

## Comments on 'Draft Technical Paper' prepared for the World Conference on Social Determinants of Health

[People's Health Movement \(PHM\)](#), in association with a wide range of public interest groups and health activists<sup>1</sup>, congratulates the World Health Organization (WHO) and the Government of Brazil for organizing the first World Conference on the Social Determinants of Health (WCSDH) by way of following up the work of the WHO Commission on the Social Determinants of Health (CSDH) and in accordance with WHA Resolution 62.14.

We appreciate the opportunity to comment on the draft Technical Paper prepared by the WHO to inform the planning and deliberations of the Conference in October.

However, we are disappointed with the draft Technical Paper for a number of reasons, among which five weaknesses stand out.

- The Paper fails to discuss or redress the power relations (national and global) and ideologies which reproduce health inequity; it largely constructs the processes involved in addressing the social determinants of health largely in terms of policy coherence and intersectoral action.
- The Paper fails to recognize features of the global economic regime which contribute to maintaining health inequalities including global trade liberalization, illicit capital flows and continued tightening of intellectual property rights which contribute to maintaining health inequalities.
- The Paper neglects the importance of adopting health as a fundamental human right. In addition, it does not acknowledge its interrelatedness and interdependency with other human rights, as core considerations when addressing health inequities.
- There is a section on the role of primary health care focused largely on equity but which fails to mention the combination of intersectoral action and community involvement which are the key strategy of the Alma-Ata Declaration for addressing the social determinants of health;
- The Paper fails to offer any practical suggestions for redressing unequal power relations, for challenging the dominance of neoliberalism as the only right way of understanding our world, and for moving towards a fairer and more sustainable economic dispensation globally.

We elaborate on these concerns hoping that they will be addressed in the final draft of the Technical Paper.

### Power relations and ideology

The Commission report was clear in noting that “a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics” deprive large numbers of people of opportunities to lead healthy lives and that reducing health inequity is “critically dependent upon changes in the functioning of the global economy”.

In contrast, the Technical Paper takes an apolitical approach to these issues as exemplified in the following passage:

*‘Conflicts and trade-offs between short- and long-term goals, and between the interests of different sectors, are inevitable. There are numerous “win-wins” in acting on social determinants, but some necessary actions will result in negative impacts or costs for some parties. These conflicts need to be carefully managed, considering how any “losses” can be minimized, how to ensure continued collaboration from the sector who “loses”, and identifying mechanisms to share benefits with the “losing” sector’ (p11).*

This construction of wins and losses in terms of different ‘sectors’ of social practice totally obscures other axes of analysis across which wins and losses are and will be distributed. These other axes of analysis – in particular, between different countries; between social classes; between men and women; between corporations and communities – are also the axes of power relations which will be critical in determining action on the social determinants of health. And yet they are invisible in this Technical Paper. The closest

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<sup>1</sup> Please refer to the below list of signatories.

the Paper comes to recognizing power relations is the discussion of 'stratification' on page 2 which is willfully atheoretical, and highlighting the need for 'a willingness to transfer real power to communities' (on page 6). 'Community participation' is as close as the Paper comes to dealing with how unequal power relations might be transformed. Beyond mentioning ethnicity as a social stratifier, the Paper neglects any useful analysis of race or ethnicity-based inequity. Race matters because racism and racial discrimination create inequity and affect health, which will not be captured unless stratification based on race is considered.

The continuing negotiations around the Doha Round illustrate the significance of power relations between countries in shaping important social determinants of health as do the continuing pressures of the USA and Europe on developing countries to sign up to unequal 'free trade' agreements (FTAs). In the Doha Round and in bilateral and regional FTAs the pressure has been on developing countries to open their markets to processed goods from the rich countries while reform of the agricultural trade regime has been stalled. The consequence of these engagements is particularly evident in relation to food security and sovereignty.

