

Policy Paper on Health

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May, 2007

“Not until the creation and maintenance of decent conditions of life for all people are recognized and accepted as a common obligation of all people and all countries – not until then shall we, with a certain degree of justification, be able to speak of mankind as civilized”. (Albert Einstein, 1945)

Introduction

Health is widely researched and the more prominent debates on health and the policy implications deriving from these debates all point to the same: health is a human right and it is one of the most powerful indicators of social justice in a society.

The 19th and 20th centuries experienced the emergence of public health revolutions which changed the history of health and disease in the developed world. The struggle for public health “became part of the big social reform project of the first wave of modernity in the developed world – with a focus on the key health determinants of the industrial revolution: water and sanitation, air, housing, education, safe work, better food, shorter work days, maternal care and access to family planning” (Kickbusch and Payne, 2004). This social reform transformed health in one of the most important pillars of holding the nation together. As Sorrell (2003) points out, the National Health System in the UK functions “not only as a source of medical treatment but as a prime medium of national solidarity and national identity.”

The right to the highest attainable standard of health – the right to health – was first reflected in the WHO Constitution in 1946 and reiterated in the 1978 Declaration of Alma-Ata and in the World Health Declaration adopted by the World Health Assembly in 1998. It has been firmly endorsed in a wide range of international and regional human rights instruments¹ (WHO, 2002).

¹ Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised, the African Charter on Human and Peoples’ Rights of 1981 and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (the Protocol entered into force in 1999). Similarly, the right to health has been proclaimed by the Commission on Human Rights and further elaborated in the Vienna Declaration and Programme of Action of 1993 and other international instruments (WHO, 2002).

In just a few months, the world will commemorate the 30th anniversary of the Alma-Ata Declaration (1978)² which called for *Health for All* by the year 2000. Yet today the world is still in the midst of a health crisis, which cuts between and within countries, along inequality lines. Thirty years ago the health community proclaimed health determinants as the stepping stone to health for all by 2000 and as a crucial part of a development agenda. Today “health for all” has been replaced by a variety of disease-specific initiatives, such as the (seriously under-financed) Global Fund to Fight AIDS, Tuberculosis and Malaria (Anderson et al., 2005). Three decades of health reforms promoting the market model and increasing privatisation have put under strong attack the values and politics of health, thereby diminishing the role of the state and people’s control and participation on national health policies. Furthermore, health systems have been badly hit and have deteriorated as a result of the health workforce crisis - a clear testimony of the failure of market-driven policies.

This paper attempts to cover some of the main debates related to health politics in the hope of eliciting among trade unions a more vivid debate about the broad picture of health, social justice and a fairer world. At the same time the paper suggests for consideration some primary guidelines on policy making, recognizing the fact that a national health policy would need to reflect society’s values about health and the health problems of people. More importantly, a national health policy should first and foremost involve people and people’s representative organizations.

It is time for a substantial change and there are spaces for policy interventions at different levels of governance. The evidence of what is and what is not working is overwhelming. The research on health is voluminous and the knowledge to address health crises is already with us. Moreover, in these times of high interdependence among countries and when the term “development” is the highlight of all national and international events, the time for change is overdue. “A fairer world is a safer world” (McMichael et al, 2003: 106) and health is a crucial indicator of a fair society, transforming health into an important factor for peace in the world.

² The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, at Alma-Ata, 1978.

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1. Health for All, Crisis for All - The Global Health Crisis

“When the history of public health is seen as a history of how populations experience health and illness, how social, economic, and political systems structure the possibilities for healthy or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life.” (Hofrichter, 2002)

Building a healthy society is a long way to go as today the world is clearly in the midst of a health crisis:

- 1400 women die needlessly in pregnancy or childbirth each day (Oxfam, 2006)
- Every day 4000 children are killed by diarrhoea, a disease of dirty water (Oxfam, 2006)
- TBC still kills 4400 people every day (WHO, 2007)
- 80% of malaria deaths are among young children living in Sub-Saharan Africa, with under-five mortality from malaria in 2002 estimated in that region at more than 800 000 deaths (WHO, 2005)
- 14 000 people become HIV positive every day, with 95% of them living in developing countries (Hemelaar, 2006)
- Six million people in poor countries urgently need antiretroviral treatment yet less than 5% have access to these drugs (People’s Health Movement, undated³)
- 100 000 people die in the United States each year because of lack of necessary care – three times the number of people who died of AIDS (Navarro, 2006)
- Across Asia, medicines comprise between 20 to 80 per cent of out-of-pocket health-care costs (Oxfam, 2006)

People’s health shapes societies. Health constitutes a central indicator of the social values of our societies. However, despite important historical evidence of successful health interventions, the health status of many countries, especially in developing countries, has not yet improved, and it has in many cases deteriorated. As Nelson Mandela put it in 2005, “Massive poverty and obscene inequality are such terrible scourges of our times – times in which the world boasts breathtaking advances in science, technology, industry and wealth accumulation – that they have to rank alongside slavery and apartheid as social evils” (UNDP, 2005).

1.1 The Health Divide Among and Within Countries

³ <http://www.phmovement.org/en/campaigns/healthnow>

Health draws another dividing line in today's unequal world. A baby girl born now in Japan could expect to live 85 years, while one born at the same time in Sierra Leone would probably not survive beyond 36 (Router, 2003). A recent report from Oxfam shows that in developing countries women still have a one in 61 chance of dying from a pregnancy-related cause compared to one in 2800 in developed countries. Eleven million children die each year from preventable communicable diseases such as measles and diarrhoea, and from malnutrition (Oxfam, 2006). And the latest data on the HIV/AIDS pandemic show that it continues to grow and there is concerning evidence that some regions (sub-Saharan Africa, Eastern Europe and Central Asia) are seeing a resurgence in new HIV infection rates which were previously stable or declining (WHO, 2006).

Tuberculosis and Hepatitis C continue to be a burden in many developing countries. Estimations are that half a billion people are suffering from tropical diseases, with a high proportion of this population living in sub-Saharan Africa. Many diseases hitting the developing and least developed world are being neglected. Between 1975 and 2004, only 21 of the 1556 new chemical entities marketed were targeted at poor country diseases like malaria and Bilharzia (Oxfam, 2006). Clearly, the target market for multinational pharmaceutical companies is those people who have not only the need but also the money to buy. Despite the advances in medical science, the extent to which the poor are not an attractive market for the pharmaceutical giants determines the significant extent to which disease continues to afflict the poor. As Chen et al. (1999: 294) stress, "lacking market power, the diseases of the poor are 'orphaned' by benign neglect".

The avian influenza threatens the lives of million across borders. Non-communicable diseases (NCD)⁴, once considered a 'burden of the rich', are increasingly affecting people in developing countries. In fact, over 80 per cent of deaths from NCD occur in the developing world. Cancer rates are expected to double between 2002 and 2020, with 60 per cent of these occurring in developing countries. Additionally, diabetes cases have risen from 30 million to 230 million over the last two decades, with most new cases occurring in the developing world (Oxfam, 2006). Obesity is increasingly becoming a disease of low and middle income countries, "especially among the more affluent populations that have the financial resources to adopt Western diets and lifestyle" (Kickbusch and Payne, 2004). Unhealthy diets and obesity are among the main factors contributing to non-communicable diseases (WHO, 2004).

⁴ Non Communicable Diseases – NCD – are diseases which are not infectious. Such diseases may result from genetic or lifestyle factors, as for example: hypertension, diabetes, cardiovascular disease, cancer, mental health problems, obesity, tobacco, etc.

Two UN agencies have pointed to another dimension of the health crisis catalysed by globalisation – the pressure of deregulation on basic health and safety standards. One person dies every 52 seconds because of occupational cancer and at least 1 in 10 cancers is the result of preventable, predictable workplace exposure (International Metalworkers Federation, 2007). Joining together on a call for prevention strategies against work-related accidents and illnesses, the ILO and the WHO highlighted the critical situation all around the world in occupational hazards:

In its latest estimates, the ILO found that in addition to job-related deaths, each year there are some 268 million non-fatal workplace accidents in which the victims miss at least three days of work as a result, as well as 160 million new cases of work-related illness. The ILO has previously estimated that workplace accidents and illness are responsible for the loss of some four per cent of the world's GDP in compensation and absence from work....

