Chapter One: Politics and the Global Public Health Crisis

By *Mark Heywood*
Created *2008/02/29 - 4:15pm*
29 February, 2008 - 16:15 ? Mark Heywood
?If you can have full employment by killing Germans, why can?t you have it by building hospitals??

> ? Tony Benn, Labour Party MP, UK, referring to the move to set up a National Health Service in Britain after the end of World War II[1]

Despite remarkable advances in modern medicine the health of millions of people throughout the world is declining.[2] Problems of malnutrition, maternal mortality and other causes of illness, disability and death persist on a huge scale. Underdeveloped and developing countries have become reservoirs for old and new pathogens, where communicable and largely preventable diseases, cause millions of deaths per annum.[3]
Thus, for example, the Global Alliance for Vaccines and Immunization (GAVI) records that 1.5 million children die per annum ?in the world?s poorest regions from rotavirus and pneumococcal disease, diseases for which newly licensed vaccines are available.? It also points out that 28 million children ?missed out on immunization during their first year of life - leaving them vulnerable to disease both in childhood and during the productive adult years.?[4]

At a national level, poverty and inequality, jointly and differently, fuel epidemics of the most locally established parasites, pathogens and viruses. In countries that are mired in poverty and economic stagnation, with little prospect of gaining ?emerging market? status, causes of ill-health are endemic, but more stable. By contrast disease is more active, epidemic and changeable in transitional economies such as Brazil, South Africa and China, where urban and peri-urban slums grow rapidly as people migrate away from rural areas in the hope of gaining access to jobs and services. In these countries there is often an almost complete absence of systems for infection control within and without health settings. There are periodic outbreaks of Cholera and Typhoid (in 2005, for example, there was a major typhoid outbreak in Delmas, an impoverished township less than 100km from Johannesburg).[5] In addition there are periodic outbreaks of bacterial infection such as Klebsiella pneumoniae, (which caused the deaths of at least 21 children at a hospital in Durban in 2005) and other nosocomial infections.[6]

However, this rise in the prevalence of certain diseases has been matched with a declining capacity to manage it through public health systems.

In China, for example, the transition to a market economy is coming at a great cost to public health. Inequalities that are well-established in most African countries are now becoming the norm in China. For example, according to the WHO and World Bank, although China is ranked 61st out of 191 countries in health status, it is ranked 181st in terms of fairness of financial contributions to health; whilst 80% of total public spending on health is in urban areas, 70% of the population live in rural areas.[7] At the 2007 Standing Committee of the National Congress of the People, China?s Health Minister admitted the massive growth in inequality and announced a major programme of investment in rural health services. However, the main reason for this seems not to be a reignited commitment to health, but fear of the growth in popular discontent about health services.[8]

Although the political context is very different, a country like South Africa shows a similar pattern. Despite pursuing an economic policy that seeks to straddle the development gap both within the country and in its relation to the industrialised world (the Accelerated and Shared Growth Initiative for South Africa or ASGISA), there is growing

inequality (including in health care) a burgeoning crisis of disease and no political will or capacity to tackle it.

In both countries elements of the health crisis can be linked to the economic transitions underway, and particularly to the rapid movement of people to urban areas. In South Africa this movement started in the last decade before the end of apartheid but has accelerated since. 9 In China the phenomena post dates the turn to a market economy. But in both countries the failure to recognize that the intensification of poverty and inequality, as their economies grew, would have dramatic consequences for health has carried through into a failure of governmental planning for health.

In South Africa, where fortunately health information is more easily available than in China, this is now obvious from a range of indicators, including.

- HIV prevalence amongst adults of nearly 20%;10
- Low Tuberculosis (TB) cure rates, combined with HIV, have led to a re-explosion of the TB epidemic11 and, more recently, spawned outbreaks of Multi (MDR) and Extremely (XDR) drug resistant TB.

Inequality in access to health and state of health is growing. Although the democratic South Africa adopted a Constitution that grants ?everyone? a right of ?access to health care services?, and enjoins the state to take ?legislative and other measures to progressively realize this right?12, in some places the quality of the public health system has degenerated to levels worse than experienced under apartheid.13 For example, based on her own horrific experience Phyllis Ntantala - the mother of ANC NEC member Pallo Jordan ? described public hospitals in the Eastern Cape as ?places of death, not life.?14 The difference with apartheid, however, is that marker for inequality is now class rather than race - however given the huge overlap between being black and poor, the change is not great.