The combination of trade liberalization, massive subsidies to agribusiness in the North and strengthened intellectual property rights has given increasing power to the corporate food industry and has undermined national food sovereignty in many countries. Between 1990 and 2001, the foreign sales of the biggest food-related transnational corporations (TFCs) (those listed among the world's largest 100 transnational corporations) rose from US\$88.8 billion to US\$234.1 billion, with total foreign assets rising from US\$34.0 billion to US\$ 257.7 billion. These TFCs dominate the whole food supply chain – including seeds, fertilizers and pesticides, the production, processing and manufacturing of foods, and the way they are sold and marketed to consumers. TFCs are now leading traders of food: 40% of food imports and exports are between and within TFCs. These trends, together with speculation on food stocks, the increasing proportion of US maize being used for bio-fuels and the impact of climate change, are primarily responsible for the recent critical food shortages in many poor countries. In low and middle income countries (LMICs), between 1970 and 2001, food imports grew by 115% compared with 45% into rich countries. In LMICs food import bills as a share of GDP more than doubled between 1974 and 2004. Food price increases in the last few years threaten the reductions achieved in poverty and hunger over the past two decades. The FAO estimates that food price rises have resulted in at least 50 million more people becoming hungry in 2008. Food insecurity is further exacerbated when local self-reliance on food, based on local and regional food production and consumption systems is undermined to the advantage of global food systems. Such food insecurity has contributed to continuing widespread malnutrition as evidenced by high stunting rates and micronutrient malnutrition, with an estimated 854 million undernourished people worldwide in 2001-2003. Simultaneously, because of the increasing reliance on imported, processed foods, there is the rapid emergence globally of chronic non-communicable diseases such as diabetes and hypertension, fuelled by growing obesity. Already 22 million children worldwide are overweight; by 2015 approximately 2.3 billion adults will be overweight and more than 700 million obese.

This regime is maintained by the power of the transnational corporations and the power of their host countries that depend on the exports and profits of these corporations to maintain their trade balance and GDP. Obscuring the realities of power under platitudes about intersectoral action and policy coherence across 'sectors' can only help to perpetuate the continuing violation of the right to health.

The global distribution of child and maternal mortality illustrates the significance of unequal power relations across gender in maintaining social conditions which reproduce high levels of mortality, largely as a result of differential access to health care. Unequal gender relations are embedded in culture and social structure and are not easy to change. However, a first important step is to acknowledge the role of power relations in maintaining the status quo and to put on the global agenda the need for practical steps towards women's empowerment. Gender is mentioned several times in the Technical Paper but in very general and abstract terms.

The Technical Paper mentions the role of primary health care in addressing the social determinants of health but fails to mention the combination of intersectoral action and community involvement which are the central strategy of the Alma-Ata Declaration for addressing the social determinants of health. This strategy assumes publicly provided, public accountable primary health care services working closely with the communities from which their patients come. In such circumstances primary health care practitioners

can work with community networks and organizations in engaging with the social determinants of health including through intersectoral advocacy. This is a function which is much less likely to be provided through private sector provision and health insurance funding. With the progressive privatization of health care provision over the last three decades, driven in large part by the IMF and the WB, this capacity has been seriously weakened. Indeed a constituency which opposes effective regulation of big pharma has been strengthened.

The term 'class' does not appear in this Technical Paper. Reference to 'stratification' may be sufficient to describe inequalities in health and in risk factors but it offers nothing by way of explanation or strategy. Widening income inequalities in the rich countries are associated with wide disparities in tobacco use, obesity and injury and the various morbidities which these cause. The concept of class provides a way of speaking about the different interests and different perspectives of groups of people who are differently positioned in relation to how the economy works. Tens of thousands of poor people, including people of colour, have lost their homes and savings during the sub-prime mortgage crisis in the US. But the policy strategies which were put in place were about protecting investors and executives. The power relations expressed in this contrast are also relevant to decisions about social security, public transport, access to health care and the regulation of the food industry. Across Europe policies are being put in place which penalize poor people to pay for the gambling losses of the rich. It is hard to take seriously a Technical Paper which deliberately avoids any firm analysis of the power relations which maintain health inequities.