The most common workplace illnesses are cancers from exposure to hazardous substances, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases and communicable diseases caused by exposure to pathogens. In many industrialized countries, where the number of deaths from work-related accidents has been falling, deaths from occupational disease, notably asbestosis, is on the rise. Globally, asbestos alone is responsible for 100,000 occupational deaths per year.

Meanwhile, in the agricultural sector, which employs half the world's workforce and is predominant in most underdeveloped countries, the use of pesticides causes some 70,000 poisoning deaths each year, and at least seven million cases of acute and long-term non-fatal illnesses, as stated in the assessment. (WHO, 2005)

Clearly, poverty condemns the poor to ill health. The UNDP Human Development Report 2005 stated the world has seen an unprecedented reversal as “18 countries with a combined population of 460 million people registered lower scores on the human development index (HDI) than in 1990”. Ironically, the report continues “in the midst of an increasingly prosperous global economy, 10.7 million children every year do not live to see their fifth birthday, and more than 1 billion people survive in abject poverty on less than a \$1 a day”⁵. At the same time, as the world population continues to rapidly urbanise the health situation aggravates even further. As the Third World Network succinctly puts it,

“.... [M]any millions of city dwellers are forced to live in overcrowded and unhygienic conditions, where lack of clean water and adequate sanitation provides breeding grounds for infectious disease. High-density populations raise the risk of respiratory disease and those transmitted through contact with pathogens in food and water. Migration and the mass movement of millions of refugees or displaced persons from one country to another - as the result of wars,

⁵ In this paper all references to dollars are to US dollars

civil turmoil or natural disasters - also provide fertile breeding grounds for infectious diseases and keep them on the move." (Third World Network website, 1996)

The consequences of ill health are devastating for many families across the world, throwing many families in a medical-poverty trap. Expenditure on pharmaceuticals ranges from 10–20 per cent of health expenditure in the richest countries to 20–60 per cent in poorer countries (Oxfam, 2006). Big differences exist in access to health services because, unlike in many rich countries, most developing countries lack universal health insurance. At the same time, access to affordable, quality medicine is essential for patients in poor countries who are highly burdened by diseases. In Peru, 70 per cent of expenditures on medicines are paid out-of-pocket, while only 52 per cent of the population has health insurance and coverage mostly excludes those living under the poverty line (Oxfam, 2006).

Clearly the world is highly divided in terms of the health quality of people's lives. Kickbusch and Payne (2004) have distinguished between the health societies of the post-modern world and the health situation within poor countries, which are in stark contrast to each other. Health societies of rich countries are characterised by high life expectancy and ageing population, an expansive health and medical care system, a rapidly growing private health market, health as a dominant theme in social and political discourse, and health as a major personal goal in life. In contrast, the health discourse in the developing world is shaped by a falling life expectancy, especially in many African countries, lack of access to even the most basic services, a disproportionately high level of income spent by the poorest on health, health as a neglected arena of national and development politics, and health as a matter of survival.

But health asymmetries are much more complicated than just a divide along countries' development stage, and so are the political implications. In the US, Whitehead et al. (2001:834) point out that the economic effect of ill health has long been a cause of bankruptcies. Evans (2001:10) notes the pervasiveness of health inequalities within countries: that in both rich and poor countries, better health is often associated with higher social position. Thus even in healthy places such as the Netherlands, Finland and the United Kingdom, the poor die five to 10 years before the rich. In this sense, inequality becomes a cornerstone of shaping health differences worldwide.

As inequality in the world increases⁶, the health crises become more severe. It is inequality, poverty, exploitation, violence and injustice that are at the root of ill-health and the deaths of poor and marginalised people (People's Health Movement, 2000). The UNDP Human Development Report 2005 points to a very dark reality when it translates inequality into human development terms: "One-fifth of humanity live in countries where many people think nothing of spending \$2 a day on a cappuccino. Another fifth of humanity survive on less than \$1 a day and live in countries where children die for want of a simple anti-mosquito bednet".

2. Global Responses to the Health Crisis and their Effects - An Overview

The strategy to address the global health crisis was already recognized 30 years ago, acknowledging the evidence of the health revolutions in the developed world. The Alma-Ata Declaration (1978) reiterated health as a human right: "Health which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector". The Declaration promoted a comprehensive approach to improving health with a strong emphasis on building health systems "from the bottom up", with substantial community involvement⁷ and through multi-sectoral cooperation⁸. The latter implies education on methods for preventing and controlling prevailing health problems; promotion of food security and proper nutrition; an adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (Hall et al., 2003).

Again, in 2000, world leaders made health a priority. The Millennium Development Goals or MDGs, where three out of eight are related directly to health, point not only to the importance of health but also to the critical situation

⁶ In 1990 the average American was 38 times richer than the average Tanzanian, while today the average American is 61 times richer. The world's richest 500 individuals have a combined income greater than that of the poorest 416 million (UNDP report, 2005).

⁷ "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care." (Alma-Ata Declaration, 1978)

⁸ "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors." (Alma-Ata Declaration, 1978)

of global health. A deeper analysis would assert that all MDGs are health goals, pointing to the organic relationship of health with poverty and malnutrition, education and gender equality, environment and the need for global cooperation. The MDGs have spurred the emergence of many global health initiatives, including the Global Fund to Fight AIDS, TB and Malaria, Stop TB, Roll Back Malaria, The Presidential Emergency Plan for AIDS Relief, and the Global Alliance for Vaccines and Immunization. Yet most of the progress reports on MDGs cast doubt as many low-income countries, especially those with the worst health statuses, are unlikely to achieve the MDGs health targets by 2015 (Travis et al., 2004). Fragmentation and fragility of health systems are the main reasons behind the failure to achieve MDGs in many developing countries, countries which are at the same time faced with devastating diseases.

For quite a number of years now, health has ranked high in the agenda of many international meetings. As Kickbusch and Payne (2004) put it, health is increasingly being discussed as a component of global security and as a key factor of sound business practice and social responsibility. Health has its own intergovernmental organisation - the World Health Organisation - covering almost all the countries in the world. One of the richest foundations in the world - the Bill and Melinda Gates Foundation - is focused on health advocacy (Kickbusch and Payne, 2004). Many programmes on fighting disease operate around the world, yet the health crisis lingers. What must be wrong?

2.1 The dominance of the utilitarian approach to health

“The pervasiveness of today’s crisis suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than from issue specific problems. If so, issue specific responses, typical to date, would be insufficient - allowing global crises to persist and even multiply”
(Kaul et al., 1999).

The critical debate on health exists within a broader picture of a development discourse which has been mostly perceived in terms of wealth and economic growth. The evidence of inter-country comparisons which indicate “that by and large income and life expectancy move together”, have tempted some commentators “to take the quick step of arguing that economic progress is the real key to enhancing health and longevity” (Sen, 1999). One of the serious handicaps of this approach is the limited understanding of development (often defined as GNP per capita) which “sees health improvement mainly in terms of improvement of human capital for development, rather than as a consequence and fruit of development” (Hall and Taylor, 2003). Secondly, the argument that economic progress leads to health implies that an economy needs first to grow and then to invest in health. Here, investment in health has largely been framed

in terms of economic productivity, emphasising the high return that an investment on health would have for the world economy.

Although health as human right is recognized by all, the ways and the means employed to ensure this right have never been so different. The world has been struggling to reach a balance between the holistic concept of health as an end in itself and the utilitarian principle of health as a means (Sen, 1998). Unfortunately, the foundation of values of health policies and actions has “become increasingly vague and unclear” (Kickbusch and Payne, 2004). The last three decades have been dominated by a philosophy weighted more towards a narrow view of health. This has seen the focus being on curing the symptoms, hence ignoring the broader context of health: lack of access to water and education, conflict, food insecurity and environmental degradation, particularly due to climate change. In effect, the health debate has been largely narrowed down to technical interventions, leading to patchy health policies with limited results.

