

## INTRODUCTION

The *Global Health Watch*, now in its fourth edition, is perceived widely as the definitive voice for an alternative discourse on health. It integrates rigorous analysis, alternative proposals and stories of struggles and change to present a compelling case for the imperative to work for a radical transformation of the way we approach actions and policies on health. It was conceived in 2003 as a collaborative effort by activists and academics from across the world, and is designed to question present policies on health and to propose alternatives. *Global Health Watch 4* has been coordinated by six civil society organizations – the People’s Health Movement, ALAMES, Health Action International, Medico International, Third World Network and Medact.

*Global Health Watch 4*, like the preceding volumes published in 2005, 2008 and 2011, provides analysis of contemporary issues that impact on health. It provides policy analysis, debates technical issues, and provides perspectives on current global processes. The GHW does not limit itself to the ‘health sector’ but extends its scrutiny to all those areas that determine whether people are able to live healthy and fulfilling lives. We hope the contents will be of use to a wide range of readers – activists, academics, developmental agencies and policy-makers. *Global Health Watch 4* provides information and analysis, but it also takes sides. The analysis and alternatives that we present are embodied in a vision of a society that is more just, more equal and more humane. Many of the stories that we include inspire hope that change can happen, and is actually happening in many parts of the world.

As in the case of the previous editions, the contents of *Global Health Watch 4* are divided into five interlinked sections. The section on the ‘The Global political and economic architecture’ locates the decisions and choices that impact on health in the present structure of global power relations and economic governance. The section ‘Health systems: current issues and debates’ looks at contemporary debates on health systems in different parts of the world, to draw appropriate lessons and propose concrete actions. The third section, ‘Beyond healthcare’, engages with multiple social and structural determinants of health. The section on ‘Watching’ scrutinizes global processes and institutions which have significant impact on global health. The final section foregrounds stories of action and resistance, from different parts of the world.

### **The global political and economic architecture**

The section begins with a scrutiny of how and why neoliberal globalization has produced a global health crisis. It traces its forty-year history, describes

three phases of neoliberalism (structural adjustment, financialization and austerity) and examines how these phases have affected health. It then looks at oppositional or countervailing forces to neoliberalism's orthodoxy, and discusses a number of policy options and political strategies that public health activists might support or pursue.

It also provides evidence from post-crisis Europe as a clear reminder of the need to defend public services. It is precisely at this juncture – when the economic crisis in Europe is eroding the livelihoods of millions of people – that public investment in education, healthcare and infrastructure is under attack.

The section further contends that the installation of several 'progressive' governments marks a new phase of transformation in the Latin American region, which could have far-reaching global repercussions. In each country, different power groups have emerged, giving rise to new contradictions and tensions. Concurrently, new forms of the 'welfare state' have started emerging, based on social rights and citizenship. New ways of defining social inequalities and what is 'socially good' are also emerging. Noteworthy, in this context, has been the rise of the idea of 'living well' (*vivir bien*) as a new paradigm, geared towards new forms of communal socialism.

The chapter 'After the Arab Spring' examines the aftermath of the spectacular fall of major Arab leaders in 2011. The uprising in the region was part of a revolutionary process against economic deprivation and political suffocation. The struggle for transformation in the region is now being forced to contend with renewed attacks by global capital, on welfare and social services.

### **Health systems: current issues and debates**

The chapter on 'Universal Health Coverage (UHC)' examines how existing public systems could be made truly universal. It argues that public systems need to be reclaimed by citizens, reformed in the interest of the people and made accountable. People's movements and organizations have much to lose from the present drift legitimized by a particular discourse in the name of UHC. Historically, healthcare systems worldwide have been shaped by labour's fight for better conditions of living – either through transformation of the capitalist system itself or through the extraction of better terms from the ruling classes. The fight for a just and equitable health system has to be part of the broader struggle for comprehensive rights and entitlements. To take this struggle forward, the dominant interpretation of UHC today – weakening public systems and the pursuit of private profit – needs to be understood and questioned.