Unequal power relations are mediated and maintained by a range of different instruments and strategies. One of the most salient of these is the projection of a particular ideology or way of understanding the world. The ideology of neoliberalism has been assiduously promoted as the only true way of understanding how the world works over the last thirty years; Margaret Thatcher explained that there was no alternative. Neoliberalism as an ideology incorporates a deep distrust of democratic decision-making, preferring instead the invisible hand of the market place; the degradation of the welfare state and public sector provision and the proposition that liberalization of trade globally will bring economic benefits to all. Of course there are alternative ways of seeing the world and alternative views about democracy, the welfare state and trade; recognizing such alternatives can be very empowering. The promotion of the ideology of neoliberalism is an important feature in the power relations which sustain the prevailing inequalities in income and health. The institutions, corporations and governments which promote this ideology need to be confronted if there are to be any shifts in the power relations around the social determinants of health. WHO would be joining these bodies if it fails to acknowledge the significance of ideology in maintaining power relations and the role of neoliberalism as the principal ideology which normalizes inequity globally.

## Global economic regime

Although one section of the document is titled 'Global action on social determinants' there is only passing reference to 'trade and security, the regulation of migration, and the role of multilateral agencies' as well as '(t)he recent global financial crisis'. Its response is to meekly venture that these have 'raised questions about the governance of global financing flows and the regulation of transnational markets' and it notes that '[c]ountries are unlikely to be able to progress on social determinants unless they can address the impacts of these issues'. In response to this acknowledged fundamental constraint to achieving health equity, it suggests vaguely: 'For many countries, this will require global partners playing a positive role' (p 22).

The language of policy coherence, intersectoral alignment and donor harmonization obscures far more than it clarifies:

*'Global governance needs alignment across sectors for action on social determinants, placing health inequities as a marker of policy incoherence. ...Alignment is also urgently required between the different stakeholders involved in development. Global partners must harmonize their individual efforts to support those of countries to develop and implement national strategies on social determinants' (p 21).*

It is not 'policy incoherence' that is responsible for the negative impact of dominant macro-economic policies, unregulated financial flows and trade relations on SDH, but rather neoliberal ideology and accompanying approaches which privilege the market above all else and limit any state intervention.

Indeed, rather than ‘incoherence’, it could be argued that there is significant policy coherence across sectors, including the health sector, whose policies have been greatly influenced by currently dominant conservative economic policies which have also promoted the market in health financing and care.

The old economies of Europe and the USA need global markets to maintain their export revenues even if it means making it impossible for ‘developing countries’ to move beyond the export of commodities and labour. The old economies need a continuing flow of capital into lending in order to keep their debt dependent economies operating. The USA needs to force more and more restrictive intellectual property (IP) laws on the rest of the world in order to maintain its export earnings from monopoly pricing. Because the European and US economies need to impose this particular regime on the rest of the world does not mean that it will be universally beneficial.

Debates around ‘free trade’, unrestricted capital markets and tightly restricted IP laws are central to the policy objectives of this Technical Paper. Managing the power relations which are expressed in the continuing drive for liberalization of trade in manufactures (but not agricultural commodities) is quite central to action on the social determinants of health. These issues are conspicuously absent from this Technical Paper (or completely buried in the language of alignment, coherence and harmonization).

The report of the Knowledge Network on Globalisation<sup>2</sup> explored these issues in detail but there is no sign that the analysis presented in their report has been drawn upon in the development of the present Technical Paper.

### **Right to Health as basis for action**

The missed opportunity to take a right-based approach to address health inequities has been clearly explained in a recent article (Chapman, 2011)<sup>3</sup>. If the CSDH would have chosen in *Closing the Gap in a generation* to follow and refer to an international human rights framework and its legal obligations, this could have empowered and mobilized a wider constituency of civil actors. The CSDH and the current Paper promoted both participatory, democratic and top-down regulatory approaches to policy making, without making a strong link to using international legal frameworks as tools for accountability and the progressive realisation of health equity indicators.