In South Africa, reflecting a pattern that is common to most African countries15, spending on health care by the 15% of the population with access to private care is approximately R40 billion per annum - about the same amount as is budgeted by government on the 70 to 85% dependent on the public sector.16 Unfortunately, the fact that South Africa has one of the largest public health infrastructures in Africa, and a per capita expenditure on health that places it amongst many ?middle income? countries, hides this inequality. Deduct expenditure on private health and per capita expenditure is much lower. Add to this the health instability caused by the economic and political transition, and it becomes less surprising that our health outcomes are significantly worse than ?comparable? countries. This is a strong pointer to the fact that there is no simple equation between poverty and poor population health. Similarly, that higher levels of health expenditure (not disaggregated according to how and where and in what context the spending takes place) do not create a gradient to better health outcomes. Population health is politically determined. It must be planned for and managed. Generally it is not.

Why is this and what can be done about it?

The Rise and Fall of World Health

In a study of the modern history of disease and its coincidence with and contribution to the rise of the modern state, Mark Harrison states that:

?..disease was central to the development of modern states and their machinery of government. From the Renaissance onwards the control of diseases became one of the most important functions of the state,..?17

Later in the book Harrison concurs with ?the traditional position that the chief cause of mortality decline was growing state involvement in public health.?18

However, if this was the case for five centuries and was particularly the case at the beginning of the twentieth century, it no longer seems to be the case today. In fact, in many ways, whilst national states have retained those accoutrements they need to protect themselves, such as standing armies, they have neglected or privatised those that have become surplus to requirement - such as health care systems. In the words of Scott Burris there has been ?a practice of transferring traditional state functions to non-state actors.? 19 Publicly funded health care and education are two such functions

Within the broader ambit of health care, the trends in research and development of new medicines illustrate this point. At the start of the twentieth century governments of industrialized countries, particularly in Europe, invested heavily in medical research that contributed significantly to breakthroughs in areas such as the treatment of TB. For example, in a 2004 report (prepared for the European Union) Richard Laing refers to European health care system as having ?a long tradition of social solidarity in which national health systems were developed to create social safety nets for all citizens?. However, the report attributes the dramatic decline in pharmaceutical innovation from the early 1990s (p8,), at least in part, to declining investments by European governments in pharmaceutical research, development and application. 20

Except in times of crisis or threat, the dominant politics of health care seems to be one where responsibility for the protection, maintenance and continual improvement of public health is increasingly being separated from the state. In the ?first world? this was driven by a complacency that infectious disease (the initial stimuli to the development of health systems) has largely been conquered. However, as a number of writers have suggested in their attempts to construct arguments to persuade powerful states to reprioritize health and health funding, the ever present threat of ?tropical diseases?, pathogens such as the much hyped strain of avian influenza, H5N1, and others yet to be named, might cause states to rue the day. 21

It is important here to distinguish the governmental response in the USA or UK to threats such as SARS or H5N1 from the historical relationship between the state and health described above. Writers such as David Fidler22 are correct to point out that this has contributed to the US government and the EU assuming new responsibilities for health. However, this is for the narrow purpose of disease control and the traditional purpose of protecting economies, rather than a reflection on a renewed commitment to health generally.

It does not detract from the argument that in the last twenty years industrialized countries have completed the transition away from proactive state-driven strategies aiming at disease prevention, to a largely passive and technical approach to managing the maintenance of health systems and infrastructure, and staying off periodic disease outbreaks. It seems that as long as major public health threats are held at bay, the actual health of persons (who are getting less healthy, but no longer primarily as a result of communicable disease), is of less concern to the state. 23

Thus, within developed countries, but in significantly varying degrees, the state supports health systems that maintain a high standard of health care ?at home?, such as the National Health System (NHS) in England or Medicaid in the USA. Compared with health systems in the third world, they offer an undreamed of standard of care. However, they too have been the subject of attack by governments that has reduced the quality of care and, in countries like the USA left millions of people uninsured and grossly discriminated against in access to decent health services.

But even the praiseworthy parts of these health systems, and the way they are managed by government, overlooks how infectious and communicable disease (which has always been global, but was once more easy to quarantine24) can take advantage of the explosion of inter and intra-national travel to move pathogens swiftly from causing localized to globalised epidemics. In most industrialized countries the government seems to believe its duties to provide health care, its budgetary responsibilities and health policies end abruptly at national boundaries - boundaries that viruses and bacteria pay scant attention to. What happens on the other side of these pourous borders is the responsibility of departments providing ?development aid?, not health.

National Health services are not linked into an integrated global strategy on health that recognizes the transnational nature of both good and bad health. Although the world has leant to acknowledge of the impact of health on development - for example the Millennium Development Goals? (MDG) include a number of health indicators - there is still no globally agreed political strategy on states? duties to tackle health or the interventions and standards that will be required to achieve the MDGs. Indeed, there are some who make a cogent argument that the construction of the health MDGs was done in such a way as to make their realisation impossible and to further entrench the systemic inequalities that contribute to bad-health across the globe.25

So, although funding for health programmes (particularly the prevention and treatment of HIV/AIDS) represents a

growing portion of development aid,[26] its implementation is usually through vertical programmes, that try to ignore or work around the political paralysis on health.