The chapter on reforms in the UK's National Health Service (NHS) describes how the shift from NHS to 'National Healthcare Market' was made possible through various failures of democracy and professional leadership and reflects on the implications of the downfall of the NHS. The scale of the threat to the NHS – coupled with the UK government's lack of a democratic mandate to end the NHS and its propensity to misinform the public – suggests

that we are in a situation where professional dissent is not just appropriate, but urgently required.

Countries in Latin America have been host to several ‘experiments’ designed to promote UHC, beginning with the health and social security reforms in Chile in the mid-1970s, carried out under the dictatorship of Pinochet. This trend continued with a wave of neoliberal reforms in most countries in the continent during the 1990s. The most celebrated was the Colombian reform of 1993, which was recommended to other countries as a successful model. With the virtual collapse of the Colombian health system, its place has been taken by the Mexican health reform and its ‘Popular Health Insurance programme’ (*Seguro Popular*). The chapter on Mexico discusses the supposed ‘success story’ of *Seguro Popular* and challenges the mainstream discourse about its ‘success’.

Brazil’s successes, in rapidly rolling out primary-care services to cover the entire country and in pioneering a model of social participation through its health councils, are discussed in the context of existing challenges. The chapter reflects about the need to overcome structural barriers that prevent the full implementation of reforms that would make the country’s unified universal health system (SUS) the dominant form of healthcare provision in Brazil.

The chapter on South Africa discusses the country’s commitment to the introduction of a tax-funded system with universal entitlements to comprehensive health services. The experience of South Africa could provide valuable lessons for other low- and middle-income countries (LMICs) that have large private health sectors.

The discussion on Tunisia looks at the current situation in the country, foreshadowed by the values of social justice and equity that were the underpinnings of the Tunisian revolution.

Community health workers (CHWs) were an important component of the original vision of a universal health system based on the principles of primary healthcare (PHC). However, over the past three decades CHW programmes have become bureaucratized and have lost the earlier intended focus on social mobilization. The chapter on CHWs looks at recent experiences from four countries – Brazil, India, Iran and South Africa – and argues that they demonstrate a number of commonalities. The most important of these is the relatively weak focus on and arrangements for inter-sectoral action on social and environmental determinants of health. The chapter discusses how CHW programmes can contribute to shaping healthcare to the expectations and reality of the community the health team serves.

In spite of some recent progress, the levels of maternal mortality and morbidity remain unacceptably high, and there are major inequities between and within countries. With a focus on Africa, the chapter on ‘maternal mortality’ discusses how universal access to reproductive and sexual health needs to be the cornerstone of programmes aimed at improving both maternal and women’s health.

The chapter on the ‘health workforce crisis’ details how the availability of a strong health workforce, supported by public funds, is a prerequisite for strong, universal and quality health systems. The current focus on UHC carries the potential threat of reducing the role of health workers to undertaking selective diagnosis and treatment, rather than addressing the health of people and communities in a comprehensive and integrated way, combining public health and individual clinical approaches. It critically analyses recent trends in the role of health workers geared towards concerns of economic efficiency.

The final chapter in the section focuses on ‘medical devices’, a hitherto neglected area in public health discourse. While the medical-device industry makes claims about how new devices (and technologies) can ‘revolutionize’ healthcare, there are too few independent studies that examine such claims. The chapter argues for regulatory regimens based on better evidence as regards the cost-effectiveness of medical technologies.

### **Beyond healthcare**

The chapter on ‘social protection’ contests the mainstream discourse on development. It advocates for a transformative agenda where development implies an end to ‘dual societies’ engendered by neoliberal policies, and for a shift away from ‘productivism’ and an exclusively growth-oriented economy.

The rise in the incidence and prevalence of non-communicable diseases (NCDs) poses a complex challenge. The discussion on NCDs calls for vigilance to ensure that the agenda is not hijacked by very powerful interests who seek to profit from disease and suffering.