The rights-based approach to health equity would provide WHO and the member states with a stronger mandate to be “the directing and coordinating authority” for the realisation of the right to health and equitable universal coverage. As the right to health is enshrined in the constitution of WHO, in the International covenant on Economic, Social and Cultural rights and in over 130 national constitutions, it can be a powerful international tool for legalisation, enforceability and implementation of policies, that are desperately needed to enhance equity between and within nations.

Moreover, the rights-based approach to health equity would allow the WHO and its member states to further develop binding treaties or regulations to address structural determinants of health, as is currently the case for the International Health Regulations and the Framework Convention on Tobacco Control. Similar treaties could help to regulate the food and beverage sectors that contribute to the growing burden of non-communicable diseases.

### **Practical suggestions**

#### Regarding content

The planners of the Rio Conference have emphasized that its focus will be on practical initiatives which can be taken to address the social determinants of health. However, there is nothing practical in this Paper about how to deal with the power relations which maintain contemporary inequities in health. The Paper simply does not address the question of how to transform the governance of the global economy so as to put in place the conditions for Health for All (including addressing climate change).

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<sup>2</sup> Please refer to the report at <http://www.globalhealthequity.ca/electronic%20library/GKN%20Final%20Report%202008.pdf>.

<sup>3</sup> Chapman, Audrey R.(2011) 'Missed Opportunities: The Human Rights Gap in the Report of the Commission on Social Determinants of Health', *Journal of Human Rights*, 10: 2, 132 — 150.

The first step would be to provide a clear analysis of the issues and of the different arguments and perspectives in play. This does not mean that WHO should adopt as a new singular truth the analysis presented in this submission. However, these are robust ideas and have wide support among many Member States and should be recognized in the mix.

There are many practical examples of countries and communities taking action around international bullying, around the privilege and power of wealthy elites, around gender equality and around alternative ways of managing national and international economic relations. There is much to learn from such examples but they need to be documented and presented in the lead up to and in the course of the Conference.

There is no mention in the Paper of how WHO might assist countries in their negotiations with the World Trade Organization or in regional or bilateral free trade or economic partnership agreements.

Confronting the power of transnational corporations in certain areas of particular relevance to health, such as food and nutrition, is within the mandate of the WHO. WHO has led the way in developing a global regulatory regime for tobacco control. The next priority should be the food industry. We strongly recommend that strategies for regulating the food industry should clearly be on the agenda of the Rio Conference.

Due to an economic crisis that the developing world did nothing to cause, there are now 200 million more people living on less than \$2 dollars a day,<sup>4</sup> causing distress and ill-health. The financial sector needs to be held accountable and contribute to addressing the vast resource gap in health by paying a small tax on financial transactions. WHO Member States could champion such an approach and further build the momentum towards the adoption of an international financial transaction tax.

We urge that the Right to Health be placed firmly at the center of this Paper. Right-based approaches are mentioned at various points in the Paper but as one of a number of strategies. We see the rights-based approach to health as powerful because it inspires marginalized and down-trodden communities to look afresh at their situation and redouble their efforts for the Right to Health.

#### Regarding participants and program

Under the heading 'Civil Society', the Technical Paper mixed the public interest groups with the organizations representing commercial interests.

Public interest civil society groups and social movements should be given an appropriate space during the Conference to share their analyses and experiences and to contribute to identifying actions and setting priorities.

Proper channels should be created through which the people's contribution to these sessions can be adequately represented in the final Conference declaration.

We propose designating one plenary session for discussing the declaration among all participants followed by a final session for adopting the declaration by member states in which civil society representatives and other actors would be observers.

Finally, we wish to thank the WHO again for initiating this consultation process. We hope that our input which represents more than 100 civil society and social movement organizations and networks across the globe will be able to contribute to objectives, themes, list of participants and program of the conference. Should the limitation of civil society representation during the conference not be rectified, the PHM and other endorsers of this letter are committed to take this consultation process forward towards a collective civil society statement which will be shared with the WHO and the Brazilian government as a contribution to the final conference declaration. This statement will also be widely distributed and independently published.

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<sup>4</sup> *The Impact of the Global Financial Crisis on the Budgets of Low-Income Countries*, report for Oxfam. Development Finance International, 2010.

## Signatures

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