One consequence of this is that foreign assistance for health is rarely driven by precisely identified and quantified local needs, but is driven by what external organizations consider those needs to be. New imbalances and inequalities in the system arise because finances end up being transferred only to those organisations in recipient countries who have the capacity to design and (usually) implement these programmes. This leads to distortions and imbalances at a local level. Another symptom of the want co-ordination in the financing of health is revealed in an article about funding for TB which showed how one disease, HIV, can squeeze out another in the ?competition? for donor funds.[27] Given that TB is the primary cause of death in people with HIV, this distortion is particularly grotesque.

Ironically therefore the wheel has come full circle: today, by omission, in both the industrialised and developing world, the politics of the modern state and government remains a primary determinant of health.

Developing Countries: Health at the Margins

The predominantly laissez faire approach to health adopted by industrialized country governments is mimicked by the governments of most developing countries. These countries replicate the ?first world? approach to health by attempting to maintain expensive but still under-funded tertiary care systems in urban centres (wrongly considered to be the template of a health system), whilst throwing in an ingredient of what Sanders et al describe as ?selective primary health care?.[28] Following the Declaration of Alma Ata in 1978, made at the International Conference on Primary Health Care,[29] the strengthening of primary health care was considered the key to unlocking many of the solutions to the world?s health problems, and as a route to the realization of health as ?a fundamental human right?. It was also considered to be a system that would be both affordable and appropriate for developing countries. However, in its implementation the concept of primary health care has been starved of imagination and funds. It has been perverted to justify the existence ?health centres? or ?clinics? that are close to ?the community? but under funded, ill-equipped, under staffed and rarely involved in community health promotion.

In South Africa, for example, a 2007 report by the South African Human Rights Commission (SAHRC), whilst admitting that primary health care clinics constituted only 50% of the facilities it visited, found that:

?many patients are by-passing clinics and going straight to hospitals. This seems to indicate that despite clinics being geographically accessible they are unable to meet patient needs.?[30]

In a similar vein, the District Health Barometer, 2005-2006, published jointly by the Department of Health and Health Systems Trust, an NGO, found significant inequalities in per capita expenditure between health districts and, predictably, significant variations in health outcomes.[31]

Finally, what is most noticeable is that population health, or public health, is rarely regarded as a political priority by developing country governments. Planning to improve health is not integrated into development or economic planning, or vice versa. For example, in South Africa the media statements that are released after every meeting of the Cabinet reveal no records of discussions of health broadly. Although there are discussions about HIV/AIDS, generally these have only taken place at points when the criticism of the country response to HIV/AIDS generated by activists has forced a defensive discussion.

In President Thabo Mbeki?s annual ?State of the Nation? speech to Parliament, given in February each year, the issue of health only ever occupies a fraction of the time given to matters of economy, international affairs and poverty, and is often treated separately from these.[32] In addition, the actual impact that poor health has on society, the numbers of people dying, and the causes of illness and death are hidden under broad generalizations about ?the burden of disease impacting on our people, including AIDS? (2004)[33]

and ?broad trends in mortality? (2005)[34]. Unbeknown to 99.9% of the South African public the ?broad trends in mortality? were an oblique reference to an official report, seen and for some time suppressed by Mbeki, that had shown

a 57% increase in adult mortality between the years of 1997 and 2003.35

The low prioritisation of health is borne out by the way in which, in many countries, poor performance and corruption is tolerated from Health Ministers and their departments. South Africa, once more, offers a case in point.

Evidence of the wholesale deterioration in health outcomes, gross mismanagement of budgets36 and the flight of health professionals from the public health sector, have all been insufficient to dislodge the incompetent Minister of Health, Dr Manto Tshabalala-Msimang from her nine year rein. In August/September 2007 there were calls for her dismissal from every corner of society after media revelations that she was ?a thief and a drunk?.37 But she keeps her post primarily because of her political loyalty to Mbeki. Not only that: South Africa?s President, oblivious to the reality of public health, defended her by stating that:

?The Presidency would like to reassure all South Africans of the integrity of the public health system as led by Minister Tshabalala-Msimang and the Cabinet collective.?38

But the political controversy in South Africa reflects a deeper trend. As a rule, developing country governments approach health reactively rather than proactively. This is evidenced by the almost complete dependence on foreign donors for health investment in many African countries; the absence of serious and consistently driven public health strategies; the acceptance of very high rates of maternal mortality (a symptom of the lower value attached to women generally); the neglect of primary health care; and the failure to control infectious diseases.