The utilitarian philosophy stands in stark contrast to the philosophy of social justice and a rights-based approach. The utilitarian approach -

....addresses symptoms, in the short term, through magic medical bullets - interventions delivered through health services. It focuses on individuals and blames them for their irresponsible behaviour. The social justice/HR (Human Rights) approach addresses root causes in the long term - miserable living conditions - through meeting basic needs for health - food, water, shelter, a means of survival, employment, physical security and basic health services. It focuses on structural poverty and violence and blames the system - social and economic determinants. (Katz, 2005)

By corollary, the utilitarian approach

.....relies on charity and international aid as sources of funding. It thereby maintains the status quo of the extreme concentration of wealth and power. The social justice/human rights approach, on the contrary, is predicated on a fair and rational international economic order through redistribution and economic justice. (Katz, 2005)

The inherent contradictions of the utilitarian approach to health have shaped health policies and actions of the last three decades.

2.2 The policy tug-of-war between primary health care and the disease-specific approach

Health policy has often been designed in terms of medical care policy and influenced by a disease-specific approach, which has attracted much public attention. With the same mindset, the rationale behind a health agenda has been predominantly to highlight the importance of investment in health and that some

investments in health or against disease would have high return rates for the economy and development. The WHO was speaking the same language when it estimated that the world would have an economic benefit reaching more than \$360 billion by 2010-2020 if the world was to invest \$60 billion per year starting 2002 (WHO, 2002). As much as an economic rationale for an investment in health is valid, it does by no means capture the holistic concept of health and it cannot lead to a healthy society. Kickbush (2002) points out that “the global health challenge is increasingly defined in economic and managerial terms rather than as a commitment to equity, justice, democracy and rule of law.” One important implication of this critical reverse approach is that health policies have been often framed “in terms of expenditure and consumption of health care services” (Kickbusch, 2004), “forgetting” to consider the social, political and economic costs of inadequate health care. Meanwhile, there has also been a tendency to treat societies using a charity model which, according to Kickbusch and Payne (2004), focuses on the ‘deserving’ and the ‘undeserving’ poor. This shift has deformed the focus on health and the concomitant decisions shaping health policies, adversely affecting systemic and sustainable solutions to the health for all agenda.

The health vision expressed by the Alma-Ata Declaration 30 years ago, to strengthen health systems through a bottom-up approach, was challenged by those who argued that to achieve a measurable effect it was necessary to focus on a limited number of cost-effective interventions through selective primary health care. Ironically, “rich health societies of the 21st century have chosen to forget, in a form of collective amnesia, what laid the basis for the health and life expectancy gains” (Kickbusch and Payne, 2004). The World Bank report (1993) marked the change to healthcare services in poor countries. It replaced Primary Health Care with “Health Sector Reform” and focused on user pays, cost recovery, private health insurance, and public-private partnerships. The “Health Sector Reform” parted from the spirit of the Alma-Ata Declaration, introducing policies which were not debated or agreed collegially as the Alma-Ata Declaration had been, and which took health politics away from people.

The developments of the last 30 years have been shaped by this shift in international development strategies. The emphasis on delivering cost-effective interventions from international organisations in combination with a weak role for the state, and even in some cases attempts to circumvent state involvement⁹, has resulted “in an increasing array of selective programmes, often being

⁹ “In their impatience to implement “their” projects, donors continue to constitute special units outside of the recipient country governments, as a mechanism to bypass the bureaucratic, salary and other constraints of recipient governments.” (Birdsall, 2004)

promoted simultaneously in countries with limited capacity to deliver”¹⁰ (Travis et al., 2004). The health establishments and the developed countries emphasised categorical interventions (a disease by disease approach) that have weakened the infrastructure of public health services, including national health services (Navarro 2004). These developments were compounded by pressure for privatisation and market praise, examples of which ironically grew in number in spite of clear evidence of the need to strengthen health systems. Moreover, the preference of the rich for private health care reduces their financial participation in public health care systems, thus increasing the fiscal burden of universal coverage and access for the poor (Chen et al, 1999: 293) and putting pressure on health workers “especially when user fees contribute to the actual wages and salaries of health workers¹¹” (Lethbridge, 2004). The poor and other vulnerable groups have been particularly affected, as ‘of all measures proposed for raising revenue from local people this [user fees] is probably the most ill advised’, reinforcing gender inequity (Whitehead et al., 2001:834). Health care has been transformed into a commodity, accompanied by “safety nets for those left outside the existing package of benefits” (People’s Health Movement, 2005).

The transformation of health politics in the last 30 years has been stark. Before, primary health care was considered to be the means for providing a comprehensive, universal, equitable and affordable health care service. During this time the strong involvement and role of the state in the provision of education, health and welfare was not questioned. Indeed, the state’s responsibility and people’s control of health systems, anchored in the human rights approach to health, were the foundation of a strategy to achieve health for all. However, the last three decades have seen a strong attack on this foundation, maybe exactly because of its political underpinning. The state’s role has been increasingly “described as moving from a “provider” to an “enabler” role” (Lethbridge, 2003), as experts and politicians of the developed countries refused “to accept the principle that communities should plan and implement their own healthcare services” (Hall and Taylor, 2003). This policy shift has increasingly blurred the value foundation of health as human right. Thus in the last three decades the world health policy has shifted from the previous vision of ‘health for all’ to an MDG agenda, which even within its limited scope seems to be hardly achievable.

2.3 The crisis of health workforce

¹⁰ “An enormous number of programmes against killing diseases have been running all over the developing world with limited result, Haiti being one of the examples where 140 non-governmental organizations have been working on the ground, not resulting in better health for the population.” (Kickbush, 2004)

¹¹ In Nicaragua, user fees have become the main source of decentralised revenue. At hospital level, 30% of the income from user fees goes towards salary supplements. (Lethbridge, 2004)

The crisis of human resources for health (HRH) lies at the core of the crisis of health care systems, as a global shortage of health workers is becoming critical in most countries. Massive migration and the HIV/AIDS pandemic have contributed extensively to the health workers crisis, particularly within labour-sending countries.

The nexus between the crises in health care systems and in health in general has become a vicious cycle. The importance of strengthening health systems has been neglected for a long time, as “in a world of vertical programmes and quick fix solutions, societies tend to invest in technologies and drugs and not in social protection, health systems or people” (Kickbusch and Payne, 2004). Often the pressure from health budget constraints has been compounded by the misallocation of resources within health systems, where money is being spent on the purchase of high-tech medical equipment rather than on human resources (PSI, 2004:12). Health workers were harder hit as they were at the same time under pressure due to three main factors: lack of investment, the HIV/AIDS pandemic and migration, the latter being accelerated as a result of the first two factors. In June 2005 the WHO and the UNAIDS were forced to recognise that their targets for the ‘3 by 5’ initiative – to treat three million people with HIV by the end of 2005 – were impossible to reach as delivery systems and human resources in the developing countries were (and still are) missing (PSI Health Focus, 2006).

The Joint Learning Initiative (JLI, 2004) was the first global initiative to tackle the roots of the health workforce crisis. These have been identified as follows:

Investment was replaced by neglect: Almost three decades of health sector ‘mis-reforms’ treated health workers as a cost burden, not as an asset (JLI, 2004). The industrial restructuring under an “American model”, saw the cheapening and reduction of the workforce as the way to reduce costs and increase efficiency (PSI, 2004:12). The irony of these reforms is, as Chen puts it, that “buildings are considered capital assets, while human capital is considered a recurring burden” (Chen 2004). Technical support for the health sector has been the main feature of donors’ interventions, undermining the need and importance of investing in human resources. Underinvestment in health workforce is particularly critical in Africa as highlighted also by a report of the Commission of the European Communities (2005). “Some of these under-capacities are a consequence of insufficient public investment in the health sector aimed at limiting unsustainable growth in salary (recurrent) costs”.

The underestimation of the health workforce has much more serious consequences than on any other aspect of health systems as it takes more than a decade to prepare a qualified health worker, but it takes much less time to

destroy the will, dedication and qualification of the worker to commit to health service (JLI, 2004).

The triple threat of HIV/AIDS. HIV/AIDS, according to the LJI report (2004), poses a triple threat to the workers: workload and skill demands of health workers; health workers dying; and the psychological stress of offering help to people who are dying, and taking care of their families. HIV/AIDS has affected health workers in a particular way, especially in Africa where the facts are alarming: "Caring for the sick is not only demanding but risky, because of the work-related hazards of contamination" (JLI, 2004). The Health GAP (2005) highlights the fact that "across Africa AIDS has killed thousands of health care workers, and large numbers of doctors and nurses are migrating to the West, driven out by impoverished health care systems and lured by elaborate recruiting packages by hospitals in G8 countries".

