People's Health Movement

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Health for ALL NOW!!

OPEN LETTER TO THE DISTINGUISHED DELEGATES OF THE 52ND DIRECTING COUNCIL/65TH SESSION OF THE REGIONAL COMMITTEE OF THE WHO

Distinguished delegates,

On behalf of the People's Health Movement we submit the comments and suggestions included below regarding some of the items appearing on the agenda of the 52nd Directing Council of PAHO/65th Meeting of the Regional Committee of WHO for the Americas. We hope that you may find time to read and consider these comments before the relevant discussions at the WHA. We hope that you find our input useful.

PHM is a global network of organizations working locally, nationally and globally for "Health for All". Our basic platform is articulated in the People's Charter for Health which was adopted at the first People's Health Assembly in December 2000. More information about PHM can be found at www.phmovement.org. PHM's activity at this convening of PAHO member states is part of its Democratising Global Health program.

The following commentary was developed in response to issues that PHM country circles in Latin America and North America viewed as particularly important in the region. We invite you to review the commentary and hope that it will further inform your position and work in these areas.

Members of the PHM group will be attending and following the discussion at the meeting this week. We would be very interested to discuss these comments with you.

Please don't hesitate to contact us at paho-watch@phmovement.org

Warm regards,
PHM-North America
PHM-Latin America
PHM-Brazil

PHM COMMENTS ON AGENDA ITEMS OF THE 52ND DIRECTING COUNCIL

Commentary on Agenda Item 4.3 Social Protection in Health
Supporting documents: Concept Paper CD52/5, Resolution CE152.R4

PHM welcomes the concept paper and the resolution about Social Protection in Health and offers the following observations.

The mention of **Universal Health Coverage** is a positive event (Para 9 and 14 in the concept paper; item 3.c in the proposed resolution). Universality is a fundamental element of a public health system to reach the goal of Health For All. However, different concepts of Universal Health Coverage are being used, often without clear distinction. In this document, the concept is not clear and is left open for different interpretations. PHM would like to make clear that we understand Universal Health Coverage as Universal Health Systems that provide coverage of comprehensive and high quality services for all, without economic barriers. This concept emphasizes the public (and not private), rights-based (and not market-based) and comprehensive (and not focalized) nature of Universal Health Systems, which by no means should be envisaged as an extension of private insurance schemes (where services are provided according to people's income and power). PHM also stresses the importance of primary health care and social determinants of health, as mentioned in the concept paper and resolution, as a base for strong and sustainable Universal Health Systems. Universal Health Coverage implies a strong government role, and interpretations of Universal Health Coverage as health insurance schemes that would fund a limited package of services, with States playing a minimal role, are not appropriate according to our view. In this sense, Universal Health Coverage should be understood as a way to ensure the right to health and should, under this concept, be integrated into a wider social protection framework–providing high quality health care to all, based on people's needs (not on income) and with strong focus on primary health care and social determinants of health.

For all that has been stated above, it is never too much to emphasize that Universal Health Systems need appropriate funding from the State. Universal coverage will not be a reality without funds, and PHM stresses that funding for health systems should be public. As an example, in Brazil, the national civil society initiative "Health + 10" is demanding that 10% of the GDP be invested in public health, which is more than twice the current expenditure.

There is a direct contradiction between decent social protection and globally promoted neoliberal policies which (a) drive widening inequality (and weakening solidarity); (b) drive 'tax competition' (an auction run by the TNCs to encourage a race to the bottom in terms of taxation levels); (c) protect tax evasion and capital flight. Health ministers must add their voice to the global movement for alternative economic policies as a condition for real social protection in health.