Why is this? Developing country governments cannot feign ignorance about the linkages between politics, health and development. 39 A succession of commissions and their reports, particularly the WHO?s 2000-2001 Commission on Macro Economics and Health (CMEH) and the 2005 United Kingdom sponsored Commission on Africa have drawn attention to the linkages. The report of the CMEH is worth quoting at some length. It says:

?The wisdom of every culture teaches that ?health is wealth? in a more instrumental sense as well. For individuals and families, health brings the capacity for personal development and economic security in the future. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. In economic terms, health and education are the two cornerstones of human capital, which Nobel Laureates Theodore Shultz and Gary Becker have demonstrated to be the basis of an individual?s economic productivity. As with the economic well-being of individual households, good population health is a critical input into poverty reduction, economic growth, and long-term economic development at the scale of whole societies. This point is widely acknowledged by analysts and policy makers, but is greatly underestimated in its qualitative and quantitative significance, and in the investment allocations of many developing country and donor governments.?40

In the face of this mountain of evidence, argument and information, it remains to try and understand the political reasons why in so many countries national health (aggregated to global health) is failing so signally? Is there an explanation other than the wiles of politicians? Why has a period in history that has seen the advance of democracy been accompanied by declines in health? Why have the citizens of the new democracies not forced health into greater focus?

Changes in Production: Globalisation and its Consequence for Public health

Throughout history economic expansion has spread disease.41 Indeed, as Harrison points out, important features of the modern state arose from the need to prevent and treat disease. Preventing armies and navies, settler populations, and the aristocracy, from being wiped out first by foreign diseases about which there was no knowledge, or for which they had no immunity, was a necessity both for the ?progress? of colonialism and the further expansion of capitalism. This necessity led to vaccination campaigns, investment in water and sewerage systems, public health legislation and the creation of rudimentary public health services.

Today, in contrast, there is a deficit of co-ordination, investment and planning in health. Ironically, however, the reason for this continues to rest in the relationship between national governments and economic expansion - just as it did when

economic expansion necessitated governmental intervention in health.

In his 2002 book, *Marx?s Revenge*, Meghnad Desai may be stating the obvious when he points out that:

?Capitalism is not a kind or a benevolent system. [But] It is the most effective mode of production discovered so far in wealth creation. It has no overarching objective since it works through the profit-seeking efforts of millions of capitalists. It generates economic growth, prosperity, employment as side-effects. It also causes much misery and destruction in its tendency towards incessant change.?[42]

Obvious though they may be, these words may offer guidance to a discussion on the determinants of health.

Everyone agrees that important changes in economy and society have taken place in the since the late 1980s - sometimes crudely linked to events that marked the end of Stalinism and the ?triumph? of capitalism. In particular revolutions in technology and communications have become the primary driver of globalization - at this stage of world history. The means of production (and thus of profit) more and more capital intensive.

Linked to this the end of the ?cold war? and the collapse of ?communism?, has opened borders and markets. This has contributed to a massive expansion in the numbers of people traveling.[43] Via travel and communication new technologies have been introduced to new and old markets creating new consumption ?needs?. These new goods depend less and less on the labour of human beings (which is still, as Marx first claimed, the source of added value) to produce them - making them cheaper. Yet, by virtue of new economies of scale unleashed by the global economy, they can be enormously profitable.

This has diminished the relative importance of human labour to the production of profit and thus wealth. More profit can be made by fewer and fewer people, leaving an enormous surplus population, particularly in developing countries.

In South Africa, for example, despite a decade of rapid economic growth unemployment remains at 40%. The tragedy is that governmental priorities change, or unless government?s are forced to create decent jobs by investing in the fabric of societies (including health), high and permanent unemployment will be a feature of the 21st century economy.

The relevance of this argument to health is that, because of the delinking of the general well-being of the working class [44] from economic productivity and profit, developing country governments no longer seem to have a material intesrest in using the state?s resources and power to invest in public health. Today it is successfully achieve economic growth whilst ignoring general population health - an approach that is also possible with corollaries such as education and other areas of social welfare.

A vicious circle has been created where each area of governmental neglect impacts negatively on the other. For example, poor health leads to poor education which leads to poor health, and so on.

If this analysis is accurate, then the disconnect between what is said about health by the world?s leaders (whether through the G8, the G77 or the United Nations) and what is done is not so surprising. If it is the case, then it also means that social reforms that are dictated by a different set of principles (I would argue human rights not market forces), will be the only way to revive the world?s failing health (but I will come to that later).