Two case studies (located in India and the Pacific Islands) individually and together illustrate the complex and dynamic global food and nutrition crisis. They are presented as stark reminders of the urgency of eliminating the ‘double burden of nutrition’ (under-nutrition and obesity), and of the clear and distressing explications of its national and global social, economic and political contexts. They underline the fact that this human crisis cannot be addressed without confronting and changing its social determinants.

The section also advocates that policy, law and guidelines on gender-based violence must incorporate a comprehensive health system response. Elimination of gender-based violence requires action at various levels, including steps to address societal issues related to power and dominance, access to resources and entitlements, among others.

The sanitation crisis is rapidly escalating, with a growing and urbanizing poor population in LMICs and a scarcity of fresh water and infrastructure. We discuss the embracing of a new strategy, termed ‘Community Led Total Sanitation’ (CLTS), by powerful international agencies and NGOs. The chapter argues that the strategy may be demeaning and represent a ‘victim-blaming’ approach to a basic health issue and human right.

The evidence demonstrating the causal relationship between exposure to

mining hazards and adverse health outcomes is denied and suppressed by industry advocates. The same is true of the huge contribution of the mining industry to a high burden of disease. The chapter on ‘extractive industries’ contends, through an examination of several case studies, that current global governance structures are grossly inadequate in the face of the tremendous power imbalances that exist between communities and mining companies.

### **Watching**

The discussion on the World Health Organization (WHO) is located in the roots of the global health crisis in the contemporary regime of economic globalization. It argues for a theory of global (health) governance that goes beyond simply listing those international institutions that deal with health issues. An expanded theory of global governance, it is contended, should also recognize imperialism and big-power bullying; acknowledge the historic competition between the nation-state and the transnational corporation as the principal agent of governance; and contextualize governance within the emerging class relations between the transnational capitalist class, the diverse national middle classes and the more dispersed, excluded and marginalized classes of both the periphery and the metropolis. The chapter describes how the WHO is under continuing pressure to retreat to a purely technical role and to withdraw from any effective engagement with the political and economic dynamics that characterize the global health crisis.

Non-governmental organizations (NGOs) have been remarkably flexible in adapting to changing global power relations. A critical analysis of the role that NGOs play today, entitled ‘A new “business model” for NGOs?’, identifies some of the ‘red lines’ that are beginning to be defined quite sharply in relation to the activities of NGOs.

The chapter contends that ‘pragmatism’ guides many NGOs today as the current hegemonic discourse abhors utopian thinking by demanding realism. Consequently, as NGOs become increasingly beholden to donor funding, they are being overtaken by the agenda set by donors.

Public policy-making is being influenced on a global level by private actors, accountable only to their board members. We discuss the mounting evidence that clearly points to a clear nexus between different private actors – private foundations, consulting and accounting firms, private industry and global public–private partnerships. The precise role of this complex nexus in subverting public policy, it is argued, needs to be examined systematically.

The Trade Related Intellectual Property Rights (TRIPS) agreement harmonized laws that protect intellectual property (IP) in all countries and thus forced LMICs to allow patents on medicines, irrespective of the domestic situation. However, at the insistence of many LMICs, the TRIPS agreement incorporated a number of ‘health safeguards’ designed to mitigate the adverse impact of a strong patent regime in LMICs. The discussion on ‘The TRIPS

agreement: two decades of failed promises' takes stock of the experience of using the 'health safeguards' in the TRIPS agreement, and examines a number of emerging trends in the global trade environment that act as barriers to medicines access.

The analysis of the Haitian cholera epidemic contends that the popular consciousness of the epidemic, in donor countries, has been based on a fabricated narrative which has centred on the plight of the refugees affected by the January 2010 earthquake. This narrative is not only misleading, it misses out on the political context in which the epidemic took place. Haiti's story and its present plight need, instead, to be principally viewed in the context of how the country's political system and economy have been systematically undermined by its imperial neighbour.