Migration. The "brain drain" of health workers, amidst the consequences of mis-reforms and AIDS pandemics, has contributed further to the "weakening of already fragile health systems" (Kickbusch and Payne, 2004). The JLI report (2004) states further that "often magnifying the geographic imbalances are within-country workforce inequalities in gender, ethnicity, skill mix, and private and public sector employment". For doctors and nurses, the regional differences are enormous. Average density is 1 worker per 1,000 populations in sub-Saharan Africa, but more than 10 per 1,000 in Europe and North America. Meanwhile, of those educated in Africa, 20% of doctors and 5% of nurses are working in an OECD country (WHO, 2006). The effects of migration have been disastrous for the health systems of many developing countries, which face serious brain drain problems. The migration of highly skilled workers has been criticised as "stealing the developing countries' intellectual property"; while intellectual property protections assure drug companies high prices and high profits, developed countries that "export" highly-skilled workers received nothing in compensation (Stiglitz, 2006: 51).

The crisis of the health workforce as expressed by the flow of health workers across national boundaries is one of the strong indicators of the crises of health systems. Today's health systems are at a crossroad, faced with important and serious challenges which need integrated interventions:

- Insufficient investment and national capacity for public health, primary health care, water and sanitation
- Lack of sustainable and equitable health systems
- Lack of health coverage/insurance for the poor
- Dramatic fall of investment in and commitment to universal health systems, coupled with the move to privatize and commercialize

- health and health care
- Lack of human resources - export and brain drain (Kickbusch and Payne, 2004)

As will be discussed later, in today's world cooperation on health at all levels becomes mandatory.

2.4 The health crisis and gaps in governance

Although health as human right is articulated in every meeting discussing health, the approach to health largely contradicts the principles of human rights. Indeed if health is a human right, then ensuring peoples' health is by definition a direct responsibility of the state. Here, international aid for health - highly dependent on donors - can be debated from many angles, especially if considered from the human rights-based approach. What constituted a revolution in the health realm was the moment when health moved beyond charity and became an element of state action and a right of citizenship. Today the debate on tackling the health crisis is broadly framed within the international aid and assistance mindset. This is in contrast to the alternative model which would see systematic national and international budgetary support for health. Moreover, this aid and assistance mindset leaves the models of globalization and growth largely unchallenged, "forgetting" that poverty is more than passing the US\$1 threshold, that "being poor is about lack of power, assets, autonomy, participation, security, welfare etc" (Ceukelaire, undated) and that "20% of the richest people in the world live in developing countries" (Navarro, 2004).

But even with regard to the modest MDG objectives, which are now recognized to be unachievable¹², the developed world has not lived up to its promise. The UNDP (2005) sadly reports that "There is a real danger that the next 10 years, like the last 15 years, will deliver far less for human development than has been promised". The UN Millennium Project's analysis ¹³ indicates that 0.7% of rich world GNI can provide enough resources to meet the Millennium Development Goals. In its assessment of the world's commitment to achieve the MDGs, the Global Governance Initiative of the World Economic Forum in a report in 2004 points to the fact that "the world is doing barely a third of what is necessary to fulfil the goals it has set". Specifically for health-related MDGs, the Initiative scored the world at four out of ten: in other words, the world is doing less than 50 percent of what it should. The Centre for Global Development has developed an index called the Commitment to Development Index which integrates seven issues: aid, trade, investment, migration, environment, security and technology. In ranking 21 of the richest countries based on their commitment to policies

¹² See UNDP Report of 2005, pg. 5

¹³ See Millennium Project website : <http://www.unmillenniumproject.org/press/07.htm>

which would benefit the five billion people living in poorer countries, the Centre ended up with an assessment pointing to the fact that “no wealthy country lives up to its potential to help poor countries” (Kickbusch and Payne, 2004).

The 0.7 percent of GNP commitment has been reiterated in different high level meetings since it was first agreed in 1970, yet the Millennium Project reports (2006) show that only 5 countries out of 22 have achieved this threshold, with the US scoring almost at the bottom of the list. Can the rich world afford the MDGs? The UNDP (2005) estimates that around \$300 billion could lift 1 billion people living on less than \$1 a day above the extreme poverty line threshold. The report goes on by saying that this amount represents 1.6% of the income of the richest 10% of the world’s population. It remains debatable whether passing the technical threshold of \$1 is going to produce better health, yet the estimations, though static, are important to make an approximate assessment of the international community’s commitment to the MDGs. Responding to the September 11th terrorist attacks, US citizens donated \$1.3 billion for victims. Yet, on the same day two years later, 11 September 2002, 30 000 children under the age of five died because of the silent crisis of poverty and ill health – malnutrition, unsafe water and lack of health care – which is the everyday reality in the poor nations (Kickbusch and Payne, 2004). The UNDP’s estimates show that \$7 billion is needed annually over the next decade to provide 2.6 billion people with access to clean water, which is less than what Europeans spend on perfume and less than what Americans spend on elective corrective surgery. This is for an investment that would save an estimated 4,000 lives each day (UNDP, 2005). Other estimates show that if the MDGs are to be achieved, it would cost to each citizen in the high-income world \$100 per year for the coming 15 years (Kickbusch and Payne, 2004). Meanwhile, as endless rhetorical speeches about the importance of the MDGs are issued at every event tackling development issues, the target related to child mortality “will be missed by 4.4 million avoidable child deaths in 2015 – a figure equivalent to three times the number of children under age 5 in London, New York and Tokyo” (UNDP, 2005).

The mobilisation of financial resources to tackle the health crisis is undoubtedly an important discussion, but the real problem is not only money. International aid is in itself beset with problems, the donor-driven approach being maybe one of the crucial ones. The issue is that this aid is often seen as highly unpredictable and thus unreliable. At the same time the proliferation of health organisations and a lack of coordination have undermined the results of health interventions. While health organisations have helped in making “a difference on the ground”, the competition and systems for international aid funds “have not helped to create reliable infrastructure for health and have frequently put additional burdens on developing countries through complex application and reporting procedures” (Birdsall, 2004). In the period from 2001 to 2002, Tanzania had 1300

foreign aid based projects, 1000 donor meetings a year and had to produce 2400 donor reports every quarter. In a nutshell, the international aid business has been characterised by having problems such as “impatience with institution building, collusion and coordination failures, failure to evaluate the results of their support, and financing that is volatile and unpredictable” (Birdsall, 2004).

Moreover, the context in which international aid operates is very important. Despite the clear limitations of disease-focused policies, which in large part are not caused by lack of finances, the same approach is still being promoted today as the blueprint for global health policy making. The trouble with this approach is that while it might help to meet short term goals, it can crowd out the development of strategies that will sustain those gains (Travis et al., 2004). Hence, raising more aid without critically assessing and reflecting on the mistakes of the past might have serious consequences.

The international aid business operates within a system of global health governance which is characterised by conflicting values and a democracy deficit, seriously undermining its legitimacy. Without entering into a debate on whether and how international aid reinforces this critical tension between values, it is essential to realise the importance of the governance context. Health policy framing is largely dominated by the WHO, the World Bank and the WTO. Although there is not much research pointing to the “patterns of influence over WHO” (Navarro, 2004), some strong signs can still be found. In fact, as Navarro points out, “the discourse and practice of these establishments – such as the use of term clients rather than patients, or promotion of health markets (erroneously identified with choice) rather than health planning (dismissed as encouraging inefficiency and bureaucracy) – now dominate in the IMF, World Bank, WTO and also WHO”. Much of the developed world is increasingly preoccupied with the possibility of having choices, shifting the focus from building trust in health systems to putting the responsibility on the individual to make the right choice.

The WTO meanwhile is driving the agenda for free trade on services, “forcing countries with national health systems or even national health insurance, such as Canada, to dismantle these services” (Navarro, 2004) so the private operators can enter. This is quite understandable if only one considers that in 1999, according to estimations from UNCTAD, health expenditures reached up to \$3 330 billion for the whole world, where the OECD countries alone represented some \$3 trillion (EI and PSI, 1999). The same interest lies behind the TRIPS¹⁴ agreement – the other notorious instrument which has affected the lives of millions across the globe and which favours private sector monopolies. It claims to sustain the innovation – which is highly debatable – by delaying the competition of

¹⁴ Trade-Related Aspects of Intellectual Property Rights

pharmaceutical patents with low-cost copies (called generics), with the result of higher prices for medicines and disastrous consequences for millions of poor people. It is at best confusing to note the contradictions in the WTO approach of promoting competition in general but preventing competition when it comes to the TRIPS agreement. The global protection of powerful vested interests has led to an industry which is over-sophisticated and over-costly, thereby “directing our health policies unwisely; and what is useful is applied to too few” (Upham, 2007).