This reality may be the fatal flaw in the recommendations of the CMEH. In its executive summary, for example, the CMEH waxed lyrically, but naively, that:

?We estimate that approximately 330 million DALYs [disability adjusted life years] would be saved for each of the 8 million deaths averted. Assuming, conservatively, that each DALY saved gives an economic benefit of 1 year?s per capita income of a projected $563 in 2015, the direct economic benefit of saving 330 million DALYs would be $186 billion per year, and plausibly several times that.?[45]

This would seem like a huge incentive to governments to invest in health. The problem is that it is not, because most of

those ill and at risk of illness are the *sans culottes* of the modern economy. Influenced by the thought of people like Jeffrey Sachs[46] and Amatya Sen,[47] the CMEH?s worthy recommendations assume:

- that governments attach an economic value to sick people who could be healthy; and
- that most of the people who are healthy, but poor, will be able to find a place in the modern economy.

But this may not be true. If economic growth can be achieved by relatively small segments of the population utilizing increasingly capital intensive technologies for ever larger markets (markets that by all accounts will continue to grow on the back of China and other emergent economies) then this assumption is mistaken.

Crudely put: illness, whilst causing widespread suffering and indignity, does nothing more to economically disable people who are already socially disabled by the fact that there is no place in the modern economy for them. Could it be that the modern state has no interest, other than a voluntary one, in population health? That would seem to be the only explanation that can help us understand the distortions in public health spending illustrated by the graph below:

Worldmapper: A Global Map of Public Health Spending[48]
, based on data from UNDP, Human Development Report, 2004.

This want of a strict economic motive for health investment is further compounded by the fact that, in many developing countries, the financial cost of sick people to the state is avoided because the collapse of health services means that most people die at home, burdening their families ? but not the fiscus.

In South Africa, as illustrated by the tables below, we have witnessed a dramatic rise in mortality - and obviously morbidity as people succumb to illnesses that eventually cause their deaths:[49]


But despite this, as seen in the next table, there was an overall decline in hospital admissions between 2001 and 2007.[50]


This suggests several things: that the hospital system is full; that people are being admitted for longer periods (because they are sicker) and that many people are bypassing the lower rungs of the health system to reach the level of central and tertiary care. However, net effect is that sick people are displaced onto their families. Confirming this Statistics South Africa reports that x% of deaths are at home.

One area, however, where the South African state cannot escape a rising cost of ill health relates to social security. Because of the Constitution and its ostensible commitment to poverty relief, South Africa?s system of rudimentary grants has become the means by which people claim state support on the grounds that they are ill. Thus there has been a massive increase in the numbers of people claiming disability grants (nearly 1.5 million by 2007) and overall state expenditure on social assistance has risen to 3.2% of GDP. This however is unique to Africa. One also wonders at the logic of paying money to people because they are sick, rather than investing more in health services.

Finally, although bodies like the World Bank and IMF, which have converted to a largely humanitarian interest in health, may bemoan poor health governance, it is in fact their chickens that have come home to roost. The original ?legitimacy? for economic policies that disincentivised and penalized investment in social infrastructure, education and health is found in the debt crisis, structural adjustment etc. However, today it is the logic of the market and the state?s surrender to this logic - rather than external conditions - that is a primary determinant of declining health.

Thus, the same logic that works to deny private investment in the research and development of new medicines for the poor (because their sale will yield no profitable return) works to deny public investment in population health - it too will have no direct benefit to the state. It may be a social good, but it is not an economic one.

In fact there might even be a disincentive for health investment, because by lifting one of the major ?unfreedoms? that paralyse poor people?s ability to participate actively in politics (rather than just holding their noses and voting), better

population health could have negative consequences for ?political stability?.

Shifts towards Global Health Governance: Winds of Change or New Winds of Adhocism?

Some might argue that the analysis/hypothesis I have offered above is unduly pessimistic. They would argue that it is contradicted by evidence of a growing political commitment globally to health. They would, for example, point to the fact that in the first half decade of the 21st century there was evidence of growing concern about the relationship between health and development.

There is no denying that something is happening around health. The HIV/AIDS epidemic, in particular, has forced third world health back onto global political agendas. The death of millions of poor people, mostly from Africa, is beginning to be seen as a morally repugnant blight on the world that, in the words of former UN Special Envoy for AIDS in Africa, Stephen Lewis, ?shames and diminishes us all?.[51] The pressure of AIDS activists that has dogged politicians since the late 1980s has opened up a space and resources for new commitments to tackling neglected diseases, including malaria, around which there had been decades of fatalistic resignation and inertia.

Significantly, the focus of activism has shifted from demanding equal rights and non-discrimination for people with HIV in the 1980s and 1990s to demanding recognition of social and economic rights. At the beginning of this century this was mainly with regard to access to medicines,[52] but increasingly it extends to demands for investment in health systems and health workers.

