control of food production systems that leads to monopolies; the speculative hoarding of basic staple foods and excessively high food prices; or the dumping of heavily subsidized produce from rich countries onto poor ones in a way that decimates local agriculture and subsistence economies.

These examples suggest that even if governments do all they can, social, economic and political arrangements that keep people living below the poverty line when there are reasonable alternative arrangements should be considered violations of human rights, even if these arrangements are legal. This implies obligations not just on governments but also upon citizens and non-government actors to re-shape political and economic arrangements to ensure the fulfilment of rights.

Given global integration, governments, corporate actors and civil society have transnational duties and responsibilities towards the fulfilment of universal human rights. At present, the emphasis in human rights discourse is on the responsibilities of governments towards their own citizens. Transnational responsibilities for the fulfilment of human rights tend to be limited to avoiding or preventing direct violations of the civil liberties of citizens of another country, or merely invoke a weak humanitarian response to help out with aid and other forms of assistance. Economic cooperation with corrupt and undemocratic governments is not considered a human rights transgression, nor is the maintenance of trade rules that perpetuate or deepen severe poverty.

In sum, the *Watch* embodies a human rights perspective that emphasizes social and economic rights; identifies political and economic institutions, including the manner in which economic relationships are organized and structured, as being beholden to human rights declarations; and calls for a greater recognition of transnational responsibilities towards the fulfilment of human rights.

Mobilizing civil society and holding institutions to account

In light of the evidence that social, political and economic arrangements are failing to address the current state of ill-health, poverty and inequity adequately, a stronger mobilization of civil society committed to the fulfilment of human rights is needed. The *Global Health Watch* is explicitly linked to many civil society struggles for health and justice. Many of the individuals, networks and NGOs associated with this report participate in civil society mobilization, lobbying efforts, policy advocacy and development work on the ground. The *Watch* draws on their experiences and offers credible analysis to strengthen their work.

Part of the aim of this alternative world health report, therefore, is to present an analysis of the performance and effect of key institutions that have a responsibility for promoting global health. Health and development reports produced, for example, by the WHO, UNAIDS and the World Bank tend not to include themselves in the analysis of factors that are promoting or negatively

impacting on health. The *Watch* hopes to fill this gap and provide another means of strengthening civil society's ability to engage with the determinants of ill health.

Overview of the *Global Health Watch*

The report is divided into six sections. Part A looks at how political and economic change at the global level influences people's health and well-being worldwide, noting how little control individuals have over these changes. It points to solutions for redressing global imbalances and shows how few of the promises made to developing countries in past years have been kept.

Part B carves out an agenda for the public sector's role in health, with a special focus on low- and middle-income countries. Its first chapter asserts that the Primary Health Care Approach adopted by the world's health ministers in the late 1970s is still relevant today, but that the public sector role in health is under threat, and that commercialization of health care has proceeded apace in the last two decades to the detriment of health. It points to the limitations of current efforts to address health priorities through selective health care interventions and pro-poor targeting. The chapter argues for a greater commitment to universal health care systems and for renewed investment in the public sector. Subsequent chapters on medicines and gene technology take up the theme of commercialization and suggest ways in which the public sector role can be strengthened. Other chapters explore two controversial issues – health worker migration in low-income countries that are short of health personnel; and the political struggle over sexual and reproductive rights, including analysis of how health care is connected to broader debates about poverty, politics and gender injustice.

Part C tackles the needs of two particular groups of people whose rights to health are frequently violated – Indigenous peoples and people with disabilities. These chapters describe their struggles for rights and outline what is needed to strengthen their claims on health and health care over the coming years.

Part D returns to the broader picture of health. The Primary Health Care Approach emphasized intersectoral action in health, recognizing that the determinants of health often lie outside the health care sector. Five chapters on education, war, environment, water and food security reveal the widespread threats to health in a diverse range of areas and circumstances, but also point to the potential for synergistic actions by governments and civil society actors that could improve livelihoods in several dimensions.

Part E scrutinizes the conduct of global institutions such as WHO, UNICEF

and the World Bank, and assesses the international actions of richer nations and big business. The analysis points to the need to redress imbalances of power at the international level; for richer nations to fulfil their promises on resource transfers to the developing world; for tighter regulation of powerful multinationals; and for better management of international institutions.

Part F concludes the *Global Health Watch* by drawing all the chapters together and making some general recommendations and possibilities for concerted action by civil society organizations.

What readers of the Watch can do

A central aim of the *Watch* is to strengthen existing campaigns and social movements by providing an alternative analysis of global health. The report also includes a number of demands that we make of governments, UN agencies and other actors. We hope that health professional associations and networks will become a more prominent voice in existing campaigns and movements to achieve a healthier and fairer world.

We encourage you to spread the word about the *Watch* widely. It is freely available on the web and on CD from the three co-ordinating organizations: People's Health Movement, the Global Equity Gauge Alliance and Medact. To comment on anything in this volume or make suggestions for the next *Global Health Watch* in 2007–8, please contact any of the co-ordinating organizations at ghw@hst.org.za.

Further information

People's Health Movement (www.phmovement.org)

Global Equity Gauge Alliance (www.gega.org.za)

Medact (www.medact.org)

References

- Chen S and Ravallion M (2004). How have the world's poorest fared since the early 1980s? *World Bank Research Observer*, 19: 141–69 (<http://wbpro.oupjournals.org/cgi/content/abstract/19/2/141>, accessed 12 May 2005).
- Navarro V (2004). The World Health Situation. *International Journal of Health Services*, 34;1: 1–10.
- Pogge T (2002). *World Poverty and Human Rights*. Cambridge, Polity Press.
- Reddy S and Pogge T (2006). How not to count the poor. In: Anand S and Stiglitz J (eds.), *Measuring Global Poverty*. Oxford, OUP.
- Unicef (1998). *The State of the World's Children 1998*. New York, Unicef.
- UNDP (1998). *Human Development Report 1998*. Oxford, OUP.
- UNDP (1999). *Human Development Report 1999*. Oxford, OUP.