We welcome the emphasis put on **conditional cash transfer programs** (Para 19 and 20 in the concept paper; items 2.d and 3.b in the proposed resolution), as we understand this is a valuable strategy to reduce poverty. However, it is important to outline that conditional

cash transfer programs should not hinder more structural initiatives to redistribute wealth, especially in countries with prominent social inequalities, which create a system of social exclusion that is not only determined by income. More structural initiatives of the State to tackle social inequalities include transforming taxing systems, subsidies and trade conditions, and land reform. The redistributive role of the State should therefore be outlined and there should be legitimate spaces for participation of the people in decision making in order to change the scenery of naturalized social inequalities and exclusion.
We emphasize that the pillar to guarantee health for all is based on universal access policies. Thus, we reject the use of or intention of creating health sub-markets (like those of private insurance schemes) funded by cash transfers. We see cash transfers as a mechanism for social inclusion but never as a way to access sub-markets of health, which would mean violation of the fundamental right to health.

Finally, we believe that conditionalities of cash transfer programs should be forcibly linked to public policies aiming to break the poverty cycles, favoring a complete social inclusion linked to education enrolment, productive inclusion and health care attendance. PHM opposes the creation of basic service packages specifically for the beneficiaries of these programs, as quoted on para 20 of the concept paper, considering the lack of equity in this measure, as it would generate a parallel low-quality health system for the "ultra-poor".

Commentary on Agenda Item 4.6 52/8: Chronic Kidney Disease in Agricultural Communities in Central America
Supporting documents: Concept Paper 52/8, Resolution CE152.R14

PHM commends PAHO for the high level of attention it is giving to Chronic Kidney Disease by addressing it at this Directing Council meeting, agenda Item 4.6 Chronic Kidney Disease in Central America. The intersectoral and cross national work that has been done until now to address the causes and social effects of the disease is a good step in the right direction. Notably, Document 52/8 notes the disparate impact of CKD, as research has demonstrated, on impoverished workers (p. 3, para 8) and acknowledging that "the exercise of the right to health can be claimed even in situations of poverty and high burden of disease". (p. 6, para 15(3)) Further, document 52/8 calls for sensitization of civil society to this public health issue so that affected communities "can participate actively in the prevention and control of the disease." (p. 6, para 15(i)).

PHM welcomes these proposals in document 52/8 in addition to the recommended actions in the Proposed Resolution, urging, among other actions, that Member States support the Declaration of San Salvador. However, we also call for further action.

Extensive research from the Ministry of Health in El Salvador, as well as similar cases in Sri Lanka, (para. 12) has demonstrated that CKD is a result of exposure to agrochemicals. Document 52/8 acknowledges this finding, however it characterizes exposure to agrochemicals as only one *main* factor among many other *main* factors causing CKD, which it calls a "multifactorial disease". Further, countries that have denounced continued use of agrochemicals have been met with heavy opposition and even ridicule from corporations,

governments and international bodies who have political and financial interest in the continued use of these chemicals in agriculture.

The many communities of Central America affected by this disease are especially vulnerable to violations of their right to health driven by political and financial gain of a few. PHM stands with El Salvador and other nations and calls on PAHO to place more emphasis on the causal relationship between agrochemicals and CKD—through education as well as supporting further research. Additionally, PHM urges member states' support of the *Director* in developing the capacity of the public health systems in affected areas to meet the challenge of this growing problem.

There are stark precedents regarding corporate suppression of research and corporate support of fraudulent research in the fields of tobacco, asbestos and global warming. PHM denounces and calls on PAHO and member states to denounce this and other research whose particular aim has been to distort and falsify findings making the connection between agrochemicals and CKD. Corporations have funded much of this research—mining, pharmaceutical, agricultural—in order to further their financial interests at the expense of people's lives. PAHO should not accept such research, conducted in isolation, and should promote independence and integrity in the research it relies on. PAHO should establish an independent Commission to review the role of corporate interests in shaping public policy in this area.

Finally, PHM welcomes the call in the resolution to "strengthen surveillance for chronic kidney disease" (2(d)), with emphasis on at-risk populations and communities" and to "continue to alert countries that might face similar situations" (3(e)). However PHM strongly recommend actively seeking other populations where the disease is occurring. Also the director and member states should be working with the WHO and other countries on global investigation and surveillance.