Activist pressure has reignited debates about health governance. The appointment, in 2002, of a Special Rapporteur on the right to health by the UN Commission on Human Rights[53] and the establishment, in 2005, of the Commission on the Social Determinants of Health (CSDH), are positive signals.[54] So too is the evidence that a number of developing country governments have begun to be more assertive of their duty to protect and fulfill the human right to health, particularly when it comes to the clash between intellectual property regimes and the affordability of essential medicines.

In 2001, for example, at the Ministerial Meeting of the WTO in Doha, developing countries rebelled against the restrictive application of the TRIPS Agreement, leading to a Ministerial Declaration that:

?Each member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted?. Each member has the right to determine what constitutes a national emergency, it being understood that public health crises,?, can represent a national emergency or other circumstances of extreme urgency.? [55]

Further, whilst developing countries initially seemed reluctant to take advantage of this victory, during 2006 and 2007 Brazil and Thailand provoked the wrath of multi-national pharmaceutical companies by issuing compulsory licenses for the essential HIV/AIDS medicines, Efavirenz and Kaletra, and are threatening to do the same with other drugs.[56] In India, the government successfully defended its intellectual property laws in a court battle instigated by Novartis in connection with its patent on the cancer drug, Gleevec.[57] These developments looked at one point as if they might revive the global campaign around the rights of governments to protect the right to health[58] - a campaign that has lost the momentum it gained in early 2001 when over 40 pharmaceutical companies ganged together to try to stop progressive medicines legislation in South Africa.[59]

As another indication of this mood, in May 2007 the World Health Assembly, adopted the WHO?s Medium Term Strategic Plan, 2008-2013, which, amongst other things, makes it a strategic objective ?to ensure improved access, quality and use of medical products and technologies?.[60] The WHO will henceforth actively encourage and assist countries to have medicine policies that promote both access and affordability.

Adding grist to the health optimist?s mill, will be the growing number of bi and multi-lateral governmental initiatives around health. For example, in March 2007, the Foreign Affairs Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, issued a statement describing governmental omissions on health as ?one of the

most important, yet still broadly neglected, long-term foreign policy issues of our time? and promising henceforth ?to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies??61

These political shifts seem to have culminated in late 2007 with the launch of the International Health Partnership and the Scaling Up for Better Health Plan, described by the ITPC as ?a cluster of recent global health initiatives encompassing Germany?s Providing for Health, Canada?s Catalytic Initiative to Save a Million Lives, the United Kingdom?s International Health Partnership, and Norway?s Deliver Now for Women and Children.? 62

Finally, another feature of the last decade that our optimist will point to is the emergence of a range of governance institutions and vertical health programmes that aim to staunch aspects of the health hemorrhage. Mechanisms such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), the US President?s Emergency Programme for AIDS Relief (PEPFAR), the International Finance Facility and the Advance Market Commitment have stepped into the breach of state and multilateral failures around health.63 Side by side with these are the global health programmes of late-in-the-day philanthropists such as Bill and Melinda Gates and Bill Clinton.64

These imaginative initiatives are making a difference and impacting on millions of lives. They are positives, but they also contain negatives. They often fragment and further weaken national health systems by tacitly accepting state failure in relation to health, and compounding it by often sucking out already scarce health workers out of public health systems.

Global and national health must be assessed not by surface impressions, wishful thinking or academic acrobatics but by critical analysis. Within each of the positive developments are contradictions that give cause for question. Are developing countries such as Brazil and India genuinely pursuing health, or primarily involved in political posturing? Why, despite the rhetoric around the MDGs, and the flurry of new health initiatives, is health aid declining? Why are the governments of Africa not meeting their pledges to increase spending on health as a percentage of total expenditure? 65

Therefore, much as we might be inclined to be misty eyed about these programmes, the questions that must be asked are (a) whether they sustainable for the few millions that depend on them, and (b) whether they will bring about any change to the ability of government?s to the ability to promote and protect health at a national level - or to citizen?s power to demand that this is done.

The answer to the first question is uncertain. The answer to the second question is ?maybe - maybe not? or ?it depends?. What it depends on is explored further in coming chapters.

February 2008

1 Tony Benn, interview in Sicko, by Michael Moore, 2007.

2 In 1997 the UNDP, Human Development Report, warned that HIV was a ?new force for impoverishment in sub-Saharan Africa? that would ?set off a cascade of economic and social disintegration and impoverishment?. In 2007 the WHO, (World Health Statistics, 2007, Ten Statistical Highlights in Global Public Health), predicted ?large declines in mortality between 2002 and 2030 for all of the principal communicable, maternal, perinatal and nutritional causes, with the exception of HIV/AIDS.? However, the methods by which this conclusion are reached seem highly problematic and would appear to be contradicted by its own evidence.

3 D Durrheim, ?Reducing Poverty by Combating Neglected Tropical Diseases?, paper presented to SANPAD Conference, June 2007.