Despite the failure of health reforms promoted by the World Bank in the developing world¹⁵, the World Bank continues to be “convinced that it has a unique capacity to provide funding in Central and West Africa, in middle-income IBRD countries, and in post-conflict countries” (Baker, 2006). Even though some commentators accept that the World Bank has ceased pushing user fees as a strategy in low-income countries, the truth is that “this discredited policy is alive and well and still causes immense distress in many countries of the southern hemisphere” (Whitehead et al., 2001). Moreover, the segmentation of health care provision aimed at focusing “public sector resources on poorer groups, leaving others to buy private care – as recommended by the World Bank” (Global Health Watch, 2006) poses another danger to health for all and to quality universal services.

The WHO has been likewise seriously affected by the language of the World Bank “with the term hunger now replaced by underweight, and inequalities now described as disparities” (Navarro, 2004). Despite the enormous problems and dissatisfaction produced by the policies of the World Bank, the IMF and the WTO, the “WHO has failed to denounce, in the strongest possible terms, unfair rules of trade and commerce, odious debt, ruthless liberalisation of economies, privatisation of public services and continued exploitation of people’s national resources” (Katz 2007).

What is most alarming is the fact that at present “there is no mechanism whereby the various actors within the pluralist global health system are held to account” (Kickbusch, 2005). Thus whilst millions of people around the world suffer and die from the impact of the market-determined health policies prescribed or forced upon poor countries, these global institutions remain free to continue to perpetuate these policies.

Clearly, the bone of contention is political will. The world is creating an enormous amount of wealth, but much of it goes untaxed. Corporate wealth held

¹⁵ The World Bank began health lending in 1985 and has quickly become the largest source of concessional financing for health in the developing world. Its health lending approaches \$2 billion a year (Kaul et al., 1999: 296).

in tax heavens is costing governments around the world up to \$255 billion annually in lost tax revenues (Global Health Watch, 2005). In fact "it is precisely this concentration of economic, political and cultural power among and within all countries that is at the root of the world's most important social (including health) problems" (Navarro, 2004). Global health governance is highly skewed, with a clear dominance of the foregoing establishments and the private sector. The international financial and political establishments see only two constituencies in the world - the private sector and what is loosely called civil society (Katz, 2005), which leaves out most of the political organizations. And yet as Katz (2005) points out -

.... human rights - that some of us enjoy today - have only ever been won through direct political action either through institutional politics but usually in the streets by trade unions, true socialist political parties and people's movements.

Indeed, exclusion of people's voices from the health debate, accompanied by the domination of the utilitarian philosophy and the disease-based approach in global decision-making, has led to many gaps in health policy.

3. An alternative policy debate on health - Canvassing some policy challenges

3.1 The need for a paradigm shift - focusing on 'Health for all'

The discourse on health canvasses various layers that integrate a range of values, ideologies, policies and actions on health. This discourse highlights once more the particularity of health as a holistic concept, while at the same time questioning some of the reasons quoted as being the roots of the health crisis. Health has never had more different meanings to different people than today. It represents a very dynamic and complex area, characterised by deep contrasts within and between countries. Naturally, prevailing values and an open debate within each society would influence the framing of questions about health: How will we treat people? Whose responsibility is health care? How will we finance health? How do we approach risk solidarity, generational solidarity or global solidarity? (Kickbusch, 2004). In a world of high inequalities in health, how do we move forward? What would a comprehensive health policy look like? At which levels are interventions needed? Where do we start?

3.2 Health is political and values are at its heart

"It is justice, not charity that is wanting in the world"
(Mary Wollstonecraft, 1792)

In the words of the famous German pathologist Virchow: "medicine is a social science and politics is nothing more than medicine practiced on a larger stage" (Matthew et al., 2005). This suggests a turning point in the health debate because as Matthew et al., point out if disease was socially derived, then ill health would be an indictment of the political system. Indeed, it is not new to acknowledge that health is political, and this acknowledgement derives from the concrete ways that health affects people's well-being and feelings of security. Health has been a key value in defining national identities and solidarities, both in the developed and developing world. Thus "health and health systems are part of the cultural fabric that allows people to engage each other with language, develop their institutions, maintain the social order necessary for survival and prosperity, play social roles, and assume personal identities" (Kickbusch, 2004). As such, health policies are and should be predominantly driven by values.

The debate on values, ethics and politics/ideology remains the prevailing one, laying the foundation for answers to many questions related to health. Health has been extensively researched and important values are attached to health. Moreover, with the progress of medicine health has become do-able as solutions exist, be they medical, economic or social¹⁶ transforming the health debate to a debate on human dignity, equity and social justice (Kickbusch and Payne, 2004). Health as human right is at the core of the health discourse, from where all health values derive. Health as human right is widely recognized, being the clear expression of the value of health as 'values take their most concrete expression in rights' (Kickbusch, 2004). It is from here that health equity becomes crucial as "in important ways, a nation's health inequities may be seen as a barometer of its citizens' experiences of social justice and human rights" (Evans et al., 2002:3). This premise transforms health politics in a powerful battle for social justice. Clearly, the debate on human dignity, equity and social justice is driving the health discourse. Although the relationship of values and the way they influence philosophies needs more elaboration, in the world today health becomes clear evidence of the obvious tension between the philosophies "emphasizing self-interest of market based economies, and the philosophy of social justice that sees collective responsibility and benefits as the prime social goal" (Kickbusch and Payne, 2004). Winning the battle of values remains essential.

Health as a global public good implies the centrality of health as "a positive-sum: one person's good health does not detract from another's" (Chen et al., 1999:

¹⁶ "With the advent of antiretroviral drugs, for example, HIV/AIDS is no longer a death sentence" (Kickbusch and Payne, 2004).

294). Global public goods are defined as such if their “benefits extend to more than one group of countries and do not discriminate against any population group or any set of generations, present or future” (Kaul et al., 1999: 16). “Indeed better health usually has positive effects on entire populations through, say, less disease transmission” (Chen et al., 1999:294). The recognition of health as a public good gives it a *public value*, and implies that health can not be reduced into a commodity, “it needs political will and public ‘push’” (Kickbusch, 2004).

Health constitutes a strong platform for democratic participation and people’s empowerment. Primary health care is perceived to be a natural process of people’s and communities’ empowerment, which work together for better health through strengthening health determinants.

The political interventions designed to address health inequities should be anchored in the foregoing values, in both the substantive and procedural dimensions of policy formulation as well as in the evaluation of the impact of health policies.

3.3 How far are we from a healthy society?

Health as a commitment to social justice and human rights

A country’s commitment to track the inequalities in health and to build policy interventions on that basis is a commitment to social justice and human rights. A strong understanding of health inequality is essential to assess the depth and width of this problem. Many studies have shown that aggregate data would tend to “hide” the inequalities. Whereas Japan scores as the country with the highest life expectancy, mortality rates for certain occupational groups like agricultural and service workers are worse than managerial and professional jobs. Hence the research emphasises two essential assumptions: “first, that health measures based on population averages are not reliable guides to what may be happening to the health of different groups in society; and second, it is always possible to (and essential) to make some assessment of the health divide” (Evans et al., 2001). Extensive methodologies and tools¹⁷ which are not inequality-blind are already available to make an assessment of a country’s health and to address problems of equal access to health determinants.

3.4 Health as a stepping stone to development

Tackling the root causes of health inequities

Good health involves reducing levels of educational failure, reducing insecurity and unemployment and improving housing standards. Societies that enable all citizens to play a full and useful role in the

¹⁷ See “Challenging inequities in health, from ethics to action”, (Evans T., 2001)

social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation (WHO, 2003).