Evidence is also presented to show that the World Bank's International Finance Corporation (IFC), through its Health in Africa initiative, works at odds with the commitment from the Bank's leadership to universal and equitable health coverage. While the initiative has failed to mobilize its target level of investment, of particular concern is the lack of focus on the poor. The Bank's response to the mid-term evaluation of the initiative does nothing to reassure critics that the IFC is genuinely committed to a pro-poor, evidence-based approach.

Finally, we analyse the growing trend of clinical trials being 'offshored' to LMICs. Case studies, presented in the chapter, reflect common trends in the preferred destinations of offshored clinical trials: weak regulatory systems and vulnerable populations that constitute a pliant pool of clinical trial subjects. The gross rights and ethical violations that are taking place reflect a nexus between multinational pharmaceutical companies, domestic regulatory agencies, pliant doctors leading clinical trials and regulatory agencies in the North.

### **Resistance, actions and change**

Three chapters in this section narrate the changing dynamics in Latin American countries that have witnessed significant social and political changes in the past decade. In Bolivia the concept of 'living well' (*vivir bien*) is contributing to the dismantling of colonial and neoliberal legacies of the past. El Salvador is embarking on a challenging process to ensure the irreversibility of the achievements made after the installation of a 'left' government in 2009. Venezuela faces the onslaught from the imperial US government and its allies in the country (the oligarchy, private media, the Catholic Church hierarchy, political parties now led by neo-fascist groups, etc.). The three countries represent different kinds of experiments, each in their own way attempting to chart a course that challenges and rejects the neoliberal framework. This contestation is being played out in the health sector as well, with entrenched neoliberal ideas being questioned and replaced by 'communitarian' approaches.

The analysis on two other countries in the region – Colombia and Peru

– represents a contrast. In both these countries, neoliberal hegemony is being challenged by popular movements. The two chapters narrate how such contestation is apparent in the struggles against reforms to the health system.

The global economic crisis has had a deep impact on people's lives in large parts of Europe. We carry vignettes, in this section, of the waves of protests and resistance movements that have started sweeping large parts of the continent. These target the austerity packages being imposed by the 'Troika' – the European Commission, the International Monetary Fund (IMF) and the European Central Bank – and also the EU–US negotiations for a new free trade agreement (the Transatlantic Trade and Investment Partnership, or TTIP). A linked case study narrates the story of Halkidiki – of a community in Greece that has collectively risen up in protest against a mining project.

We also focus, in this section, on the Right to Food (RTF) campaign in India. Over these years the RTF campaign has expanded into a wide network with members across the country representing different groups, including agricultural workers' unions, women's rights groups, Dalit rights groups, single women's networks, child rights organizations, those working with construction workers, migrant workers, homeless populations, etc. These groups have come together in the belief that 'everyone has a fundamental right to be free from hunger and that the primary responsibility for guaranteeing basic entitlements rests with the state'.

Finally the section foregrounds the story of the 'Aboriginal community-controlled health services in Australia'. This movement has been one of the key vehicles through which the Aboriginal community has been able to engage in the struggle for health. This struggle combines collective actions to access healthcare with those that address the social determinants of health.

### **Towards a shared narrative for change**

We acknowledge that a single volume cannot encompass the wide range of issues that have a bearing on health in different parts of the world. Each community, country, region and continent has its own specificities, all of which need to be addressed. However, we do hope that the contents of *Global Health Watch 4* will stimulate readers to reflect more concretely about what needs to change, how things can be done differently, and how people can be at the centre of bringing about desired change. Above all, this volume is 'work in progress' towards the development of a shared narrative, located in a vision of equity and justice, and imbued with the urgency that the present global health crisis demands. Many of the ideas that are explored in this book are further detailed on the website of the Global Health Watch ([www.ghwatch.org](http://www.ghwatch.org)). Readers are invited to visit the website and contribute their own perspectives, so as to enrich this narrative that we seek to develop.