4 GAVI Alliance, ?Progress and Achievements, Fact Sheet?, Information Current as of January 2007. See www.gavialliance.org

5 See www.tac.org.za Electronic Newsletter, 18th September 2005 & Letter to Minister of Health, 17 September 2005.

6 C Lougrahn, Infection Prevention and Control Policy in South Africa, unpublished research paper, AIDS Law

Project, 2006 available at www.alp.org.za.

7 See: ?The Physician Will Not Heal Himself? www.chinadevelopmentbrief.com/node/262 ; L Jacobs, Between Cultural Relativism and Uniform International Compliance: An Empirical Framework for Judging China?s Human Rights Performance, Chapter for M Madsen and G Verginen eds, *Towards a Sociology of Human Rights: Theoretical and Empirical Contributions*, forthcoming in 2008.

8 See: J Watts, China?s Health Reforms Tilt Away From the Market, www.thelancet.com Vol 371, Jan 26 2008.

9 For evidence of the social impact of internal migration see: The Presidency, *A Nation in the Making, A Discussion Document on Macro-social Trends in South Africa*, 2006, p. 55 available at: www. ; South Africa Human Development Report, 2003, UNDP, Oxford University Press; UN rapporteur on housing.

10 Nelson Mandela Foundation, *South African National HIV Prevalence, HIV incidence, Behaviour and Communication Survey*, 2005.
11 The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007, pp 33-35.
12 Constitution of the Republic of South Africa, Act 108 of 1996, s 27.

13 See, ?Provincial Findings in Preparation for the South African Human Rights Commission Public Enquiry into the Right to Have Access to Health Care Services, Synthesis Report?, May 2007, available at: www.sahrc.org.za

14 P Ntantala, Mail and Guardian, 22 October 2006.

15 See Commission for Africa, p. 190 ?in Africa in 2001 .. only 38% [of health spending] was government spending. 34% was ?out of pocket? spending when ill. These costs are a cause of poverty for some people.?

16
17 M Harrison, *Disease and the Modern World, 1500 to the Present Day*, Polity Press, 2004, 2.

18 Ibid, 143.
19 S Burris, Governance, Microgovernance and Health, *Temple Law Review*,
20 R Laing, *Priority Medicines for Europe and the World*, WHO, November 2004.

21 See: Lawrence O. Gostin, Why Rich Countries Should Care About the World?s Least Healthy People, *JAMA*. 2007; 298:89-92. L Gostin, ?Meeting Basic Needs for The World?s Least Healthy People: Toward A Framework Convention On Global Health?, Investiture and Inaugural Lecture, Georgetown University Law Centre, April 19 2007.

22 See for example, D Fidler Constitutional Outlines of Public Health?s ?New World Order?, Temple Law Review?

23 See as an example, *On the State of Public Health, Annual Report of the Chief Medical Adviser (UK)*, 2005, which identifies obesity, binge drinking, smoking and food purchasing habits as major population challenges for health. Although HIV and West Nile virus receive mention, these are minority problems. See www.dh.gov.uk/en/publicationsandstatistics/publications/AnnualReport/dh_4115776

24 Harrison, pp. 97-105

25 JP Unger argues that the MDG focus on health outcomes, rather than the systems needed to deliver health, encourages vertical, externally driven health programmes, rather than a sustainable investment in the infrastructure and humans needed for health.

26 A recent report has pointed out that within the European Union this is in fact not the case. The report claims that funding for health dropped from 7% of Overseas Development Assistance in 1996 to 5% in 2005 and that ?only one third of these commitments were actually disbursed.? Action for Global Health, *An Unhealthy Prognosis, The EC?s Development Funding for Health*, May 2007.

27 S Kaufmann, S Parida. Changing Funding Patterns in Tuberculosis, *Nature Medicine*, 13, 2007
28 D Sanders, D Werner, *Questioning the Solution: The Politics of Primary Health Care and Child Survival*, HealthWrights.
29 www.who.int/hpr/NPH/docs/Declaration_almaata.pdf
30 SAHRC, , .34
31 www.hst.org.za/publications/701
32 (check SA govt records of Cabinet discussion on health) See www.anc.org/thabo mbeki

33 President Mbeki, Address at the Second Joint Sitting of the Third Democratic Parliament, www.anc.org.za/ancdocs/history/mbeki/2005/tm0211.html

34 www.anc.org.za/ancdocs/history/mbeki/2005/tm 0203.html
35 *Mortality and causes of death in South Africa, 1997-2003,* Statistics South Africa, 2005
36 See: Pubic Service Accountability Monitor (PSAM) ?.
37 This was the front page headline of the Sunday Times on ?.