Health stands at the core of a broader picture of development, as asserted in the Alma-Ata declaration. From here, “an adequate conception of development must go much beyond the accumulation of wealth and the growth of gross national product and other income-related variables” (Sen, 1999). The Nobel Prize-winner Amartya Sen asserted in his book, *Development as Freedom* (1999), that as development has to be primarily concerned with enhancing the lives we lead and the freedoms we enjoy, then one of the most important freedoms that we have is the freedom from avoidable ill-health and from escapable mortality. The core importance of health in development points directly to the fact that there cannot be development without health and that the two must go hand in hand. Indeed, as Sen (1999) puts it –

For a variety of historical reasons, including a focus on basic education and basic health care, and early completion of effective land reforms, widespread economic participation was easier to achieve in many of the East and South-East economies in a way it has not been possible in say, Brazil or India or Pakistan, where the creation of social opportunities has been much slower and acted as a barrier for economic development.

The development framework emphasises the importance of access to health determinants, pointing to the fact that health is more dependent on health determinants than on health infrastructure per se. Indeed, the Alma-Ata Declaration reinforced the understanding that much of the most influential action to create health is found in other sectors other than health (Kickbusch and Payne, 2004). The same framework would argue that health inequities¹⁸ are directly related to people’s unequal access to society’s resources. In this regard the health of the population becomes more dependent on distributive policies (Navarro, 2004: 215) as “much depends on how the fruits of economic growth are used” (Sen, 1999). Evidence has shown that “in order to improve the health of a population, it is far more effective to develop universal programmes that reduce inequalities than to develop programmes specifically targeted at reducing poverty and which focus on means-tested programmes for the poor” (Navarro, 2004: 222). This conclusion is strengthened by the debate focused on poverty as a structural problem of systems which enforce inequality, though recognizing the fact that poverty contributes extensively to health asymmetries and crisis. Evidence from countries like Bangladesh and Haiti, which face severe famine despite having enough productive land to feed their populations 5 times over (Navarro, 2004) supports the same argument. Most important is that, as Navarro

¹⁸Inequalities are considered inequities when they are unfair (arising from social injustices) and avoidable.

(2004) points out, “the inequality is in itself bad, i.e., the distance among social groups and individuals and the lack of social cohesion that this distance creates is bad for people’s health and quality of life”.

Hence any intervention on health determinants would demand an equality focus: “public policies aimed at reducing social inequalities are components of a national health policy” (Navarro, 2006). The following boxed case study of Sweden demonstrates this.

Swedish Public Health Policy: Focusing on determinants of health

The new Swedish Public Health Policy, adopted in 2003, aims to create equity in health. In the 1980s, there were large health inequalities in Sweden, and so a parliamentary commission was formed to create a strategy to create equal conditions for good health through a focus on the structural determinants of health. The main objectives include, but are not limited to, economic and social security, secure and favourable conditions during childhood and adolescence, participation and influence in society, healthier working life and increased physical activity.

Many ministries and governmental agencies have to become involved in the implementation of Swedish Health Policy due to its focus on determinants of health. Policy-makers in Sweden have concluded that economic policy (redistribution between income groups, age groups and regions), social welfare policy (accessibility of basic social services), labour policy (employment rate), secure growing up conditions (quality of schools and day care), environmental policy, food and agricultural policy (food subsidies), and alcohol policy (reducing supply) are all integral to creating equity in health in Sweden.

Source: Kickbusch (2004)

Indeed, if we have to tackle health, we have to tackle health determinants, being political, social and economic, both as the underlying conditions of health for all and as a long-term strategy towards a healthy society¹⁹. Essential to this is the concept of “solidarity as an integrative force for both social movements and for identity and cohesion within the nation state” (Kickbusch and Payne, 2004). Clearly, the deepening of the health crisis calls for strong intra-generational solidarity, which works both ways. More than a century ago, the developed world made fundamental change by recognizing the significance of health determinants and solidarity. Today as then we need to revive that historical recognition that the most important foundation to achieve health societies is “a strong state, laws and regulation, public health, public education and the understanding of health as part and parcel of citizen’s right” (Kickbusch, 2004). This would need first and foremost the strengthening “of political cultures that stress the solidarity and social cohesion that reproduce a sense of community” (Navarro, 2004: 226).

¹⁹ “Improvements in living and working conditions led to reductions in death from major infectious diseases - not medicine and immunisation” (Hofrichter, 2002).

The health determinants debate is increasingly echoed at the international level, as “although responsibility for health remains primarily national, the determinants of health and the means to fulfil that responsibility are increasingly global” (Jamison et al. 1998: 515). Health has been one of the main areas highlighted by global cooperation; since “international cooperation within the health field and between the health sector and other development sectors will become mandatory” (Kaul et al., 1999: 297), global health governance becomes an important issue in the health agenda.

3.5 Reforming health governance Putting values at the heart

“It is not just a question of money, it is question of paradigm”
(Kickbusch, 2004)

At the core of the debate is the fact that health is political and that spaces for policy intervention exist at different levels. Hence governance processes become very important as “health governance is always about inclusion and exclusion and health governance debates are always also debates about values and social justice” (Kickbusch, 2004). A governance debate needs first to be based on the realisation that health cannot be addressed without a real involvement of people and their organisations at all the levels, and that it is essential to have an open debate about the values attached to health.

We enter an historical phase of health interdependence with the joint recognition of health as global public good and of the fact that ‘no individual or nation state can fully guarantee its own health’ (Kaul et al., 1999:297). The health arena has seen an increasing “pluralism of global health actors”²⁰ (Kaul et al., 1999) that is increasingly “transforming the global playing field in health - its norms, rules, practices and, especially, its power politics” (Kickbusch, 2005). As they hold different interests and share different values, the results often have been questionable and have led to what can be termed Balkanisation²¹ of global health.

²⁰ “The global health area has been transformed in recent years by a proliferation of actors, as indicated by the growth of civil society organizations (CSOs), the rise of trans-national companies (TNCs), and the increasing involvement in health by organizations, such as the World Bank, regional development banks and regional organizations like the European Union. Since the 1980s, United Nations (UN) agencies other than WHO, such as UNICEF, UNDP, and UNFPA, have increasingly been dealing with health issues as they converge with their respective mandates. This has been reinforced by a number of UN summits that have included health goals in their major recommendations. New organizations, such as the Joint UN Program on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have been created to take on health matters.” (Kickbusch and Payne, 2004)

²¹ “The term is used to describe the process of fragmentation or division of a region into many smaller regions that are often hostile or non-cooperative with each other.” (Kickbusch, 2005)

Here again values become crucial, as governance is translated more and more in managing power relationships, which often represent different interests.

In the light of the above, there is a need for a new policy model, “based on entitlement, in which good health is an integral part of social, economic and cultural rights and citizenship and is insured as a global public good” (Kickbusch and Payne, 2004). There remains an important political challenge to create a system of health governance based on a new global social contract, anchored in the values of health as human right and in a vision of health for all, being a system anchored in government responsibility which ensures access to health care. In these times of excessive wealth creation and accumulation, and when it costs about \$30-\$40 per capita to provide basic healthcare coverage in a low-income country (UNDP, 2005), access to health care becomes a very contentious political issue. And in that context it would seem appropriate to make the “gradual change from direct payments to social health-insurance systems, in which healthy, high-income groups subsidise care for low-income groups” (Whitehead et al., 2001) as the main source for financing universal health access. Yet, this option finds little room in the language of the health establishments, and not only the international health establishments²².

The financial solutions are quite clear considered from a redistributive justice perspective. Health as human right translates directly into solutions which prevail over the “concept of charity that is inherent in ‘aid’ and ideas such as ‘debt forgiveness’” (Global Health Watch, 2005). Transparent and accountable mechanisms aimed at the redistribution of wealth should enable prevention, universal coverage and strengthening of public services. What is needed is a solid and “adequate tax base, both nationally and internationally, to cover all the public services, as well as proper funding of public institutions such as WHO through regular budgets so that they may fulfil their international responsibilities unimpeded by corporate interests” (Katz, 2007).

Redistributive justice ought to apply to other contentious issues such as debt cancellation and reparation, fair trade, abolition of tax heavens, and democratic control of TNC activities. The United Nations Research Institute for Social Development (UNRISD, 2000), based on estimations of off-shore deposits (which according to the IMF are around \$8 trillion), calculated a taxation income which would more than make up for the cost of providing basic social services for developing countries. A transfer of 5 percent of the income of the richest 20 percent in Brazil and Mexico would: lift 26 million people above \$2 a day in Brazil, cutting the poverty rate from 22% to 7%; and in Mexico would take about

²² “The root of world’s health and social problems is that the dominant classes in the developed world have allied with dominant classes in the developing world who are against a redistribution of resources that would adversely affect their interests” (Navarro, 2004: 1321).