Commentary on Agenda Item 4.9 Cooperation for Health Development in the Americas

Supporting documents: Concept paper 52/11, Resolution CE152.R13

PHM welcomes the PAHO policy paper and the proposal regarding cooperation for health and development, and we offer some observations.

PHM commends PAHO for its leadership in recognizing the importance of South-South cooperation (SSC) and Triangular Cooperation (TrC). PHM agrees that South-South cooperation as a development mechanism is of paramount importance to pursue. PHM believes that funding for health and development, however, should not be the sole responsibility of LMIC countries of the region. PHM is concerned that PAHO recognizes the declining rates of ODA and development assistance for health (para 7) but does not decry that fact. PHM finds the declining rates of ODA and development assistance for health unacceptable, particularly in a climate of unprecedented global wealth. PHM encourages PAHO to insist that HDC member states renew the commitment to achieve the ODA target

of 0.7% of GNP as agreed to in the 1970 UN General Assembly resolution, renewed international commitments in 2002 at the International Conference on Financing for development in Monterrey, Mexico, and the World Conference on Sustainable Development in Johannesburg, South Africa.

Financial assistance for 'development' (including health development) is dwarfed by tax evasion, capital flight, unfair terms of trade and the need to 'insure' against speculative attacks on national currency by buying official bonds in strong currencies. Much international financial assistance for health is provided through narrow vertical disease specific funding bodies, which fragment health systems. PHM would like to see the scope of this resolution widened to include monitoring and evaluating contemporary development assistance policies internationally.

PHM agrees that many actors need to be involved in cooperation for Health and Development in the Americas (para 17, para 22) and that such actors will be required to be guided by values and principles such as solidarity, mutual benefit, respect for national sovereignty, respect for diversity, and non-conditionality (para 18). The rights of minority and marginalized populations are critical factors as well. While in principle many actors are needed to enact cooperation for health development, PHM remains concerned that commercial interests are becoming increasingly prioritized over the health of peoples and the environment of communities across the region.

PHM recommends that a high priority for SSC for Health in the Americas should be medicines regulation including action around aggressive marketing which drives over use and misuse. Likewise PHM urges the countries of the South to cooperate around legislative reform, particularly in relation to IP in pharmaceuticals, to ensure that domestic legislation provides for the full implementation of TRIPS flexibilities.

Many threats to and opportunities for health development lie outside the health sector, for example, in the areas of trade and economic cooperation. WHO Resolution A56.29 committed the Organization to supporting policy coherence across trade and health (more broadly this should include economic policy and health). The resolution was fiercely criticized by the US and has never been effectively implemented. There is presently continuing pressure for new trade agreements (such as the Trans Pacific Partnership Agreement, TPP) that are directed to global economic integration to provide easier market access for transnational corporations. The provisions of the TPP have huge implications for health including increased prices of medicines and allowing corporations to sue countries for implementing public health regulations. PHM would like to see the scope of the proposed resolution widened to include regional cooperation to promote policy coherence across health, trade and economic policies generally as envisaged in A56.29.

PHM is concerned particularly that Canada – which has collapsed its development agency into a mega-ministry of trade, foreign affairs and development, (DFATD) – has failed to protect its development programs from undue interference from commercial interests. Exemplary of this trend, DFATD is working closely with extractive industries registered in Canada that have substantial economic activity in Latin America. Those industries are

influencing the health development agenda through multiple mechanisms, such as tying government ODA provided to NGOs to places and projects where private mining operations work and by prioritizing countries receiving ODA based not on need but on the size of Canadian mining operations. PHM is troubled by considerable and growing evidence that the health and environments of mining communities in the Latin American region are thus being either damaged or ignored, based on the agendas of transnational corporations in the mining sector as trade, finance and development merge in the new paradigm.

PHM asks that PAHO (1) assist and support states that are proposing legislation to protect the health and environment of affected communities from undue political influence, labor exploitation, environmental degradation, water supply contamination, or any other deleterious effect of extractive industries and (2) use its influence to have ODA offered by countries, such as Canada, controlled by LMIC countries and communities, without political or commercial interference.