38 This Minister was appointed to office in 1999. In the context of a controversy over the firing of the Deputy Health Minister, President Mbeki repeatedly defended her record in the face of evidence of a huge health crisis and growing public outrage about the state of public hospitals. For political background see: How Manto Dodged the Axe, *Mail and Guardian,* 18 May 2007; For examples of President?s protection see: *ANC Today*, 29 July-7 August, 2007: ?Facts, Fiction and Miniskirts?; *ANC Today*, 17 - 24 Aug, Who are our Heros and Heroines??; Presidency, Statement on Allegations Leveled Against the Minister of Health, 13 August 2007.

39 Cabinet Ministers and civil society delegations troop in great numbers and with expensive regularity to the WHO in Geneva, to the UN in New York, and to a plethora of largely unnecessary international conferences on aspects of health. The fervor for Dollar per dieums, however, is the primary reason.

40 WHO, Report of the Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development,* 2001, 21-22.
41 See K F Kiple, The History of Disease, in *Cambridge Illustrated History of Medicine*, 1996.

42 Desai, M. *Marx?s Revenge, The Resurgence of Capitalism and the Death of Statist Socialism,* Verso, 2002, p. 313. Earlier in the same chapter Desai points out that ?the advantages of capitalism - its wealth producing ability, its dynamism, its innovativeness, ? are dialectically connected to its disadvantages.? (p.295) . He does not say what these are other than ?instability and cycles, inequality of wealth and income.? However, looking at the recent period of rapid expansion based upon technological change it is possible to say that capitalism both creates ill health, and the means to correct it, and that after periods of expansion, there have - in the past - been periods where societies attempt to mitigate some of the problems, including around health.

43 According to a 2000 report by the CIA every day two million people cross national borders. ?.

44 This term has become outmoded. In developing countries most of the people who were traditionally described as the ?working class? do not work and many are unlikely ever to do so. What we really mean is those who are wholly dependent on their labour to make and - in the absence of employment - are wholly dependent on the state to receive essential social services, such as education and health. The absence of formal employment means that people survive via a range of informal activities, activities that often make them more prone to ill health.

45 Ibid. Executive Summary, pp 12-13.
46 J Sachs, The End of Poverty, xxx

47 A. Sen, *Development as Freedom*, Anchor books, 2000. In the chapter on Markets, State and Social Opportunity (at p.143) Sen refers to ?the remarkable history of public action dealing respectively with education, health care, land reforms and so on? as making it possible for the ?bulk of people to participate directly in the process of economic

expansion.? In the context of government?s contemporary unwillingness to expand internal markets to the permanently poor, this statement may hold a future truth, as well as a past one.

48 See: www.worldmapper.org/display.php?selected=213
49 Statistics South Africa, xxx
50 Treasury, Intergovernmental Fiscal Report, 2007, Health.
51 S Lewis, *Race Against Time*, Anansi, 2005.
52 Edwin Cameron and Jonathan Berger, ?Patents and Public Health: Principle, Politics and Paradox? (2005) 131 *Proceedings of the British Academy* 331 (also published in David Vaver (ed.), *Intellectual Property Rights* (Routledge, London: 2005)).
53 For information about and the reports of the UN Special Rapporteur see: www.essex.ac.uk/human_rights_centre/rth/rapporteur.shtm
54 See www.who.int/social_determinants/en . The CSDH is due to issue its findings in June 2008 - one wonders, however, whether it will tell us anything we don?t know.

55 World Trade Organisation, Doha Ministerial Declaration on the TRIPS agreement and Public Health, 20 November 2001, available at: www.wto.org/english/thewto_e/min01_e/minded_trips_e.htm

56
57 See: Medecins Sans Frontieres, Indian Court Ruling in Novartis Case Protects India as the ?Pharmacy of the Developing World?, 6 August 2007; www.lawyerscollective.org Madras High Court Dismisses Novartis? Challenge to the Indian Patent Law, 6 August 2007.

58 TAC Newsletter, 24 January 2007; MSF

59 Heywood, M. ?Debunking Conglomo-talk?: A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation, *Law, Democracy and Development*, 5, 2001(2), 133-163.

60 WHO, Medium Term Strategic Plan, 2008-2013, p. 158, see www.who.int.
61 The Oslo Ministerial Declaration, ?Global Health: a Pressing Foreign Policy Issue of our Time?. The www.thelancet.com, April 2, 2007
62 Open Letter to the Leaders Of the Health-8 (H-8) about the *Scaling Up For Better Health* Plan from the International Treatment Preparedness Coalition (ITPC), 17 December 2007.

63
64 See www.gatesfoundation.org and www.clintonfoundation.org

65 See: African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases, April 2001 which pledged to set a target of ?at least 15% of our annual budgets to the improvement of the health sector.?