12 million people out of poverty, as nationally defined, and reduce the poverty rate from 16 percent to 4 percent (UNDP, 2005).

Other sources could be a currency transaction tax (Tobin Tax), an arms trade tax, a global environmental tax or an airline tax. Some other ideas include a Marshall Plan for the developing world and financial compensation for the migration of health workers from low-income countries with staff shortages.

A broad discussion necessitates a new and stronger mandate for the WHO although its constitution and many of its policies “are still valid and offer a framework for addressing the important health problems in today’s world” (Navarro, 2004). The policies in which the WHO engages need “to respond to health challenges in a manner that benefit the poor, avoids vertical approaches, ensures intersectoral work, involves people’s organisations and trade unions in the World Health Assembly, and ensures independence from corporate interests” (People’s Health Charter, 2000). Kickbusch and Payne, (2004) discuss proposals to explore the possibilities whether the “WHO should be able to take countries to the international court for crimes against humanity if they clearly refuse to take action based on the best public health evidence and knowledge”. The acceptance of health as a global public good demands that national health policies and global responses coordinate to complement each other.

It is time to consider a *global domestic policy* (Kickbusch, 2005) of integrated intervention that responds to the challenges of health at all levels in the following areas:

- reform and strengthen global institutions and international law for health
- control unsafe goods and products and ensure corporate responsibility
- ensure access to essential medicines, vaccines and health knowledge and research
- increase human capacity and health literacy
- create primary health care and public health infrastructures, surveillance and information systems
- create professional capacity and ensure human resources
- fight major diseases and defined global health emergencies, including rapid responses. (Kickbusch, 2005)

The interventions underline the importance of the state and the public sector, calling in fact for “a reliable and accountable mechanism for global governance and a strengthened public sector at all levels” (Kickbusch and Payne, 2004).

3.6 Strengthening public health care systems and Human Resources for Health

Strengthening of public health systems is crucial as they are essential in promoting health and preventing disease. There is nothing new in this as in 1948 the world articulated the right to health care as a human right²³. The State has a prominent role in ensuring the provision of health care, as the acceptance that health is a public value implies the necessity of “State intervention to promote morally desirable ends” (Staley, 2001: 2). As the evidence is overwhelming that “the markets in themselves have no capacity to imagine or create a decent society for all” (UNSRID, 2000), the responsibility of the nation-state becomes mandatory. Kickbush (2002) emphasizes that “the scope of the challenges indicate that no amount of philanthropy or NGO action can replace the responsibility of the nation states both for their own population and for the global community at large”. Here the importance of building public health systems which are sustainable at the national level remains crucial for both developing and developed countries and this holds more important than ever for health workers in times of shortages of global health workers. Health workers are the backbone of health systems – and they ought to be treated like that. Any intervention to strengthen health systems should address issues of concern for health workers: the way that health workers are treated translates directly into the quantity and quality of the services offered to patients²⁴.

A long term investment in skills and working conditions of health workers is essential to build nationally sustainable health systems. The massive migration of health workers from the developing countries due to deteriorating health systems or due to the increasing shortage (not only because of retirement) of health workers in the developed countries is a clear indicator of the problems in health systems. In times of high labour mobility which accelerates migration, it becomes essential to address the pull and push forces in both the developing and developed world. Hence, strengthening national health systems is better understood as a direct contribution and an integral part of the global battle for Health for All.

Using poverty as an excuse for states not fulfilling their obligations for health care is at best unjustifiable. As relevant as resources are to every government, discussions about resources implies a question of “costs involved against the benefits that can be anticipated in human terms” (Sen 1999). The case of Sri Lanka echoes Sen’s observation (1999:44-45) that “a poor country may have less money to spend on health care and education, but it also needs less money to spend to provide the same services which would cost much more in richer countries”, especially given the fact that these services are labour intensive.

²³ Article 25.1 of the Universal Declaration of Human Rights (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.

²⁴ “Low pay or insecurity affects the quality of service delivered by health workers” (PSI, 2003).

Beside the fact that more than one-third of its population lives on less than two dollars per day Sri Lanka has achieved great success in reducing maternal mortality:

Over the course of the 1990s the number of maternal deaths halved, from 520 to 250 women per year, in a population of 18 million. Today over 96 per cent of deliveries are attended by a skilled birth attendant and over 90 per cent take place in a health facility. How has this been achieved? By providing public health services free of charge – essential in making them accessible to poor people – and by providing a large number of health posts: almost everyone now lives less than 1.5km from their nearest centre. These measures have been strongly supported by education policies that provide free education for girls up to university level, resulting in a literacy rate of 88 per cent among adult women and an increase in the average age of marriage. (Oxfam, 2006)

The Sri Lankan case strongly supports Sen's argument (1999) that in fact a discussion on financial prudence is not really the main issue when discussing health policies. What really matters in this debate is "the use of public resources for purposes where the social benefits are very far from clear, such as the massive expenses that now go into the military in one poor country after another (often many times larger than the public expenditure on basic education or health care)" (Sen, 1999). The need for participatory politics and broad information for public discussion becomes essential as people are not just receivers of health services, but ought to be also "agents of change".²⁵ Hence "the principles of transparency, accountability and participation (TAP) deserve widespread adoption and implementation, through participatory models of political control" (PSI, 2003). Indeed as Sen (1999) argues, "the penalty of inaction and apathy can be illness and death".

It is critical that there be a long term intervention on health determinants together with a concerted policy to eliminate barriers to poor people's access to health services; barriers such as insufficient funding and capacity, user fees for health services and poor health services. Of equal importance is the fact that health equity measures should ensure that resources be allocated according to need, regardless of the ability to pay (Evans et al., 2001). Policy-makers should incorporate citizens' participation and necessary monitoring to ensure that resources are deployed to meet the stated objectives of equity.

4. Another World is Possible and so is Health for All!²⁶

²⁵ "Ultimately there is nothing as important as informed public discussion and the participation of the people in pressing for changes that can protect our lives and liberties. The public has to see itself not merely as a patient, but also as an agent of change" Sen (1999).

²⁶ (Katz, 2005)

4.1 Health as a political battle for unions

Clearly, the core of the health debate has been left hollowed by a utilitarian and disease-based approach leading to unsustainable remedies to the health crisis. The dominating approach, which is inherently prone to short-termism and to symptomatic cure, proved to be highly unsustainable, as discussed earlier in this paper. The dominating paradigm has eroded the foundation of health politics – the government’s responsibility to insure people’s health. The legitimacy of a government is expressed (among other criteria) in terms of its capacity and ability to provide social security to its own citizens. Restructuring, privatization and other market-led reforms have gradually taken this power away from governments.

Castells (in McMichael, 2000) argues that “it is the disembodiment of power from place that generates a legitimacy crisis undermining the meaning and function of institutions in the industrial era (e.g., the nation state, class politics, citizenship...)”. He points to this contradiction as the basis for social movements, which emerge “to restore local systems of power and identity or to refashion power and identity in trans-national level” (in McMichael, 2000). The wave of protests in Europe during the 1990s was largely a response in defence of jobs and welfare against the austerity programmes associated with EMU (European Monetary Union) convergence criteria. Taylor and Mathers (2002) provide examples of IG Metall (the German metal workers’ union) which successfully mobilised a national strike in defence of sick pay agreements that were jeopardised by social security reforms, the strikes in Italy, Belgium and Greece against pay restraint, pension reform and privatisation. People are protesting in many parts of the world.

Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us”. (People’s Health Charter, 2000)

The global health crisis presents an historical moment – a perfect storm – for unions to adapt and utilize their organizational, representational and mobilization powers. As Wahl (2005) emphasizes, “People’s discontent with current developments has to be taken seriously; their anxiety and dissatisfaction should be politicised and channelled into trade union and political class-based struggles for their working and living conditions”. Health is one of the issues that “has generated global debates and has spurred national and global social movements” (Kickbusch and Payne, 2004). One example is the People’s Health Movement, the largest health movement to date, comprised of a network of organisations and people fighting for health for all and increasingly pushing the

agenda on health. The “forgotten” debate of wealth and power distribution is resuscitated again as a debate at the heart of the discourse on health, challenging openly the actual world order (disorder).

Unions have been historically regarded as powerful distributive forces in society, contributing to social cohesion, an enhanced sense of power and participation and a feeling of smaller social distance.²⁷ As the health discourse has at its heart the principles of justice and equity, the participation of unions in designing a sustainable health policy becomes crucial. Unions’ involvement in the battle for health is particularly important not only because unions represent workers of all levels and are accountable to a broad constituency, but also because a worker is at the same time a citizen who is directly affected by many dimensions of health policies: as an individual concerned with her/his own health, a patient in the health care system, a voter on health care issues and as a social actor (Kickbusch, 2004). These principles constitute trade unions’ legitimacy to stand at the forefront of the health debate and to address those issues of democracy and transparency-deficits which characterise current health governance. Unions have the forums and the mechanisms to democratically channel and voice workers’ needs and inputs, from the workplace to national, regional and global levels.

The political debate on health urges the active participation of unions as political organisations²⁸. It is important not to lose sight of the broader picture of the political inter-connectedness of issues. The history of unions has been shaped by unions’ involvement and active participation in political battles for a just society. This battle is now complemented by global health movements, involving global civil society, the global health community, women and marginalised groups, all of which are very much active and dominating much of the alternative thinking on health. Nonetheless, the relevance of unions remains high, because “if the goal of social movements is to construct a world that balances liberal economic priorities with egalitarian values, such an aim only stands a chance of being accomplished if workers’ organisations play a large part in the struggle” (O’Brien, 2000: 554). Moreover, if different groups “combined their struggle for better health, working within common political and social instruments, they could achieve greater influence and power” (Navarro, 2006).

²⁷ “Countries with strong labour movements, with social democratic and socialist parties that have governed for long periods of time, and with strong unions (Sweden, for example), have developed stronger redistribution policies and inequality-reducing measures of a universalistic type (meaning that they affect all people) rather than antipoverty, means-tested, assistance types of programs. These worker-friendly countries consequently have better health indicators than those countries where labour movements are very weak, as is the case in the United States, a corporate-class-friendly country. The reason for this difference is that the sense of social cohesion is larger in the worker-friendly countries, the sense of power and participation is higher, and the feeling of social distance is smaller than in the corporate-class-friendly countries. The evidence for this conclusion is plainly overwhelming.” (Navarro, 2004)

²⁸ “An organisation that lives and operates in a society influences and is influenced by it, and it is not apolitical.” (Wedin, 1974)

Will we seize this opportunity? The role and active participation of trade unions in the struggle for health is essential. The human resources for health crisis may be used as an access point for unions to elicit political change in the health debate at all levels of governance²⁹. This movement may be transformed into an excellent opportunity for trade unions to undertake a process of union revitalisation and to broaden the trade union agenda. At the same time these new dynamics require “a more ‘social movement’ unionism” which would involve “a complex interaction of local, national, regional and global responses” (Ghigliani, 2005). Such a form of unionism seeks interaction with people fighting for the right to water, food security, housing, sanitation, education, a safe and healthy working and living environment, as well as people engaged in the full range of issues affecting health. Such issues span a wide range but include the use of genetic sciences and patents, the role of international institutions and the impact of chemicals on the environment. Coordinating efforts and building on the strength of different groups is crucial and it will call at the same time for “a greater concern for rank-and-file needs, bottom-up organisation building and the extension of grassroots activity” (Ghigliani, 2005) as illustrated by the case study of the trade union SEWA, in the box below.

Since 1972 the Self-Employed Women’s Association (SEWA) has endeavoured to protect the economic and social security of poor self-employed women working in India’s informal sector. In addition to addressing economic hardship, SEWA recognizes the serious impact of poverty and social inequality on the health of women. In 1984, SEWA expanded its activities to respond to members’ own demands for health services.

After over thirteen years of health work, SEWA initiated a Baseline Health Survey in 1997 to assess member health status, future priorities, and the impact of SEWA’s health programs. The survey aims to identify general health trends among members as well as to explore areas for further study. This report focuses on members’ morbidity patterns, utility of health services, reproductive health and response to SEWA health services.

SEWA’s Health Team focuses on grassroots-level primary health care, maternal and child health initiatives, training and education, and the development of sustainable health cooperatives. In nine districts of Gujarat State, SEWA works to ensure that good health, often recognized as “women’s only wealth,” is an integrated component of its organizing and economic activities.

Source: SEWA (undated)

²⁹ See Xhafa, E. 2006. “Sustaining strategies addressing the human resources for health crisis through union participation”. Pg. 78-87

As importantly, social movement unionism calls for alternative ways in strategising and acting which aim at reaching different target groups and different objectives. An example of this approach is the following case study of the Service Employees International Union (SEIU) trade union.

The SEIU (Service Employees International Union), a trade union organisation with over members in US, Canada and Puerto Rico, has launched a project "Americans for Health Care". The project is a grassroots health care reform organisation in the country, fighting for quality, affordable health care for everyone.

... Since 2002, SEIU has created state-based grassroots campaigns in 20 states, and we is now working with nearly 500,000 Health Care Voters across the country to make health care for every man, woman, and child a reality.

Highlights of the campaigns' work include:

- mobilizing voters on health care
- passing legislation to expand access and affordability
- creating demand for health care reform

Health Care Voters are out in force, talking to presidential candidates about the importance of making health care reform a top priority.

Source: Americans for Health Care (2007), *from:*

<http://www.americansforhealthcare.org/about-us/>.

A global Right to Health and Health Care campaign (RTHHC)³⁰, which involves coordinated national and international level action, is being launched by the People's Health Movement. It aims at changing the international approach to health and development and to show that quality health services can be made available to every human being on earth. People and people's organisations in different parts of the world are reacting, networking and fighting for health. Indeed, peoples' opposition to the political elite around the world is forging the belief that another world is possible, and so is health for all (Katz, 2005).

Conclusion

Health as human right is widely accepted and yet the approaches to health - underpinned by different philosophies - have never been so different. Today the world is in the middle of a health crisis, which stands paradoxically in the face of the knowledge, technology advancement and the amount of wealth being created. The recognition is with us that something is wrong, pointing to the fact that it is more than a challenge of disease but a challenge of ill politics. Moving

³⁰ See for more information: <http://www.phmovement.org/en/campaigns/righttohealth>

away from a disease-specific approach to a *health for all* agenda necessitates a radical change in policy-making, “health” and “all” being the signposts for this change. Hence, it is imperative to adopt a new mindset for reforming health governance and health politics at national and international level.

Clearly, the dual view of health as both an end and a means remains highly politicised and gives rise to a discourse on values. From there, devising a *health for all* policy necessitates first and foremost opening up an all-inclusive debate on the values that society attaches to health and the significance health has for society. Health inequalities reflect to a large extent the inequalities in society, and so health becomes a strong indicator of society’s commitment to pursue social justice. It is here that health stands at the core and heart of a broad picture of development.

A human rights-based approach to health translates as being the state’s political responsibility to ensure people’s health and translates as government policies which transcend the concept of aid and charity in health. Hence the *health for all* policy should address the issue of access to health determinants and to sustainable national health systems, which in turn demands (among others) tackling the crisis of health workers. These issues combined urge an integrated strategy, particularly including strong cooperation within and between countries. Such cooperation becomes mandatory if health is really to be recognized as a public good and as a determinant factor for peace in the world. In this light significant reform of health governance implies simultaneous changes at different levels of policy making and a continuous assessment of the impact that health policies have on the poor and on the empowerment of people.

Indeed, “participation in health is often a step towards wider societal involvement” (Kickbusch and Payne, 2004) and towards the consolidation of democracy. *Health for all* is a political struggle for an equal and just society and it is a long and challenging distance away. The history of trade unions has from the outset been shaped by the struggle for social justice. Hence, their’s is a crucial role in building a healthy society and in mobilizing people and people’s organisations around a *health for all* political agenda. One hundred years ago the developed world made remarkable achievements in controlling disease and reducing death, and it did this by recognising the importance of building strong national public health systems and of creating safer living and working conditions. Nonetheless, “[the] improvements were not given; they were demanded and won through people’s actions and in the face of massive opposition from the political elite. And so it will be today, in the 21st century” (Katz, 2005).

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